ROBERT "BO" RYALL
President & CEO

July 20, 2018

The Honorable Greg Walden
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

The Honorable Gregg Harper
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairmen Walden and Harper:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred healthcare facilities and their more than 40,000 staff members as they strive to care for all Arkansans who seek care while complying with thousands of pages of statutory and regulatory requirements. The Association works to support, safeguard and assist our members in providing safe, high quality, patient-centered care in a rapidly evolving – and highly regulated – healthcare environment.

While we are honored to respond to your inquiry about the number of Sexual Assault Nurse Examiners (SANE) in Arkansas, the Arkansas Hospital Association has no regulatory authority. We do not dictate the services provided by our members or establish applicable standards of care. In fact, one of our primary missions is to assist our members as they comply with those thousands of pages of regulations applicable to their operations.

The American Hospital Association recently conducted a study of the impact of existing federal regulations from just four agencies – CMS, OIG, OCR and ONC – on health systems, hospitals and post-acute care providers and found that those agencies alone account for 629 discrete regulatory requirements across nine domains. The report noted that an average-sized community hospital spends nearly $7.6 million annually on administrative activities to support compliance with federal regulations (and this figure rises to $9 million for hospitals with post-acute care beds). Nationally, this equates to $38.6 billion each year to comply with the administrative aspects of regulatory compliance *in just these nine domains*. Regulatory burden costs $1,200 every time a patient is admitted to a hospital.

Arkansas is a rural state with an overall budget of about $40 billion from all sources each year. Our state and its people are incredibly collaborative and do an excellent job of working through broad coalitions to maximize our talents and limited resources. To that end, responding appropriately and efficiently to patients who have been through unthinkable traumas is a community effort.

In 1991, the Arkansas legislature passed Act 727 that created the Arkansas Commission on Child Abuse, Rape, and Domestic Violence. This Commission, led by talented experts and advocates, has published and made widely available a hospital and community protocol for sexual assault forensic and medical examination. Regardless of whether the hospital is classified as urban or rural, the same protocol applies. Representatives of the Arkansas Crime Laboratory, the Arkansas State Police, the Arkansas Coalition Against Sexual Assault, the Office of the Attorney General, the Office of the Prosecutor Coordinator, Partners for Inclusive Communities, a number of Rape Crisis Centers, and Children's Advocacy Centers continue to work together with hospitals, physicians, nurses, and other healthcare providers to improve care for victims of sexual assault.

The AHA believes that the information in your letter that Arkansas has eight SANE nurses registered in the International Association of Forensic Nurses (IAFN) database is correct. The state does not maintain a separate database; however, we are aware that there are additional specially-trained nurses providing sexual assault forensic and medical examinations in the state. This training has been provided to the nurse locally and free-of-charge. Our state has done an excellent job of providing resources to hospitals as they assist victims in the emergency setting.

While the number of SANEs in the database is small, there are efforts underway to increase this number. Furthermore, all hospital emergency departments have access to protocols for sexual assault forensic and medical examination, and once again, these protocols are free of charge to the facility. Copies of the Arkansas-specific decision tree and healthcare protocol, as well as the comprehensive publication that includes state and national resources, are included with this letter.

The Arkansas State Crime Laboratory provides evidence collection kits to all hospitals throughout the state and has recently created a tracking system for each kit that ensures patient safety and chain of custody. While information in this system is not available to the general public, victims are provided access so that they are able to track their own kit's progress through the system.

The Commission on Child Abuse, Rape, and Domestic Violence has made educational presentations to the Regional Trauma Advisory Committees that encompass emergency medical technicians, physicians, nurses, hospital administrators, and others. The Commission has also planned a statewide, three-day training conference in November of this year and is working with the AHA to create presentations for our upcoming district meetings to be held throughout the state.

While you can see that Arkansas has done a good job of taking care of our citizens, one of our primary barriers continues to be a lack of federal resources to support these and other state initiatives. In the current environment in which more and more unfunded mandates is the norm, our hospitals constantly struggle to comply with the overwhelming statutory and regulatory burden while providing excellent care. Often, these mandates – even if well-intentioned – divert crucial resources from the patient's bedside.

We sincerely thank you and your colleagues for your interest in ensuring that victims of sexual assault have all the resources available to them that can help them heal. We also thank you for reaching out to the Arkansas Hospital Association and allowing us an opportunity to inform you of the vast collaborative efforts in our state intended to achieve that same goal.

Sincerely,

Bo Ryall

BR/ae

Sexual Assault/Child Sexual Abuse: Emergency Department Response

All Licensed Emergency Departments Shall Provide Medical Forensic Examinations for Sexual Assault Victims per Arkansas Code 12-12-403 a; 403 e

Allegation of sexual assault/abuse: Is the patient under 18 years of age?

NO

1. Ask patient if they would like an advocate. If so, call _____. It is not a HIPAA violation to place this call.
2. If the sexual assault occurred within 96 hours, ED will offer/provide a Rape Kit Exam.
3. The incident does not have to be reported to law enforcement in order to provide Rape Kit exam.
4. If patient wants to report for investigation, make police report.
5. No exam shall be performed without patient's consent.
6. Basic health exam and STI/pregnancy prophylaxis should still be offered even if Rape Kit collection declined.

YES

Make mandated report to AR Child Abuse Hotline (1-800-482-5964). Include safety concerns in report.

Report Accepted by Hotline?

Yes

Ask hotline if Arkansas State Police/Crimes Against Children Division (ASP-CACD) **<u>or</u>** Department of Children and Family Services (DCFS) will be assigned as primary

Arkansas State Police/ Crimes Against Children Division (ASP-CACD) assigned:

-<u>HOLD</u> for contact by Arkansas State Police/ Crimes Against Children Division to coordinate plan of care

Department of Children and Family Services (DCFS) Assigned:

-No rape kit needed if offender < 10 years old (regardless of time frame)
-Basic health exam
-Contact Department of Children and Family Services (DCFS) on-call if immediate safety concern

No

Is the patient under 18 years of age ***AND*** there was either lack of consent or ability to consent?
<u>OR</u>
Is the patient under 16 years of age and more than 3 years age difference between age of patient and alleged offender (regardless of consent)?

Yes

Make police report

Did the event occur in the last 96 hours?

Yes

Provide/refer for Rape Kit Exam

No

Rape kit not indicated. Basic health exam. Test for Sexually Transmitted Infections (STI's) and pregnancy if indicated.

ARKANSAS DEPARTMENT OF HEALTH

Sexual Assault Hospital Protocol Conference
November 7-9, 2018

Agenda Wednesday

7:30- 8:15	Registration
8:15- 8:45	Welcome Will Jones, SID Deputy Attorney General
8:45- 9:45	Neurobiology of Trauma Jonathan Sheets, Arkansas Coalition Against Sexual Assault
9:45-10:00	Break
10:00- 11:00	Sexual Violence: Dynamics and Advocacy Kiah Hall, Arkansas Coalition Against Sexual Assault
11:00-12:00	Adult Sexual Assault Exam Sherrie Searcy, UAMS Emergency Department
12:00-1:00	Lunch
2:45- 3:45	Evidence Collection Lisa Channell, Section Chief, Arkansas State Crime Laboratory
3:45- 4:15	Sexual Assault Kit Tracking System Kermitt Channell, Executive Director, Arkansas State Crime Laboratory
2:30 – 2:45	Break
2:45-3:45	Victims With Disabilities Roberta Sick, UA Partners for Inclusive Communities
3:45-4:45	Presenter Panel
4:45-5:00	Closing

Agenda Thursday

8:00- 8:15 Opening

8:15- 9:45 Pediatric Sexual Assault Exam
Karen Farst, MD, Arkansas Children's Hospital

9:45-10:00 Break

10:00- 12:00 Child Sexual Assault Response

10:00 CACD Response
- Gary Glisson, Administrator AR State Police CACD Hotline
- Debbie Roark, Administrator AR State Police CACD Investigations

11:00 DCFS Response
- Mischa Martin, Director DCFS

12:00-1:00 Lunch

1:00- 3:00 Child Sexual Assault Response Continued

1:00 Child Advocacy Centers
- Elizabeth Pulley, Executive Director CACA

2:00 Child Abuse Multidisciplinary Teams
- Nancy Chambers, MDT Coordinator ACCARDV

3:00- 3:15 Break

3:15-4:15 Law Enforcement Hospital Response

4:15-4:45 Presenter Panel

4:45-5:00 Closing

Agenda Day 3

8:15- 8:30	Opening Corey Scott, MD, PhD, FACEP, Medical Director, CHI St. Vincent
8:30-9:30	Crime Victim's Reparation Fund and Sexual Assault Program Lynette Parham, Administrator, Attorney General's Office
9:30- 9:45	Break
9:45- 11:00	Arkansas Sexual Assault Laws Ginger Kimes, Staff Attorney, Prosecutor Coordinator's Office
11:15- 1:00	Lunch and Learn COSAR Arkansas Coalition Against Sexual Assault
2:00 – 0:00	Presenter Panel – Challenges Q & A

ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

University of Arkansas for Medical Sciences

Healthcare Protocol Manual for Sexual Assault

ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

The Arkansas General Assembly created the Arkansas Commission on Child Abuse, Rape, and Domestic Violence by Act 727 of 1991. The following groups were merged as a result of this act: the Governor's Task Force on Rape, the Arkansas Child Sexual Abuse Commission, and the Governor's Advisory Committee on Crime. The merger was intended to enhance the coordinated approach in providing services to victims of child abuse, rape, and domestic violence.

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1. Introduction

Sexual violence is a significant and prevalent public health problem. According to the 2010-2012 national Intimate Partner and Sexual Violence Survey, 21.4% of women in Arkansas have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration. However, this is likely a very conservative estimate because it does not include men, children or other forms of sexual violence. Sexual violence means enormous physical and psychological consequences for victims and their families. It can damage one's sense of safety in the world, self-esteem, educational development and later, the ability to be a productive citizen.

There are many myths about sexual violence that contribute to the pain a victim experiences. For instance, many people believe the majority of sexual assaults are perpetrated by strangers. However, according to the 2010-2012 National Intimate Partner and Sexual Violence Survey, most victims of rape and sexual assault knew the perpetrator. Another common belief is that there is a great deal of false reporting. According to the FBI, "False reports of rape are rare, occurring only 2 to 8 % of the time" (FBI, 1995).

Imagine what it might be like to be a victim of sexual violence who has come to a health care facility for a sexual assault examination. Consider what it must be like to endure such an intrusive examination after surviving the trauma of an assault. Now imagine having to answer a seemingly endless list of questions about this experience to a number of total strangers who may have negative attitudes and beliefs about sexual assault.

Individuals who experience this trauma deserve competent and compassionate care. Having a positive experience with the healthcare and criminal justice system can have a great impact on the healing process for a victim. A victim-centered approach recognizes that people who have been sexually assaulted are central participants in the sexual assault examination process and deserve timely, compassionate and respectful care.

The purpose of this publication is to educate Arkansas healthcare professionals about responding to the needs of adult sexual assault victims. This manual was specifically designed as a guide for health care professionals who respond to victims of sexual assault. It is important to note that the term "victim" is used as well as the term "patient" because this manual addresses a multi-disciplinary response. The term "victim" simply acknowledges that persons who have disclosed sexual assault should have access to needed services in an effort to help them recover, be safe and seek justice. The

term "patient" is used when discussing the role of healthcare providers. We hope this manual will be helpful in assisting communities to develop victim-centered care that is sensitive to the needs of sexual assault patients.

Definitions

The following is intended as an introduction to terms that might be useful to those professionals providing services to sexual assault patients. Many of the terms are explained throughout the text; however, it may be helpful to read over the terms in advance.

A

Abuse: Term used to describe behavior by one party that results in significant negative emotional or physical consequences on another party. Also described as harmful or injurious treatment.

AIDS (Acquired Immuno-deficiency syndrome): Illness triggered by infection with HIV (human immunodeficiency virus). It is transmitted in body fluids, usually blood or semen, through sexual contact or the shared use of needles, accidental needle sticks or contact with contaminated blood. AIDS causes a weakening of the immune system leaving the body vulnerable to opportunistic diseases.

Assault: Arkansas law states a person commits assault: if he recklessly engages in conduct which creates a substantial risk of death or serious physical injury to another person; or which creates a substantial risk of physical injury to another person; or if he purposely creates apprehension of imminent physical injury in another person.

B

Battery: The unlawful touching of another without their consent.

Bindle: a leak proof container/package that securely holds collected evidence, trace materials or foreign matter; can be constructed of clean table paper folded in thirds, then thirds again, then in half.

Bull's eye injury: a patterned injury assuming the shape of the offending object; whether circular, linear oval…; there is a pale center with a hypervascular, petechial or contused surrounding.

C

Care: The concept of 'care' was first defined by Florence Nightingale who stated that care was 'putting the patient in the best possible condition for nature to act upon him'. Care further is defined as "to be concerned or interested"

Chain of custody: Chain of Custody or Chain of Evidence: steps taken to ensure that everyone who has handled/taken possession of a particular piece(s) of evidence along the continuum from initial collection to presentation in court has documented their handling of said evidence in writing, with appropriate signatures, date and time of receipt and release.

Child abuse: Behavior of a parent, guardian or other adult that results in significant negative emotional or physical consequences for a child. Abuse may be identified as emotional abuse, physical abuse, neglect or sexual abuse.

A Child Advocacy/Safety Center (CAC/CSC): A not-for-profit child friendly facility that provides a location for forensic interviews, advocacy services and access to specialized medical examinations and trauma focused mental health services during the course of a child maltreatment investigation.
Child neglect: Failure on the part of a parent, guardian or other adult to provide the necessities of life such as adequate living conditions, nutrition, education, medical care, failure to provide adequate emotional support, stimulation or to adequately supervise or protect the child.

Circumstantial: Usually refers to evidence that is indirect and concerning matters surrounding an event, rather than the event itself. It may or may not be relevant to the situation or case being considered.

Clinical forensic medicine: Study and practice which applies the principles of medicine to patients of trauma, involving the scientific investigation of trauma and the processing of forensic evidence.

Colposcope: A binocular instrument with variable magnification capabilities used to assist in the detection of injuries; can be equipped with a camera or video to provide photo documentation.

Commercial Sexual Exploitation of Children (CSEC): This term refers to a range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person.

Compassion Fatigue: A state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper.

Confidentiality: Protection of individual's privacy by keeping their private information unknown to others.

Coroner: A public official who is primarily charged with the duty of determining how and why persons under their jurisdiction die. A coroner is generally an elected county official.

Crisis intervention: A facilitated process that brings concerned individuals together to take action to assist with a victim's emotional recovery after a crisis by providing support in a non-judgmental manner while engaging in assessment, treatment, advocacy, planning, etc.

D

Defense wounds: Wounds made as the victim attempts to defend him or herself against an attack. Defense wounds are most often associated with injuries to the hands and arms, but can be on any part of the body that is used as a shield.

DNA (deoxyribonucleic acid): The genetic material contained in the cells of the body which provides the developmental plan that makes each individual unique, with the exception of twins. DNA acts as a 'genetic blueprint'.

Deposition: A sworn statement of evidence. Given under oath and recorded for legal proceedings. It is a method of pretrial discovery in which the statement of a witness is taken under oath in a question and answer format.

Deviate sexual activity: Arkansas law states deviate sexual activity means any act of sexual gratification involving the penetration, however slight, of the anus or mouth of one person by the penis of another person; or the penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person.

Domestic violence: A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. Also called interpersonal violence or intimate partner violence.

Double-swab Technique: A technique used to collect dried secretions, such as salvia, semen or blood.

Drug-facilitated Sexual Assault (DFSA): The use of drugs or alcohol to facilitate sexual assault. Alcohol is the most frequently used substance, which the victim may consume voluntarily which does not negate the fact that a sexual assault has occurred.

E

Ecchymosis: also referred to as bruises; hemorrhagic area of the skin or mucous membrane; blackish-blue and purple, commonly changing to greenish-brown, then yellow.

Elder abuse: Elder abuse is any form of mistreatment that results in harm or loss to an older person. It is generally divided into the following categories:

- **Physical abuse** is physical force that results in bodily injury, pain, or impairment. It includes assault, battery, and inappropriate restraint.
- **Sexual abuse** is non-consensual sexual contact of any kind with an older person.
- **Domestic violence** is an escalating pattern of violence by an intimate partner where the violence is used to exercise power and control.
- **Psychological abuse** is the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal conduct.
- **Financial abuse** is the illegal or improper use of an older person's funds, property, or resources.
- **Neglect** is the failure of a caregiver to fulfill his or her care giving responsibilities.
- **Self-neglect** is failure to provide for one's own essential needs.

EMT (emergency medical technician): A trained medical technician who provides a wide range of emergency services at the scene, during transport to the hospital or in other locations. An EMT is usually licensed or credentialed after one year of formal education or completion of a recognized training program and/or testing.

Emergency contraception: Used to prevent pregnancy after sexual intercourse by stopping ovulation, fertilization or implantation. It is most effective if taken within 72 hours but has some efficacy out to 120 hour following unprotected sex.

Evidence preservation: The collection, labeling, fixing, packaging and storing of items that will provide for no alteration of the quality or composition of the evidence.

Evidence, trace: The trace evidence section of the Arkansas State Crime Lab analyzes hairs, fibers, gunshot residue, ignitable liquids, glass, paint, soil, lamp filaments, duct tape, plastics and other materials as requested. The forensic biology section analyzes body fluids, blood, semen, saliva, etc.

Evidence, transfer: Physical evidence that is produced by contact of persons or objects. For example, a person brushing against another person might transfer hairs, dirt or debris.

Evidence, transient: A type of physical evidence that is temporary in nature. It is expected to change. Might include things such as temperature, imprints, indentations, odor, etc.

Expert consultant: A person with specialized knowledge or experience that reviews a case to provide analysis. Does not have to be associated with expectation to testify in court.

Expert testimony: Testimony in court by a person with specialized knowledge or experience. The expert witness must possess greater understanding of the subject than the jury. The expert witness is often described as one who can "educate the jury" on the specialized nature of certain information in the case.

F

Female genital mutilation: A term used to refer to the removal of part, or all, of the female genitalia.

Forensic: Belonging to, used in, or suitable for courts of judicature or to public discussion and debate. Comes from a Latin word which means forum or market place where legal disputes were settled in the Roman era.

Forensic Nurse Examiners: A nurse who is with specialized trained in the process of collecting forensic evidence.

G

Gamma Hydroxy Butyrate (GHB): drug used in DFSA; illegal to sell, make or possess in the US. A.K.A.: liquid ecstasy; scoop; easy lay; Georgia Home Boy; Grievous Bodily Harm; Liquid X.

Gerophilia: A desire for sexual relations or activities with elderly persons.

H

HIV (Human immunodeficiency virus): Any of a group of retroviruses that infect and destroy helper T-cells of the immune system.

Hymen: A membranous tissue that partly occludes the external vaginal orifice.

I

Incest: Sexual intercourse, deviate sexual activity or marriage of person 16 years of age or older with a person 16 years of age or older, that is an ancestor or descendant, stepchild or adopted child, brother or sister of the whole or half blood, an uncle, aunt, nephew or niece or a step- grandchild or adopted grandchild.

Informed consent: An ethical and legal principle that requires persons be allowed to make competent decisions about their care.

K

Ketamine: A drug used in DFSA; has a legal use as an animal tranquillizer. A.K.A.: jet, super acid, Special "K", green, K, cat Valium, Kit-Kat.

L

Labia majora: Two rounded folds of tissue that make up the external boundaries of the vulva. They are the visible folds of the adult female genitalia.

Labia minora: Two folds of tissue that lie beneath the labia majora.

M

Malpractice: A professional's improper conduct in performance of duties.

Medicolegal: Pertaining to law and medicine.

Morbidity: State of being diseased. The number of sick persons or cases of disease in relationship to a described population.

Mortality: The death rate. This is the ratio of the number of deaths in a described population.

N

Neglect: Any omission of an act which causes significant negative emotional or physical consequences.

Negligence: Failure to exercise the degree of care that a responsible, prudent person would exercise under the same or similar circumstances. Falls below the established professional standards.

P

Patterned injury: An injury that forms a distinctive shape that reflects the object it is inflicted by. For example, the circular line pattern of a looped electrical cord, used as a weapon to strike.

Pedophilia: A desire for sexual relations or activities with children.

Penetration: Arkansas law states penetration occurs if there is passage into or through, however slight, of the anus or mouth of one person by the penis of another person; or of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person.

Petechia: Pinpoint, flat, round, purplish red spots caused by intradermal or submucous hemorrhage.

Plaintiff: The party that institutes a legal suit in the court system.

Pornography: The depiction of erotic behavior in pictures or writing that is intended to bring about sexual excitement.

Prosecutor: The attorney empowered to act on behalf of the government and the people.

Post-traumatic Stress Disorder (PTSD): an anxiety disorder that can occur following the experience or witnessing of life-threatening events. Victims with PTSD are unable to function at normal levels or have difficulties in one or more areas. The four major symptoms PTSD are: re-experiencing the trauma; social withdrawal; avoidance behaviors and actions; and increased physiological arousal

characteristics. Patients that have been sexually assaulted may experience PTSD related to sexual assault. This is also referred to as Rape Related PTSD.

R

Rape: Arkansas law defines Rape as sexual intercourse or deviate sexual activity by forcible compulsion; or with one who is incapable of consent because they are physically helpless, mentally defective, or mentally incapacitated; or with one who is less than 14 years of age; or with one who is less than eighteen (18) years of age, and the actor is the victim's guardian, uncle, aunt, grandparent, step-grandparent, or grandparent by adoption, brother or sister (whole or half blood) or by adoption, nephew, niece, or first cousin.

Perpetrators of rape may include acquaintances, intimate partners, spouses, family members, personal care assistant, or complete strangers.

Recidivism: The tendency to repeat or relapse into former patterns of behavior or repeat criminal activities.

Registered sex offender: Arkansas law states a person is required to register as a sex offender if the person is adjudicated guilty on or after August 1, 1997, of a sex offense; or is serving a sentence of incarceration, probation, parole, or other form of community supervision as a result of an adjudication of guilt on August 1, 1997, for a sex offense; or is committed following an acquittal on or after August 1, 1997, on the grounds of mental disease or defect for a sex offense; or is serving a commitment as a result of an acquittal on August 1, 1997, on the grounds of mental disease or defect for a sex offense; or was required to be registered under the Habitual Child Sex Offender Registration Act.

Rohypnol: A drug used in DFSA; illegal to sell, make or possess in the US A.K.A.: R-2, Mexican Valium, roofies, rophies, circles, the forget me pill. Rohypnol is the trade name for flunitrazepam which is a sedative-hypnotic benzodiazepine and still prescribed in Europe.

S

Sexual abuse: Involvement in sexual activities of developmentally immature children or adolescents or those unable to comprehend the nature of the activity or to give informed consent or in sexual acts that violate taboos or family relationships.

Sexual assault: A term used to describe any type of forced sexual activity on one person by another. This may include rape or any type of forced sexual contact.

Sexual contact: Arkansas law defines sexual contact as any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, or buttocks, or anus of a person or the breast of a female.

Sexual intercourse: Arkansas law defines sexual intercourse as the penetration, however slight, of the vagina by a penis.

Sexual Assault Evidence Collection Kit: a sealed kit containing bindles or envelopes to hold various biological and reference specimens collected during the evidentiary exam. Also called the rape kit.

Sexual Assault Forensic Examiner (SAFE): see sexual assault nurse examiner

Sexual Assault Nurse Examiner (SANE): A registered nurse who possesses advanced skills in the evaluation of injuries consistent with forced sexual contact. SANE's perform medico-legal examinations, collect legal evidence, utilize psychosocial skills in aiding the patient and participate in legal proceedings as an expert witness in cases involving sexual assault. SANE's can be designated as "A" SANE for those trained in adolescent/adult response (post-pubertal to postmenopausal and other older adult patients) and P-SANE for those trained in pediatric response which also includes adolescent patients (birth to 18)."

Sexual Assault Response Team (SART): A coordinated, multidisciplinary team, which pursues a collaborative investigation, physical examination, treatment, counseling, and prosecution of sexual assault/abuse cases.

Stalking: Crime that occurs when someone knowingly engages in a course of conduct that would place a reasonable person in the victim's position under emotional distress and in fear for his or her safety or a third person's safety.

Subpoena: A paper issued under authority of a court to compel the appearance of a witness at a judicial proceeding, the disobedience of which may be punishable.

T

Tanner Staging: methodology of describing sexual development including breast development, pubic hair distribution, secondary sexual hair distribution, and penile development

Tear: injury of soft tissue resulting from ripping, overstretching, pulling apart, shearing, bending and/or blunt force.

Toluidine Dye (TB Dye): an aqueous, blue dye used to identify abrasions/lacerations by enhancing visualization of the genitalia.

Trafficking of Humans: The U.S. Government defines human trafficking as sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (See also Commercial Sexual Exploitation of Children (CSEC).)

V

Verbal abuse: Use of words or language to bring about emotional or psychological injury.

Victim: One who is harmed by an act of another, a circumstance, or a condition.

Violence: Physical force for the purpose of damaging or abusing another person.

Chapter

2

2. Multi-Disciplinary Response

Effective treatment and intervention for sexual assault or abuse patients requires a team effort. Services will be provided by professionals and/or volunteers from differing disciplines. These team members may include representatives from law enforcement, emergency medical services, hospitals/healthcare facilities, physicians, Sexual Assault Nurse Examiners (SANE) and other healthcare professionals, victim advocates, State Crime Lab, mental health and/or disability providers, prosecutors and others. The patient is best served when the participating members of these disciplines strive for a coordinated approach.

Emergency Medical Services (EMS)

Members of EMS will provide initial assessment, stabilization and transport to the hospital if the patient has sustained injuries that require treatment on the scene. EMS may also become involved if the patient or others call for emergency care. The victim may dial 911 or other emergency number and EMS will respond to provide emergency care and transport while maintaining evidence preservation as much as possible.

Since much of Arkansas is served by Emergency First Responders and volunteers, it is essential that these departments and organizations receive training and education about care for sexual assault patients. They are integral partners in the multi-disciplinary response to sexual assault.

Hospitals/Healthcare Facilities

If medical care is required, the patient who has been sexually assaulted will often be treated initially in an Emergency Department. In some cases, care is provided at a community clinic or physician's office. Currently in Arkansas, the majority of forensic evidence collection exams for patients of sexual violence are done in Emergency Departments. A growing trend is to provide these services at sexual assault treatment centers outside the hectic atmosphere of the Emergency Department.

Physicians

Physicians commonly evaluate sexual assault patients in hospital emergency departments, clinics, offices, or child advocacy centers. They may be part of a formal multi-disciplinary team for the

evaluation and management of sexual assault. Physician examiners in most counties are considered part of an ad hoc case-specific team. Their responsibilities are to provide medical evaluations and treatment, interpret forensic findings, access existing systems for their patients, provide or refer for subsequent medical and mental health care, communicate effectively with other involved professionals, and testify in court if needed.

A-SANE

An A-SANE is an RN that has completed a didactic training program, demonstrated competence in the performance of sexual assault medical/forensic examinations of adults and adolescents and the related clinical skills, and has successfully passed the Forensic Nursing Certification Board. For more information go to www.IAFN.org. (International Association of Forensic Nurses, 2018).

P-SANE

A P-SANE is an RN that has completed a didactic training program, demonstrated competence in the performance of sexual assault medical/forensic examinations of pediatric and adolescent patients and the related clinical skills, and has successfully passed the Forensic Nursing Certification Board. For more information go to www.IAFN.org. (International Association of Forensic Nurses, 2018).

The state of Arkansas does not require certification to practice as a SANE or receive reimbursement from Arkansas Crime Victims Reparations Board and the Sexual Assault Reimbursement Program.

Law Enforcement

Representatives of law enforcement may include patrolmen, sheriff's deputies, investigators, detectives or others. In general, their initial responsibility is to protect the victim, protect the crime scene for evidence, collect evidence, take statements, document the circumstances as reported, and to arrange for transport to healthcare facility for examination, care and forensic evidence collection. In many areas, law enforcement will maintain responsibility for any evidence collected at the scene or during the forensic evidence collection exam until it is properly delivered to the Arkansas State Crime Lab for processing. Law Enforcement representatives will then attempt to locate and arrest the person who committed the assault.

Initial Law Enforcement Response: Many sexual assault patients will have their initial contact following the assault with a law enforcement officer. The primary responsibilities of this officer are to ensure the immediate safety and security of the victim, protect the crime scene and to obtain some basic information about the assault in order to apprehend the assailant. Resources and referral information for victim services should be provided. The officer may be able to transport the victim to a designated facility for examination and treatment dependent on agency guidelines.

The responding officer should convey the following information to the sexual assault victim:

- The importance of seeking an immediate medical examination. Despite the period of time elapsed since the assault, forensic evidence may still be gathered by documenting any findings obtained during the examination (i.e.: bruises, lacerations, etc.), photographs, bite-mark impressions (if appropriate) and statements about the assault made by the victim.
- The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that such evidence can be

inadvertently destroyed by activities such as washing, showering, brushing teeth, using mouthwash, douching etc.

- The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault as well as on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes.

Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so that the responding officer is able to relay information that may be vital to the apprehension of the assailant. The preliminary interview should include the following:

- Description of any injuries to the victim.
- A brief description of what happened.
- Where the assault took place.
- The identity or description of the assailant(s), if known.
- Where the assailant(s) lives and/or works, if known.
- The direction in which the assailant left and by what means.
- Whether or not a weapon was involved.

At the examination or treatment facility, the responding officer should provide the healthcare provider with any available information about the assault which may assist in the examination and evidence collection procedures. This procedure also helps to avoid collecting evidence that has already been collected.

Law Enforcement Investigative Interview: Many police departments, especially within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigations. These officers usually do not answer the initial call, but enter the case after the responding officer has written his/her report. Upon arrival at the examination or treatment facility, the investigator should talk with the responding officer and/or healthcare staff to obtain information about the assault and the condition of the victim.

In some cases, the investigator may conduct the follow-up interview after the victim has already been interviewed by the responding officer and the healthcare staff. Therefore, it is very important that the need for this third interview be explained to the victim, especially the reason why more detailed questions must be asked. Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to develop an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for the law enforcement investigative interview:

- The interview should be conducted after the medical-legal examination and evidence collection procedures have been completed. In some cases, it may be necessary to delay this interview for several hours or even until the next day. Often, delays at hospitals are caused by the length of time necessary for the medical examination and treatment of the victim and the priorities and demands of a busy Emergency Department.
- If the follow-up interview is conducted at the hospital or examination facility, it must be held in a private setting, where interruption is not likely. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place.

- With the consent of the victim, a support person who may have been present during the medical and evidence collection examination may also be present during this interview.
- The interviewer should be sympathetic and understanding of the victim's trauma while at the same time, effective in collecting all necessary information about the case.
- The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures by family, friends or others, as well as from possible harm or threats made by the assailant.
- The victim should be allowed to tell his/her story without interruption by the interviewer.
- The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear. Be aware that trauma can affect memory recall.
- For children, the best practice is for the interview to be performed prior to the exam, if possible. Otherwise, the medical provider or medical social worker should obtain a medical history focused on information necessary to plan the child's medical care and make a report for investigation. A formal forensic interview should then be conducted by someone with a training specific to the forensic interview of a child which is often available at a community-based children's advocacy center on referral from an investigator. Children should be interviewed alone to avoid distraction or influence (verbal or nonverbal) by another person. Whenever possible, the investigator(s) should be present for the formal forensic interview to ensure all needed information is obtained at this time in order to avoid duplicating the interview process.

Transportation: Transportation should be arranged when the patient is ready to leave the hospital or examination facility. In some cases, this will be provided by a family member, friend or victim advocate who may have been called to the location for support. In other cases, transportation may be provided by the local law enforcement agency.

Victim Advocacy Programs

A sexual assault victim advocate provides crisis intervention and emotional support to victims of sexual violence. Advocates are generally available to respond to the Emergency Department anytime, day or night to provide support through the forensic exam process and assist the victim in making safety arrangements following the exam. Later, the advocate will follow-up with the victim to provide follow-up services, information and referral, and assistance throughout the criminal justice process.

In the aftermath of a rape, the advocate is usually present during the evidence collection and often provides referral information and clothing following the exam. Other assistance may include helping a victim access needed physical and mental health care; referrals of patients to various human services providers, arranging for provision of basic necessities, and assistance with medical care, law enforcement and legal systems with which their case is involved.

Crisis intervention is most effective when it is begun during the first few hours following a sexual assault. The advocate provides immediate support and can play a vital role in preventing the harmful consequences of rape and sexual assault and may decrease the probability of onset of rape-related post-traumatic stress disorder. The survivor has the best chance at emotional recovery if she/he is able to establish a rapport early with an advocate. (NOVA, 2001).

Mental Health Professionals

The role of mental health professionals is to provide supportive and re-integrative services to patients who have been sexual assaulted. These services may be provided immediately after the report of the assault, at the hospital or other facility, or as follow-up service. Counselors may also provide services such as support groups, crisis intervention, treatment or other forms of assistance. Arkansas now has many therapists who are trained in trauma-focused cognitive behavioral therapy. A list of TF-CBT therapists can be obtained at http://www.uams.edu/arbest/map.asp (select "trained clinicians" then click on the desired county).

Prosecutors, Judicial System

Prosecutors are licensed attorneys that represent the State of Arkansas against the accused also known as the defendant. The primary responsibility of prosecution is to see that justice is accomplished. In the case of rape or sexual assault, after an investigation by law enforcement and if there is sufficient evidence to file criminal charges, the prosecutor will file what is called an "information." The prosecutor's job going forward is to handle all aspects of trying the case. The judicial system is a broad term but generally speaking refers to the courts or judges. The judicial system's overall function is the search for "truth and justice" and to prevent future crime by the guilty offender(s).

Forensic Laboratory Scientists

The physical evidence (the sexual assault evidence collection kit and the patient's clothing) will be analyzed by the Arkansas State Crime Laboratory. Other items of evidence (such as bed sheets, vehicle seats, fingerprints, weapons, etc.) may be collected by the law enforcement officer. The items will be examined for body fluids, epithelial (skin) cells, hairs, fibers, debris or any other pertinent information. DNA analysis can be performed on items with semen, saliva, blood, or hairs. DNA analysis can also be performed on items with no body fluid from the perpetrator such as a vaginal swab where digital penetration is alleged. A report will be released to the law enforcement officer who submitted the case and then the analyst will testify in court as to their findings.

Sexual Assault Response Team (SART)

A SART, as defined by National Sexual Violence Resource Center, is a collection of professional service providers and officials that respond essentially as a group, and in a timely fashion, to the various needs of rape victims. At a minimum, core team members on a SART should include:

- Healthcare provider
- Law enforcement
- Prosecutor
- Victim advocates

Chapter

3

3. Comprehensive Treatment

This section is to be used by healthcare providers to ensure comprehensive care of sexual assault patients. When providing medical/forensic care to sexual assault patients, the sensitivity and competency of the care received will begin the process of recovery.

General Information

It is recommended that a healthcare provider (physician, nurse practitioner, or Sexual Assault Nurse Examiner) with specialized education and training in the evaluation and treatment of sexual assault patients complete the examination and provide treatment for these patients. In addition, it is also recommended for these providers to participate in ongoing continuing education specific to the care of sexual assault victims.

Most examinations for adults should be performed in a Sexual Assault Treatment Center or Hospital Emergency Department. These facilities are available 24 hours per day and have the appropriate equipment and staff to conduct the forensic evidence collection examination. Photo-documentation of examination findings is standard of care for sexual assault/abuse examinations in pediatric-aged patients which is often only available in a children's advocacy center or children's hospital emergency department.

Coordinated Team Approach

Recommendations At A Glance:

- Understand the dual purpose of the exam process.
- Be familiar with local services.

A Coordinated Team Approach among involved disciplines is strongly recommended to simultaneously address the needs of both patients and the justice system. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford patients access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Raising

public awareness about the existence and benefits of a coordinated response to sexual assault may lead more patients to disclose the assault and seek the help they need.

Understand the dual purpose of the exam process.
One purpose is to address the medical needs of individuals disclosing sexual assault. This is by:

- Evaluating and treating injuries;
- Conducting prompt examinations;
- Providing support, crisis intervention, and advocacy;
- Providing prophylaxis against STDs;
- Assessing female patients for pregnancy risk and discussing prophylactic and treatment options, including reproductive health services; and
- Providing follow-up care for medical and emotional needs.

The other purpose is to address justice system needs. This is accomplished by:

- Obtaining a history of the assault;
- Documenting exam findings;
- Properly collecting, handling, preserving evidence; and
- Interpreting and analyzing findings (post exam); and
- Subsequently, presenting findings and providing factual and expert opinion related to the exam and evidence collection.

Be familiar with local support services. Services offered by advocates during the exam process may include:

- Accompanying the patient through each component (advocates may accompany patients from the initial contact and the actual exam through to discharge and follow-up appointments);
- Assisting in coordination of patient transportation to and from the exam site;
- Providing sexual assault patients with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Actively listening to patients to assist in sorting through and identifying their feelings;
- Letting patients know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocating for patient's needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting patients in voicing their concerns to relevant responders;
- Responding in a sensitive and appropriate manner to sexual assault patients from different backgrounds and circumstances and advocating for the elimination of barriers to communication;
- Serving as an information resource for patients (e.g., to answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand their options in regard to treatment for STDs, HIV, and pregnancy, and provide referrals);
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aiding sexual assault patients in identifying individuals who could support them as they recover (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers);

- Helping patient's families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support sexual assault patients may need from them; and
- Assisting sexual assault patients in planning for their safety and well-being.

Victim-Centered Care

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way. Every action taken by responders during the examination process should be useful in facilitating the patient's care and healing as well as the investigation.

All licensed emergency departments shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims. All victims shall be exempted from the payment of expenses incurred as a result of receiving a medical-legal examination if the victim receives the medical-legal examination within ninety-six (96) hours of the attack. (AR Code12-12-403)

A medical facility or licensed healthcare provider shall not transfer the victim to another medical facility unless the victim or a parent or guardian of a victim under eighteen (18) years of age requests the transfer, or a physician or other qualified medical personnel when a physician is not available has signed a certification that the benefits to the victim's health would outweigh the risks to the victim's health as a result of the transfer; and the transferring medical facility or licensed healthcare provider provides all necessary medical records and ensures that appropriate transportation is available. (AR Code12-12-402)

Recommendations At A Glance:

- Sexual assault patients should have priority as emergency patients.
- Provide privacy.
- Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient.
- Interpreter needs should be assessed and provided.
- Recognize it is the patient's decision whether or not, and to what extent, they share personal information.
- Recognize the importance of victim advocates within the exam process.
- Respect patient's request to have a person remain during the exam unless considered harmful.
- Try to limit the number of persons in the exam room during the exam.
- Carefully describe each exam procedure & its purpose.
- Respect sexual assault patient's decisions.
- Integrate medical and forensic exam procedures when possible.
- Assess safety.
- Physical comfort needs should be provided.
- Provide written information for sexual assault patients.
- Be familiar with various cultural issues faced by patients.

Sexual assault patients should have priority as emergency patients. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and undergo a medical forensic exam.

Provide privacy. Use discretion to avoid the embarrassment of being identified as a sexual assault victim in a public setting. Make sure that the first responding health care providers attend to sexual assault patient's initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy.

Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient. Patient's experiences during the crime and the exam process, as well as their post-assault needs, may be affected by multiple factors. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help. Procedures should be adapted to accommodate each individual patient & situation.

Interpreter needs should be assessed and provided. Effective Communication is a critical element of the process and interpreters should be available for those patients in need.

Recognize that it is the patient's decision whether or not, and to what extent, they share personal information. While it is useful for responders to get a full picture of sexual assault patient's circumstances, it is the patient's decision. During the exam process, responders may ask information such as age or whether they think the assault was drug-facilitated. Questions about sexual orientation, religion or previous victimization are not necessary and are strongly discouraged.

Recognize the importance of victim advocates within the exam process. Sexual assault advocacy programs and other victim service programs, offer a range of services before, during, and after the exam process. Ideally, advocates should begin interacting with patients prior to the exam, as soon after disclosure of the assault as possible. Advocates can offer a tangible and personal connection to a long-term source of support and advocacy.

Respect patient's request to have a person remain during the exam unless considered harmful. An exception would be if responders consider the request to be potentially harmful to the patient or the exam process. Patient's requests not to have certain individuals present in the room should also be respected. Examiners should get explicit consent from sexual assault patients to go forward with the exam with another person present.

Try to limit the number of persons in the exam room during the exam. An advocate, personal support person or interpreter is appropriate, but only with patient's permission. The primary reason is to protect patient's privacy. Law enforcement representatives should not be present during the exam. Patient's permission should also be obtained when additional health care personnel are needed for consultation (e.g., a surgeon).

Carefully describe each procedure and its purpose. Some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain each procedure, its purpose and their options, patients may be able to relax, feel more in control of what's occurring, and make decisions about their needs.

Respect sexual assault patient's decisions. Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

Integrate medical and forensic exam procedures when possible. Medical care and evidence collection procedures can be integrated to maximize efficiency and minimize trauma to sexual assault patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information gathering by health care and legal personnel to minimize the need for sexual assault patients to repeat their statements.

Patient's safety should be addressed. Upon arrival at the exam site, health care providers should assess the patient's safety concerns. Follow facility policy on response to this and other types of threatening situations. Prior to discharge, assist patient in planning for their safety. Local law enforcement or victim advocates should be able to help a patient develop a safety plan.

Physical comfort needs should be provided. While the patient should not wash, bathe or change clothes prior to the sexual assault examination, provide an opportunity to wash in privacy (offering shower facilities if possible), brush their teeth, change clothes (clean and ideally new replacement clothing should be available), get food and/or a beverage, and make needed phone calls. They may also require assistance arranging for transportation to their home or another location.

Sexual Assault Information Packet

Offer sexual assault patients information that they can review later at their convenience.

- The crime (e.g., facts about sexual assault and related criminal statutes);
- Normal reactions to sexual assault (stressing that it is never the patient's fault), and signs and symptoms of traumatic response;
- Victims' rights;
- Victim support and advocacy services;
- Mental health counseling options and referrals;
- Resources for the patient's significant others;
- The examination—what happened and how evidence/findings will be used;
- Medical discharge and follow-up instructions;
- Planning for their safety and well-being;
- Examination payment and reimbursement information;
- Steps and options in the criminal justice process;
- Civil remedies that may be available to sexual assault victims; and
- Procedures for sexual assault patients to access their medical record or applicable law enforcement reports.

Informed Consent

The process by which fully informed patients participate in choices about their health care. Patients have the legal and ethical right to direct what happens to their body and from the ethical duty of the clinician to involve them in their health care.

Recommendations At A Glance:

- Seek informed consent, as appropriate, throughout the evaluation in accordance with state law and your hospital policy.

- Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise.
- Make sure policies exist to guide seeking informed consent from certain populations.
- Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated.

Seek informed consent as appropriate throughout the evaluation in accordance with state law and your hospital policy. There are two essential but separate consent processes—one for medical evaluation and treatment and another for the forensic exam and evidence collection. Sexual assault patients can decline any part or all of the examination. However, the informed consent process includes making patients aware of the impact of declining a procedure, as it may negatively affect the quality of care and the usefulness of evidence collection. It may also have a negative impact on a criminal investigation and/or prosecution.

Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to the communication skill level/modality and language of sexual assault patients. Encourage patients to ask questions. Make sure all signatures and dates needed are obtained on written consent forms and document consent or reasons for declining to consent as appropriate (either on the medical record or forensic report forms).

Make sure policies exist to guide seeking informed consent from those who have difficulty understanding written forms or spoken instructions. It is always important for examiners to assess a patient's ability to provide informed consent. In addition, facilities should have internal policies based on applicable jurisdictional statutes governing informed consent. The medical provider will generally need to assess whether the patient has the cognitive capacity to give consent for the examination, and, if not, the provider should follow their internal policies and jurisdictional statutes. A patient may be unable to give informed consent for a variety of reasons. These include being compromised by intoxicants, being unconscious, being under duress from other party, lack of fluency in the language spoken by the examiner, or inability on the part of the patient to understand the implications of the decision to give his or her consent. When informed consent cannot be given as a result of language differences between patient and examiner, an interpreter should be obtained. When the patient is unable to understand the questions being asked as a result of an intellectual disability (or another condition), the examiner may consider providing an accommodation such as finding someone who is able to explain the process more clearly in a way the patient can understand. Care should be taken not to invite a service provider whose interests may be served by wielding influence over the situation

Policies should include procedures to determine whether or not patients are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect. Exam facilities should also have policies in place to address consent for treatment in cases in which patients are unconscious, intoxicated, or under the influence of drugs, and are therefore temporarily incompetent to give consent.

Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated. In cases of adolescent sexual assault patients, jurisdictional statutes governing consent and access to the exam should be followed. For instance, a State statute may allow minors to receive care for STDs and

pregnancy, but not a medical forensic examination without parental or guardian consent. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian can't be found and the collection of evidence needs to be done quickly. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.

In all cases, the medical forensic evaluation should never be done against the will of the patient. Responders should not touch sexual assault patients or otherwise perform exam procedures without their permission. It is not appropriate to physically or chemically restrain a patient to conduct an acute assault exam. Even if, in the case of a child, a parent provides informed consent for an acute sexual assault exam, the minor should assent to the exam if they are developmentally able to do so.

Confidentiality

Confidentiality is the expectation that anything revealed or any services provided will be kept private. Policies to protect the patient's personal health information related to the medical forensic examination must be followed. The confidentiality of records (as well as forensic evidence and photographic and video images) is intricately linked to the scope of patient's consent.

Recommendations At A Glance:

- Be sure jurisdictional policies address confidentiality issues related to the exam process.
- Consider the impact of the Federal privacy laws regarding health information on sexual assault patients.

Be sure that jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared. Members of a SART or other collaborating responders should inform sexual assault patients of the scope of confidentiality with each responder and be cautious not to exceed the limits of patient consent.

Consider the impact of Federal privacy laws regarding health information on sexual assault patients. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (found at 45 CFR Parts 160 and 164), established national standards for the protection of certain individually identifiable health information created or held by health care providers, health insurance companies, and health clearinghouses. The impact of these privacy laws on the provision of services to sexual assault patients is unclear, because interpretation of the laws depends on individual situations and the law of the particular State. Responders are encouraged to contact their state healthcare association for further discussion about the impact of the HIPAA regulations on their participation in the exam process.
(U.S. Department of Justice, Office of Violence Against Women, 2004).

Anonymous or Blind Reporting

Communities may want to consider alternatives to reporting such as anonymous or "blind" reporting. This is useful in cases where victims do not want to immediately report or are unsure about reporting, but are willing to make an anonymous report.

To develop an anonymous/blind reporting system, law enforcement agencies can:

- Establish and maintain a policy of patient confidentiality;
- Allow sexual assault patients to disclose the extent of information they wish to provide;
- Accept the information whenever patients are ready to provide it. A delay in disclosure is not an indicator of the validity of the statement;
- Develop procedures and forms to facilitate anonymous information from third parties (e.g., examiners);
- Clarify options with patients for future contact—where, how, and under what circumstances they may be contacted by the law enforcement agency; and
- Maintain these reports in separate files from official complaints to avoid inappropriate use.

Sexual assault patients making anonymous or blind reports and going through the medical forensic exam should be informed about jurisdictional policies regarding storage of evidence and exam payment. In some communities, it is a challenge to find adequate space to hold evidence in cases where a report has not been made.

Promote a victim-centered reporting process. Some approaches for communities to consider:

- Encourage patients to consent to the medical forensic history, an examination, and documentation regardless of whether an evidence collection kit is used.
- Explore the myriad reasons why patients are reluctant to report and how the actions or attitudes of agencies may help perpetuate these fears. Help agencies consider how to reduce reluctance and fears.
- Evaluate local trends regarding reporting and patient's involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multi-disciplinary response to sexual assault.
- Increase victim-sensitivity education for first responders (e.g., educate law enforcement investigators on interviewing versus interrogating skills, educate health care personnel to be compassionate and not blame patients for the assault, and educate prosecutors to be victim-centered in their approaches).
- Encourage criminal justice statistical reports that accurately reflect the frequency and severity of sexual assaults reported in a jurisdiction.
- Initiate community education, outreach, and services targeting groups that may be reluctant to seek assistance after an assault.
- Offer viable options for reimbursement of exam costs for which patients are responsible.
- Encourage the development of a coordinating council and/or SART to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence.
- Support the formation of specialized examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of involved responders, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a victim-centered response, and positively advertise services offered.
- Develop jurisdiction-wide public information initiatives on mandatory reporting—mandatory reporters need to know applicable statutes regarding reporting sexual assault cases that involve minors or adults with conditions that result in an inability to protect themselves from abuse. A toll-free hotline number exclusively dedicated to abuse reports may also help simplify reporting and ensure a written report of each case and referrals to appropriate agencies. Such a hotline could be operated at a State, tribal, regional, or local level. To encourage both reporting and follow-through, protective agencies that investigate these cases should work collaboratively

with local law enforcement agencies to ensure that each case is dealt with in the best possible manner and that further harm does not occur.

- In institutional settings such as prisons, jails, immigrant detention centers, nursing homes and assisted living programs, in victim treatment centers, and group homes, ensure that patients can report assaults to outside agencies and are offered protection from retaliation for reporting.
- In each case, strive to create an environment in which patients are encouraged to report and are supported throughout the criminal justice process and beyond. Even in those cases that do not develop beyond an initial report to the police, patients should feel that they are respected.
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about the potential benefits of reporting, how to go about reporting, what happens once a report is filed, and jurisdictional legal advocacy services available (if any) for sexual assault patients. Build upon already existing public awareness efforts of local advocacy programs.

(Office of Violence Against Women, 2004).

Arkansas Guidelines for "Jane Doe" Rape Kit

On July 31, 2007 Act 676 of 2007 changed the law that required sexual assault victims to report and cooperate with law enforcement for reimbursement of the medical-legal examination. This law now states that a sexual assault victim does not have to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam and to be reimbursed for charges incurred. This law has created the need for guidance on implementation procedures. A committee made up of members from the Arkansas Commission on Child Abuse, Rape and Domestic Violence, Ozark Rape Crisis Center, University of Arkansas for Medical Sciences SANE Program, Arkansas State Crime Lab, Arkansas Department of Finance and Administration, the Arkansas Attorney General's Office and the Office of the Prosecutor Coordinator met over the course of several months and developed the following guidelines:

1. If a sexual assault victim presents for a medical-legal examination (rape kit) and does not want to report to law enforcement, perform the examination regardless. Studies show that victims, who initially do not want to pursue criminal action, may later change their minds.
2. Please keep the rape kit stored in your medical facility for a minimum of 60 days. This allows the victim 60 days to change his/her mind. Should the facility choose to do so, kits may be stored for longer than 60 days. With a rape kit available for later processing, law enforcement and prosecutors will be able to go forward with the case when the victim changes his/her mind.
3. The victim is not to be billed for services. For payment of the medical-legal examination;
   a. Complete the Sexual Assault Reimbursement Form attached to this memo. The form is also available on the Arkansas Attorney General's website at; http://www.arkansasag.gov/pdfs/SARP_Form.pdf
   b. Follow normal procedures in billing. Please note, however, that pursuant to the federal VOCA Crime Bill amendment federally financed benefits programs such as Medicaid, Medicare, Champus, or VA must be billed in cases when the victim is covered by these benefits.
   c. Submit the Sexual Assault Reimbursement Form along with the itemized statement to the Arkansas Crime Victims Reparations Board. Acceptance of payment of the expenses for the medical-legal examination by the Board shall be considered payment in full and bars

any legal action for collection. Questions regarding payment procedures may be directed to the Board staff at (501) 682-1020 or (800) 448-3014

Specific Populations

To gain a basic understanding of potential issues and concerns facing different groups of sexual assault patients, this section explores several specific populations. Clearly, this exploration is not inclusive of all populations of sexual assault patients, but a more comprehensive discussion on this topic is beyond the scope of this document.

Be familiar with issues commonly faced by sexual assault patients from specific populations. It is important to realize that for some patients, certain personal characteristics (e.g., culture, language skills/mode of communication, disability, gender, and age) may strongly influence their experiences in the immediate aftermath of a sexual assault and during the exam process.

Cultural Competency

- Understand that culture can influence beliefs about sexual assault, its victims, and offenders. It can affect health care beliefs and practices related to the assault and medical treatment outcomes. It can also influence beliefs and practices related to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.

- Understand that some patients may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own. They may fear or distrust responders or assume they will be met with insensitive comments or unfair treatment. They may benefit from responders of the same background or at least who understand their culture.

- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when patients disrobe. Also, it may be uncomfortable for patients from some cultures to speak about the assault with members of the opposite sex.

- Understand that patients may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render patients unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.

- Recognize that some cultures (e.g., American Indian tribes) may have their own laws and regulations to address sexual assault, in addition to or in place of applicable jurisdictional laws. Responders should be familiar with procedures for coordinating services and interventions for patients from these communities.

- Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among patients of different cultural backgrounds. Also, understand

that what helps one patient deal with a traumatic situation like sexual assault may not be the same for another patient.

- Help patients obtain culturally specific assistance and/or provide referrals where they exist.

- Be sensitive and understanding toward patient's language skills and barriers, which may worsen with crisis.

- Make every attempt to provide interpretation services and translated materials for patients who do not speak English. Use certified interpreters when possible and not patient's families or friends. Take the patient's country of origin, acculturation level, and dialect into account when responding or arranging interpretation. Remember to speak directly to patients when interpreters are used.

- Train interpreters about issues related to sexual assault, confidentiality, and cultural concerns whenever they are needed to facilitate communication in these cases.

Sexual Assault Patients with Disabilities

- Understand that patients are diverse and that disability is one aspect of the diversity that medical professionals encounter. There is also much diversity among people with disabilities.

- Be prepared to provide accommodations if requested. Accommodations may include providing written materials in electronic format, reading forms to the patient, providing a sign language interpreter, or facing a hard of hearing person while speaking.

- When requesting sign language interpreters, make sure the interpreter is holds a license to practice in Arkansas and that the person holds a high-level certification. Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Other means of communication such as the use of technology may need to be considered.

- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities is statistically much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender. Personal care assistants, direct support professionals, family members, or friends may be responsible for the sexual assault.

- Respect patient's wishes to have or not have personal care assistants, direct support professionals, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of patients during the exam process. If professional assistance is required (e.g., from a sign language interpreter or another service provider) this should be arranged.

- Speak directly to patients with disabilities, even when interpreters, intermediaries, or guardians are present.

- Assess a patient's level of ability and need for assistance during the exam process. Explain, the exam procedures to patients and ask what help they require, if any (e.g., people with physical disabilities may need help to get on and off the exam table or to assume positions necessary for the exam). Do not assume the patient will need assistance. Ask for permission before providing assistance, handling a mobility or communication device, or touching a service animal).

- It is critical that communication be as effective for patients with disabilities as it is for those without disabilities. Again, this may require the provision of accommodations such as word boards, speech synthesizers, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using these strategies or tools. Be aware that some patients with sensory disabilities may prefer communicating through a communication assistant who is familiar with their patterns of speech.

- Do not make assumptions about a person's intellectual ability based on the presence of a physical condition or disability.

- Recognize that, due to the lack of access to health care often experienced by people with disabilities, it may be the first time the patient has had an internal exam or they may have had a negative experience with an exam in the past.

Patients with Intellectual Disabilities

- Follow exam facility and jurisdictional policy for assessing adults' ability to consent to the exam and evidence collection. Again, note that guardians could be offenders.

- The procedure should be explained in detail in language the patient can understand. The patient may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.

- Keep in mind that, just like nondisabled patients, patients with disabilities may be reluctant to report the crime for fear of not being believed. They may not consent to the exam for fear of losing their independence. For example, they may live independently, but now because of assault, have to enter a long-term care facility if their personal care assistant assaulted them or may need extended hospitalization to treat and allow injuries to heal. This can be traumatic for people to lose their sense of security and familiarity within their environment.

- While a patient's disability may have resulted in them being targeted or more at risk to an assault, it is important to listen to their concerns and what the experience was like for them, and not focus on the disability. Treat them as a person and acknowledge the victimization. Assure them that it is not their fault that they were sexually assaulted. Offer resources on counseling and advocacy if they need support or if they are concerned about their safety in the future.

Male Sexual Assault Patients

- Help male sexual assault patients understand that male sexual assault is not uncommon and that the assault was not their fault. Many male patients focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.

- Because some male patients may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.

- Offer male patients assistance in considering how friends and family members will react to the fact that they were sexually assaulted (by a male offender or a female offender).

- Male patients may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.

- Encourage advocacy programs and the mental health community to build their capacity to serve male sexual assault patients and increase their accessibility to this population. Requests by male patients to have an advocate of a particular gender should be respected and honored if possible.
  (Lipscomb, 1992)

Adolescent Sexual Assault Patients

- Adolescents may be brought to the exam site by their parents or guardians. The presence of parents or guardians creates an additional challenge for those involved in the exam process because they are often traumatized by their child's victimization.

- Understand that parents or guardians may blame patients for the assault if the patient disobeyed them or engaged in behaviors perceived as increasing risk for victimization.

- Health care providers must assess the physical development of adolescent patients and take their age into consideration when determining appropriate methods of examination and evidence collection. Involved professionals should be well versed in jurisdictional policies related to response to minor patients.

- Recognize that the sexual assault medical forensic evaluation may be the first time an adolescent female patient has an internal exam. There may be a need to go into detail when explaining what to expect.

- Adolescence is often a time of experimentation. Reassure these patients that regardless of their behavior (e.g., using alcohol and drugs, engaging in illegal activities, or hitchhiking), no one has the right to sexually assault them, and they are not to blame for the assault.

- Ideally, attending health care providers should gather information from adolescents without parents or guardians in the room, subject to patient's consent. The concern is that parents or guardians may influence or be perceived as influencing patient's statements.

- Inform patients, particularly those who do not involve parents or guardians in the exam process, of facility billing practices (e.g., that their parents may get a bill or statement of services provided).

Older Sexual Assault Patients

- Keep in mind that the emotional impact of the assault may not be felt by older sexual assault patients until after the exam when they are alone and become aware of their physical limitations, reduced resilience, and mortality. Fear, anger, and depression can be especially severe in older patients who are isolated, have little support, and live on a fixed income.

- Be aware that caretakers may sexually assault their older dependents. Offenders may bring patients to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.

- Note that older patients are generally more physically fragile than younger patients and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and limitations.

- Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older sexual assault patients also tends to be longer than for younger patients.

- Hearing loss and other physical conditions due to advancing age, coupled with the initial reaction to the assault, may render older patients unable to make their needs known, which could result in prolonged or inappropriate treatment. Do not mistake this confusion and distress for senility.

- Health care personnel should follow facility policy for assessing a vulnerable adult's ability to consent to the exam and evidence collection, as well as involving adult protective services.

- Some older patients may want to talk about their perceptions of the role their age and physical condition might have played in making them at risk to an assault. Listen to their concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage further discussion on this issue in a counseling/advocacy setting.

- Older patients may be reluctant to report the crime or seek treatment because they fear the loss of independence. Although sometimes relatives wish to place older patients in an assisted living situation after an assault occurs, such an action is not always necessary or useful to a patient's recovery. When a change in living environment is truly needed, assist patients and their relatives in making plans that maximize independence yet enhance safety.

- Encourage use of follow-up medical, legal, and non-legal assistance. Older patients may be reluctant to seek these services or proceed with prosecution. For example, they may rely on family members for transportation and may not want to burden them by asking to be taken to post exam follow-up appointments.
(Office of Violence Against Women, 2004).

Lesbian, gay, bisexual, or transgender (LGBT) victims

- Intake forms and other documents that ask about gender or sex should allow patients to write in a response, or include transgender and intersex options. Make sure questions appropriately distinguish between sexual orientation (the gender(s) someone is attracted to), gender identity (the internal sense of being woman, man, or gender non-conforming), and their sex.

- Always refer to victims by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask. (i.e., she/her/hers, he/him/his etc.)

- Treat the knowledge that the person is LGBT as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBT victims may not know their
gender identity or sexual orientation.

Additional suggestions specific to victims who are transgender or gender non-conforming:

- It is critical to not show surprise, shock, dismay, or concern when you are either told or inadvertently discover that a person is transgender. Be particularly attentive to your body language – gasping, sighing, a sharp intake of breath, or widening eyes can all be very upsetting to someone who may worry that you are making a judgment or assessment of their body.

- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Keep in mind that transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the victim does consent to an exam, it is important to explain what you want to do and why before each step, and respect their right to decline any part of the exam.

- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all. Reflect the victim's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the victim to write or draw) if necessary.

- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There

may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.

- Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
- Transgender people may engage in self-harm as a coping mechanism. However, cutting and genital mutilations are also frequently part of anti-transgender hate crimes. Be nonjudgmental and careful when documenting such injuries.
- Some transgender victims may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their value in possible prosecutions under hate crime laws, document any anti-transgender statements the victim says were made during the assault. Otherwise, listen to the victim's concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.
- Ensure that all referrals given to a transgender victim have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
- Include opportunities for LGBT individuals to influence the development of sensitive responses for victims of sexual assault.

Chapter

4

4. Adult Medical/Forensic Exam

Recommendations At A Glance

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- Evidentiary Purpose
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Overview

The sexual assault evidentiary examination goes beyond addressing and treating the sexual assault patient's acute medical needs. The comprehensive examination, referred to as the medical forensic (or medical legal) exam is also used to properly collect, document, preserve, and maintain the chain of custody for evidence collected during the assessment and treatment of a patient presenting post sexual assault. The patient's account of events, the physical findings from the exam, along with the collected evidence, should be correlated to provide information that can be utilized to verify or negate details about the events. The patient needs to understand that the examination is a focused exam and does not provide routine medical care (e.g., pap smear).

In the majority of sexual assault cases the patient knows the suspect. Many suspects will admit to sexual contact; however, they will claim that it was consensual. Evidence collected, documentation of physical findings, and the patient's detailed account will assist in supporting or refuting force and/or coercion. However, the absence of physical trauma does not negate the occurrence of coercion and/or force nor does it prove that the encounter was consensual. Additionally, the presence of physical trauma does not prove that a sexual assault occurred. Correlation of physical findings (or lack of physical findings) with the patient's account of events is the focus of the medical forensic examination. *Therefore, it is necessary that the healthcare provider that takes the patient's history is the same person that performs the examination.* For the purpose of this text, the examiner will be referred to in the female pronoun, though males can perform the exams.

Each examiner will eventually develop a routine and flow for performing medical forensic examinations. It is important that each examiner follow the same sequence with each exam to ensure consistency and to avoid omissions. The exam needs to follow a logical sequence, and flow from least to most invasive questions and physical examination. At any time, the patient has a right to decline a portion of, or the entire exam.

Evidentiary Purpose

It is important to recognize the evidentiary purpose of the exam. During the exam, examiners methodically document physical findings and collect evidence from the patient's body and clothing. The findings in the exam and collected evidence often provide information to help reconstruct details about the events in question in an objective and scientific manner. Healthcare needs and concerns of patients that present in the course of the exam should be addressed prior to discharge and appropriate referrals made. However, patients must understand that the exam does not provide routine medical care. For example, a pap smear will not be done during the female pelvic exam.

Collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit. Collected evidence is potentially used in four ways in sexual assault cases:

- identification of the suspect;
- documentation of recent sexual contact;
- documentation of injuries, force, threat, or fear; and
- to identify corroboration or contradiction between the patient's account and the evidentiary findings.

Remember, as a forensic examiner your job is to be objective. You advocate for your patient by providing an objective and comprehensive exam; however, as a forensic examiner you are not in the role of patient advocate.

Timing Considerations for Collection of Evidence

Currently the Arkansas Crime Reparations Board can provide reimbursement if the evidence kit is obtained within 96 hours post-assault. This in no way precludes an assessment and examination of a patient reporting sexual assault. Evidence may still be gathered through documentation of physical findings (such as bruises or lacerations), photographs, and statements about the assault made by the

patient. Additionally, the clothing the patient is wearing may contain evidence from the perpetrator and may need to be collected. Law enforcement officers may gather additional evidence such as bedding or towels from the scene.

While evidence collection in pediatric patients is not indicated past the 72 hour time window (96 hours if it is an adolescent girl with a history of vaginal penetration), detailed medical evaluations with photo-documentation of examination findings are still warranted beyond the 72 hour window since healed injuries and STD's could have forensic significance. Incidents involving kidnapping or extensive trauma may still warrant kit collection even if there is uncertainty regarding the time frame. Additionally, if the examiner feels that collecting a kit is warranted then he/she should proceed to do so.

The Arkansas State Crime Laboratory will provide kits free of charge. Kits may be obtained by sending a request to the Arkansas State Crime Laboratory via FAX at (501) 227-0713 or call (501) 227-5747 for an email address. Should any questions arise concerning the utilization of the kit, contact the Crime Laboratory at (501) 227-5747. The tracking of sexual assault evidence kits in the state of Arkansas in compliance with Arkansas Act 1168 of the 2015, 90th General Assembly is now available through a secure online tracking system. Authorized medical, law enforcement, and lab personnel shall manage the status of sexual assault evidence kits under the jurisdiction of their agency. Also, victims of sexual assault can view the history and current status of their sexual assault evidence kit. Healthcare providers will log into the system to accept sexual assault kits that have been sent to their facility.

A physical examination, referrals and follow up appointment should be provided in all cases of sexual assault, regardless of the length of time that has elapsed between the assault and the examination. Some patients may ignore symptoms which would ordinarily indicate serious physical trauma, such as strangulation, internal injuries sustained from blunt force trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises that are not apparent at the time of initial examination.

Healthcare Providers

Healthcare providers who perform medical forensic examinations should have knowledge and skills in the following areas:

- The dynamics and impact of sexual victimization.
- Jurisdictional laws related to sexual offenses.
- Coordination of the multidisciplinary response, including the roles of each responding agency, and procedures for inter-agency communication.
- The importance of examiner neutrality and objectivity.
- The broad spectrum of potential evidence and physical findings in sexual assault cases.
- Pre-existing needs and circumstances of patients that may affect how the exam is conducted and interpreted.
- Screening, treatment options and procedures for common concerns such as

pregnancy, Sexually Transmitted Diseases (STDs), and Human Immunodeficiency Virus (HIV) infection.

- Equipment, supplies and medication typically utilized for a medical forensic history and examination.
- Precautions to prevent exposure to potentially infectious materials.
- Indications for follow-up health care and referrals.
- Applicable laws and protocols regarding performance of medical forensic exams and standardized forms used to document findings.
- Knowledge about crisis intervention, victim advocates, and referrals, including local resources and procedures for accessing resources.
- The importance of establishing procedures to ensure the quality of the exam and related documentation.
- Examiner court testimony (fact vs. expert witness).
- Applicable research findings, technological advances, evidence-based and promising practices.
- Gathering information from patients for a medical forensic history and utilizing the history as a guide when performing the medical forensic exam.
- Explaining to patients what items need to be collected for evidence and the purposes.
- Explaining the "Jane Doe" option for patients not wanting to report.
- Knowledge about required and optional reporting to law enforcement (LE) representatives and collaboration with LE to optimize the collection of evidence from patients, suspects, and crime scenes.
- Ability to identify and describe pertinent genital and anorectal anatomical structures and external landmarks.
- Identify and document injuries and interpret physical findings; including diagraming on anatomic body maps, providing a written description of the findings and forensic imaging.
- Use and limitations of enhancement techniques for detection of findings (such as Toluidine Blue Dye and/or a colposcope).
- Collect and preserve evidence for analysis by the crime laboratory.
- Collect and preserve toxicology samples in suspected alcohol or drug-facilitated sexual assault cases.
- Maintain and document the chain of custody for evidence.
- Maintain the integrity of the evidence to ensure optimal lab results.
- Recognize evidence-based conclusions and limitations in the analysis of findings.
- Discuss evidentiary findings with investigators, prosecutors, and defense attorneys (according to jurisdictional policy).

The above knowledge and skills are taught as a part of the sexual assault nurse examiner (SANE) training curriculum. To become a SANE in Arkansas, a registered nurse must complete appropriate didactic training that meets criteria set forth by the International Association of Forensic Nurses (IAFN). These courses are 40 hour didactic courses for specific populations – one for adult/adolescent and a separate for pediatric; or a combined course at 64 hours can be completed. To obtain certification, a registered nurse practicing at a minimum of 2 years as a nurse, must complete the appropriate didactic training course, subsequent supervised practice, and successfully pass the International Association of Forensic Nurses (IAFN) certification exam. The title A-SANE (sexual assault nurse examiner for adults and adolescents) and P-SANE (sexual assault nurse examiner for

pediatrics) are protected titles and require successful completion of IAFN requirements. Certification as an A-SANE and/or P-SANE signifies that a sexual assault nurse examiner has demonstrated the highest standards of forensic nursing practice (International Association of Forensic Nurses, 2013). Credentialing through IAFN is highly recommended. In addition, the Arkansas State Board of Nursing Rules and Regulations state that forensic examination and evidence collection is within the scope of practice of registered nurses in Arkansas (ASBN, 1997).

Facilities

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires emergency and ambulatory care facilities to have established policies for identifying and assessing victims of sexual assault. It also requires staff to be trained on these policies. As part of the assessment process, JCAHO requires these facilities to define their responsibilities related to the collection and preservation of evidentiary materials. Facilities should also be familiar with the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to re-route patients with emergency medical conditions. If a transfer from the initial healthcare facility to another healthcare facility that has been designated as a sexual assault examination site is necessary, a protocol that minimizes time delays and loss of evidence should be utilized.

The facility should have procedures in place to accommodate the patient's communication skill level and preferred mode of communication. This is particularly important for patients with communication-related disabilities and non-English speaking patients. Family members and friends should not be used to interpret for the patient.

Room, Equipment and Supplies

The initial examination or triage of sexual assault patients is considered a medical emergency. Although many patients may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. A private location and quiet examination area should be utilized. Establishing a sexual assault response center or designating a private area in or near the Emergency Department is recommended. The designated room should have a pelvic table and attached bathroom to complete the interview, examination, evidence collection, and medication administration. If a designated room is not possible it may be advantageous to have a stocked, mobile cart. (A crash cart works nicely for this purpose). Once the collection process begins, the examiner MUST keep all evidence with him/her at all times. In the event the examiner has to leave the room, the cart could be wheeled with him/her. Whether using a designated exam room or a mobile cart, having all of the supplies accessible is essential. Items to stock in the designated room or on a mobile cart:

- Alcohol prep
- Betadine
- Distilled water
- 3 ml syringes
- Nonpowdered gloves
- Nail clippers
- Tweezers
- Extra swabs

- Blank index cards
- Clear packing tape
- Scaled ruler
- Tape measure/small ruler
- Envelopes
- Blank legal-sized white paper for bindles
- Lunch size paper bags
- Grocery size paper bags
- Roll of table paper
- 2 x 2's
- Lancets
- Dixie cups if no swab dryer available
- Extra pens
- Black Sharpie
- Extra evidence tape
- Required forms to be completed, including consent form(s)

In addition, plan to have the following equipment and supplies readily available for the exam, according to institutional and jurisdictional policies:

- A copy of the most current exam protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment and pelvic/rectal exam.
- Comfort supplies for patients, even if minimal. Suggested items include clean and preferably new replacement clothing, toiletries, food and drink, and a phone in a private a location (some advocacy programs will assist with comfort items).
- Sexual assault evidence collection kits and related supplies.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure that the evidence is not contaminated. If a passive swab dryer is used there should be disposable locks available.
- A camera and related supplies for forensic photography during initial and follow-up examinations. Related supplies might include digital media, batteries and/or charger, a flash, a color bar, and a scale ruler for size reference.
- Laboratory testing supplies that may be needed, but are not included in the evidence collection kit. (i.e. cultures or supplies for toxicology).
- Medications, as appropriate for individual patient needs.
- An alternate light source which can aid in examining patient's bodies, hair, and clothing. It can be used to scan for evidence, such as dried or moist secretions, fluorescent fibers not visible in ambient light, and subtle injury.
- An anoscope may be useful for cases involving anorectal penetration or anal/rectal trauma to assist in visualizing the anal injury and identifying and collecting trace evidence. However, this is a technically advanced procedure and should not be performed unless the examiner is specifically trained in the use of an anoscope.
- Toluidine blue dye.
- For pediatric and adolescent exams, a colposcope or videoscope with the ability to capture magnified images of the ano-genital findings should be used. The colposcope is also preferred, but not required, for adult examination. Although some injuries can be detected visually by examiners without the colposcope, the colposcope enhances identification of microscopic

trauma. Photographic equipment, both still and video can be attached for forensic documentation.
- Evidence log book to record cases, support chain of evidence and track cases.
- Some jurisdictions, particularly those in rural and remote areas, are beginning to utilize advanced technology such as real-time video consultation, storing and forwarding video consultation, and interactive video consultation to support examiners conducting exams. Using this type of technology, examiners can eliminate the barriers of geography and consult with offsite medical experts. Equipment needed to facilitate use of telemedicine may include, but is not limited to, computers, software programs, and the Internet. Jurisdictions that utilize this technology should ensure confidentiality and have written protocols in place.
- Written discharge and educational materials for patients.

Triage

Many hospitals have developed code words to describe the care required for a patient presenting with a history of sexual assault. Designations such as "code R" or "code SA" work well for this purpose. This limits the need for describing the type of care required (sexual assault examination) in a public location where a breach of confidentiality might inadvertently occur. Institutions are encouraged to develop their own plan to ensure privacy.

Acute medical needs take precedence over evidentiary needs. Trauma care and safety needs should be addressed before the interview or evidence collection. Patients should be instructed not to wash, change clothes, urinate, defecate, smoke, drink, eat or take medication until evaluated by an examiner (unless necessary for treating emergency medical issues). If the patient needs to urinate prior to the medical forensic examination ensure that the urine sample is collected properly and the chain of custody is maintained.

The forensic examiner should be involved in all aspects of the medical forensic examination of the sexual assault patient. As soon as possible after the initial triage, management, and stabilization of acute medical problems and before treating non-acute injuries, the evidentiary exam should be conducted. When patients are seriously injured or impaired, examiners must be prepared to work alongside other health care providers who are stabilizing and treating the patient. In such cases, examiners may need to perform exams in a health care facility's emergency department, operating room, recovery room, or intensive care unit.

The importance of having a support person available to sexual assault patients cannot be overemphasized (although family members and friends should **not** be allowed to stay during the forensic interview and examination as it may influence the patient's disclosure). Additionally, these individuals could be subpoenaed as a witness. The use of trained sexual assault victim advocates is preferred. The patient should be asked for their consent to have an advocate present. The victim advocate can provide crisis intervention, support, act as liaison for family or friends of the patient, and provide items such as clothing, and referrals for support groups or counseling services, etc. A victim advocate can also help with other information such as the availability of victim compensation programs or other types of assistance.

Victim advocates are often available through non-profit organizations such as a sexual assault or rape crisis center, children's advocacy center, law enforcement, prosecutor's office or through other

programs. Most advocacy programs provide services during the initial response and evidentiary exam. Comprehensive advocacy programs offer follow-up services, including support for the patient throughout the entire criminal justice process.

Adult patients presenting for medical treatment as the result of a sexual assault, shall decide if they wish to report the incident to a law enforcement agency. The adult patient is not required to report the incident in order to receive a medical forensic examination and treatment. If a victim chooses to report a crime, the report should be made to the law enforcement agency where the assault occurred. Forensic evidence will be collected only with the permission of the patient. However, permission shall not be required in instances where the patient is unconscious, mentally incapable of consent, or intoxicated (Arkansas Attorney General, 2004).

Informed Consent

Prior to providing care, utilize the institution's standardized form(s) to obtain informed consent for the examination process; evidence collection (including any technology); and administration of medications. The full nature of procedures and options should be explained in detail. Some agencies use multiple consents (evidence collection, examination, medication administration, photography, Jane Doe information, etc.) and others utilize a single, comprehensive form. Follow institutional policy. Informed consent should be completed through formal documentation prior to the examination as well as receiving verbal consent from the patient throughout the entire examination process.

Documentation

It is vital that the documentation be thorough, precise, unbiased, and accurate. Examiners are responsible for documenting the medical forensic interview and examination; diagrammatic renderings with body maps; forensic imaging; treatment provided; patient education and documentation required for the evidence collection kit. The medical record is not part of the evidence collection kit. The complete medical forensic record of the sexual assault visit should be maintained separately from the patient's medical record to limit disclosure of unrelated information and to preserve confidentiality. The institution should have clear policies about who is allowed access to these records and under what circumstances.

Interview for Medical Forensic History

The forensic history of the assault is used to guide the exam, evidence collection, treatment and crime lab analysis findings. If an in-depth forensic history will not be performed prior to the medical evaluation, the medical provider will need to obtain enough information to plan the patient's medical care and guide the evidence collection. Collaboration and sharing of information between the medical provider and law enforcement is needed involved, they will collect information from patients for investigative purposes and to help identify the potential apprehend the suspect(s) and plan for the patient's safety. Examiners should focus their history ask only for on information related to treatment and collecting/interpreting physical and lab findings. While information related to patient safety and

evidence collection may need to be asked by the medical provider, asking investigative questions unrelated to the medical care of the patient could be considered is outside of their role and scope of practice. The patient may have difficulty communicating due to their emotional and physical condition. Therefore, there should be no interruptions and no time constraints for the interview and examination (Ledray, 1999).

Specific questions may vary from one jurisdiction to the next, as do forms for recording the history. Examiners should explain that questions, although probing in nature, are routine, necessary and asked during every sexual assault examination. However, in order to establish a rapport with the patient, the questions that are least invasive (medical history) should be asked prior to the more invasive questions (forensic history). The following information should be routinely sought from patients:

Pertinent patient medical history: This includes last menses, recent anal-genital injuries, surgeries, diagnostic procedures, medication, contraception, alcohol/drug use, blood-clotting history, and other medical conditions or treatment, as appropriate. Interpretation of physical findings may be affected by the history provided. Any allergies, especially to medication need to be ascertained as well. Date of the last Tetanus injection and Hepatitis B vaccination status should be obtained.

Date and time of the sexual assault(s): It is essential to know how much time has elapsed between the assault and the physical examination, collection of the evidence, and assessment of injuries. The interpretation of physical findings and evidence analysis is influenced by the passage of time.

Recent consensual sexual activity: This is due to the sensitivity of DNA analysis. Consensual sex consisting of anal, vaginal, and/or oral sex, and whether a condom was used needs to be ascertained. Semen or other bodily fluid may be identified that are not associated with the crime. Once identified, the results can be matched with a consensual partner(s), and then used for elimination purposes and to aid in the interpretation of evidence.

Post-assault activities of patient: Quality of evidence is affected by the patient's activities. It is crucial to know what activities occurred post assault and prior to the examination, including:

- Urination, defecation or vomiting;
- wiping genitals, douching, removing/inserting tampon/sanitary pad/diaphragm, or Nuvaring;
- use of oral rinse/gargle or brushing teeth;
- bathing or showering;
- eating or drinking;
- smoking;
- change of clothing; or
- ingesting drugs or medication (legal, illegal, over the counter or prescribed).

Assault-related patient history: Information such as the location of non-genital or oral injury, tenderness, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding directs evidence collection and medical care. Patients should also be questioned about strangulation since this type of injury can result in airway obstruction if swelling occurs. Strangulation associated symptoms can include: memory loss, lapse of consciousness, vomiting, non-genital injury, pain and/or bleeding. Memory loss and lapse of consciousness, which is also suggestive of a Drug Facilitated Sexual Assault (DFSA) should be extensively evaluated. Additional information on DFSA can be found on page 48.

Suspect information (if known): It is important to seek evidentiary items that contacted or were transferred among patient, suspect(s), and crime scene(s). The gender and number of suspects may

offer guidance to the types and amounts of foreign materials that might be found on the patient's body and clothing. Suspect information gathered during the interview should be limited to issues that will guide the exam and forensic evidence collection.

Nature of the assault: Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by the suspect is crucial to the detection, collection, and analysis of physical evidence. Methods may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, physical restraints, strangulation, burns, threat(s) of harm to the patient or loved ones, and involuntary ingestion of alcohol/drugs. Knowing if suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood or fingernail scrapings) and in the event of an arrest it may provide corroborating support of the incident (e.g., bruising, fingernail marks or bite marks).

Suspicion of alcohol- or drug-facilitated sexual assault (DFSA): It is critical to collect information such as memory loss, lapse of consciousness, or vomiting; if the patient was given food or drink by the suspect; or if the patient voluntarily ingested drugs or alcohol. Collect toxicology samples if there is known or suspected ingestion of drugs or if there was loss of memory or lapse of consciousness. Information related to collection/detection of drugs/alcohol can be addressed to the Arkansas State Crime Lab and additional information on DFSA can be found on page 48.

Description of the sexual assault: An accurate and detailed description in chronological order of occurrence is crucial to detecting, collecting, and analyzing physical evidence, including the transfer of evidence. The description should include:

- penetration of genitalia (vulva and/or vagina of female patient), however slight;
- penetration of the anal opening, however slight;
- oral contact with genitals (of patient's by suspect(s) or of suspect'(s) by patient);
- other contact with genitals (of patient's by suspect(s) or of suspect'(s) by patient);
- oral contact with the anus (of patient's by suspect(s) or of suspect'(s) by patient);
- non-genital act(s); such as licking, kissing, sucking, strangulation; and biting;
- other acts (urination, defecation on patient) or use of objects;
- whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, clothing, bedding or other); and
- use of condoms and/or lubrication.
- Be aware, the patient may not know all of the above information.

Physical Examination and Evidence Collection

Healthcare providers should remember that sexual assault is a legal matter and not a medical diagnosis. Providers should refrain from expressing an opinion either verbally or in writing.

Questions, as discussed above, are asked from least invasive to more invasive and potentially embarrassing. In the same manner the physical exam should begin with the least invasive and progress to the more invasive forensic examination. Patients should be allowed to stay clothed throughout the questioning and disrobe at the time of the physical examination.

The patient's body is considered the "crime scene". The physical assessment and examination will be guided by the medical forensic history previously provided. The forensic medical examination and evidence collection should be done in tandem as a seamless process to increase efficiency, and decrease omissions and patient anxiety. It is important to wear powder-free gloves and change them throughout the exam/evidence collection, especially between sites. A systematic head-to-toe approach should be consistently utilized, performing the genitalia exam lastly. Patients should always be informed about the examination and the purpose of evidence collection, procedures used to collect evidence, any discomfort that may be involved, and how the medical forensic examination may be used during the investigation and prosecution.

The American College of Emergency Physicians issued general rules for forensic evidence collection:

- There is only one chance to collect.
- When in doubt, collect.
- Air dry, no heat.
- If once living, such as blood and body fluids, refrigerate. However, according to the Arkansas State Crime Lab, completed kits can be stored at room temperature since there are no liquid samples in the Arkansas kit.
- Use paper or glass only, no plastic. Plastic may retain moisture and promote degradation of biological evidence.
- Label, date, seal, and initial everything.
- Separate items collected.
- Do not touch items that may contain fingerprints; package to preserve prints.
- The 96 hour presumptive guideline of collection may change because it was a function of the sensitivity of forensic testing which is constantly advancing.
- Suspect's DNA has been found in the vaginal vault of patients for as long as 3 weeks but can degrade as quickly as 24-48 hours. DNA on clothing items can be identified months or years later.
- Collect samples without water if possible-ease off stain and place in bindle; if needed place one drop of either distilled water or saline solution on a swab to collect.
- Sterile collection is not necessary; however, it is necessary to change gloves between sites to avoid cross-contamination.
- Core evidence needed consist of blood, oral, vaginal, and anal samples, as appropriate.
- Collect appropriate specimens if drug-facilitated sexual assault is a possibility.
- Evidence collection changes as technology changes; keep current and follow universal precautions (American College of American Physicians, 1999).

General physical examination: Note the date and time of the exam, patient's vital signs, physical appearance, general demeanor, behavior, orientation, and condition of clothing on arrival. Record all physical findings including visualized injuries; tenderness on palpation; physiologic changes; and observed foreign materials (e.g. grass, sand, stains, dried or moist secretions, or positive fluorescence) in narrative and on body diagrams.

Collection of Clothes: Collection of clothing and other evidence should be guided by the medical forensic history. Often clothing contains important evidence in a case of sexual assault for the following reasons:

- Clothing provides a surface upon which foreign material can be found, such as the assailant's semen, saliva, blood, hairs, fibers, and debris from the crime scene.

- Damaged or torn clothing is significant and may be evidence of force. It can also provide laboratory standards for comparing trace evidence from the clothing of the patient with evidence collected from the suspect and/or the crime scene.

Prior to the full examination, the healthcare provider should determine if the patient is wearing the same clothing worn during the assault. If so, the clothing should be collected. The forensic scientists at the Crime Lab will examine the clothing for any foreign material, stains or damage. If it is determined that the patient is not wearing the same clothing, the healthcare provider should inquire as to the location of the original clothing. The information about the location of the clothing should be given to the investigating officer so that arrangements to retrieve the clothing can be made. The most common items of clothing that are collected from patients for analysis are underwear and bras. In some cases, guided by history, it is necessary to collect hosiery, blouses, shirts, and/or pants. In rare cases, coats and shoes may need to be collected as well.

In order to minimize the potential for the loss of evidence, the patient should disrobe over a cloth sheet with exam table paper laid over the sheet. This is accomplished by placing a clean cloth sheet on the floor and then placing a sheet of table paper over the cloth. The cloth sheet prevents transfer of debris from the floor to the piece of paper. The patient should disrobe over the piece of paper and any debris that falls from the clothing should be collected in a bindle for the crime laboratory (See Appendix A). Do not shake out the patient's clothing or microscopic evidence will be lost. If it is necessary to cut off items of clothing from the patient, do not cut through existing rips, tears, or stains. Cut close to a seam if possible. Include in the documentation which items of clothing were cut and the location of the cuts.

The clothing should then be collected and packaged according to the following:

- Wet and damp clothing should be air-dried prior to packaging in new paper bags (grocery-type bag).
- Place the underwear in the paper bag marked "UNDERWEAR" provided in the sexual assault evidence collection kit. The underpants should be collected, even if they are not the pair the patient was wearing at the time of the assault. It is possible that secretions or ejaculate may drain from the patient and be found on the underpants.
- If a bra is present, and history dictates the necessity to collect it, then place it in a separate paper bag and label it appropriately.
- Other clothing items should be placed in separate paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain so that the stains are not in contact with the bag or other parts of the clothing.
- Label all bags with the patient's name, the date and time item was collected, the name of the item and the collector's name or initials.
- Seal the bags, using tape. Initial and date over the seal on each bag.

Record all physical findings utilizing the acronym TEARS: T (tearing/lacerations), E (ecchymosis/bruising), A (abrasion), R (redness), and S (swelling). Further assess for foreign materials such as grass, sand, stains, dried or moist secretions. Note areas of tenderness and induration. Carefully inspect the body, including the head, hair, and scalp, and work down from head to toe in a systematic manner assessing for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat and saliva) and other foreign material. Information and/or findings should be noted in the narrative and on body maps.

It may be beneficial to label all envelopes prior to collection, with the patient's name, date and health care provider's name. After envelopes are labeled, the healthcare provider should keep them in view at all times to preserve the chain of evidence. When sealing the evidence collection envelopes, use tape or tap water to seal the pre-gummed flap. DO NOT LICK the flap. Printed patient labels can be applied across the flap and then dated, time-stamped and signed by examiner.

Dried secretion collection procedure: The preferred method is to gently flake off the dried stain into an envelope; however dried secretions can also be collected by slightly moistening a swab with distilled water or a normal saline solution. After moistening, use the double-swab technique in the indicated area and swab the moistened area with a dry swab. Separate swabs should be used for every sample area collected. The swabs should be placed in separate envelopes and sealed, labeled with the patient's name, date and time, collector's name and location of the collection site. Air-dry all specimens, package swabs, label, seal, and initial seals. If dried secretions are on hair (head, facial or pubic) flake off material if possible or cut matted hair only with patient's permission. Place in a separate envelope.

Blood collection procedure: A blood sample is collected from patients for DNA analysis to distinguish the patient's DNA from that of the suspects. A blood card is included in the AR Sexual Assault Evidence Collection kit.

- If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection and is easier to store.
    - Using a Betadine swab, wipe the tip of the left or right ring finger.
    - Using a sterile lancet, prick the finger.
    - While holding the finger over the circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for remaining circles. The circles do not need to be filled completely.
    - Air-dry the blood collection card.
    - Place the dried card in the envelope marked "KNOWN BLOOD SAMPLE", seal and label the envelope and return it to the evidence collection kit.

Oral (Buccal) swab collection procedure: This is a part of the evidence required in the AR Sexual Assault Evidence Collection Kit. This sample is taken to retrieve any seminal fluid if an oral assault occurred. Swabs from the oral cavity should be taken first so that the patient can rinse their mouth and/or drink fluids as soon as possible.

- Place swabs together to collect specimen from oral cavity by moving along the gum line; between the gums and cheeks; and under tongue (do not pre-moisten the swabs).
- Attention should be paid to those areas of the mouth where seminal material might remain for the longest amount of time, such as the junction of the gum and teeth.
- Remove dentures and swab with the same swabs.
- The swabs should be allowed to air dry or be placed in a swab dryer especially designed for this purpose. When the oral swabs have dried, they should be inserted in the paper envelope marked "ORAL SWABS". The envelope should be sealed and labeled as previously described and returned to the evidence collection kit.

Use of an Alternate Light Source:
Depending on institutional policy and availability, an alternate light source (ALS) may be used in a darkened room to examine the patient's entire body. Wear recommended glasses (450 nm wavelength). Also, protect the patient's eyes when using ultraviolet light. Specifically examine the head, face, hair, lips, perioral region, and nares; chest and breasts; inner thighs, skin, and other areas indicated by the medical forensic history. Dried semen stains may have a shiny appearance and tend to flake off the

skin or may exhibit an off-white fluorescence with the use of an ALS. Fluorescent areas may appear as smears, streaks or splash marks. Moist or freshly dried semen may not fluoresce. The appearance of fluorescent areas does not confirm the presence of semen, as other substances such as urine or body lotions may fluoresce. Restraint marks, bite marks, recent contusions, and other subtle injuries may be more visible with the aid of an ALS.

Collection of foreign materials and swabs from the surface of the body:
Obtain swabs from any suspicious area that may be a dry or moist secretion or stain; any area that fluoresces with ALS in correlation with the patient history provided; and any area for which patients relate a history or suspicion of bodily fluid transfer (licking, kissing, biting, splashed semen, urine, defecation, or suction injury). Place swabs in a marked envelope, seal and label as previously described and place the envelope in the evidence collection kit.

Bite mark evidence:
Bite marks may be found on patients that have been sexually assaulted. The collection of saliva and photographs of the affected area are the minimum procedures which should be followed in cases where a bite mark is present. Documentation of the bite mark, size, location and description of injury is also needed.

Saliva, like semen, may demonstrate DNA characteristic of their donor. Therefore, the collection of saliva from the bite mark should be made prior to cleansing or dressing the wound. To collect a specimen form the bite mark area, slightly moisten a swab with distilled water and gently swab the affected area. If the skin is broken, swabbing of the actual punctures should be avoided. Air-dry the swabs, place in an envelope marked "BITE AREA", seal and label as previously described and place in evidence collection kit.

If bite photographs are needed it is important that the photographs of the bite marks be taken properly. It is recommended that a representative of the law enforcement or a forensic photographer be consulted on the proper instructions for forensic evidence photography. To demonstrate the size of the bite mark, a ruler or standard should be placed adjacent to but not touching or covering the bite mark and then photographed. An additional photograph without the ruler or standard should also be made. The camera should be placed perpendicular to the bite mark.

Fingernail swabs:
The purpose of collecting swabs from the fingernails is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the patient will be in contact with the environment as well as with the assailant. Materials such as skin, blood, hairs, soil and fibers (from upholstering, carpeting, blankets, etc.) can occasionally be collected under the fingernails of the patient.

The patient should be asked whether or not they scratched the assailant's face, body or clothing. If fibers or other materials are observed under the patient's fingernails, the under part of the nails should be swabbed, one hand at a time, using a cotton-tipped swab, one for each hand. The patients may want to perform this procedure themselves. The swabs are then packaged back in the original sleeves and placed in an envelope. The envelope should be properly sealed and labeled, being sure to note which hand the evidence was collected from, and placed in evidence collection kit.

Collection of pubic hair combing:
Pubic hair combing is part of the evidence requested in the AR Sexual Assault Collection Kit. Use the comb, paper sheet, and envelope included in the evidence collection kit. This process is intended to

collect hairs that may have been deposited by the perpetrator. This is not a known, pulled hair sample. Pubic hairs should not be cut. Place the unfolded paper sheet under patient's buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper in the envelope marked "PUBIC HAIR COMBINGS". Package, seal and label as previously discussed. Return the envelope to the evidence collection kit.

Some patients may shave their pubic region and have no hair or stubble. In this case, a visual examination for hair and debris can be done and hairs may be manually placed in the unfolded paper sheet. The paper sheet can then be placed in the envelope, sealed and labeled as previously described, and placed in evidence collection kit.

Assessment of female genitalia for injury:
Make sure to wear gloves throughout the exam and to follow Universal Precautions. Examine the external genitalia and perineal area for injury (TEARS), and foreign materials in the following areas: labia majora, labia minora, clitoral hood and surrounding area. Examine the structures internal to the labia majora: peri-urethral tissue/urethral meatus, hymen, fossa navicularis and posterior fourchette. Examine the buttocks, perianal skin, and anal folds for injury, foreign materials and other findings. Using swabs collect any foreign material and/or secretions as described earlier in this chapter. Document all findings on a body map according to facility's policy. The use of describing position of the noted injury by the hands of a clock is helpful (e.g., 4 cm laceration on labia minora at 3 o'clock). The use of a colposcope during the genital exam of an adult female enhances visualization of microscopic trauma and may be utilized to provide photographic documentation.

Collect female external genital swabs:

- Swab area of labia majora and clitoral hood which are dry-skin areas with two swabs (do not pre-moisten the swabs).
- Air-dry swabs.

Package swabs in one of the paper sleeves marked "VAGINAL/PENILE SWABS." Note on the package that these were swabs of labia majora/external genitalia.

Toluidine blue dye:
Toluidine blue dye (1-% aqueous solution) is controversial in some jurisdictions. It may be perceived by the court as changing the appearance of the tissue and is not universally used. If utilized, it needs to be applied before the internal and speculum examination. Any tears that are illuminated by the dye may be challenged as having been caused by insertion of a speculum if proper sequence is not followed. The solution is a spermicide and should only be applied externally.

- Apply by cotton swab across the fossa navicularis, posterior fourchette and related areas.
- Wait for 1 minute and blot excess dye away with 1% acetic acid solution.
- Recent lacerations will show up bright blue.
- Advise patients that small traces of the dye might shed in their clothing for about 2 days.
- Examiners should be familiar with false positive results (e.g., infections).

Assessment of vagina and cervix and collection of sample:
If the patient is able to tolerate insertion of a vaginal speculum, insert a speculum and examine vagina and cervix for injury, foreign materials, and foreign bodies. When collecting the vaginal specimens, it is important not to irrigate the vaginal vault or to dilute the secretions. It is prudent to collect swabs from both the vagina and cervix if possible.

- Use one swab for the vaginal vault and one swab for the cervix. If the patient cannot tolerate a speculum exam, do 2 deep vaginal swabs and roll the swab while in the vagina to maximize exposure to the surface of the swab for absorption. , swab the vaginal vault and cervix.
- Air-dry the swabs.
- Place the dried swabs in the 2nd paper sleeve, marked "VAGINAL/PENILE SWABS", seal and label the paper sleeve as previously discussed, and return to evidence collection kit.
- Be sure to label the outside of each sleeve as either "internal swabs" or "external swabs"

Please note: if a speculum is used, it is important to document the use of a speculum only after the external genitalia have been visualized and examined. Lubricate the speculum with water only. Do not use gel lubricant.

Assessment of male genitalia:
Make sure to wear gloves throughout the exam and to follow facility's Universal Precautions. Examine the external and perineal area for injury, foreign materials, and other findings, including the urethral meatus, shaft, scrotum, perineum, glands, testes, buttocks, perianal skin and anal folds. Document the findings on a body map and according to facility's policy. For the male patient, the presence of saliva on the penis could indicate that oral-genital contact was made, the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice and feces or lubricants might be found if rectal penetration occurred.

Collect male external genital swabs:
- Lightly moisten both swabs with distilled water and swab the glans and shaft of the penis.
- Air-dry the swabs.
- Insert the dried swabs into the envelope marked "VAGINAL/PENILE SWABS".
- Seal and label envelope as previously described and return it to the evidence collection kit.

In the rare instance in which a urethral specimen is indicated it is important not to irrigate or dilute the secretions. Using one cotton swab at a time, swab just inside the urethral meatus of the penis. Repeat this procedure with at least one additional swab. After the swabs have air- dried, place the swabs in an envelope and mark it "URETHRAL", seal and label the envelope as previously described and place it in the evidence collection kit.

Collection of rectal sample:
The patient may be placed in a lateral position to increase comfort during the anal/rectal exam and evidence collection. Inspect the anal/rectal area for injury and foreign materials prior to collection of swabs. To obtain rectal swabs:
- Slightly moisten the cotton swabs with distilled water. One cotton swab at a time should be used to swab the rectum. Very slight penetration is adequate.
- Repeat the procedure to obtain the second swab.
- After the rectal swabs have air dried, place the swabs in the envelope marked "RECTAL" and place it in the evidence collection kit.

Other evidence may be collected beyond what is required for the sexual assault evidence collection kit. This could include toxicology samples or other evidence based on the unique history and circumstances of the case.

Obtain Urine Specimen:

Ideally, it is best to obtain the urine specimen after the genitalia examination and evidence collection since evidence can be lost if the patient voids. This is not always possible and therefore a specimen should be collected. In this case the patient should be instructed not to wipe after urinating. The collection does not need to be a clean catch, unless per protocol for pathogens (institutional testing, NOT Arkansas Crime Lab).
Do not include urine specimen in evidence collection kit. The urine specimen may be used to test for STD's, pregnancy, dehydration, and ketosis. Before administration of any prophylactic medication, it is vital to rule out pregnancy.

Urine can also be utilized in cases of suspected Drug-Facilitated Sexual Assault and is discussed on page 48.

Read and follow the State of Arkansas Sexual Assault Evidence Collection Kit Instructions found inside each kit. Be sure to complete the paperwork found in the evidence collection kit (steps 1 and 9 of instructions) in addition to institutional paperwork. Obtain and store the evidence submission sheet, affix evidence seals so that the box is sealed closed (initial and date the seal), affix biohazard seal, and complete information on the top of the kit.

Evidence Integrity:

Follow institutional and jurisdictional policies for drying, packaging, labeling, and sealing evidence. It is critical to air-dry wet evidence at room temperature in an expedited manner that prevents contamination. Ideally, an air dryer that locks can hold the specimens in a secure place, while drying the specimens. Clothing must be kept in sight or locked in a secure location. Jurisdictions and institutions should have policies for handling, securing and locking down evidence, including evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and blood samples.

Minimize transit time between collection of evidence and transport to the Arkansas Crime Lab. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and wet evidence in a timely fashion. Only a law enforcement official can transfer evidence from the exam site to the Arkansas State Crime Lab.

In the event that kit transport does not occur in a timely manner, and storage is required, the type of storage will depend on the types of specimens to be stored. The use of dried blood samples on blood collection cards is encouraged because they do not require refrigerated storage. If there is a time delay between evidence collection and submission to the crime lab, urine should be refrigerated or frozen and blood specimens (except blood collection cards) should be refrigerated.

Photography

Taking photographs of patients may be required as part of the medical forensic examination process in sexual assault cases. Photographing injuries may unjustly compromise a case if poor or inadequate photos are taken; therefore, the examiner needs to be trained in forensic photography. Basics of photography are taught in the A-SANE and P-SANE course; however advanced training is essential. Some facilities contact the local police department and request a criminal photographer or crime scene

investigator to come to the facility and take photographs. However, photographs should not be used to interpret subtle and/or nonspecific findings (e.g., erythema or redness).

All photos should be documented and described in correlation to the medical forensic history and exam. In addition to photographing examination findings, some jurisdictions photograph the face of patients for identification purposes (follow institutional policies). Images should be linked to the patient's name; date of exam; and the examiner. Digital imaging can automatically embed the date/time and other required data in each image. This information can be accessed when the image is downloaded onto the computer.

Photograph evidence in place before moving it or collecting it. Do not alter the evidence prior to photographing, and make every effort to minimize background distraction in photographs while maintaining the focus on areas being photographed.

- Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom, or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.
- Take close-up images of specific injuries, with and without the scale (this verifies that the scale was not concealing anything). The scale provides a reference for size. Color scales are useful to provide perspective of the photographed area.
- When photographing a wound, show its relationship to another part of the body.
- In some cases, a full body photograph may be appropriate to show scope of injury or state of clothing. Photos taken solely for the purpose of identification should be done with patients fully clothed or in a gown.
- Photographing close-ups of hands and fingernails may show traces of blood, skin, hair, or damaged/missing nails.
- Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks.
- Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.
- Photograph bite marks.
- All photographs should be clearly labeled and the chain of custody maintained. Do not include photographs in the evidence collection kit sent to the crime lab.
- Follow-up photographs should be taken if new or different evidence on patient's bodies is found post-exam (e.g., bruising may appear days later). In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy and nonspecific findings like redness or swelling that could be confused with acute injuries.
- Examiners should take a forensic photography course to expand skills, knowledge and techniques that enhance evidentiary evidence collection and retention.
- Write and maintain policies on use of photography and consider institutional consent form for photography.

Pregnancy Evaluation and Emergency Contraception

Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable pregnancy intervention options. Clinicians must be careful not to unduly influence a patient's choice of intervention.

Recommendations at a glance:

- Discuss probability of pregnancy with female sexual assault patients.
- Administer a pregnancy test for all patients with reproductive capability.
- Discuss intervention options.

Any female of reproductive capability (Tanner Stage 3 and above, irrespective of menarche and current contraceptive method) can potentially become pregnant from a single sexual encounter. The risk of pregnancy from sexual assault is estimated to be 2% – 5% and the probability of conception depends on several variables, including:

- use of contraceptives
- regularity of the menstrual cycle
- fertility of the patient and the perpetrator
- time in the cycle of exposure and
- whether the perpetrator ejaculated intravaginally.

Because of genuine fear of pregnancy, and the compounding trauma that a pregnancy could inflict, intervention options should be made clear to the patient. The conversation should include a thorough discussion, including mechanism of action, side effects, benefits, dosing, and follow-up. Information should also be provided in writing.

With the exception of a patient that is already pregnant, all female sexual assault patients should have a pregnancy test conducted. In the case of a pregnant patient, medical management would be best managed by or in collaboration with the patient's obstetrician. Most commercially available urine pregnancy tests are sensitive and will detect pregnancy 7 days after conception, before a menstrual period is missed. If the pregnancy test is positive, emergency contraception is contraindicated and prophylaxis medications need to be re-evaluated.

Emergency contraception (EC), or the "morning-after" pill, is birth control that women can use to prevent pregnancy after unprotected intercourse. EC is 95% effective when taken within 24 hours, and is 88% effective if taken within 72 hours. Although efficacy decreases across time, EC is still considered effective and can be administered up to 120 post-assault. (Follow institutional protocol). EC is not an abortifactant and should not be confused with the "abortion pill" Mifeprex, or RU486. EC works in several ways: by suppressing ovulation, disrupting the development of the endometrial lining to prevent implantation, and altering the effectiveness of tubal transport of the ovum. There is no evidence of increased incidence of ectopic pregnancy and the use of EC cannot interrupt an established pregnancy.

The most common side effects are nausea and vomiting. The frequency of nausea and vomiting with the progestin-only method is significantly lower. Dramamine 25-50 mg, or other antiemetic medication taken 30 minutes before taking a dose of EC, can decrease these problems. If vomiting occurs within one hour after taking either dose, repeat dosing may be considered. (However, it seems reasonable to infer that if gastrointestinal symptoms are estrogen-mediated secondary to an effect on the central nervous system, absorption of the dose should have occurred by the time of emesis).

The Yuzpe regimen, combination oral contraceptive, consists of a 0.5 mg of levonorgestrel and 50 mcg of ethinyl estradiol which can be administered after a negative pregnancy test. The dose is repeated in 12 hours. The combination pill is considered more effective in patients that have a BMI of 30 or greater. The Plan B option consists of two tablets, each containing 0.75 mg of levonorgestrel and is generally preferred to the Yuzpe regimen. Levonorgestrel, a synthetic progesterone hormone is recommended because of its higher efficacy rate, ease of dosing, and fewer side effects, particularly nausea and vomiting. In addition, a World Health Organization (WHO) multicenter randomized trial showed that the dose does not have to be split but can be taken as a single 1.5-mg dose (Plan B One Step). One dose simplifies the EC without causing an increase in side effects. The progesterone only method is available over the counter in pharmacies. No ID or prescription is required.

Emergency Contraception Methods

EC Method	Regimen
Yuzpe Regimen Combination oral contraceptive method	0.1 mg of ethinyl estradiol + 1.0 mg of DL-norgestrel (equivalent to 0.5 mg of levonorgestrel) in two doses taken 12 hours apart
PLAN B Progestin-only method	0.75 levonorgestrel in two doses taken 12 hours apart
PLAN B ONE STEP	1.5 mg of levonorgestrel in a single dose
Ella	30 mg of ulipristal acetate in a single dose

Follow-up Care: The patient should be provided an oral explanation and written information regarding EC. Patients should be informed that there may be heavier or lighter menses than usual and the menses onset may not occur at the expected time. If no bleeding has occurred within three weeks, the patient should be re-evaluated and a repeat pregnancy test performed. **The patient must be advised not to have unprotected intercourse until after the next menses has occurred**, or the repeat pregnancy test is negative.

Drug-Facilitated Sexual Assault (DFSA)

Many drugs are used as "club drugs" to heighten sexual awareness and erotic sensations, however; drugs that are classified as "date rape drugs" and used in the commission of drug facilitated sexual assault (DFSA) have the unique ability to cause antegrade amnesia. Antegrade amnesia causes the patient to forget all or part of the events that occurred while the drug was in effect.

The four most common substances used in DFSA are alcohol, Gamma Hydroxy Butyrate (GHB), rohypnol, and ketamine. Alcohol is the number one substance used in DFSA. A brief discussion

about the other three substances follows; however, the effects of each substance are dependent upon a number of variables including: dose ingested, purity of the drug, and individual factors such as body size, metabolism, concurrent drug(s) and alcohol consumption.

Rohypnol is classified as a Class I narcotic; benzodiazepine; central nervous system (CNS) depressant; which is 7-10 times stronger than Valium. The onset of action is within 30 minutes and peaks in 1-2 hours with a duration of 8-12 hours. However, fatigue, confusion, and inability to focus may last 2 days. Effects of rohypnol ingestion include impaired judgment and motor skills; disinhibition; amnesia; confusion; excitability followed by lethargy; reduced reflexes; dangerous level of hypotension; and coma.

Gamma Hydroxy Butyrate or GHB is classified as a Class I narcotic and is a CNS depressant. Onset of action is 15 to 20 minutes and it peaks in 20-60 minutes with duration of 4-5 hours. Effects of GHB include euphoria, amnesia, hypnosis, depressed respirations, hallucinations, confusion, seizures, nausea and vomiting, coma, and death.

Ketamine is a legal anesthetic, used mostly in pre-op and by veterinarians. Ketamine is related to PCP and has an onset of action in about 30 seconds if used IV and 20 minutes if ingested orally. The duration of action is 30-60 minutes, but amnesia effects may last much longer. The effects of ketamine ingestion include dissociate reaction with dreamlike effects; out of the body experience, amnesia; confusion; paranoia, delirium, hallucinations and the patient may become combative with excessive drooling.

Drugging should be recognized as a separate and distinct act of victimization and is a separate crime. It is a crime at both the State and Federal level. In Arkansas it is prosecuted under Arkansas Code Annotated § 5-13-210 and is a Class Y felony if a person introduces a controlled substance into the body of another person without that other person's knowledge or consent with the purpose of:
(1) Committing any felony sexual offense, as defined in Arkansas law;
(2) Engaging in any unlawful sexual act, as defined in § 5-14-101 et seq.;
(3) Engaging in any unlawful sexual contact, as defined in § 5-14-101; or
(4) Engaging in any act involving a child engaging in sexually explicit conduct, as defined in § 5-27-302.

It is also important to document a patient's voluntary use of drugs and alcohol. Patients should understand that information related to voluntary alcohol or drug use may be used to undermine their credibility in court, but also that in some instances it might be helpful in prosecuting a case by documenting their vulnerability. Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and negatively impact patient's ability to make informed decisions about treatment and evidence collection.

Routine toxicology testing is not recommended. However, if any of the following situations occurred then toxicology is warranted:

- If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills or severe intoxication).
- If a patient suspects drug involvement, especially if the patient reports a lack of recollection of the event(s).
- If a patient or accompanying persons states the patient was or may have been drugged.

Toxicology testing procedures should be explained to patients. Seek informed consent from patients to collect toxicology samples. Patients should understand the following:

- The purpose of toxicology testing and the scope of confidentiality of test results.
- The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time period following ingestion.
- There is no guarantee that testing will reveal that drugs were used to facilitate the assault.
- Testing may or may not be limited to drugs commonly used to facilitate sexual assault and may reveal other drugs or alcohol that patient ingested, including those that were voluntarily ingested.
- Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired patient's consent and prevented legal consent).
- Declining testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution.

With DFSA the examiner may not be able to use the patient's history as a guide for the medical forensic examination so it is imperative to be thorough, collecting all specimens, and inspecting the entire body and clothing. Extreme patience is required in interviewing due to patient's inability to remember, and hence uncertainty, of events that occurred and incomplete timeline. Reassure the patient that "I don't know" is a perfectly acceptable answer and record the answer in quotation marks.

Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement. The sooner specimens are obtained the greater the chances of detecting substances since they are quickly eliminated from the body. The length of time that drugs used in the commission of DFSA remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, patient's body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated). Urine allows for a longer window of detection of drugs opposed to blood.

Ideally, the first available urine sample of 30 cc of urine should be obtained and packaged in a clean glass or plastic, leak proof container for transport to the crime lab. The patient should not urinate until after evidence is collected. However, if the patient previously urinated, the number of times that urination occurred prior to collection of the sample should be documented. Do NOT put urine into the Sexual Assault Evidence Kit. Label, sign, seal and maintain proper chain of custody. Refrigerate the specimen (in a locked refrigerator) until it is released to law enforcement. Some jurisdictions may also require a blood specimen. If DFSA is suspected a blood sample in two full tubes (any color top) should also be drawn. If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample (since the end metabolite from the drug will be detected for a longer duration in urine).

If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion and use betadine (not alcohol) as the prep for venipuncture.

Establish policies and follow them for collection, packaging, labeling, storage of samples, and handling when patients are undecided about reporting or awaiting transfer of specimens to the crime lab. As with any forensic evidence, the chain of custody must be maintained.

It is not in the scope of this manual to educate health care providers about all aspects of DFSA and it is recommended that those persons performing medical forensic exams obtain additional and specific training.

Patient Education and Discharge

After the examination and evidence collection is complete, the patient should be provided with clear and concise oral and written instructions for care and follow-up. Information should include the following:

- A file or case number if one has been assigned.
- Instructions about what to expect after a pelvic examination (i.e. slight bleeding, etc.).
- Instructions for medications (including name, dose, possible side effects)
- Signs and symptoms that require immediate follow up.
- Instructions not to engage in unprotected intercourse until after completing all medications, follow-up testing, and return of menses.
- If EC was administered and there is no menses within 3 weeks, follow up care is warranted.
- Make sure patient's medical and mental health needs related to the assault have been addressed.
- Recommend follow-up appointments for patients. Make it clear that patients do not have to disclose the assault to receive follow-up medical care (although it is advised to allow a thorough evaluation).
- For patients with evidence of acute trauma, a short-term follow-up appointment is needed 2 to 3 days after initial exam to re-examine and document the development of visible findings and photography of the areas of injury. An exam 2 to 4 weeks later is then needed to document resolution of findings or healing of injuries.
- Primary health care providers or other nonacute care providers (such as public health departments) can provide longer term care as needed (e.g., for HIV testing, STD testing, and administering doses of Hepatitis B vaccine).
- Information on advocacy and counseling services including rape crisis advocates, counselors, and therapy groups.
- For patients who have not made a law enforcement report, they should be given information on who to contact and how to make a report if they change their mind. They should also be given information concerning the length of time kits will be kept in storage prior to destruction (See Guidelines for Jane Doe Rape Kit on page 22)

Chain of Custody

It is important to adequately and accurately label each evidence collection envelope, package, vial and specimen container. Information required includes the patient's name, date, identifying/case number, type of specimen (if not already on the envelope or package) and examiner's name. It is important to date and initial the flap after the envelope has been sealed. The date and examiner's initials should be written in such a way that it is both on the flap and on the envelope. Another way to seal envelopes and packages is by placing a pre-printed patient label across the flap and dating and initialing over seal.

The custody of an evidence collection kit and the specimens it contains must be accounted for from the moment the evidence kit is opened, through the collection process and until it is introduced in

court as evidence. Therefore, anyone who handles the evidence should sign the chain of evidence document. The purpose of establishing a chain of custody is to guarantee that the items admitted into evidence at trial are authentic (i.e., that they are the same items and in substantially the same condition as those taken from the patient during the forensic examination).

After the examination is complete, law enforcement is responsible for picking up and delivering the Sexual Assault Evidence Collection Kit to the Arkansas State Crime Lab. For chain of custody and tracking purposes, healthcare personnel and law enforcement should follow the instructions and protocol set forth in the Arkansas Crime Lab's secure online Sexual Assault Kit Tracking System. In addition, follow the directions on the kit for documentation of the exchange of the collection kit from the examiner to law enforcement.

Sexual Assault Kit Tracking System

The tracking of sexual assault evidence kits in the state of Arkansas in compliance with Arkansas Act 1168 of the 2015, 90th General Assembly is now available through a secure online tracking system. Authorized medical, law enforcement, and lab personnel shall manage the status of sexual assault evidence kits under the jurisdiction of their agency. Also, victims of sexual assault can view the history and current status of their sexual assault evidence kit. Healthcare providers will log into the system to accept sexual assault kits that have been sent to their facility.

Chapter

5

5. Evaluation and Care of Sexually Transmitted Diseases and Human Immunodeficiency Virus

Contracting a sexually transmitted disease (STD) and/or Human Immunodeficiency Virus (HIV) from an assailant is typically a significant concern for sexual assault patients. STD and HIV should be addressed as part of the medical forensic exam.

Recommendations at a glance:

- Offer patients information about the risks of STDs and HIV including symptoms, what to do if symptoms occur, testing and treatment options, follow-up care, and referrals.
- Encourage patients to accept post-exposure prophylaxis (PEP) against STDs at the time of the initial exam. If accepted, provide care that meets or exceeds Centers for Disease Control and Prevention (CDC) guidelines.
- Encourage follow-up STD examinations, testing, immunizations, and treatment if indicated.
- Offer post-exposure prophylaxis (PEP) for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. Follow current CDC guidelines. Discuss risks and benefits of the prophylaxis with patients prior to their decision to accept/decline treatment. Careful monitoring and follow-up by a health care provider or agency experienced in HIV issues is required.
- Consider the need for testing patients for STDs during the initial exam on a case-by-case basis. If testing is done, follow the guidelines of the most current CDC guidelines.

STD Evaluation and Care

The medical forensic exam presents an opportunity to identify preexisting STDs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment.

Trichomoniasis, Bacterial Vaginosis, gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who have been sexually assaulted. Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection and risk of infertility if untreated. However, the presence of an STD after an assault in a sexually active woman does not necessarily imply acquisition during the assault. In addition, Hepatitis B Viral infection can be prevented by post-exposure administration of hepatitis B vaccine (CDC, 2010).

The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Care systems for survivors should be designed to ensure continuity (including timely review of test results), support adherence, and monitor for adverse reactions to any therapeutic or prophylactic regimens prescribed. Testing for STDs at the time of the exam gives examiners and patients the option to defer empiric prophylactic antimicrobial treatment if it is not needed. However, testing at the time of the initial exam does not typically have forensic value if patients are sexually active. Since the identification of an STI in a previously sexually active adult might represent an infection acquired prior to the assault, it may prove to be more important for the psychological and medical for public health management of the patient than for legal purposes (CDC, 20105). However, since compliance with follow-up visits is historically poor among sexual assault patients, a routine preventive therapy after a sexual assault should be encouraged for post-pubertal girls and adult women who would be at risk for ascending pelvic infection if exposed from the assault. Current CDC guidelines are used to determine PEP treatment and include a regimen to protect against Chlamydia, Gonorrhea, Trichomonas, and the Hepatitis B Virus. PEP treatment can also reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

Testing for STD's in young children or adolescents who are not yet sexually active can yield results with potential forensic significance. It is imperative that providers understand the need for confirmatory testing in such cases prior to providing treatment.

Laws in all 50 states strictly limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STDs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment also is enforced in most states. However, despite rape shield laws, there may be a concern that positive test results could be used against patients (e.g., to suggest sexual promiscuity). There may, however, be situations in which testing has legal purposes, as in cases where the threat of transmission or actual transmission of an STD was an element of the crime. Or, for non-sexually active patients, a baseline negative test followed by an STD diagnosis could be used as evidence, if the suspect also had an STD.

STD PEP Treatment

Adolescent and Adult Females:
The following prophylactic regimen is suggested as preventive therapy:

- Post-exposure Hepatitis B vaccination, without HBIG. This vaccine should be administered to sexual assault patients at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomoniasis.

If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a follow-up examination. Document the patient's consent for prophylaxis or their decisions and rationales for declining prophylaxis in their medical records.

Recommended Regimens:

Ceftriaxone 250 mg IM in a single dose or Cefixime 400 mg orally in a single dose

PLUS

Metronidazole 2 g orally in a single dose

PLUS

Azithromycin 1 g orally in a single dose or Doxycycline 100 mg orally twice a day for 7 days

Refer to the most current CDC Sexually Transmitted Diseases Guidelines. At time of publication these guidelines can be found at: http://www.cdc.gov/std/treatment/2015/sexual-assault.htm.

Note that metronidazole should NOT be used within 72 hours of alcohol intake to avoid a disulfiram reaction. Inquire if the patient consumed alcohol within 72 hours pre-assault or post assault. Caution patients to abstain from alcohol for 72 hours if metronidazole is given.

Provide the patient with written and verbal information about the risks of STDs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, the need for abstinence from sexual intercourse until treatment is completed, follow-up care, and referrals as needed. Referrals should include free and low-cost testing, counseling, and treatment offered in various sections of the community.

If patient's clinical presentation suggests a pre-existing ascending STD, they should be evaluated and treated for the ascending infection.

Refer to the CDC recommendations (https://www.cdc.gov/std/tg2015/default.htm) related to HBV diagnosis, treatment and prevention including: pre-vaccination antibody screening; post-exposure prophylaxis; and special considerations.

The CDC recommends initial testing for syphilis and HIV (within 72 hours post assault) and then repeated at 6, 12 and 24 weeks after the assault if initial test results were negative.

Males and Children:
The following prophylactic regimen is suggested as preventive therapy:

- Post-exposure Hepatitis B vaccination, without HBIG. This vaccine should be administered to sexual assault patients at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.

Refer to the CDC recommendations (https://www.cdc.gov/std/tg2015/default.htm) related to HBV diagnosis, treatment and prevention including: pre-vaccination antibody screening; post-exposure prophylaxis; and special considerations.

The CDC recommends initial testing for syphilis and HIV (within 72 hours post assault) and then repeated at 6, 12 and 24 weeks after the assault if initial test results were negative.

HIV Evaluation and Care

Always address concerns about HIV infection thoroughly and remember contracting HIV is typically of grave concern for sexual assault patients. Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse the risk for acquiring HIV infection through a single episode of sexual assault is low. As with other STDs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence or condoms during sexual intercourse until treatment and testing are completed. Include local referrals for testing/counseling and comprehensive HIV services.

In discussing testing options it should be explained that baseline HIV testing is not typically an exam component. However, if the assault is considered a high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by health care personnel. Even if the assault is not considered a high risk for HIV exposure, some patients may still wish to be tested. HIV testing should be done in settings where follow up appointments and counseling can be offered to explain results, implications, treatment and referrals. (Office of Violence Against Women, 2004).

HIV Status of Source

Several factors impact the medical recommendation for HIV PEP and affect the assault patient's acceptance of the recommendations, including:

- the likelihood of the assailant having HIV,
- any exposure characteristics that might increase the risk for HIV transmission,
- the time elapsed since the event, and
- the potential benefits and risks associated with the PEP.

Determination of the assailant's HIV status at the time of the sexual assault examination is usually not possible. Therefore, the health-care provider should assess any available information concerning:

- characteristics and HIV risk behaviors of the assailant(s) (e.g., a homosexual or bisexual man, an IV drug user, or a commercial sex worker),
- local epidemiology of HIV/AIDS, and
- exposure characteristics of the assault (e.g., anal penetration; ejaculation on mucous membranes; multiple assailants; mucosal lesions on the assailant or patient; presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, and presence of a STD or genital lesions in assailant or patient (CDC, 2015).

Persons with exposures to potentially infectious fluids of persons of unknown HIV status may or may not be at risk for acquiring HIV infection. When the source is known to be from a group with a high prevalence of HIV infection, the risk for transmission is generally increased. The risk for transmission may be higher if the source person has been infected recently, when the viral load in blood and semen

are higher. However, ascertaining this information in the short time available for PEP evaluation and treatment is rarely possible. When the HIV status of the source is unknown, it should be determined whether the source is available for HIV testing. If the risk associated with the exposure is considered substantial, PEP can be started until there is a determination of the HIV status of the source and then stopped if the source is non-infected.

Transmission Risk from the Exposure

The estimated per-act transmission risk from unprotected exposure to a partner known to be HIV infected is variable, depending on the type of exposure (see Appendix B). The highest levels of estimated per-act risk for HIV transmission are associated with blood transfusion, needle sharing by injection-drug users, receptive anal intercourse, and percutaneous needle stick injuries. Insertive anal intercourse, penile-vaginal exposures, and oral sex represent substantially less per-act risk.

Bite Injuries represent another potential means of transmitting HIV. However, HIV transmission by this route has rarely been reported. Transmission might theoretically occur either though biting or receiving a bite from an HIV-infected person. Biting an HIV-infected person, resulting in a break in the skin, exposes the oral mucous membranes to infected blood; being bitten by an HIV-infected person exposes non-intact skin to saliva. Saliva that is contaminated with infected blood poses a substantial exposure risk. Saliva that is not contaminated with blood constitutes a negligible exposure risk.

HIV PEP Treatment

In considering the use of antiretroviral agents after possible exposure through sexual assault, the provider must:

- evaluate the patient's risk of contracting HIV;
- balance the potential benefits of treatment against possible adverse side effects;
- and take into consideration the patient's desires.

Refer to CDC Guidelines @ http://www.cdc.gov/std/treatment/2015/sexual-assault.htm

Chapter

6

6. Sexually Abused/Assaulted Children and Adolescents

Introduction

In the United States, more than 100,000 cases of reported sexual abuse are found to be true each year. This figure does not tell the whole story, however, because almost one-fourth of surveyed adults have reported they were sexually abused as children. Many of them were less than 6 years of age when the abuse occurred, and most perpetrators were relatives or people well-known to the children and families.

Sexual abuse can be defined for healthcare purposes as the involvement of children and adolescents less than 18 years of age in sexual activities they do not understand, are unable to give informed consent, or that violate the social taboos of family or society roles. Sexual abuse may involve attempted intercourse. However, other sexual activities, such as fondling and exhibitionism, also constitute sexual abuse.

Child sexual abuse may present following an acute assault, but often presents after it has been occurring over time. It is also true that while adolescent/adult sexual assault (rape) often presents acutely, these cases can also be occurring over time in abusive relationships. The 2 categories are compared in the following table:

	Child Sexual Abuse	**Sexual Assault (Rape)**
Age of Victim	Early childhood into teens	Usually postmenarchal
Engagement	Threats, bribes, manipulation	Fear, intimidation, force
Sexual Activity	Touching, rubbing, grooming to sexual intercourse and sodomy	Attempted or actual sexual intercourse and sodomy
Perpetrator	▪ Known to child and family; family member ▪ Has an abnormal attraction to children	▪ Stranger or acquaintance ▪ Power motive
Duration	Often many years	1 to 2 times
Presentation	Disclosure usually occurs days or years after event	Disclosure usually occurs soon after event
Physical Findings	▪ Usually acute findings are absent ▪ Older, healed findings are generally absent due to the non-violent nature of the acts, delayed disclosure, and rapid	▪ May have acute injuries ▪ Healed injuries be cannot be differentiated from prior consensual events

	healing of tissues	
Laboratory	▪ Presentation usually too late for rape kit collection ▪ Testing for GC, Chlamydia Chlamydia and Trichomoniasis if indicated by history ▪ Blood drawn at presentation and 3 months after last event for events that could have involved STD transmission	▪ Rape kit collection commonly indicated ▪ Testing for GC, Chlamydia and Trichomoniasis ▪ Blood for RPR, HIV and Hepatitis B to be drawn initially and 3 months after event ▪ Pregnancy and prophylaxis may be appropriate
Report	Child Abuse Hotline, Law Enforcement	Law Enforcement

Myths about child sexual abuse are common. The following is a list of some of the more common myths:

MYTH	FACT
Children are abused by strangers.	Typical for a child's abuser to be known to the child and family
All abusers are male.	The majority of cases involve males. The number of reported female abusers is increasing.
Victims are always female.	Incidence is higher in girls, but under-reporting is even more common in boys than in girls.
Children fantasize about sex with adults.	Children fantasize about those things that are in their experiences. They may fantasize about romance, not sex.
Children never lie.	Children lie to stay out of trouble, not to get into trouble. More commonly they will lie to deny abuse.
Children feel negatively about the abuse.	Sometimes they have a close, warm relationship with an abusive adult. They may feel protective of that adult. The sexual touching may feel good.
Children usually tell.	It is difficult for children to disclose. When disclosure does occur, it is usually delayed and tentative. Recantation can occur if the child is not supported.
There are usually physical findings of abuse.	In the majority of cases, especially those involving the very young child, there will be NO findings. This is compounded by the delayed reporting on the part of the child.
Emergent medical examination is needed.	Except in acute rape cases, a poorly done examination by a disinterested healthcare professional is worse than no exam.
Exams are painful with the use of a speculum.	Exams performed by experienced examiners are usually not painful and a speculum is rarely required.

Child sexual abuse examinations usually require interpretation of physical findings that may be healed injuries, rather than the fresh trauma more commonly seen in sexual assault patients. The examiner must be able to distinguish normal genital variations and changes as children grow from evidence of healed injuries of sexual abuse. The medical evaluations must be performed with sensitivity and low stress for the child and family, and the examiner must have knowledge, skill, and experience. Although most health care providers will not want to examine sexually abused children, all should know when to suspect and report it and make appropriate referrals to an experienced examiner.

The objective of this section is not to make readers into child sexual abuse examiners. One does not actually learn to perform the examinations from print material, lectures, or electronic programs, but rather by performing them under an experienced examiner. The *objectives of this section* are to enable the reader who encounters a child suspected of having been sexually abused to do the following:

- Report suspicions to the Arkansas State Police (ASP) Child Abuse Hotline
- Document available history, especially in regard to immediate safety of the child
- Make referrals to qualified examiners at appropriate times
- Understand the qualifications, levels, and types of examiners
- Judge the performance of examiners to whom one refers
- Determine the skills the reader may wish to develop

The knowledge acquired will help the health care professional protect and facilitate the recovery of children and families in a team-like approach with community agencies and courts.

Reporting

Almost everyone who works with children in a professional capacity, including physicians and nurses, is required to report a suspicion of child abuse to the Arkansas State Police Child Abuse Hotline. The telephone number is (800) 482-5964. The reporting of a suspicion (not necessarily a certainty) is legally required of health care providers, who frequently will not be certain that abuse occurred. Good faith reporting is considered to provide immunity from suit.

Disclosure of relevant information to the Hotline is not a violation of HIPAA. If an investigator needs to quickly interview the child and determine safety of discharge from your office or emergency department, this information should be provided clearly to the Hotline intake personnel.

History

The initial healthcare provider needs information to plan the type of examination and testing needed as well to assess for immediate safety concerns. This can be accomplished with a focused medical history. A more in-depth, disclosure interview requires specific training and should be performed in conjunction with an investigating agency, which may be local law enforcement, Arkansas State Police or the Arkansas Department of Human Services. If a health care provider alone interviews, the child will be re-interviewed by an investigator, and multiple interviews of children are undesirable.

Unfortunately, sexually abused children might not disclose in an interview. The perpetrator may have ensured their past silence for days, weeks or months by intimidation or bribery, causing them to remain cautious about repeating the disclosure to a stranger. Since the offender commonly is a family member, the non-offending parent often is conflicted as to whether to believe the child's disclosure or the adult's denial, and the safety of the child becomes a concern.

If the child is clearly safe, the clinician does not need to maintain the presence of the child and family for an immediate interview by an investigator. If the safety of the child from an alleged perpetrator is uncertain, however, prompt interview and assessment of the child and family by an investigator *before they leave the health care provider's office or emergency room* is essential. This assessment is obtained by reporting the suspected abuse to the Child Abuse Hotline and clearly and directly describing the imminent concern for the child's safety.

Arkansas now has a statewide hospital protocol decision tree flowchart posted in emergency departments. Healthcare providers should refer to this chart for procedures to follow for a child victim. After making a report to the Child Abuse Hotline, wait for contact by Arkansas State Police Crimes Against Children Division before discharging the patient.

Sites of Evaluation

Immediate examinations are sometimes needed for timely medical intervention or when biologic material from an alleged perpetrator is likely to be recovered. They are commonly performed in hospital emergency rooms. Emergency exams are indicated in the following situations:

- Alleged sexual abuse occurred less than 96 hours previously and biological material may have been exchanged.
    - Collection of Collection of biologic material out to 96 hours is indicated in post-menarchal females with a history of vaginal penetration with ejaculation.
- Child has current urinary, genital, or rectal complaints
- Child discloses current pain or bleeding
- Child has bruises or other signs of trauma
- Alleged perpetrator is known or believed to have a sexually transmitted disease
- Child will be exposed to the alleged perpetrator
- Suspicion of DFSA

Hospital emergency rooms are highly stressful environments for sexually abused children and their families and sometimes lack the appropriate equipment and expertise. Fortunately, most evaluations of sexually abused children can be postponed to an appointment time in a regional center or children's advocacy center for the medical evaluation of sexually abused children. In order to be considered such a center, a facility should:

- Support pediatric forensic medical issues through demonstrated leadership, quality assurance, and continuing education in child abuse issues
- Provide a timely forensic medical response to child sexual abuse
- Participate in ongoing review of examinations with abnormal or unclear findings with an experienced child sexual abuse provider.
- Accept appointments by referral to a specialized center for the medical evaluation if the history meets the criteria for delayed examination or if there is an examiner available to perform an acute examination. Children's advocacy centers and the Arkansas Children's Hospital Rice Medical Clinic meet these criteria.

Overview of Physical Evaluation

Scientifically based, appropriate, and minimally invasive examination techniques are required, usually with magnification. The science is evolving rapidly; accurate diagnosis and treatment is dependent upon the clinician's understanding of the current state of the art. *A skillful examination must be conducted, physical findings documented, forensic materials preserved, and tests for infection obtained. A poorly performed examination can result in added stress to the child, loss of evidence, and failure to diagnose a sexually transmitted disease. An incorrectly interpreted exam can result in failure to protect a child, unnecessary disruption of a family, and false accusation of an alleged perpetrator.* Diagnostic quality photographic still and/or video documentation of examination findings enables peer review and expert or second opinions.

The potential benefits of a pediatric physical evaluation are more than forensic. The purposes include the following:

- Diagnosis and treatment of medical conditions resulting from sexual abuse;
- Identification and documentation of evidence of abuse;
- Assessment of the child's safety;
- Differentiation of variants of normal anatomy commonly mistaken for injury;
- Diagnosis and treatment of other medical problems which may mimic abuse;
- Reassurance of the child and family when the exam is normal (since the examinations of most sexually abused girls and boys are normal);
- Referral for counseling if indicated;
- Provision of expert witness testimony.

All children who are suspected victims of child sexual abuse should be offered physical evaluations. *Situations in which immediate or delayed examinations are likely to be the most critical are listed in the following:*

The SIX "Ps"

1. PENILE CONTACT or PENETRATION by any object

- Penile contact with the genitalia, anus or mouth of a possible victim poses a risk of an STD, whether or not penetration clearly occurred.
- Insertion of a finger or object inside the genital or anal area

2. PAINFUL CONTACT

- Any contact that caused pain in the anal or genital area of the victim.

3. PHYSICAL SIGNS

- Genital or anal pain, discharge, sores, bleeding, or painful urination could indicate an injury or STD.

4. PROBLEMATIC SEXUAL BEHAVIORS

- Young children (10 years and younger) who force or coerce other children into sexual contact and children who are displaying sexual acting out behaviors beyond normal developmentally appropriate ranges (child resists being distracted from sexual behaviors/viewing sexual material, self-touching that causes pain, imitating sexual acts with others or with dolls, sexual contact with animals). These problems are not diagnostic that sexual abuse has occurred but warrant evaluation.

5. PERPETRATOR EXPOSED CHILDREN

- A victim's siblings or step-siblings that were exposed to the alleged perpetrator often have been sexually abused in spite of denials.
- Siblings of a child with an STD may also be infected.
- Children of a suspected perpetrator often have been sexually abused and have their own reasons for denial.

6. PREDISPOSITION OF A CHILD TO DENY

Denial of sexual abuse when circumstances suggest it may have occurred, especially when a child:

- Is related to or has close attachment to the suspected perpetrator
- Perceives being blamed by family for causing problems
- Has low self-esteem, low self-confidence
- Seeks approval, tends to obey anything asked of them
- Has cause for fear/anxiety due to prior abuse/violence in the home or has been threatened that harm would occur with disclosure
- Is less that age 5 and/or has cognitive delays making verbalization of abuse more difficult.

Levels of Sexual Abuse Examiners of Premenerchal/Prepubertal Children

In Arkansas, examiners of premenarchal/prepubertal children suspected of having been sexually abused can be divided into three current functional levels based on training, experience and continuing education. All providers should be licensed to practice in their respective field by the state of Arkansas.

Urgent Care (Level I) Examiners

Examinations of sexually abused children are often performed by Level 1 examiners. They perform preliminary assessments because of necessity when an examination is needed without delay for availability of a more experienced examiner. Level 1 examiners often are community hospital emergency department or

primary care physicians that have training in the overall care of emergent medical needs of children, but are not specifically trained in child sexual abuse. They commonly:

- Document presence of injuries by verbal description or drawings in the medical record.
- Test for sexually transmitted diseases (STDs) and provide appropriate initial management.
- Address potential pregnancy issues in post-pubertal female patients.
- Refer most children to a more experienced examiner to assess for non-acute, healed injuries and make appropriate referrals and follow-up appointments.

Ideally, all sexual abuse examinations would be performed by Level 2 or Level 3 examiner so that follow-up exams would not be needed. However, in a rural state such as Arkansas, that is not always possible.

Skilled (Level 2) Examiners

These medical providers have had specific training in the recognition of acute injuries, normal findings, healed injuries, and STD's. They perform the following:

- Obtain a screening medical history to determine whether an examination needs to be performed immediately, or can be scheduled at a later time.
- Obtain a complete medical history, including past medical history, current symptoms, and recent treatment, if any.
- Understand the concept of differential diagnosis, and the signs and symptoms which can be caused by conditions other than abuse.
- Have completed both didactic and clinical training specifically in the field of child sexual abuse, participate in ongoing continuing education in the field and participate in review with a Level 3 provider or child abuse expert of all examination findings thought to be abnormal or indicative of trauma from sexual abuse.
- Evaluate children and adolescents for evidence of acute (fresh) injuries of sexual assault/abuse utilizing photo documentation (or drawings of findings if the child objects to use of photo-documentation device); recognize genital and anal findings that are clearly normal or normal variants; utilize peer review for findings thought to indicate physical evidence of sexual abuse or unclear findings; deferment of final assessments pending review of photographs if concerning findings are present.
- Test for STDs and provide appropriate initial management. Understand the need to perform confirmatory testing of certain types of STD's prior to treatment.
- Address potential pregnancy issues in post-pubertal female patients.
- Collect forensic evidence as appropriate, depending on time since last incident and other factors.

- If needed, refer to a Level 3 examiner for confirmation that a healed injury may be present; otherwise, arrange other appropriate referrals (including mental health) and follow-up tests for STDs and pregnancy.

- Understand and accept responsibility for providing court testimony if needed.

- Participate in ongoing continuing medical education on child abuse issues.

Most pediatric SANE nurses evaluating children in Arkansas' children's advocacy centers are Level 2 examiners.

Tertiary (Level 3) Examiners

- Perform the items listed for a Level 2 provider.

- Have advanced training as a nurse practitioner or physician in the overall assessment of the health and developmental status of children.

- Have had specialized post graduate/post residency training in the evaluation of child sexual abuse cases.

- Participate in ongoing professional continuing education specific to the field of child sexual abuse.

- Commonly provide initial evaluations of children and adolescents, perform second opinion examinations for less experienced examiners, and review photographs for other examiners.

How is the quality of the evaluations of secondary and tertiary examiners assessed? In addition to utilizing the preceding qualifications, an examiner should provide care at current nationally recognized standards. These standards include:

- Utilize a photo-documentation system that allows for magnification and capture of diagnostic quality still or video images of the ano-genital findings. The "colposcope" was traditionally used to accomplish this, but other options are available to provide the needed light source, magnification and capture/storage functions of a colposcope.

- Avoids overcalling insignificant findings as significant. Experienced providers will typically have significant findings in no more than 10 % of their overall cases.

- Routinely participates in review of examination findings that are abnormal or unclear with other expert or Level 3 providers.

- Documenting the location of injuries in an anatomically correct manner (labia, vestibule, hymen, urethral orifice, intra-vaginal, anal verge, anus or rectum);

- Documenting the location of injuries as if a clock was superimposed over the genital or anal area, such as "at 4 o'clock";

- Never using outdated or slang terms for the status of the hymen such as "intact", "marital", or "virginal";

- Limiting the diagnosis or "proof" of sexual abuse from the medical exam alone to:
    - Identification of perpetrator DNA in the patient;
    - Acute or healed complete transection (tear) of the hymen in the absence of a history of accidental penetrating trauma;
    - Acute injuries to the anal or genital structures in the absence of a history of accidental trauma;
    - Certain sexually transmitted diseases;
    - Pregnancy in the absence of a legal, consensual relationship.
- Adherence to an evidence-based documentation scheme in reporting the results of the physical exam. Common "findings" which are not evidence-based indicators of sexual abuse include:
    - Absence of the hymen;
    - Apparently large hymenal opening without other findings;
    - Generalized redness in genital area without bruising, bleeding, or petechiae;
    - Anal dilatation without specific measurement in different planes (directions) and notation of absence of visible stool;
    - Anal "scars" in midline.

    (Jones, J.G., 2005)

Arkansas Children's Advocacy Centers

A Child Advocacy/Safety Center (CAC/CSC) is a not-for-profit child friendly facility that provides a location for forensic interviews, advocacy services and access to specialized medical examinations and trauma focused mental health services during the course of a child maltreatment investigation. It provides a coordinated, collaborative and culturally competent Multi-Disciplinary Team (MDT) response to allegations of child abuse. To the greatest extent possible, components of the team response are provided at the CSC.

Currently Arkansas has 15 functional CAC's, with other communities in varying stages of interest and center development. (http://cacarkansas.org/find_a_cac.php) CAC's offer access to specialized medical evaluations for alleged sexual abuse and many have access to these services on-site. Typically, centers utilize pediatric-Sexual Assault Nurse Examiners (P-SANEs), physicians or advance practice nurses who have received specific training in pediatric sexual assault examinations and are physician supported (if not an advanced practice nurse), to complete the exams.

Arkansas' centers also offer access to specialized trauma focused mental health services, either on site or through linkage agreements with local providers. The CAC's advocate will help the child and non-offending caregiver access the appropriate treatment to meet their individual mental health needs. Mental health services provided on site at the CAC are provided free of charge.

Trauma-Focused Mental Health Services

Children who have been sexually abused may suffer from a variety of symptoms related to their trauma. It is recommended that these children are referred for assessment to determine if they are suffering from trauma-related symptoms to assist in treatment planning. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based approach that has been shown to be helpful for children dealing with trauma. Children treated with TF-CBT have shown improvement in PTSD, depression, anxiety, shame, and behavior problems when compared to supportive therapy. These improvements have been maintained when followed up after two years. TF-CBT also focuses on the parents' needs. Improvement in parental distress, parental support, and parental depression has also been maintained in two-year follow-ups. The treatment is successful with diverse ethnic and racial populations. It is recommended that children who have trauma-related symptoms receive TF-CBT or other evidence-based therapies. Support and education for parents is crucial as parent support for victims is the most critical factor in positive outcomes for children.

Many children who have experienced traumatic events go without treatment or receive treatment that has not proven to be effective in treating traumatic stress symptoms. There is a tremendous need for mental health professionals to be trained in evidence-based models for treating trauma. Mental health professionals may access resources in Arkansas for TF-CBT training or to find TF-CBT-trained therapists listed at www.uams.edu/arbest.

Family Treatment Program

The Family Treatment Program (FTP) is a specialized mental health treatment program within the UAMS Department of Pediatrics that provides assessment and treatment for victims of sexual abuse, youth who have offended, and the parents of both. A team approach is used for victims of child sexual abuse and their families, including secondary victims such as non-offending parents, siblings, and grandparents. Specialized services in the FTP include individual, family, and group therapies. Therapists also work with community agencies to coordinate services for children and minimize system trauma for the child and family. FTP provides TF-CBT and treatment to address family reunification issues. Referrals are made by community agencies, CACs, the Arkansas Division of Children and Family Services, courts, and the families themselves.

The Adolescent Sexual Adjustment Project (ASAP) is a specialized program within the Family Treatment Program that has provided assessment and victim-centered treatment of children and adolescents with sexual behavior problems since 1995. A specially trained and experienced staff assists families and community agencies in safety and treatment planning. Services include psychosexual assessments, specialized individual, group, and family treatment for young children and adolescents with sexual behavior problems, and educational groups for their parents. Referrals are made by Juvenile Courts and the Division of Youth Services and the Division of Children and Family Services.

Chapter

7

7. Arkansas Law

The following is a composition of statutes from **Arkansas Code Annotated** that may be relevant to your work as a medical professional conducting sexual assault exams. For more information: http://www.arkleg.state.ar.us

The Arkansas Legislature meets every other year, in odd numbered years (2011, 2013, etc.) to address substantive law issues and it meets every year to address fiscal issues. Should you notice that the laws as presented here are inconsistent with current laws, please contact the Arkansas Commission on Child Abuse, Rape and Domestic Violence at (501)661-7975 for an updated version.

Reporting

Reporting Sexual Assault - Adult Patients

The decision to report a sexual assault to law enforcement or not is made by the adult patient. Should the patient decide to report the incident to a law enforcement agency, the appropriate law enforcement agency shall be contacted. Generally, this will be the law enforcement agency in the area where the assault occurred, if known. Arkansas Code §12-12-402.

Also, the victim of sexual assault is not required to participate in the criminal justice system or to cooperate with law enforcement in order to be provided with a forensic medical exam or reimbursement for charges incurred on account of a forensic medical exam, or both.

Forensic evidence will be collected only with informed consent of the patient. However, permission shall not be required in instances where the patient is unconscious, mentally incapable of consent or intoxicated.

Reporting Sexual Assault or Abuse - Child Patients

Reporting the sexual assault or abuse of a minor is mandatory for many professionals. Arkansas Code Annotated Section 12-18-402. Reports of child abuse, sexual abuse, and neglect made pursuant to § 12-18-402 can be made to the child abuse hotline at 1-800-482-5964. All investigations shall begin within seventy-two (72) hours, however; if the notice contains an allegation of severe maltreatment, or of neglect, then the investigation shall begin within twenty-four (24) hours. Investigations of sexual abuse, physical abuse and neglect are conducted by the Department of Human Services Division of Children & Family Services; the Arkansas State Police Crimes Against Children Division and local law enforcement personnel pursuant to existing contracts, written, or verbal agreements.

Medical Legal Examinations

§ 12-12-401. Definitions

As used in this subchapter, unless the context otherwise requires:

(1) **(A)** "Appropriate emergency medical-legal examinations" means health care delivered with emphasis on the collection of evidence for the purpose of prosecution.

(B) It shall include, but not be limited to, the appropriate components contained in an evidence collection kit for sexual assault examination distributed by the Forensic Biology Section of the State Crime Laboratory;

(2) "Licensed health care provider" means a person licensed in a health care field who conducts medical-legal examinations;

(3) "Medical facility" means any health care provider that is currently licensed by the Department of Health and providing emergency services; and

(4) "Victim" means any person who has been a victim of any alleged sexual assault or incest as defined by § 5-14-101 et seq. and § 5-26-202.

HISTORY: Acts 1983, No. 403, §§ 1-3; A.S.A. 1947, §§ 41-1820 -- 41-1822; Acts 1991, No. 612, § 1; 2001, No. 993, § 1; 2003, No. 1390, § 3.

12-12-402. Procedures Governing Medical Treatment

(a) All medical facilities or licensed health care providers conducting medical-legal examinations in Arkansas shall adhere to the procedures set forth in this section in the event that a person presents himself or herself or is presented for treatment as a victim of rape, attempted rape, any other type of sexual assault, or incest.

(b)(1)(A) Any adult victim presented for medical treatment shall make the decision of whether or not the incident will be reported to a law enforcement agency.

(B) No medical facility or licensed health care provider may require an adult victim to report the incident in order to receive medical treatment.

(C)(i) Evidence will be collected only with the permission of the victim.

(ii) However, permission shall not be required when the victim is unconscious, mentally incapable of consent, or intoxicated.

(2)(A) Should an adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility or licensed health care provider or the victim's designee.
(B)(i) The victim shall be given a medical screening examination by a qualified medical person as provided under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, as in effect on January 1, 2001, if the victim arrives at the emergency department of a hospital, and the person shall be examined and treated and any injuries requiring medical attention will be treated in the standard manner.
(ii) A medical-legal examination shall be conducted and specimens shall be collected for evidence.
(C) If a law enforcement agency has been contacted and with the permission of the victim, the evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.
(c)(1) Any victim under eighteen (18) years of age shall be examined and treated, and any injuries requiring medical attention shall be treated in the standard manner.
(2) A medical-legal examination shall be performed, and specimens shall be collected for evidence.
(3) The reporting medical facility or licensed health care provider shall follow the procedures set forth in Subchapter 4 of the Child Maltreatment Act, § 12-18-101 et seq., regarding the reporting of injuries to victims under eighteen (18) years of age.
(4) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.
(d) Reimbursement for the medical-legal examinations shall be available to the medical facility or licensed health care provider pursuant to the procedures set forth in § 12-12-403.
(e) A medical facility or licensed healthcare provider shall not transfer the victim to another medical facility unless:
(1) The victim or a parent or guardian of a victim under eighteen (18) years of age requests the transfer, or a physician or other qualified medical personnel when a physician is not available has signed a certification that the benefits to the victim's health would outweigh the risks to the victim's health as a result of the transfer; and
(2) The transferring medical facility or licensed healthcare provider provides all necessary medical records and ensures that appropriate transportation is available.
Credits
Acts of 1985, Act 400, §§ 1, 2; Acts of 1985, Act 838, §§ 1, 2; Acts of 1991, Act 612, § 2; Acts of 2001, Act 993, § 2, eff. Aug. 13, 2001; Acts of 2009, Act 758, § 23, eff. July 31, 2009; Acts of 2017, Act 250, § 4, eff. Aug. 1, 2017; Acts of 2017, Act 845, § 3, eff. Aug. 1, 2017.

12-12-403. Examinations and Treatment - Payment

(a) All licensed emergency departments shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims.
(b)(1)(A) All victims shall be exempted from the payment of expenses incurred as a result of receiving a medical-legal examination if the victim receives the medical-legal examination within ninety-six (96) hours of the attack.
(B) However, the time limitation of ninety-six (96) hours may be waived if the victim is a minor or if the Crime Victims Reparations Board finds that good cause exists for the failure to provide the medical-legal examination within the required time.

(2)(A) This subsection does not require a victim of sexual assault to participate in the criminal justice system or to cooperate with law enforcement in order to be provided with a forensic medical exam or reimbursement for charges incurred on account of a forensic medical exam, or both.
(B) Subdivision (b)(2)(A) of this section does not preclude a report of suspected abuse or neglect as permitted or required by the Child Maltreatment Act, § 12-18-101 et seq.
(c)(1) A medical facility or licensed health care provider that performs a medical-legal examination shall submit a sexual assault reimbursement form, an itemized statement that meets the requirements of 45 C.F.R. § 164.512(d), as it existed on January 2, 2001, directly to the board for payment.
(2) The medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the board to the victim.
(3) Acceptance of payment of the expenses of the medical-legal examination by the board shall be considered payment in full and bars any legal action for collection.

Credits
Acts of 1983, Act 403, §§ 4, 5; Acts of 1991, Act 396, § 8; Acts of 2001, Act 993, § 3, eff. Aug. 13, 2001; Acts of 2007, Act 676, § 4, eff. July 31, 2007; Acts of 2009, Act 758, § 24, eff. July 31, 2009; Acts of 2017, Act 920, § 1, eff. Aug. 1, 2017.

§ 12-12-404. Reimbursement of Medical Facility – Rules and Regulations

(a) The Crime Victims Reparations Board may reimburse any medical facility or licensed health care provider that provides the services outlined in this subchapter for the reasonable cost for such services.
(b) The board is empowered to prescribe minimum standards, rules, and regulations necessary to implement this subchapter. These shall include, but not be limited to, a cost ceiling for each claim and the determination of reasonable cost.

HISTORY: Acts 1983, No. 403, § 6; A.S.A. 1947, § 41-1825; Acts 1991, No. 396, § 1; 2001, No. 993, § 4.

§ 12-12-405. License Suspension or Revocation

Noncompliance with the provisions of this subchapter is grounds for licensure suspension or revocation pursuant to the provisions of § 20-9-215 or any other provisions governing the licensure of medical facilities or health care providers.
HISTORY: Acts 1991, No. 612, § 3; 2001, No. 993, § 5.

Sexual Offenses

5-14-101. Definitions

As used in this chapter:

(1) "Deviate sexual activity" means any act of sexual gratification involving:
(A) The penetration, however slight, of the anus or mouth of a person by the penis of another person; or
(B) The penetration, however slight, of the labia majora or anus of a person by any body member or foreign instrument manipulated by another person;
(2) "Forcible compulsion" means physical force or a threat, express or implied, of death or physical injury to or kidnapping of any person;
(3) "Guardian" means a parent, stepparent, legal guardian, legal custodian, foster parent, or any person who by virtue of a living arrangement is placed in an apparent position of power or authority over a minor;
(4)(A) "Mentally defective" means that a person suffers from a mental disease or defect that renders the person:
(i) Incapable of understanding the nature and consequences of a sexual act; or
(ii) Unaware a sexual act is occurring.
(B) A determination that a person is mentally defective shall not be based solely on the person's intelligence quotient;
(5) "Mentally incapacitated" means that a person is temporarily incapable of appreciating or controlling the person's conduct as a result of the influence of a controlled or intoxicating substance:
(A) Administered to the person without the person's consent; or
(B) That renders the person unaware a sexual act is occurring;
(6) "Minor" means a person who is less than eighteen (18) years of age;
(7) "Physically helpless" means that a person is:
(A) Unconscious;
(B) Physically unable to communicate a lack of consent; or
(C) Rendered unaware a sexual act is occurring;
(8) "Public place" means a publicly or privately owned place to which the public or a substantial number of people have access;
(9) "Public view" means observable or likely to be observed by a person in a public place;
(10) "Recording" includes without limitation an image or video;
(11) "Sexual contact" means any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
(12) "Sexual intercourse" means penetration, however slight, of the labia majora by a penis;
(13) "Sexually explicit conduct" means the same as defined in § 5-27-302; and
(14) "State of nudity" means the same as defined in § 5-26-302.

Credits
Acts of 1975, Act 280, § 1801; Acts of 1985, Act 327, § 1; Acts of 1985, Act 563, § 1; Acts of 1995, Act 525, § 1; Acts of 2001, Act 1724, § 1, eff. Aug. 13, 2001; Acts of 2009, Act 748, § 7, eff. July 31, 2009; Acts of 2017, Act 664, § 1, eff. Aug. 1, 2017.

5-14-103. Rape

(a) A person commits rape if he or she engages in sexual intercourse or deviate sexual activity with another person:
(1) By forcible compulsion;
(2) Who is incapable of consent because he or she is:
(A) Physically helpless;
(B) Mentally defective; or

(C) Mentally incapacitated;
(3)(A) Who is less than fourteen (14) years of age.
(B) It is an affirmative defense to a prosecution under subdivision (a)(3)(A) of this section that the actor was not more than three (3) years older than the victim; or
(4)(A) Who is a minor and the actor is the victim's:
(i) Guardian;
(ii) Uncle, aunt, grandparent, step-grandparent, or grandparent by adoption;
(iii) Brother or sister of the whole or half blood or by adoption; or
(iv) Nephew, niece, or first cousin.
(B) It is an affirmative defense to a prosecution under subdivision (a)(4)(A) of this section that the actor was not more than three (3) years older than the victim.
(b) It is no defense to a prosecution under subdivision (a)(3) or subdivision (a)(4) of this section that the victim consented to the conduct.
(c)(1) Rape is a Class Y felony.
(2) Any person who pleads guilty or nolo contendere to or is found guilty of rape involving a victim who is less than fourteen (14) years of age shall be sentenced to a minimum term of imprisonment of twenty-five (25) years.
(d)(1) A court may issue a permanent no contact order when:
(A) A defendant pleads guilty or nolo contendere; or
(B) All of the defendant's appeals have been exhausted and the defendant remains convicted.
(2) If a judicial officer has reason to believe that mental disease or defect of the defendant will or has become an issue in the case, the judicial officer shall enter orders consistent with § 5-2-327 or § 5-2-328, or both.
(e) A person convicted of rape is subject to § 9-10-121.

Credits
Acts of 1975, Act 280, § 1803; Acts of 1981, Act 620, § 12; Acts of 1985, Act 281, § 2; Acts of 1985, Act 919, § 2; Acts of 1993, Act 935, § 1; Acts of 1997, Act 831, § 1, eff. March 26, 1997; Acts of 2001, Act 299, § 1, eff. Aug. 13, 2001; Acts of 2001, Act 1738, § 1, eff. Aug. 13, 2001; Acts of 2003, Act 1469, § 3, eff. July 16, 2003; Acts of 2006 (1st Ex. Sess.), Act 5, § 2, eff. July 21, 2006; Acts of 2009, Act 748, § 8, eff. July 31, 2009; Acts of 2013, Act 210, § 2, eff. March 1, 2013; Acts of 2017, Act 472, § 19, eff. Aug. 1, 2017.

5-14-124. Sexual Assault in the First Degree

(a) A person commits sexual assault in the first degree if:
(1) The person engages in sexual intercourse or deviate sexual activity with a minor who is not the actor's spouse and the actor is:
(A) Employed with the Department of Correction, the Department of Community Correction, the Department of Human Services, or any city or county jail or a juvenile detention facility, and the victim is in the custody of the Department of Correction, the Department of Community Correction, the Department of Human Services, any city or county jail or juvenile detention facility, or their contractors or agents;
(B) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the minor while the minor is on probation or parole or for any other court-ordered reason;

(C) A mandated reporter under § 12-18-402(b) and is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(D) An employee in the victim's school or school district, a temporary caretaker, or a person in a position of trust or authority over the victim; or
(2) The person is a teacher, principal, athletic coach, or counselor in a public or private school in kindergarten through grade twelve (K-12) and the actor:
(A) Engages in sexual intercourse or deviate sexual activity with a person who is not the actor's spouse and the victim is:
(i) Less than twenty-one (21) years of age; and
(ii) A student enrolled in the public or private school employing the actor; and
(B) Is in a position of trust or authority over the victim and uses his or her position of trust or authority over the victim to engage in sexual intercourse or deviate sexual activity.
(b) It is no defense to a prosecution under this section that the victim consented to the conduct.
(c) It is an affirmative defense to a prosecution under subdivision (a)(1)(D) of this section that the actor was not more than three (3) years older than the victim.
(d) Sexual assault in the first degree is a Class A felony.

Credits
Acts of 2001, Act 1738, § 2, eff. Aug. 13, 2001; Acts of 2003, Act 1391, § 1, eff. July 16, 2003; Acts of 2003, Act 1469, § 2, eff. July 16, 2003; Acts of 2009, Act 748, § 10, eff. July 31, 2009; Acts of 2009, Act 758, § 2, eff. July 31, 2009; Acts of 2013, Act 1044, § 1, eff. Aug. 16, 2013; Acts of 2017, Act 418, § 2, eff. Aug. 1, 2017.

5-14-125. Sexual Assault in the Second Degree

(a) A person commits sexual assault in the second degree if the person:
(1) Engages in sexual contact with another person by forcible compulsion;
(2) Engages in sexual contact with another person who is incapable of consent because he or she is:
(A) Physically helpless;
(B) Mentally defective; or
(C) Mentally incapacitated;
(3) Being eighteen (18) years of age or older, engages in sexual contact with another person who is:
(A) Less than fourteen (14) years of age; and
(B) Not the person's spouse;
(4)(A) Engages in sexual contact with a minor and the actor is:
(i) Employed with the Department of Correction, the Department of Community Correction, any city or county jail, or any juvenile detention facility, and the minor is in custody at a facility operated by the agency or contractor employing the actor;
(ii) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the minor while the minor is on probation or parole or for any other court-ordered reason;
(iii) A mandated reporter under § 12-18-402(b) and is in a position of trust or authority over the minor; or
(iv) The minor's guardian, an employee in the minor's school or school district, a temporary caretaker, or a person in a position of trust or authority over the minor.
(B) For purposes of subdivision (a)(4)(A) of this section, consent of the minor is not a defense to a prosecution;

(5)(A) Being a minor, engages in sexual contact with another person who is:
(i) Less than fourteen (14) years of age; and
(ii) Not the person's spouse.
(B) It is an affirmative defense to a prosecution under this subdivision (a)(5) that the actor was not more than:
(i) Three (3) years older than the victim if the victim is less than twelve (12) years of age; or
(ii) Four (4) years older than the victim if the victim is twelve (12) years of age or older; or
(6) Is a teacher, principal, athletic coach, or counselor in a public or private school in a grade kindergarten through twelve (K-12), in a position of trust or authority, and uses his or her position of trust or authority over the victim to engage in sexual contact with a victim who is:
(A) A student enrolled in the public or private school; and
(B) Less than twenty-one (21) years of age.
(b)(1) Sexual assault in the second degree is a Class B felony.
(2) Sexual assault in the second degree is a Class D felony if committed by a minor with another person who is:
(A) Less than fourteen (14) years of age; and
(B) Not the person's spouse.

Credits
Acts of 2001, Act 1738, § 3, eff. Aug. 13, 2001; Acts of 2003, Act 1323, § 1, eff. July 16, 2003; Acts of 2003, Act 1720, § 2, eff. July 16, 2003; Acts of 2009, Act 748, §§ 11 to 13, eff. July 31, 2009; Acts of 2009, Act 758, § 3, eff. July 31, 2009; Acts of 2011, Act 1129, § 1, eff. July 27, 2011; Acts of 2013, Act 1086, § 2, eff. Aug. 16, 2013; Acts of 2017, Act 418, § 3, eff. Aug. 1, 2017.

5-14-126. Sexual Assault in the Third Degree

(a) A person commits sexual assault in the third degree if the person:
(1) Engages in sexual intercourse or deviate sexual activity with another person who is not the actor's spouse, and the actor is:
(A) Employed with the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the actor is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity;
(B) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the person while the person is on probation or parole or for any other court-ordered reason;
(C) Employed or contracted with or otherwise providing services, supplies, or supervision to an agency maintaining custody of inmates, detainees, or juveniles, the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the actor is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(D) A mandated reporter under § 12-18-402(b) or a member of the clergy and is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(2)(A) Being a minor, engages in sexual intercourse or deviate sexual activity with another person who is:

(i) Less than fourteen (14) years of age; and
(ii) Not the person's spouse.
(B) It is an affirmative defense under this subdivision (a)(2) that the actor was not more than three (3) years older than the victim.
(b) It is no defense to a prosecution under this section that the victim consented to the conduct.
(c) Sexual assault in the third degree is a Class C felony.

Credits
Acts of 2001, Act 1738, § 4, eff. Aug. 13, 2001; Acts of 2003, Act 1324, § 1, eff. July 16, 2003; Acts of 2007, Act 363, § 1, eff. July 31, 2007; Acts of 2009, Act 748, § 14, eff. July 31, 2009; Acts of 2009, Act 758, § 4, eff. July 31, 2009; Acts of 2017, Act 418, § 4, eff. Aug. 1, 2017; Acts of 2017, Act 660, § 1, eff. Aug. 1, 2017.

5-14-127. Sexual Assault in the Fourth Degree

(a) A person commits sexual assault in the fourth degree if the person:

(1) Being twenty (20) years of age or older:

(A) Engages in sexual intercourse or deviate sexual activity with another person who is:

(i) Less than sixteen (16) years of age; and

(ii) Not the person's spouse; or

(B) Engages in sexual contact with another person who is:

(i) Less than sixteen (16) years of age; and

(ii) Not the person's spouse; or

(2) Engages in sexual contact with another person who is not the actor's spouse, and the actor is employed with the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or a city or county jail.

(b) (1) Sexual assault in the fourth degree under subdivisions (a)(1)(A) and (a)(2) of this section is a Class D felony.

(2) Sexual assault in the fourth degree under subdivision (a)(1)(B) of this section is a Class A misdemeanor if the person engages only in sexual contact with another person as described in subdivision (a)(1)(B) of this section.
HISTORY: Acts 2001, No. 1738, § 5; 2003, No. 1325, § 1; 2009, No. 630, § 1.

The Impact of HIPAA on Disclosure of Patient Health Information

HIPAA is an acronym referring to the federal Health Insurance Portability and Accountability Act of 1996. HIPAA has two key purposes. The first (Title I) is intended to protect health insurance coverage for workers and their families when they change or lose their jobs. The second (Title II) addresses, through new protections, the security and privacy of patient health data. This latter area has different requirements regarding the protection of health information for adult and child victims of sex crimes.

Adults

AR Code Arm 12-12-402 states that "any adult victim who presents for medical treatment for rape, sexual assault, or incest shall make the decision of whether or not the incident will be reported to a law enforcement agency." Since health professionals are not required to report, *no HIPAA exception to disclosure of protected health information for adult rape victims exists*. The patient's written permission must be obtained utilizing a form that meets HIPAA standards. The form utilized in the Arkansas Children's House of the University Of Arkansas College Of Medicine is Appendix C.

Persons Less Than Age 18 or Mentally Incompetent

Child abuse/neglect are specifically addressed in two separate sections of the HIPAA regulations. *Section 160.203* makes it clear that HIPAA preempts state laws where they are contrary to HIPAA.

Section 164.512 addresses situations where the subject's consent may not be required. A covered entity may disclose information (beyond mere reporting) about victims of child maltreatment or domestic violence, even if otherwise "protected health information," to appropriate government authorities only if:

- Such disclosure would be authorized or required by law or regulations; and
- Disclosure of information on the victim is considered necessary to prevent serious harm to them or to other potential victims; or
- The victim consents to the disclosure.

When information is sought about child victims of crimes, provisions for disclosure to police are similar to those in Section 164.512(c). There are further exceptions for providing information to coroners or medical examiners.

Accounting Versus Obtaining Authorization for Disclosure

Any disclosure for purposes of treatment, payment or healthcare operations, or for which there is patient authorization to make the disclosure, is permissible under HIPAA and does NOT have to be accounted for in a log maintained by the health care facility. *Any disclosure for the following purposes MUST be accounted for in a log maintained by the health care facility, unless written consent is provided:*

- A disclosure required by law;
- A disclosure to a law enforcement official;
- A disclosure pursuant to a subpoena, court order, warrant or during testimony given in court;
- A disclosure to a coroner, medical examiner, funeral director or to an organ procurement organization such as ARORA;

- A disclosure to a health oversight agency responsible for overseeing the health care system.

Disclosure of protected health information for any purpose other than treatment, payment or healthcare operations, even if required by law to report, must be recorded in the log unless the legal guardian has signed an authorization for disclosure of the information. Thus, the most expedient approach may be to request everyone to sign an authorization for disclosure of protected health information.

Forms

Each patient must be given a *Notice of Privacy Practices*. HIPAA requires covered entities to make "good faith efforts" to obtain written verification that patients have received a copy of a Notice of Privacy Practices. Covered entities should have patients sign an *acknowledgement form* when they receive a copy of the Notice of Privacy Practices. Medical practices should also keep a copy of this written acknowledgement in patient's medical records.

The following materials and forms must be available upon patient request:

1) Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties
2) Request for Limitations and Restrictions of Protected Health Information
3) Request to Inspect and Copy Protected Health Information
4) Request for Correction/Amendment of Protected Health Information
5) Request for an Accounting or Certain Disclosures of Protected Health Information
6) Patient Complaint Form

Use of a consent form for examination and treatment of a patient is optional. It does not take the place of an authorization for disclosure of protected health information. Practices that decide to obtain signed consent forms from its patients must still make a good faith effort to obtain written acknowledgement from them of receipt of the Notice of Privacy Practices in order to be in compliance with the Privacy Rule.

Penalty for Violation of HIPAA

HIPAA violations carry fines and penalties that would be assessed against a covered entity or an individual. A staff member who caused the privacy breach could be held accountable for any financial penalties the covered entity incurs – either by way of HIPAA violations or private actions. (American Academy of Pediatrics, 2004). It is not a HIPAA violations for place a call to an advocate upon the victim's request.

Disclaimer

The above information is provided for informational purposes and should serve only as suggested starting points in your practice's compliance with HIPAA. Additional information is needed for compliance. This section is not intended to substitute for technical or legal advice. Reliance on information presented is at your own risk.

Chapter

8

8. Testifying in Court

A patient examination after sexual assault is a medical as well as a legal examination. It should be the expectation that the healthcare provider conducting the examination will be called on to testify in court as either a fact and/or expert witness. Court testimony will not always be needed, an arrest may not be made, a plea bargain may be agreed upon or the prosecuting attorney may decide not to try the case. Despite those possibilities, the healthcare provider should conduct and document each exam with the thought that legal testimony may occur. Most prosecutors are willing to work with the healthcare provider's busy schedule, and will allow them to be on call rather than sitting in the courthouse all day.

To prepare for potential testimony, the healthcare provider should first assure that documentation at the time of the exam is legible, objective, concise, and complete and includes diagrams when appropriate.

When preparing to testify the following guidelines may be useful:

- Meet with the prosecuting attorney in advance, if possible.
- It is reasonable to request if the attorney or victim witness coordinator could contact you with an appropriate lead time to avoid waiting at the courthouse for several hours.
- Refresh your memory about the case. Do not rely on your memory alone. Some cases may not come to trial for months or years after the event. Review written charts or records of the examination.
- Be prepared as an expert witness to educate the court, particularly the jurors. Consider in advance the terminology and descriptions that will most clearly advise the lay members of the court about the procedures, symptoms, etc. that are involved in the case.
- Remember that anything that you write about the case is potentially "discoverable". This means that it could be brought before the court as part of your testimony or to refute your testimony. You may be asked about any notes you have written or files you have concerning this case. If you have made notes or files about a case, you might discuss these with the prosecuting attorney.

- Keep a log of any material that you review for the case. For instance if you reviewed the medical record of John Doe's emergency department visit, your log entry might state: "Medical record of emergency department visit 1/2/00 reviewed on 6/29/00." To be even more specific, you might state: "Emergency department visit 1/2/00, reviewed results of CBC, chest x-ray, chlamydia screen, physician notes, nursing progress note and physician orders."

- Be prepared to "prove" your qualifications as an "expert". You may be asked about your education, clinical experience and prior experience as an expert witness. If you are testifying to facts in a case, you may be asked to explain how you are qualified to testify as to those facts. It is helpful to keep a portfolio that lists your education, experience and previous appearances as a witness.

During the testimony, it may be helpful to:

- Dress appropriately. Most of the lawyers and others in the courtroom will be dressed in business attire. Some studies say that people form an opinion about an individual in the first few seconds after meeting them. To this end, it is important to dress professionally.

- Be sincere, polite and appear in control. Being nervous is normal, even for those who have testified previously. Make eye contact with those who are questioning you. Avoid behaviors that display nervousness, such as: slouching in the chair, whispering, excessive hand movements or giggling.

- If you are unable to answer a question, be honest. If you need to refresh your memory, ask the judge or questioning attorney if you can refer to your report or to the record. If you do not know the answer to a question, say so. It is not necessary to defend yourself or provide an explanation for why you don't know the answer.

- Answer only the questions that are asked of you. Be concise and correct in your responses.

- If you do not understand a question that is asked of you, do not assume. Ask the questioning attorney for clarification or to restate the question.

- Avoid medical jargon if possible. It may be necessary to use medical terminology; however, its usage will need to be defined.

Our legal system is an adversarial system. This means there are two opposing sides that will both have the opportunity to question you. Be as sincere, polite and in control with the defense attorney as you were with the prosecutor. You do not have a side in the case. You are there to present the facts. If you have been called as a witness by the prosecutor's office, then you will be cross examined by the defendant's attorney. If you have been called by the defense attorney, you will be cross-examined by the prosecutor. In order to help you during cross- examination, remember to:

- Be sincere, polite and appear in control. Remain calm. Your credibility will be harmed if you appear angry, rude or out of control.

- You may disagree when appropriate, but do so calmly. Avoid arguing or interrupting during your disagreement.

- Look for "tricks" or "hidden meanings" designed to place doubt on your testimony. For instance, if a compound question is asked, the answer to one part may be "yes" and answer to the other part may be "no". Be sure to divide your answers instead of simply responding "Yes" or "No".

- When referring to the individuals involved in the case, use their names rather than calling them the patient and the suspect.

- Listen to the question and only answer what is asked of you. Don't elaborate unless you are asked to do so.

- Be sure your answers are concise and correct. You may be asked the same question several times, using different wording. Be sure your answers match each time.

- Be precise in your speech. Avoid terms such as "I believe" or "I think". And remember, if you don't know, say so.

- If an error or omission occurs in your testimony, acknowledge it politely. Do not make excuses, argue or take it personally.

- Always think before you answer a question. Allow time to consider your answers and clearly compose them before speaking.

- Listen to the questions fully and carefully.

After the legal proceedings are over, try to meet with the attorney to evaluate your testimony. Seek input concerning suggestions for improvement. Watch other experts testify when possible (Arndt, S., 1998).

Arkansas System for Juvenile Sexual Assault Patients

Reporting to the Child Abuse Hotline

Arkansas law requires that professionals (mandated reporters) must report to the Child Abuse Hotline if he or she has reasonable cause to suspect that a child has been subjected to child maltreatment which is defined to include sexual abuse.

(20) "Sexual abuse" means:
(A) By a person fourteen (14) years of age or older to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(iii) Indecent exposure; or
(iv) Forcing the watching of pornography or live sexual activity;

(B) By a person eighteen (18) years of age or older to a person not his or her spouse who is younger than fifteen (15) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(C) By a person twenty (20) years of age or older to a person not his or her spouse who is younger than sixteen (16) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(D) By a caretaker to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(iii) Forcing or encouraging the watching of pornography;
(iv) Forcing, permitting, or encouraging the watching of live sexual activity;
(v) Forcing the listening to a phone sex line;
(vi) An act of voyeurism; or
(vii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(E) By a person younger than fourteen (14) years of age to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or
(F) By a person eighteen (18) years of age or older to a person who is younger than eighteen (18) years of age, the recruiting, harboring, transporting, obtaining, patronizing, or soliciting of a child for the purpose of a commercial sex act

Failure to report by a mandated reporter in the first degree is a Class A misdemeanor and failure to report in the second degree is a Class C misdemeanor. Making a false report is a Class D felony. Your report initiates an investigation and assessment of safety. The telephone number of the Hotline is 800-482-5964.

Investigations

Your report will be transmitted, by the Hotline to the State Police area in which the incident is alleged to have occurred or the DHS/DCFS County where the family resides, which may give the local law enforcement office (police or sheriff) the opportunity to investigate. Once initiated, a safety assessment will be conducted and if the patient is not safe in the current environment, the Division of Children and Family Services will be notified and their involvement requested. Thus, investigations are conducted by agencies to determine whether civil or criminal proceedings should be initiated, or whether DHS will need to apply safety measures.

In some situations, the Hotline may not accept your report based on specific criteria. However, it is legally and ethically safer to have made the report.

Court Proceedings

Both criminal and civil laws may apply to sexual abuse and rape of teenagers. Investigators are often subpoenaed to appear in different court proceedings involving the same sexual event.

Civil proceedings are typically initiated by the Arkansas Department of Human Services (DHS) to either remove a child from a dangerous environment or to ensure that the child is properly protected from future harm or neglect. Although the identity of persons who caused harm to a child is often relevant in civil proceedings, those cases typically focus on the abuse and the parent or custodian who should have protected the child. In many instances, DHS attorneys must obtain an immediate order (sometimes referred to as a temporary or emergency order) to protect a child from a potentially dangerous situation until the investigation can be completed. Medical information relating to the child's injuries must be presented to a judge, but at this stage, testimony can sometimes be presented by medical affidavit. If the matter is not resolved, further court proceedings will be scheduled, and it will be necessary for medical personnel to testify in court. DHS cases are decided by a judge, not a jury.

DHS also conducts administrative proceedings for which subpoenas may be issued. These proceedings are conducted before an administrative law judge who is an employee of DHS, and the hearings are held in DHS offices throughout the state. If requested in advance of the hearing, the administrative law judges may allow medical testimony by telephone.

Criminal cases are assigned to prosecuting attorneys or their deputies, who file charges against persons suspected of causing the injuries. These two types of cases often involve the same facts and witnesses. However, the legal proceedings are in different courts, presented by different attorneys, and utilize different rules of evidence. Criminal proceedings also involve proof of injury or abuse, but they usually focus on the person(s) who allegedly harmed the patient. Defendants in criminal cases are entitled to a trial by jury unless waived by both the defendant and the prosecuting attorney. A non-jury trial is often referred to as a bench trial.

Sharing of Protected Health Information

Examiners are often unclear with whom they can provide protected health information. Even when a parent or guardian has signed the HIPAA Authorization, examiners still will need to exercise care in providing this information regarding any teenager less than age 18. In the following situations, you must have the following:

- Consent of a legal guardian to provide information to relatives of the sexual assault patients;
- A subpoena for a medical affidavit unless the patient is in DHS custody;
- Consent of the sexual assault patient's guardian or court order to provide information to a defense attorney
- HIPAA order for disclosure to share information to an attorney ad litem or CASA worker.
- A subpoena in order to testify in court.

If in doubt regarding the legality of providing health information, talk with your program's legal advisor.

Chapter

9

9. Reimbursement

Sexual Assault Reimbursement Program

In an effort to consolidate services offered by the Arkansas Crime Victims Reparations Board and the Sexual Assault Reimbursement Program, responsibility for the administration of the sexual assault program was transferred from the Office of the Prosecutor Coordinator to the Office of the Attorney General through Act 396 of 1991.

It is the objective of this legislation to ensure that in the instance of an alleged sexual assault, evidence can be collected without the burden of the expense falling on the shoulders of the alleged victim. The Sexual Assault Reimbursement Program simply pays for the collection of evidence and in no way attempts to prove or disprove the allegation of sexual assault.

In order for a medical facility to seek reimbursement for the expenses incurred while performing the medical-legal examination, the victim must seek treatment within seventy-two (72) hours, except in the case of a minor. A request form for reimbursement must be completed and signed by a physician or sexual assault nurse examiner who performs the examination. On July 31, 2007 Act 676 of 2007 changed the law that required sexual assault victims to report and cooperate with law enforcement for reimbursement of the medical-legal examination. This law now states that a sexual assault victim does not have to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam and to be reimbursed for charges incurred. The reimbursement form and an itemized statement should then be submitted to the Attorney General's Office.

The Sexual Assault Reimbursement Program will not cover expenses that are eligible to be paid by a federally financed benefits program, such as Medicaid, Medicare, TriCare or VA. In addition, this program will not cover expenses related to treatment of physical injuries that are directly related to the alleged assault or for a pre-existing injury.

Eligible expenses consist of the emergency room or facility fee, the physician or SANE fee, the ambulance fee, lab fees and colposcopy fee. In addition, medications for preventive measures are eligible.

The Arkansas Crime Victims Reparations Board instituted policies and procedures for the Sexual Assault Reimbursement Program that provides for the following maximum limits on the eligible expenses:

- Facility fee (includes medications) $350.00
- Physician or SANE fee $350.00
- Ambulance fee $350.00
- Lab fees $200.00
  (outside lab facilities will be given priority)
- Colposcopy fee $160.88

Medical facilities that transfer or receive a transferred patient alleging to have been sexually assaulted must complete the area on the sexual assault reimbursement form. In these instances, the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the transferring and receiving facility. This documentation includes justification of the decision to transfer the alleged victim. In these instances, the medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection.

The Sexual Assault Reimbursement Program covers only the expenses involved in performing the medical-legal examination. The victim or authorized claimant would need to submit any expenses pertaining to other treatment to the Crime Victims Reparations Board for consideration of payment. For additional information or an application, please contact:

Arkansas Crime Victims Reparations Board
Office of Attorney General Dustin McDaniel
323 Center Street, Suite 200
Little Rock, Arkansas 72201
(501) 682-1020 or 800-448-3014 (outside Pulaski County)

Crime Victims Reparation Fund

The Arkansas Legislature created the Arkansas Crime Victims Reparations Act when it passed Act 817 of 1987. The legislation provides a method of compensating and assisting victims and their dependents who have suffered personal injury or death as the result of a violent crime, including DWI. The program is funded primarily by the assessment of court costs and fees; however, the program also receives court-ordered restitution and federal funding through the Victims of Crime Act.

It is the intent of Act 817 to provide compensation for expenses incurred as a direct result of the criminal acts of other persons. Examples of economic loss covered under the law are: medical care,

counseling, lost wages, replacement services, funeral expenses, loss of support and crime scene clean-up. The maximum award is $10,000; however, for victims receiving catastrophic injuries resulting in total and permanent disability on or after August 1, 1999, the maximum award is $25,000. The law does not cover property loss or pain and suffering.

Eligible claimants are: a victim, a dependent of a deceased victim, or a person authorized to act on behalf of a victim or a dependent. Also, claimants must meet certain other eligibility criteria, including the following:

- Incident occurred in Arkansas on or after July 1, 1988
- Application is filed within one year of incident
- Incident must be reported to proper authorities within 72 hours (minors excluded)
- Victim must suffer personal injury or death as a result of a criminal act
- Victim or claimant must cooperate with the investigation and/or prosecution
- Victim's expenses must not be covered by a collateral source
- Victim or claimant must not have a criminally injurious felony conviction
- Victim's conduct did not contribute to the incident
- Victim was not engaged in illegal activity at the time of the incident
- Victim was not incarcerated at the time of the incident
- If injuries result from the use of a motor vehicle, the incident must involve intent to inflict harm, be a hit and run, or be in violation of the Omnibus DWI Act.

Many local offices may have applications to the Crime Victims Reparations Board, including law enforcement agencies, hospitals, prosecuting attorneys and victim advocacy organizations. Applications and further information can also be obtained by contacting the Crime Victims Reparations Board within the Attorney General's Office by calling 501-682-1020 or toll free at 1-800-448-3014 (outside Pulaski County).

Office of the
Arkansas Attorney General
Leslie Rutledge

ARKANSAS CRIME VICTIMS
REPARATIONS BOARD

SEXUAL ASSAULT REIMBURSEMENT
PROGRAM

REIMBURSEMENT FORM
(for medical facilities only)

Reimbursement will be made ONLY on the following conditions:

1. Treatment is sought and rendered within 96 hours of the assault. (This will be waived if the victim is a minor or if good cause is shown);

2. Treatment was not for a pre-existing injury, a physical injury directly relating to the assault, or any other condition; and

3. The victim is <u>not</u> covered by a federally financed benefits program, such as Medicaid, Medicare, Champus or VA. This stipulation has been made pursuant to a VOCA amendment adopted as a part of the Crime Bill.

SEXUAL ASSAULT VICTIM INFORMATION

Victim's name
_____

Victim's date of birth _____ Social Security No.
_____

Victim's full address
_____

_____

Is victim covered by a federally financed benefits program (if yes, please state which program and the victim's identification number)?
_____

Date and time of assault
_____

Date and time treatment sought
_____

Name and address of law enforcement agency notified
_____

_____

Name and address of medical facility rendering treatment
_____

_____

Telephone number _____ Contact person _____

Was the victim transported by ambulance? _____ If so, please give the name of the ambulance service.

_____

Was an outside lab facility used to perform or analyze specimens? _____ If so, please give the name of the facility.

_____

Transferred victims

Was the victim transferred from your facility? _____ If so, please attach documentation justifying the decision to transfer and the name of the facility to whom the victim was sent.

Was the victim transferred to your facility? _____ If so, please give the name of the facility that transferred the victim.

_____

In the case of transferred victims, please be advised that the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the transferring and receiving facility. In addition, these medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

Do you have knowledge of the victim incurring expenses with another facility that are related to the sexual assault examination? _____ If so, please give the name of the facility.

_____

ATTENDING PHYSICIAN'S OR SANE CERTIFICATION

Brief description of examination, treatment and tests

_____

_____

I hereby certify that this patient received a medical-legal examination, which included laboratory tests needed by the State to collect evidence for prosecution.

Physician's or SANE signature_____ Date_____

LAW ENFORCEMENT OR VICTIM ASSISTANCE COORDINATOR

If law enforcement was notified, please complete the following section:

I hereby certify that the named law enforcement agency received a report that the victim had been sexually assaulted. The information contained in the application is true and correct to the best of my knowledge or belief.

_____

(Law enforcement/victim witness coordinator/verified victim advocate signature)

Title/Agency

_____

Date _____ Badge Number_____

Pursuant to Arkansas Code Annotated 12-12-404, the Crime Victims Reparations Board will reimburse a medical facility for costs incurred in performing a medical-legal examination and tests for venereal disease on sexual assault victims. The medical facility must complete all relevant sections, including the necessary signatures. A copy of the *itemized* bill (including current procedural terminology (CPT) codes), along with any other relevant information to substantiate the claim must be attached to this form to ensure payment. NOTE: In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection. Information should be forwarded to the **Arkansas Crime Victims Reparations Board, 323 Center Street, 200 Catlett-Prien Tower Building, Little Rock, AR 72201. You may fax the form and itemized statement to (501) 682-5313 or (501) 683-5569. Questions may be directed to 1-800-448-3014 or (501) 682-1020**.

Chapter

10

10. Follow-up Services and Referrals

It is important that sexual assault patients are fully informed about follow-up services and provided with the appropriate referrals. Referrals may include follow-up for medical or mental health needs. Sexual assault advocates usually offer a variety of services in addition to those offered during the sexual assault examination. Often these services include support groups as well as providing referrals for services such as counseling.

Patients may need to follow-up with law enforcement for an interview or information on their case. Examiners should coordinate with law enforcement or victim advocates to discuss safety planning, the investigative and judicial process, as well as follow-up contact procedures.

It is helpful to offer clear and concise verbal and written information about such services at the skill level/ modality and language that is appropriate for the patient. The following pages are handouts that may be helpful for sexual assault patients and their families to understand the healing process and locate needed services in their area. They may be photocopied and distributed.

Sexual Assault State and Nationwide Resources

1-800 helpline telephone numbers, national and statewide

AGENCY	PHONE
Arkansas Coalition Against Sexual Assault	1-800-632-2272
Adult Protective Services	1-800-482-8049 or 501-682-8491
Arkansas Crime Victims Reparation Board	1-800-448-3014 or 501-682-1020
Office for Victims of Crime Resources Center	1-800-851-3420
Suicide Crisis Hotline	1-800-784-2433
CDC National STD Line	1-800-227-8922
R.A.I.N. (Rape, Abuse and Incest National Network)	1-800-656-HOPE
Children's Advocacy Centers of Arkansas	501-615-8633

LOCAL RESOURCES

Program Name	Address	Phone	Hotline	Email	Area Served
Angels of Grace	406 Pecan St. Helena, AR 72342	870-338-8447	877-572-9530	ggonner0614@yahoo.com	Phillips, Lee, Woodruff
Anna's Place	406 Pecan St. Helena, AR 72342	870-338-8447	877-572-9530	rosieburton96@yahoo.com	St. Francis, Lee Monroe, Cross
Center for Healing Hearts and Spirits	2416 South Chester Street Little Rock, AR 72206	501-372-3800	501-372-3800	joyce.raynor@sbcglobal.net	Pulaski, Saline, Lonoke, Garland
Crisis Intervention Center	5603 South 14th Street Fort Smith, AR 72901	479-782-1821	800-359-0056	allison@fscic.org candace@fscic.org	Crawford, Franklin, Logan, Polk, Scott, Sebastian
Delta Crisis Center	1393 Highway 243 South Helena/West Helena, AR 72390		870-816-8022	deltacrisiscenter@gmail.com	Phillips
Family Crisis Center	P.O. Box 721 Jonesboro, AR 72403	870-253-9611	870-933-9449	vgestring@neafamilycrisiscenter.org brogers@neafamilycrisiscenter.org	Craighead, Greene, Poinsett, Lawrence, Clay, Mississippi, Randolph
Family Violence Prevention	P.O. Box 2943 Batesville, AR 72503	870-698-0006	800-798-8111	fvp2943@gmail.com	Independence, Izard, Stone
Northwest Arkansas Rape Crisis	2367 N. Green Acres Road, Suite 1 Fayetteville, AR 72703	479-445-6448	800-794-4175	www.nwarapecrisis.org	Benton, Madison and Washington
Options, Inc. Rape Crisis	P.O. Box 554 Monticello, AR 71657	870-460-0684	870-367-3488	watchman59@yahoo.com	Ashely, Bradley, Desha Chicot, Drew
Ozark Rape Crisis	715 W. Main, Suite A Clarksville AR 72830	479-754-6869	800-818-1189	Dorinda.Edmisten@gmail.com orcc.advocate@gmail.com	Boone, Carroll, Newton, Marion, Searcy and Johnson

Rape Crisis Services (RCS)	P.O. Box 9090 Pine Bluff, AR 71611	870-541-5386	870-541-7100	howard_denice@rocketmail.com	Jefferson and Lincoln
Safe Passage	P.O. Box 755 Melbourne, AR 72556	870-368-3236	870-368-3222	safepassage72556@yahoo.com	Izard, Fulton
Serenity, Inc.	P.O. Box 1111 Mountain Home, AR 72654	870-424-7576 Yellville 870-449-7576	870-424-7233	paulette@serenityinc.org	Baxter, Marion, Fulton
Southwest Arkansas Crisis and Resource Center Inc.	116 South 4th De Queen, AR 71832	(870) 642-2141	1-800-338-9844	debbielynnmc@gmail.com	Sevier, Howard, Pike, Polk, Montgomery, Little River, Garland, and Hot Spring
Union County Family Violence Center (Turning Point)	900 E. First El Dorado, AR 71730	870-862-3672	800-980-0929	turningpointvip@suddenlinkmail.com	Union, Columbia Calhoun
UCA- Counseling Center	201 Donaghey Conway, AR 72033	501-450-3138		reesar@mail.uca.edu	Faulkner
U of A-Fayetteville- STAR Central	Pat Walker Health Center 525 N Garland, Fayetteville, AR 72701	479-575-7252		survivor@uark.edu mwyandt@uark.edu	Washington
Women's Crisis Center of South Arkansas	P.O. Box 1149 Camden, AR 71701	870-836-0375	888-836-0325	acadv6@sbcglobal.net	Calhoun, Cleveland, Columbia, Dallas, Ouachita
Women's Shelter of Central Arkansas (Sexual Assault Crisis Response of Central Arkansas	P.O. Box 2557 Conway, AR 72033	501-730-9864	866-358-2265	wsca@conwaycorp.net wsca1@conwaycorp.net	Faulkner
Women and Children First	P.O. Box 1954 Little Rock, AR 72203	501-376-3219	1-800-332-4443	amcgraw@wcfarkansas.org	Pulaski

CHILDREN'S ADVOCACY CENTERS OF ARKANSAS

Member Centers	Physical Address	Telephone	Executive Director	Email Address	Satellite Location
Central Arkansas Children's Advocacy Center	574 Locust St., Conway, AR 501.328.3347	501.328.3347	Tess Fletcher	tfletcher@hopeandjustice.org	
Children's Advocacy Center of Benton County	2113 Little Flock Dr., Little Flock, AR 72756 479.621.0385	479.621.0385	Natalie Tibbs	natalie@cacbentonco.com	
Children's Advocacy Center of Eastern Arkansas	905 N Seventh, West Memphis, AR 72301 870.702.5933	870.702.5933	Lori Wilson	l1wilson@mshs.org	Forrest City

Children's Advocacy Center of Pine Bluff	211 W Third, Ste. 130, Pine Bluff, AR 71601 870.850.7105	870.850.7105	Christa Menotti	cacdirector@pbreynoldscenter.org;	
Children's Advocacy Center of South Arkansas	1130 East Main St., El Dorado, AR 71730	870.862.2272	Robin Krneta	director@13southcasa.com	
Children's Protection Center - Little Rock	1210 Wolfe St., Little Rock, AR 72202	501.364.5490	Jennifer Long	jlong@childrensprotectioncenter.org	
Children's Safety Center - Springdale	614 E. Emma, Ste. 200, Springdale, AR 72764	479.872.6183	Elizabeth Shackelford	elizabeth@childrenssafetycenter.org	
Cooper-Anthony Mercy Child Advocacy Center	216 McAuley Court, Hot Springs, AR 71913	501.622.2531	Karen Wright	Karen.Wright@Mercy.Net	Mena
Grandma's House Children's Advocacy Center	501 W Stephenson, Harrison, AR 72601	870.391.2224	Michelle Steiner	msteiner@grandmashousecac.com	Green Forest
Hamilton House Child Safety Center	Mercy Medical Tower	479.783.1002	Jackie Hamilton	calljackie@aol.com	
Northeast Arkansas Children's Advocacy Center	1302 Stone St., Jonesboro, AR 72401	870.275.7902	Kaye Beall (Interim)	kaye.beall@yahoo.com	
Percy and Donna Malone CSC	442 Mt. Zion Rd., Arkadelphia, AR 71923	870.403.6879	Christa Neal	christaneal86@gmail.com	
River Valley Children's Advocacy Center	2206 Red Hill Lane	479-498-4747	Marilyn Sanders	msanders.paris@gmail.com	
Texarkana Children's Advocacy Center	1201 Main St, Texarkana, TX 75503	903.792.2215	Brandy Eldridge	brandyeldridge@casatexarkana.org	Nashville
Wade Knox Children's Advocacy Center	1835 SW Front St., Lonoke, AR 72086	501.676.2552	Karen James	kjames.wadecac@sbcglobal.net	Brinkley
White County Children's Safety Center	414 Rodgers Dr., Searcy, AR 72143	501.268.4748	Robin Connell	robinconnell@yahoo.com	

Information You Should Have as a Sexual Assault Survivor

What is sexual assault?
Sexual assault occurs when there is an unwanted sexual behavior without your consent or if you are unable to consent. Some examples of sexual assault include: rape, attempted rape, fondling, voyeurism and sexual harassment.

Perpetrators of sexual assault can be anyone. They can be an acquaintance, date, stranger, or even a spouse. Sexual assault is a crime of power, not lust. It is done to hurt or humiliate and it is a crime.

Common Reactions
Sexual assault can be one of the most painful and upsetting things that can happen to a person. You shouldn't be surprised if you experience a wide variety of emotions following an assault. Here is a list of common feelings and reactions that survivors have reported:

- Reluctance to go to work/ school
- Fear
- Loss of control
- Guilt
- Panic
- Inability to concentrate
- Anger
- Stomach or headache
- Wondering "why"
- Betrayal
- Numbness or Emptiness
- Rage
- Difficulty Sleeping
- Withdrawal
- Sense of loss

You may find yourself constantly thinking about the sexual assault or refusing to think about it. All of these feelings, thoughts and reactions are normal. It is important for you to have support to help you express and deal with these reactions. Don't be afraid to talk with someone about your reactions, particularly someone trained in issues relating to sexual assault.

Your options: What do you do if you have been sexually assaulted?
Making decisions after a sexual assault is often confusing and overwhelming. In addition to making decisions about who to tell, you may be struggling with your medical and legal decisions. If you decide to report the sexual assault to law enforcement, you have a right to have someone of your choosing remain with you at all times during the law enforcement questioning and the sexual assault exam.

Medical treatment: What to expect
If they are available in your area and if you desire, a sexual assault advocate or a social worker can be called to talk with you and stay with you through the sexual assault exam for support. This person can also explain procedures and options available to you.

Paperwork
A nurse or physician will ask you some difficult and possibly painful questions. They may include:

- Have you had sexual activity in the last five days?
- Have you been drinking alcohol or using drugs?
- Do you know the person who raped or sexually assaulted you?
- Have you ever had consensual sex with this person?
- Are you currently using any method of birth control?

These questions are not meant to imply that you are at fault. **You are not to blame for this assault.** These questions simply help document the circumstances and event that are relevant to the assault. They also help us provide the best medical care for you.

Sexual Assault Exam

Once the paperwork is completed, a doctor, emergency room nurse or a sexual assault nurse examiner will begin the sexual assault examination. This may include:

- Asking you to undress. Your clothes will be kept as part of the evidence collection. If you did not bring any clothes with you to wear home, additional clothing may be available from an advocate or the hospital or you may call a family member or friend to bring you additional clothing.
- Check for injuries. Depending on you injuries, X-rays or photographs may be taken.
- Taking specimens from various areas of your body including your fingernails, samples of pubic hair, swabbing the inside of your mouth, your vagina for a woman or your penis for a man and anal area. This type of collection occurs with every sexual assault examination.
- Given medicine to prevent infection from sexually transmitted diseases and being screened for emergency contraception.
- Drawing blood.
- Being given referrals to various support services.

Legal Issues

In Arkansas, rape and sexual assault are criminal offenses. However, you have the right to decide whether or not you want to report the sexual assault to the police/ sheriff. **Making a report to the police/ sheriff does not mean that you have to press charges.** We encourage you to talk with the police/ sheriff so there will be a record of this crime.

The police/ sheriff may ask you some of the same questions as the hospital staff as well as additional, possibly difficult, questions. This information could help catch the perpetrator. They will want to know the time, date, and location of where the sexual assault occurred. **None of these questions are meant to blame you for the sexual assault.** They are simply part of a thorough investigation. If you do choose to report the sexual assault, the evidence that is collected will be turned over to the police/ sheriff.

Who will pay for this?

Neither you nor your private health insurance should be billed for any costs associated with the sexual assault examination. There may be additional charges if you have any physical injuries. If your health insurance plan does not cover these charges, you may be eligible for the Arkansas Crime Victim's Reparation Board. If you are billed for the sexual assault examination or would like to know more about the Crime Victim's Reparation Board, please call the Attorney General's Office at (501) 682-1020 or 800-448-3014.

Follow-up Medical Care

Because not all injuries show up right away, do not be surprised if you discover additional bruising over the next day or two. If this happens, call the police officer who is assigned to your case. They may want to take additional photographs.

Also, you will need to follow-up for Sexually Transmitted Diseases as recommended by your healthcare provider.

Support Services

Allow yourself enough time to heal. Don't be afraid to talk with someone about your feelings and reactions, especially someone trained in issues relating to sexual assault. They may be able to help you with medical and legal questions. **No one should go through this alone.**

Follow your inner feelings about the people you trust with sharing your emotions. Do not be afraid to question what they say or how they act toward you. Choose someone who will understand your experience and feelings. This person will allow you to take as much time as you need.

Things You Can Do

- Address immediate concerns such as medical and legal issues. Identify your options.
- Breathe. Try to relax and take deep breaths.
- Be patient with your self. It takes time to heal.
- Honor your experiences. Appreciate yourself and your strength for having survived!
- Reassure yourself. Many people who suffer from a sexual assault feel this way.
- Find help. Look for people such as counselors, clergy or friends that can help.
- Go to a support groups for survivors. Other survivors are wonderful support. Contact your local rape crisis center for a support group near you.
- Educate yourself. Read books or contact your local rape crisis center to get information about the common myths and misconceptions about sexual assault.
- Be familiar with people and places that make you feel unsafe. Find help creating a safety plan that addresses your needs and concerns.

Resources

You may need additional resources to help in your recovery. Other local support services may provide you with additional information. Below are some state and national resources.

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu

Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.us

Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

Office of Victims of Crime (Victim Rights)
http://www.ovc.gove/rights/compliance.html

Always remember that you are a survivor.

Helping Your Son or Daughter after Sexual Assault

Common Reactions

Learning your child has been a victim of sexual assault can be one of the most painful and upsetting things that can happen to a parent. Often learning who assaulted your child can also be overwhelming. Conflicting loyalties can be an issue if the perpetrator is someone close to you or your child. You shouldn't be surprised if you and your child experience a wide variety of emotions following an assault. Here is a list of common feelings and reactions that survivors of sexual assault have reported:

- Fear
- Numbness or emptiness
- Guilt
- Reluctance to go to school/ work
- Sense of loss
- Disbelief
- Regression
- Anger
- Stomach or headache
- Nightmares
- Difficulty concentrating
- Agitation
- Shame
- Withdrawal
- Rage
- Difficulty sleeping
- Panic
- Wondering "why me?"
- Replay the event
- Betrayal

All of these feelings and reactions are normal. It is important you and your child have the support you need to express and deal with these feelings and reactions. Looking out for your child and the rest of your family can be exhausting and overwhelming. You would not expect your child to handle this alone so don't expect that of yourself. Don't be afraid to talk with someone about your reactions, particularly someone trained in issues relating to sexual assault.

Your child and your family need you more than ever. Don't be afraid to reach out and comfort them. Remember to always respect their feelings and reactions. Give them and yourself space when needed.

Things You Can Do

- Address immediate concerns such as medical and legal issues. Identify your options.
- Take steps to ensure your child's safety and explain to him/her what you are doing.
- Be patient. This is a difficult thing for your child to share with you.
- Allow your child to talk about his/ her fears and come up with a plan to address them.
- Let you child know you are proud of him/ her for disclosing the sexual assault.
- Create situations that allow your child to feel in control and empowered.
- Find help. Look for people such as counselors, clergy or friends that can help guide and support you and your family.
- Educate yourself. Read books or contact your local rape crisis center to get information about the common myths and misconceptions about sexual assault.

Thing you can say

- Tell your child you believe him/her and thank them for trusting you enough to tell you about the abuse.
- Let your child know you will do everything in your power to keep them safe.
- Let your child know that his/ her feelings and reactions are normal.
- Tell your child the sexual assault is not his/ her fault.

- Tell your child not to worry about you- it is your job to worry about him/ her.
- Be honest with your child about specific things that are happening.

What is Next?

Law Enforcement Investigation
Whether or not the perpetrator of this crime is prosecuted, a law enforcement office may get in touch with you for a follow-up interview. You and/or your child will have to talk about the assault again. If at any time you feel uncomfortable as to why a certain question is being asked, you have a right to ask why it is being asked.

Follow-up Medical Care
Because not all injuries show up right away, do not be surprised if you discover additional bruising over the next day or two. If this happens, call the police officer who is assigned to your case. They may want to take additional photographs.

Support Services
Allow yourself and your child enough time to heal. Don't be afraid to talk with someone about your feelings and reactions, especially someone trained in issues relating to sexual assault. They may be able to help you with medical and legal questions. **No one should go through this alone.** Crisis counseling can make all the difference in your recovery.

Follow your inner feelings about the people you trust with sharing your emotions. Do not be afraid to question what they say or how they act toward you. Choose someone who will understand your child's experience and feelings. This person will allow as much time as needed for recovery.

Resources
We recognize you and your child may need help in your recovery from this traumatic experience. Below are some state and national resources that may provide additional information:

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu

Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.ws

Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

References

A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents (2013) U.S. Department of Justice, Office on Violence Against Women. International Association of Forensic Nurses.

American College of Emergency Physicians. 2008. *Evaluation and management of the sexually assaulted or sexually abused patient.* Dallas, TX: Author

American Academy of Pediatrics. 2004. *HIPAA: a how-to guide for your medical practice.* Elk Grove Village, IL: Author.

Arkansas State Board of Nursing. 1998. *Position Statement 95-1: Scopes of Practice.* Retrieved March, 2006 from http://www.arsbn.org.

Arkansas State Board of Nursing. 1998. *Position Statement 98-6: Decision-making Model.* Retrieved March, 2006 from http://www.arsbn.org.

Centers for Disease Control and Prevention. 2010. *National Intimate Partner and Sexual Violence Survey.* Retrieved August, 2013 from http://www.cdc.gov/violenceprevention/nisvs/

Centers for Disease Control and Prevention (2014). Sexual Assault Treatment Guidelines available at: http://www.cdc.gov/std/treatment/2015/sexual-assault.htm

Center for Disease and Prevention: Sexually Transmitted Diseases Guidelines. Retrieved November, 2013 from http://www.cdc.gov/std/treatment/2015/sexual-assault.htm

Brodsky, S. (2001). Testifying in Court: Guidelines & Maxims for the Expert Witness. American Psychological Association, Washington, DC.

Federal Bureau of Investigation. 1995. *Crime in the United States.* Uniform Crime Reports. Washington, D.C. U.S. Department of Justice, Federal Bureau of Investigation.

Jones, J.G. 2005. Management of sexually abused children by non-forensic sexual abuse examiners. *Arkansas Medical Journal,* 101, 224-226.

Hammer, R.M., Moynihan, B. & Pagliaro, E.M. (2013). Forensic Nursing, A Handbook for Practice. Jones & Bartlett, Burlington, MA.

Kellogg, N. and the Committee on Child Abuse and Neglect. 2005. The Evaluation of Sexual Abuse in Children. *Pediatrics*, 116, 506-512.

Ledray, L. 1998. *SANE Development and Operations Guide.* Washington, D.C. Sexual Assault Resource Service and the U.S. Department of Justice, Office for the Victims of Crime.

Lipscomb, G. 1992. Male Victims of Sexual Assault. *Journal of the American Medical*

Association, 267, pgs.

Medscape. *Compassion Fatigue: An Expert Interview With Charles R. Figley, MS, PhD*. Retrieved January, 2014 from http://www.medscape.com/viewarticle/513615

National Women's Health Information Center. 2002. *Emergency Contraception.* Washington, D.C. U.S. Department of Health and Human Services, Office on Women's Health, National Women's Health Information Center. Retrieved December, 2005 from www.4woman.gov/faq/econtracep.htm.

National Organization for Victim Assistance. 2001. Alexandria, VA. Retrieved in 2001 from http://www.try-nova.org.

Office of Violence Against Women. 2004. *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/ Adolescents.* Washington, D.C. U.S. Department of Justice, Office of Violence Against Women.

Ruggiero, K.J., & Kilpatrick, D.G. 2003. *Rape in Arkansas: A Report to the State.* Charleston, SC: National Violence Against Women Prevention Research Center, Medical University of South Carolina.

Sexual Trauma/Assault Rape Response System. 2000. *STARRS Policy and Procedure Manual.* Fort Smith, AR.

Non-referenced material was taken from the original edition of this manual.

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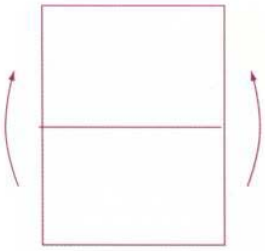
APPENDIX A

Folding a Bindle



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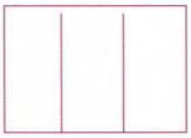
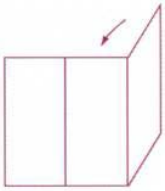
Fold the paper in half.



2
Fold the half-sized paper into thirds.



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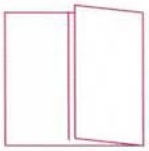
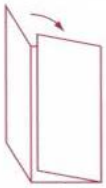
Fold over the right flap.



4



5
Fold over the left flap.

6

7
Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape before sealing.

APPENDIX B

ARKANSAS CHILDREN'S HOSPITAL
SOCIAL WORK DEPARTMENT

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. I authorize Arkansas Children's Hospital to disclose **protected health information** to the persons or entities indicated below, including the release of any information contained in the medical records of

Patient Name: _____ **Date of Birth** _____

2. I authorize disclosure of the information indicated below **to all of the persons/entities listed below unless noted otherwise. These agencies have a right to this information according to the Child Maltreatment Law.**
Please place your initials in each blank:

____AR State Police
____Police Department of the city (s) of_____
____Sheriff's Office of _____County(s)
____AR Dept of Human Services of _____County (s)
____Child Maltreatment Multidisciplinary Team of _____County

3. I authorize disclosure of the information indicated below to all person/entities listed below that I have initialed.

____Circuit Court of _____County(s) & its agents
____Juvenile court of _____County(s) & its agents
____Prosecuting attorney of _____County(s)
____Other:_____

4. Information to be released

❑Discharge Summary	❑Operative Report	❑Clinic Report	❑Medical Abstract	❑Social History
❑Psychiatric Evaluation	❑X-Ray & Lab	❑Tx Plan	❑Substance Abuse	❑Progress Notes
❑Psychological Evaluations	❑Education Information	❑ER Report	❑History & Physical	❑Diagnosis

5. The information is need for:
❑Continuity of Care ❑Legal Reasons ❑School ❑Disability ❑Insurance

6. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by the Federal privacy laws and regulations.

7. Arkansas Children's Hospital, employees, and attending physicians are released from responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

9. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to AR Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires two (2) years from the date signed below, or until the investigation and legal proceedings involving the patient(s) are completed, whichever is later.

10. **Purpose of request to release records/protected health information**: Support of investigation, management, treatment, and/or legal action in cases of possible child maltreatment.

NOTE: An ACH social worker may call in the next few days.

_____
Patient Name

_____ _____
Signature of Parent/Guardian Legal Relationship to Patient

_____ _____
Witness Date

PROVIDE A COPY TO PARENT or OTHER LEGAL REPRESENTATIVE SIGNING THIS FORM

AUTH. ROI

ADDITIONAL RESOURCES

Patient's Medical History and Sexual Assault Information

1. Patient's Name: _____

2. Date of Birth: _____ **3.** Race: _____

4. Male: ☐ Female: ☐

5. Date and time of alleged assault: Date: ___/___/___ Time: _____

6. Date and time of hospital examination: Date: ___/___/___ Time: _____

7. Examining physician: _____ **8.** Examining nurse: _____

9. Between the assault and now, has the patient:

☐ Douched ☐ Defecated ☐ Brushed Teeth ☐ Urinated ☐ Drank
☐ Vomited ☐ Mouthwash ☐ Bathed/ Showered ☐ Changed Clothes

10. Was there penetration of (if known):

	Attempted	*Successful*		*Yes*	*No*	*Not Sure*
Vagina:	☐	☐	Ejaculation:	☐	☐	☐
Anus:	☐	☐	Ejaculation:	☐	☐	☐
Mouth:	☐	☐	Ejaculation:	☐	☐	☐

11. Oral/ Genital Sexual Contact (if known): ☐ Fellatio ☐ Cunnilingus

12. Did assailant use (if known): ☐ Lubricant ☐ Condom ☐ Insert foreign object/s

13. Was patient menstruating at time of assault? ☐ Yes ☐ No

14. Any consensual intercourse in the last 96 hours? ☐ Yes ☐ No

If yes Date: Time: If yes, was condom used? ☐ Yes ☐ No

15. Is patient pregnant? ☐ Yes ☐ No

16. Any injuries to patient resulting in bleeding? ☐ Yes ☐ No

If yes, describe: _____

17. Number of assailants: _____ **18.** Race of assailant/s if known: _____

19. Assailant/s relationship to patient:

☐ Stranger ☐ Acquaintance ☐ Intimate partner ☐ Relative (specify)

_____

20. Was any medication taken by patient prior to or after assault? ☐ Yes ☐ No

If yes, describe: _____

21. Is patient still wearing same clothes from the assault:

_____

_____

_____

22. Patient's description of alleged assault:

_____

_____

_____

_____ _____

Signature of Medical Provider Date

It is recognized that not all information may be known by the patient or may not be suitable to ask children. Any additional information or evidence that can be provided will be of great assistance. Information provided is used by the crime lab to facilitate processing of the evidence.

Sexual Assault Hospital Protocol Conference
November 7-9, 2018

Agenda Wednesday

7:30- 8:15	Registration
8:15- 8:45	Welcome Will Jones, SID Deputy Attorney General
8:45- 9:45	Neurobiology of Trauma Jonathan Sheets, Arkansas Coalition Against Sexual Assault
9:45-10:00	Break
10:00- 11:00	Sexual Violence: Dynamics and Advocacy Kiah Hall, Arkansas Coalition Against Sexual Assault
11:00-12:00	Adult Sexual Assault Exam Sherrie Searcy, UAMS Emergency Department
12:00-1:00	Lunch
2:45- 3:45	Evidence Collection Lisa Channell, Section Chief, Arkansas State Crime Laboratory
3:45- 4:15	Sexual Assault Kit Tracking System Kermitt Channell, Executive Director, Arkansas State Crime Laboratory
2:30 – 2:45	Break
2:45-3:45	Victims With Disabilities Roberta Sick, UA Partners for Inclusive Communities
3:45-4:45	Presenter Panel
4:45-5:00	Closing

Agenda Thursday

8:00- 8:15 Opening

8:15- 9:45 Pediatric Sexual Assault Exam
Karen Farst, MD, Arkansas Children's Hospital

9:45-10:00 Break

10:00- 12:00 Child Sexual Assault Response

10:00 CACD Response
- Gary Glisson, Administrator AR State Police CACD Hotline
- Debbie Roark, Administrator AR State Police CACD Investigations

11:00 DCFS Response
- Mischa Martin, Director DCFS

12:00-1:00 Lunch

1:00- 3:00 Child Sexual Assault Response Continued

1:00 Child Advocacy Centers
- Elizabeth Pulley, Executive Director CACA

2:00 Child Abuse Multidisciplinary Teams
- Nancy Chambers, MDT Coordinator ACCARDV

3:00- 3:15 Break

3:15-4:15 Law Enforcement Hospital Response

4:15-4:45 Presenter Panel

4:45-5:00 Closing

Agenda Day 3

8:15- 8:30	Opening Corey Scott, MD, PhD, FACEP, Medical Director, CHI St. Vincent
8:30-9:30	Crime Victim's Reparation Fund and Sexual Assault Program Lynette Parham, Administrator, Attorney General's Office
9:30- 9:45	Break
9:45- 11:00	Arkansas Sexual Assault Laws Ginger Kimes, Staff Attorney, Prosecutor Coordinator's Office
11:15- 1:00	Lunch and Learn COSAR Arkansas Coalition Against Sexual Assault
2:00 – 0:00	Presenter Panel – Challenges Q & A

Congress of the United States

House of Representatives

COMMITI EE ON ENERGY AND COMMERCE
2125 RAYBURN HousE OFFICE Bu1LDING
WASHINGTON, DC 20515--6115
M ajority (202) 225-2927
Minority (202) 225-3641

June 21, 2018

Mr. Bill Welch
Secretary
Nevada Hospital Association
5190 Neil Road
Suite 400
Reno, NV 89502

Dear Mr. Welch:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is continuing its investigation into the availability of sexual assault forensic exams at hospitals across the United States.

In 2016, the U.S. Government Accountability Office (GAO) published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." According to the GAO, a sexual assault forensic exam, also known as a "rape kit," may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training ("SAFE rape kits") "may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates."[1] The GAO found that in each of the six states examined, the number of SANEs "does not meet the need for exams within their states."[2]

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Not all hospitals employ SANEs or provide SAFE rape kits to patients,[3] and there are no federal requirements regarding the availability of SANEs in health care facilities.[4] According to the GAO, a Joint Commission accreditation standard requires that hospitals "establish policies for identifying and assessing possible victims of sexual assault and to train staff on those policies, [but] each hospital is responsible for determining the level of specificity of such policies, including the minimum level of training required of its medical staff that performs exams."[5] In other words, hospitals may simply choose not to provide these services.

Indeed, according to recent news reports, victims of sexual assault often have trouble obtaining a rape kit.[6] Moreover, GAO found that the lack of SANEs can be particularly acute in rural areas, where there may be just one SANE or one SANE program to serve multiple counties, and a patient may have to travel several hours to reach a facility that offers SAFE rape kits.[7] However, the issue is not isolated to rural areas.[8] In some metropolitan areas, including Washington, DC and Las Vegas, NV, there may be only one facility that provides SAFE rape kits.[9] As such, a rape victim must go to that specific hospital to get the most appropriate treatment.

Data on the availability of SANEs and SAFE rape kits nationwide is limited.[10] According to the Department of Justice, the most comprehensive database on SAFE facility locations is administered by the International Association of Forensic Nurses (IAFN). However, this database is based on self-reporting by facilities with SAFE programs, and as such, is incomplete. The IAFN database lists as few as two locations in some states, including Connecticut, Hawaii, Mississippi, South Dakota, and Wyoming. IAFN estimates that between 13 and 15 percent of hospitals in the United States provide SAFE rape kits. It is not clear what happens to a victim of

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6 *Atleast Half of Rape Victims in SC Aren't Seen by a Sexual Assault Nurse,* GREENVILLENEWS(Ju ly 20, 2017), https://www.greenvilleon line.com/story/news/20I7 / 07/20/sexuaJ- assault-nurses-sh ort-supply/49293500I/; *lawmakers Want Easier Access to Rape Kits,* COLUMBIA BASIN H ERALD (Jan. 29, 2018), http://www.columbiabasinherald.com/local_news/20180129/lawmakers want easier access to rape kits; *Why Did ft Take Nine Hours and Three Emergency Rooms For This Woman to Get a Rape Kit?,* COSMOPOLITAN, http://www.cosmopolitan.com/politic$a58941/dinisha-bal1-rape-kit-texas'emergency-ro om/.

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sexual assault if he or she visits one of the roughly 85 percent of hospitals that do not provide these vital services.

On March 13, 2018, the Committee sent letters to 15 hospitals across the United States inquiring about the availability of SANEs at each hospital. The responses varied widely. Several hospitals reported that SANEs were available within the hospital at all times. At the hospitals that do employ SANEs, the number of SANEs on staff ranged from 6 to 23. The reported costs of administering those SANE programs ranged from roughly $158,000 to roughly $220,000 annually. Several hospitals reported that SANEs were available on an on-call basis through a contract with a local SANE service or crisis center. Finally, several hospitals reported that they do not employ or contract with SANEs, and victims would be referred to a local crisis center. In such cases, the victim may be provided transport by the hospital, though at least one hospital rep01ied that such transport could include providing a victim with a taxi voucher, and at least one hospital did not offer transport services for victims. The distance from the hospitals to those crisis centers ranged from. 5 miles to more than 60 miles.

According to the IAFN database, your state has 2 locations with SANE programs. Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee is interested in learning more about the Nevada Hospital Association's work with regard to the availability of sexual assault forensic exams at hospitals across Nevada. Please provide written answers to the following questions by July 5, 2018.

1. How many hospitals in Nevada is Nevada Hospital Association aware of that have a SANE program? N/A

2. Does Nevada Hospital Association maintain a database of hospitals and/or other entities across Nevada that have a SANE program? N/A

    a. If so, is that database publicly available? N/A

3. What steps, if any, has the Nevada Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Nevada? N/A

    a. Does Nevada Hospital Association pminer with law enforcement agencies in m1y capacity to provide access to SAFE kits? N/A

4. What challenges has Nevada Hospital Association identified that hospitals face in providing access to these services? N/A

    a. How is Nevada Hospital Association working with your hospitals to address those challenges? N/A

5. For hospitals in Nevada that do not have a SANE program, does Nevada Hospital Association provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking a SAFE kit? N/A

a. If so, what procedures are recommended? N/A

b. If so, please provide copies of any such guidance, standards, or best practices. N/A

c. Do the procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center? N/A

An attachment to this letter provides additional information about responding to the Committee's request. If you have any questions regarding this request, please contact Brighton Haslett with the Majority Committee staff at (202) 225-2927. Thank you for your prompt attention to this matter.

Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Frank Pallone, Jr., Ranking Member
Committee on Energy and Commerce

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE

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WASHINGTON, DC 20515--6115
Majority (202) 225-2927
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June 21, 2018

Mr. Bill Welch
Secretary
Nevada Hospital Association
5190 Neil Road
Suite 400
Reno, NV 89502

Dear Mr. Welch:

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In 2016, the U.S. Government Accountability Office (GAO) published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." According to the GAO, a sexual assault forensic exam, also known as a "rape kit," may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training ("SAFE rape kits") "may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates."[1] The GAO found that in each of the six states examined, the number of SANEs "does not meet the need for exams within their states."[2]

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Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Frank Pallone, Jr., Ranking Member
Committee on Energy and Commerce

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

Nevada Hospital Association

5190 Neil Road • Suite 400 • Reno, NV 89502
(775) 827-0184 • Fax (775) 827-0190

September 6, 2018

Greg Walden
Chairman
US House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Gregg Harper
Chairman, Subcommittee on Oversight and Investigations
US House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Walden and Mr. Harper,

In response to the U.S. House of Representatives Committee on Energy and Commerce request for sexual assault nurse examiner (SANE) policies and procedures in Nevada, the Nevada Hospital Association (NHA) conducted the following:

- Surveyed our acute care hospitals and followed up with them via conference call to clarify answers
- Reached out to state-based resources for additional information

The intent of the survey was to determine processes in place regarding SANEs. Survey questions included:

1. Does your hospital have a Sexual Assault Nurse Examiner (SANE) Program?
2. Does your hospital provide sexual assault kit (SAK) collection services?
3. If yes, who conducts SAK collection services at your hospital?
4. If services are conducted by a third-party vendor, please provide that information.
5. What is the primary challenge to providing SAK collection services at your hospital?
6. Is your facility in contact with local sexual assault programs to connect patients to resources, if needed?

The following information resonated from further discussion:

- Most hospitals have policies to transfer but are not able treat patients for sexual assault in the facility.
- Hospitals that do not have policies are willing to implement a policy.
- The process to provide services may take up to 3 hours.
- Chain of custody
    - Evidence is crucial to proving court cases. This evidence may include DNA samples, photographs, and documents that corroborate testimony or disprove an argument. To keep track of evidence at all times, a chain of custody must be established to rule out the possibility of mishandling or tampering.
    - If a hospital collects the evidence, they must prove that a chain of custody has been maintained until law enforcement can pick it up.

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    - Not all hospitals have rape kits. If they have rape kits, they are only used to collect high level evidence, such as placing a towel from the rape kit on the floor to remove clothing.
    - This process is complicated. To protect the chain of custody, it is of utmost importance that you have competency in forensic nursing; otherwise, you would not be able to establish proof.
- If there is medical necessity, a hospital stabilizes the patient and then transports to a facility that has a SANE or other program in place.

There are some processes in place throughout the state to care for victims of sexual assault including:

Washoe County

- Washoe County has an independent contractor with 19 years of experience that has been providing services and training nurses on the process.
- The program is housed in the Washoe County Adult and Child Advocacy Center in Reno, Nev.
- The program has four trained nurses and they are in the process of training four more.
- There are 20-25 reported cases per month in Washoe County.
- Most hospitals call law enforcement to come to the hospital and transport the victim to the Washoe County Adult and Child Advocacy Center.
- Law enforcement handles calling the SANE and making arrangements for someone to be at the center when they arrive with the victim.
- If the victim refuses transport by law enforcement, they provide the address to the victim and call the SANE at the Washoe County Adult and Child Advocacy Center.
- If available, hospitals will call victim support services, such as the Rape Crisis Center to provide volunteer support to the victim. If possible, they stay with the victim throughout the entire process.

Clark County

- University Medical Center houses the program.
- There are approximately 600 cases per month.
- There are trained SANE nurses and the DA will not allow other nurses to perform the service.

Carson City

- Carson City used to have a program but did not have enough patients to develop competencies. They now call law enforcement and the victim gets transported to the Washoe County Adult and Child Advocacy Center.

Rural Areas

- Rural/critical access hospitals refer victims to a SANE program in the larger urban areas closest to their facility (University Medical Center in southern Nevada or the Washoe County Adult and Child Advocacy Center in Reno).

Nevada Hospital Association

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- The rural/critical access hospitals rarely have sexual assault victims come to their emergency departments; therefore, their nurses are unable to develop competencies to process the sexual assault kits.
- They typically call law enforcement, transfer the victim and call the SANE nurse; otherwise, they are provided transportation with a medical transport company and the hospital contacts the SANE.
- If the sexual assault victim refuses transport, they are referred to a SANE program closest to the rural facility in Las Vegas or Reno and are transported via private vehicle.
- The rural/critical access hospitals in White Pine County, Lincoln County and Eureka County belong to a Tri-County Agreement. There is one SANE available for all three counties. Hospitals will call her when they have a sexual assault victim come into the ED. If she is available, she will come to the hospital to perform the exam. If she is not available, they call the Sherriff's office to come transport the victim to Reno.
- Banner Churchill Hospital states they were working with the Naval Air Station who has a SANE, but they were only seeing 5-6 victims a year, which is too low to develop competencies; therefore, they also transport to Reno
- There are not victim advocate support services in Churchill County.

In working with NHA members on this important issue, we determined that it is challenging to train a SANE and develop the competencies needed for this position. Also, many nurses aren't interested in advanced SANE training due to the rigorous testimony that occurs if they are required to appear in a legal case. In addition, we discovered that the equipment needed for a comprehensive and complete exam, such as a high-powered, digital camera, can be expensive.

If you have additional questions, please contact me.

Sincerely,

Bill M. Welch
President & CEO

cc: Robyn Bash, American Hospital Association

Oregon Association of Hospitals and Health Systems

July 19, 2018

Submitted Electronically

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House
Washington, DC 20515

The Honorable Gregg Harper
Ranking Member
Subcommittee on Oversight and Investigations
U.S. House
Washington, DC 20515

Chairman Walden and Ranking Member Harper,

The Oregon Association of Hospitals and Health Systems (OAHHS) appreciates the opportunity to respond to your questions about the availability of sexual assault forensic exam kits (SAFE kits).

OAHHS is a statewide, nonprofit trade association representing all 62 acute care hospitals in Oregon. OAHHS works closely with local and national government leaders, business and citizen coalitions, and other professional health care organizations to enhance and promote community health. OAHHS has been working and building relationships with the Oregon Attorney General's Sexual Assault Task Force (Oregon SATF) over the past year connecting hospitals with the Oregon SATF for technical assistance and resources relating to sexual assault trauma.

The Oregon SATF is a private, non-profit, non-governmental statewide agency which seeks to facilitate cross-discipline collaboration and cultivate victim-centered approaches to sexual assault primary prevention, victim advocacy, medical forensic care, criminal prosecution, and sex offender management and treatment. The Oregon SATF operates three programs; a sexual assault training institute, a prevention program, and a sexual assault nurse examiner program. The Oregon SATF oversees and appoints the members of the Oregon Sexual Assault Examiners (SAE) and Sexual Assault Nurse Examiners (SANE) Certification Commission.

The Oregon SAE/SANE Certification Commission's purpose is to approve the certification of registered nurse practitioners and nurses practicing in Oregon who fulfill the requirements to become SAE/SANE. It is the commission's mission to ensure nurses and health care practitioners who provide sexual assault medical care and conduct forensic examinations in Oregon have the necessary training and qualifications to do so in accordance with the best standards of care using a victim-centered approach.

In the 2003 Oregon Legislative Session, legislators passed SB 752 which created the Sexual Assault Victims' Emergency Medical Response Fund (SAVE Fund). The SAVE Fund is comprised of funds from the Criminal Injuries Compensation Account of the Department of Justice, federal funds, and private donations. The SAVE Fund ensures that medical assessments are available to every sexual assault victim in the state, regardless of ability to pay. The SAVE Fund pays for a "Complete Medical Assessment," which includes a medical examination and the collection of forensic evidence. The Complete Medical Assessment must be conducted within 84 hours of the assault. The SAVE Fund also pays for a "Partial Medical Assessment," which does not include the collection of forensic evidence and must be conducted within 7 days of the assault. The SAVE Fund does not cover the cost of treatment of injuries.

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503-636-2204 Fax 503-636-8310

In the 2018 Oregon Legislative Session, legislators passed HB 4049, directing the Oregon State Police (OSP) to establish a committee on tracking of SAFE kits. The legislation specifies the duties of committee and membership, requires OSP to implement the committee's recommendations for a SAFE kit tracking system and identifies the requirements of the tracking system. HB 4049 requires all law enforcement agencies, medical facilities, crime laboratories, and others to fully participate in tracking system within one year of the system becoming operational and requires the committee submit a status report to the Task Force on Testing of SAFE Kits, Governor, and Attorney General no later than January 1, 2019.

In its letter to us, the subcommittee posed several specific questions. Our responses are listed below.

How many hospitals in Oregon is Oregon Association of Hospitals and Health System aware of that have a SANE program?

The Oregon SATF recommends an entity must be organized (ex. call schedule, established reimbursement, and infrastructure) and have a consistent response time to be considered a SANE program. Currently, in Oregon, we are aware of 21 hospitals that participate in a regional SANE program and three hospitals that operate their own SANE program.

- Fifteen hospitals contract with Rapid SAVE Investigators (RSI) for their regional SANE program.
- Three hospitals in central Oregon contract with RSI for their regional SANE program.
- In southern Oregon three hospitals contract with Sexual Assault Response Teams (SARTs) for their regional SANE program.
- Three hospitals operate their own SANE program.

Additionally, 38 hospitals are listed as employers of certified SANEs and 40 hospitals have sought reimbursement through the SAVE Fund.

Outside of these models, a SANE may also be employed by one hospital and may contract with many hospitals for these specific services. Based on data the Oregon SATF maintains, there are 144 certified SANEs in Oregon. This does not include nurses who are trained but not certified, nationally certified, or certified in another state and practicing in Oregon. Oregon does not require a nurse to be certified as a SANE in order to perform a sexual assault exam; a registered nurse without certification must provide proof of current SANE competency that is consistent with the Commission's standards.

There are multiple ways a nurse or health care provider can be trained or certified as a SAE/SANE. Oregon has established its own certification process through the Oregon SAE/SANE Certification Commission. This training is provided through the Oregon SATF. Additionally, the Oregon SAE/SANE Certification Commission has established standards (ORS 147.403) for the training and education requirements required for an Oregon registered nurse to perform a sexual assault exam. Nationally, the International Association of Forensic Nurses has established SANE educational guidelines and provides online SANE training to registered nurses or advanced practice registered nurses.

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Oregon does not have a public registry of SANE certified or trained SAE examiners.

Does Oregon Association of Hospitals and Health System maintain a database of hospitals and/or other entities across Oregon that have a SANE program? If so, is that database publicly available?

OAHHS does not maintain a database of hospitals and/or other entities across Oregon that has a SANE program. By law (ORS 147.403) each hospital shall adopt policies for the treatment or referral of acute sexual assault patients and the district attorney in each county shall organize a SART (Sexual Assault Response Team) (ORS 147.401).

The Oregon SATF has two lists of SANE providers and the facilities where they practice. This list is available upon request.

What steps, if any, has the Oregon Association of Hospitals and Health System taken to increase access or address the lack of access to SAFE kits in hospitals across Oregon? Does Oregon Association of Hospitals and Health System partner with law enforcement agencies in any capacity to provide access to SAFE kits?

As previously mentioned, OAHHS has been working in collaboration with our partners at Oregon SATF. Most recently, OAHHS held a webinar for hospital staff in partnership with the Oregon SATF that reviewed hospital obligations when a sexual assault patient presents for treatment, county mandates around SARTs, and patient rights specific to post-sexual assault, including: personal representatives, financial coverage for medical-forensic exams, and options around law enforcement involvement.

OAHHS and Oregon SATF have been discussing ways to improve hospital policies and the number of SANEs trained in hospitals across Oregon.

Currently in Oregon, SAFE kits are provided free of charge from the forensic laboratories through the Oregon State Police. We are not aware of any shortage or lack of access to SAFE kits in hospitals across Oregon.

What challenges has Oregon Association of Hospitals and Health System identified that hospitals face in providing access to these services? How is Oregon Association of Hospitals and Health System working with your hospitals to address those challenges?

All Oregon emergency room physicians can perform a sexual assault medical assessment and collect forensic evidence. Many hospitals cross train their registered nurses to be SAE/SANE and some of those nurses may work in multiple hospitals. Only registered nurses who are have a valid Oregon license, certified and trained as SANE/SAE can provide forensic examinations of sexual assault victims.

Oregon SAE/SANE Certification Commission criteria for certification is:

- Hold a current unrestricted RN, NP, PA, MD, or DO license in Oregon.
- Have two years of nursing or clinical experience.

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- Maintain an average of 16 hours per month of relevant active clinical patient care practice.
- Complete a 40-hour didactic adult/adolescent SANE/SAE training that meets the National Training Standards for Sexual Assault Medical Forensic Examinations set by the International Association of Forensic Nurses (IAFN).
- Complete all non-clinical certification requirements, including meeting with law enforcement, the District Attorney's office, an advocacy organization, and the crime lab, as well as doing court observation.
- Complete ten pelvic speculum exams and be able to demonstrate competency.
- Observe one sexual assault medical forensic exam by an experienced SANE/SAE.
- Complete three sexual assault medical forensic exams with increasing independence, de-identified and submitted on the Oregon SA Medical Forensic Exam Form 2016 or 2017.
- Complete one critique and self-reflection for each sexual assault medical forensic exam demonstrating self-awareness and improving skills.

Small and rural hospitals typically only have one emergency physician available at any time and may not have a SAE/SANE qualified examiner on staff. (Rural providers do not see the volume of sexual assault cases needed to maintain a provider's SAE/SANE certification). The exam, collection and documentation of forensic evidence typically take 4-6 hours; ideally with no disruption. If an emergency physician begins a sexual assault medical assessment the hospital would likely need to have its emergency department go on divert if another emergency presents in order to prevent an interruption in the exam. With that said, rural hospitals often do not have their emergency room physicians perform the sexual assault medical assessment and will transfer the patient to a hospital with a higher level of care if they do not have access to a SANE provider.

If the victim is a child, and they do not present at a specialized children's hospital they will likely be transferred to a higher level of care facility that specializes in children's needs. The local community hospital may not have the infrastructure or personnel that specialized in performing a sexual assault medical assessment. The current response to acute child and adolescent sexual assault in Oregon differs from county to county. The response depends on county protocols, provider training, provider availability and access to child abuse providers.

In general, when a patient needs to be transferred, these transfers are done via an ambulance. However, the patient may decide to have a family member or friend take them via a private car. The patient also has the right to excuse themselves or self-release themselves. If this is the case, the patient signs a release form and it is documented in the patient's medical chart.

In building a relationship with the Oregon SATF, we have opened the lines of communication so we can 1) identify hospitals that need assistance with their policies; 2) identify hospitals that might have capacity and would benefit from having more nurses participate in SANE training; and 3) be a conduit to push communications and information between the Oregon SATF and member hospitals including training opportunities and resources. The Oregon SATF provides training and resources for Oregon hospitals and OAHHS will connect hospitals with those resources to address any challenges.

For hospitals in Oregon that do not have a SANE program, does Oregon Association of Hospitals and Health System provide guidance, standards, or best practices on how to treat patients that

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come to the hospital seeking a SAFE kit? If so, what procedures are recommended? If so, please provide copies of any such guidance, standards, or best practices. Do the procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center?

OAHHS provides venues and opportunities for those more qualified on SAFE kits to provide such guidance to Oregon hospitals. In partnership with Oregon SATF, OAHHS held a webinar, "Sexual Assault: New Regulations & Laws" on June 20, 2018 for hospital staff. The webinar reviewed hospital obligations when a sexual assault patient presents for treatment, county mandates around SARTs, and patient rights specific to post-sexual assault, including: personal representatives, financial coverage for medical-forensic exams, and options around law enforcement involvement. OAHHS and the Oregon SATF recommended hospitals 1) ensure their transfer policy for victims of sexual assault mirrors a transfer for any other specialty and 2) hospitals should be in touch with or develop relationships with their local SART.

OAHHS and hospitals are committed to providing care at the right place and the right time. This is a balance for many of our rural hospitals serving our frontier communities where resources and capacity are limited. Oregon does not have enough SANE providers to be available at every hospital, but hospitals can ensure triage, stabilization and transport for all patients regardless of the level of care needed. For rural hospitals, providing a SANE is particularly challenging because the lack of available financial resources, and, a SANE needs to be practicing regularly to keep proficient. In many rural areas with a census of 2 patients a day in the emergency room, this is not possible.

In closing, thank you for your time and attention to this important issue.

Sincerely,

Andy Davidson
President & CEO
Oregon Association of Hospitals and Health Systems

Attachments:

- Oregon SAE/SANE Certification Commission standards ORS 147.403
- Oregon Statute requiring the district attorney in each county shall organize a SART (Sexual Assault Response Team) ORS 147.401
- OAHHS in partnership with Oregon SATF webcast, "Sexual Assault: New Regulations & Laws" on June 20, 2018 for hospital staff
- List of Oregon hospitals that have a SANE program or affiliation

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Oregon Association of Hospitals and Health Systems

1) Oregon SAE/SANE Certification Commission standards

2017 ORS 147.403[1]
Policies, guidelines and training requirements for providers of medical care to sexual assault patients

(1) Each hospital, emergency medical service provider, intermediate care facility, skilled nursing facility, long term care facility and residential care facility in this state shall adopt policies for the treatment or referral of acute sexual assault patients, if such policies are not otherwise provided for by statute or administrative rule.

(2)(a) Each hospital, emergency medical service provider, intermediate care facility, skilled nursing facility, long term care facility and residential care facility in this state that performs forensic medical examinations of sexual assault patients shall:

(A) Adopt, in addition to the facility's own guidelines, if any, the State of Oregon Medical Guideline for Sexual Assault Evaluation of Adolescent and Adult Patients developed and published by the Attorney General's Sexual Assault Task Force.

(B) Except as provided in paragraph (b) of this subsection, employ or contract with at least one sexual assault forensic examiner who has completed didactic training sufficient to satisfy the training requirement for certification by the Oregon SAE/SANE Certification Commission established by the Attorney General.

(b) Paragraph (a)(B) of this subsection does not apply to a hospital that performs forensic medical examinations only of sexual assault patients who are minors. A hospital described in this paragraph may use physicians, physician assistants licensed under ORS 677.505 (Application of provisions governing physician assistants to other health professions) to 677.525 (Fees), naturopathic physicians licensed under ORS chapter 685 and nurses to conduct the examinations in consultation with a social worker trained in assisting sexual assault victims who are minors. [2011 c.511 §2; 2014 c.45 §28; 2017 c.356 §19]

Note: See note under 147.401 (Sexual assault response teams).

[1] Legislative Counsel Committee, CHAPTER 147—Victims of Crime and Acts of Mass Destruction, https://-www.-oregonlegislature.-gov/-bills_laws/-ors/-ors147.-html (2017) (last ac-cessed Mar. 30, 2018).

[2] Legislative Counsel Committee, Annotations to the Oregon Revised Stat-utes, Cumulative Supplement - 2017, Chapter 147, https://-www.-oregonlegislature.-gov/-bills_laws/-ors/-ano147.-html (2017) (last ac-cessed Mar. 30, 2018).

[3] OregonLaws.org assembles these lists by analyzing references between Sections. Each listed item refers back to the current Section in its own text. The result reveals relationships in the code that may not have otherwise been apparent.

Oregon Association of Hospitals and Health Systems

2) Oregon Statute requiring the district attorney in each county shall organize a SART (Sexual Assault Response Team)

2017 ORS 147.401[1]
Sexual assault response teams
(1) The district attorney in each county shall organize a sexual assault response team to consist of:

(a) A representative of the district attorney's office;

(b) A representative of a prosecution-based victim assistance program or unit;

(c) A sexual assault forensic examiner;

(d) At the discretion of the district attorney, a representative of the county sheriff's office or a representative of local law enforcement agencies or both;

(e) A representative of a nonprofit agency or program that receives moneys administered by the Department of Human Services or the Department of Justice and that offers safety planning, counseling, support or advocacy to victims of sexual assault; and

(f) Other persons the district attorney considers necessary for the operation of the team or as recommended by the team.

(2) Each team must meet:

(a) At least quarterly at a time appointed by the district attorney of the county; and

(b) Independently of the county's multidisciplinary child abuse team.

(3)(a) Each team shall develop and adopt protocols addressing the response to adult and adolescent sexual assault victims in the county.

(b) Protocols adopted pursuant to paragraph (a) of this subsection may incorporate by reference, in part or in whole, protocols relating to child sexual abuse developed pursuant to ORS 418.747 (County teams for investigation). [2011 c.511 §1]

Note: 147.401 (Sexual assault response teams) and 147.403 (Policies, guidelines and training requirements for providers of medical care to sexual assault patients) were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 147 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

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[1] Legislative Counsel Committee, CHAPTER 147—Victims of Crime and Acts of Mass Destruction, https://-www.-oregonlegislature.-gov/-bills_laws/-ors/-ors147.-html (2017) (last ac-cessed Mar. 30, 2018).

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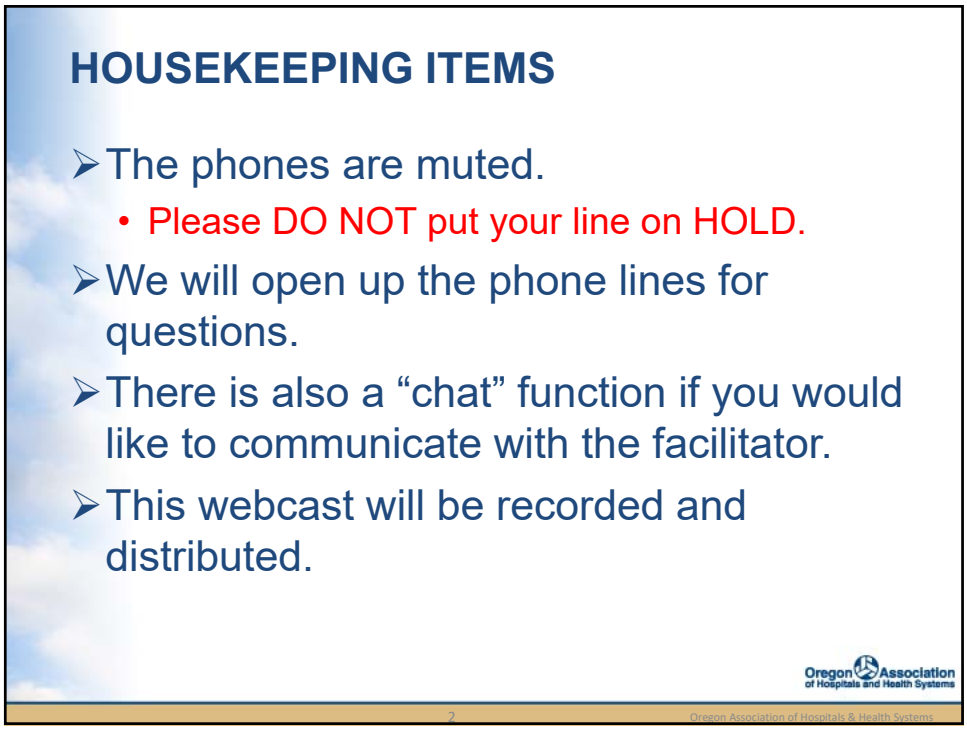
Oregon Association of Hospitals and Health Systems

3) OAHHS in partnership with Oregon SATF webcast, "Sexual Assault: New Regulations & Laws" on June 20, 2018 for hospital staff.



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Oregon Association of Hospitals and Health Systems

Sexual Assault: New Regulation & Laws

SATF OREGON

Attorney General's Sexual Assault Task Force

3

Before We Begin…

The materials you have received were created by the Oregon Attorney General's Sexual Assault Task Force (ORSATF) for the purposes of this training. Please do not reproduce this material without consultation of the ORSATF. If you share or present information from this presentation, please give written credit to the ORSATF noting the training was taken from and the date. Note the statistics, information, and best practices change regularly, and information may become outdated after the training.

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Oregon Association of Hospitals and Health Systems

Webinar provided on June 20, 2018

Disclaimer:

This session is intended to provide general information. The contents do not constitute legal advice and should not be relied upon as such.

Overview

- SART Protocol
- Provide or transfer statute
- Review SB795/Personal Representative
  - What changed
  - What stayed the same
- Community-based, Tribal-Based, District Attorney-based advocacy response
- Oregon SAVE Fund
- Anonymous Kits
- Making a plan

6

Oregon Association of Hospitals and Health Systems

Welcome

- Nicole Broder, SANE Coordinator
- Michele Roland-Schwartz, Executive Director

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Oregon Attorney General's Sexual Assault Task Force

Formed in 1999 by Attorney General Hardy Myers at the request of a group of advocates and multidisciplinary responders in order to organize statewide efforts to address adolescent and adult sexual assault in Oregon. The SATF incorporated into a 501(c)(3) non-profit, non-government organization in 2003.

Mission: The effective prevention of and response to sexual violence through collaborative, comprehensive, survivor-centered strategies.

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Oregon Association of Hospitals and Health Systems

Oregon Attorney General's Sexual Assault Task Force

SATF membership is comprised of approximately 100 Oregonians who serve on our Task Force Advisory Council, which is made up of 8 subcommittees, reflective of our multi-disciplinary spirit.

SUBCOMMITTIES

- Offender Management
- Criminal Justice
- Campus
- Medical Forensic
- Legislative Public Policy
- Victim Response
- Prevention Education
- Men's Engagement

Next Task Force Meeting: August 2, 2018
RSVP to judyhays@oregonsatf.org

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Oregon Association of Hospitals and Health Systems

SART Statute

ORS 147.401 Sexual Assault Response Teams

The district attorney in each county shall organize a sexual assault response team to consist of:

(a)A representative of the district attorney's office;

(b)A representative of a prosecution-based victim assistance program or unit;

(c)A sexual assault forensic examiner;

(d) At the discretion of the district attorney, a representative of the county sheriff's office or a representative of local law enforcement agencies or both;

(e)A representative of a nonprofit agency or program that receives moneys administered by the Department of Human Services or the Department of Justice and that offers safety planning, counseling, support or advocacy to victims of sexual assault; **and**

(f) Other persons the district attorney considers necessary for the operation of the team or as recommended by the team.

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SART Statute

ORS 147.401 Sexual Assault Response Teams

(2) Each team must meet:

(a) At least quarterly at a time appointed by the district attorney of the county; **and**

(b) Independently of the county's multidisciplinary child abuse team.

(3)(a) Each team shall develop and adopt protocols addressing the response to adult and adolescent sexual assault victims in the county.

(b) Protocols adopted pursuant to paragraph (a) of this subsection may incorporate by reference, in part or in whole, protocols relating to child sexual abuse developed pursuant to ORS **418.747 (County teams for investigation)**. [2011 c.511 §1]

Note: **147.401 (Sexual assault response teams)** and **147.403 (Policies, guidelines and training requirements for providers of medical care to sexual assault patients)** were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 147 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

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Oregon Association of Hospitals and Health Systems

147.403 Hospital Responsibilities

147.403 Policies, guidelines and training requirements for providers of medical care to sexual assault patients. (1) Each hospital, emergency medical service provider, intermediate care facility, skilled nursing facility, long term care facility and residential care facility in this state shall adopt policies for the **treatment or referral of acute sexual assault patients**, if such policies are not otherwise provided for by statute or administrative rule.

(2)(a) Each hospital, emergency medical service provider, intermediate care facility, skilled nursing facility, long term care facility and residential care facility in this state that performs forensic medical examinations of sexual assault patients shall:

(A) Adopt, in addition to the facility's own guidelines, if any, the State of Oregon Medical Guideline for Sexual Assault Evaluation of Adolescent and Adult Patients developed and published by the Attorney General's Sexual Assault Task Force.

(B) Except as provided in paragraph (b) of this subsection, employ or contract with at least one sexual assault forensic examiner who has completed didactic training sufficient to satisfy the training requirement for certification by the Oregon SAE/SANE Certification Commission established by the Attorney General.

SB795 – How we got here

ORS 147.425

Access to services

Access to information

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Oregon Association of Hospitals and Health Systems

147.425 Personal Representative

(2) A victim of a person crime, who is at least 15 years of age at the time the crime is committed, may select a person who is at least 18 years of age as the victim's personal representative for purposes of this section. The victim may not select a person who is a suspect in, or a party or witness to, the crime as a personal representative.

(3) Except for grand jury proceedings and child abuse assessments occurring at a child advocacy center recognized by the Department of Justice, a personal representative may accompany the victim to those phases of the investigation, including medical examinations, and prosecution of the crime at which the victim is entitled or required to be present.

(4) A health care provider, law enforcement agency, protective service worker or court may not prohibit a personal representative from accompanying a victim as authorized by subsection (3) of this section unless the health care provider, law enforcement agency, protective service worker or court believes that the personal representative would compromise the process.

SB 795 Personal Representative

Strengthens language to require that an advocate be called for every exam

Advocate must clearly inform patient that their services may be declined at any time

If law enforcement has not called advocacy, it is the responsibility of medical staff to dispatch an advocate

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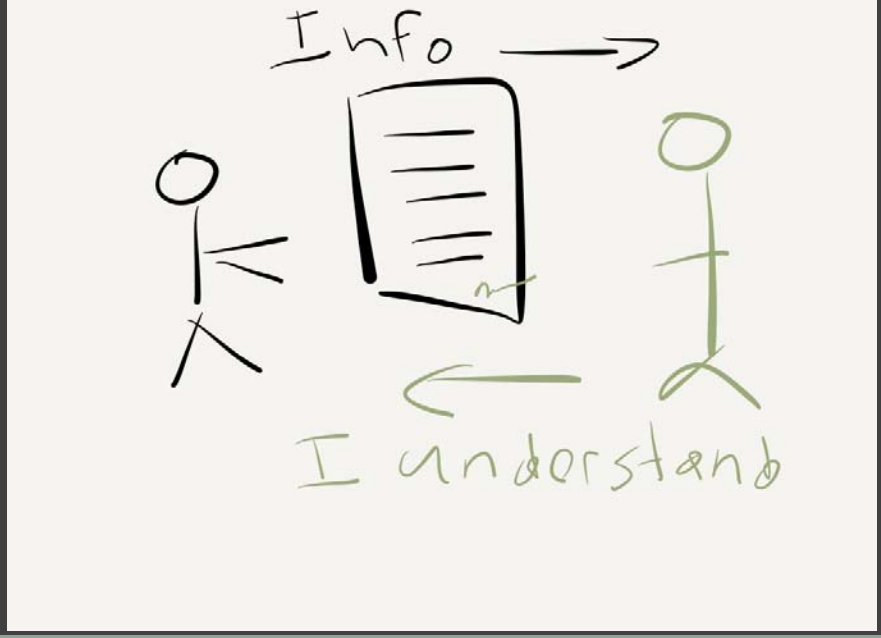

Informed Consent

SB 795
What Changed?

18

Oregon Association of Hospitals and Health Systems

(1)Upon a sexual assault victim's decision to participate in a medical assessment, as soon as practicable and in a manner consistent with the county's sexual assault response team protocols adopted under ORS 147.401 and the protocols and procedures of the county multidisciplinary child abuse teams described in ORS 418.747, the provider of the medical assessment or, if applicable, a law enforcement officer shall contact a victim advocate and make reasonable efforts to ensure that the victim advocate is present and available at the medical facility in which the medical assessment occurs. (2) A victim advocate contacted under subsection (1) of this section: (a) Shall clearly inform the victim that the victim may decline the services of the victim advocate at any time; and (b) May not impede the medical assessment, the provision of medical services to the victim or the collection of evidence. (3) As used in this section, "medical assessment" has the meaning given that term in ORS 147.395.

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(1)Upon a sexual assault victim's decision to participate in a medical assessment, as soon as practicable and in a manner consistent with the county's sexual assault response team protocols adopted under ORS 147.401 and the protocols and procedures of the county multidisciplinary child abuse teams described in ORS 418.747, the provider of the medical assessment or, if applicable, a law enforcement officer shall contact a victim advocate and make reasonable efforts to ensure that the victim advocate is present and available at the medical facility in which the medical assessment occurs.

20

Oregon Association of Hospitals and Health Systems

SB 795
What stayed the same?

21

(1)Upon a sexual assault victim's decision to participate in a medical assessment, as soon as practicable and in a manner consistent with the county's sexual assault response team protocols adopted under ORS 147.401 and the protocols and procedures of the county multidisciplinary child abuse teams described in ORS 418.747, the provider of the medical assessment or, if applicable, a law enforcement officer shall contact a victim advocate and make reasonable efforts to ensure that the victim advocate is present and available at the medical facility in which the medical assessment occurs. (2) A victim advocate contacted under subsection (1) of this section: (a) Shall clearly inform the victim that the victim may decline the services of the victim advocate at any time; and (b) May not impede the medical assessment, the provision of medical services to the victim or the collection of evidence. (3) As used in this section, "medical assessment" has the meaning given that term in ORS 147.395.

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Oregon Association of Hospitals and Health Systems

SB 795

(2) A victim advocate contacted under subsection (1) of this section:

(a) Shall clearly inform the victim that the victim may decline the services of the victim advocate at any time; and

(b) May not impede the medical assessment, the provision of medical services to the victim or the collection of evidence.

CURRENT PRACTICE AND LAW

- An advocate's role is to provide information so victims can make informed choices about services. It is currently our practice to respect the victim's autonomy, including whether to decline our services.
- ORS 147.425 Personal Representative law: personal representative can't be excluded unless it is believed they would compromise the process

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Community Autonomy

(1)Upon a sexual assault victim's decision to participate in a medical assessment, as soon as practicable and in a manner consistent with the county's sexual assault response team protocols adopted under ORS 147.401 and the protocols and procedures of the county multidisciplinary child abuse teams described in ORS 418.747

ORS 147.401

- County specific
- Multi-disciplinary SART
- Meets quarterly
- Develop & adopt a protocol

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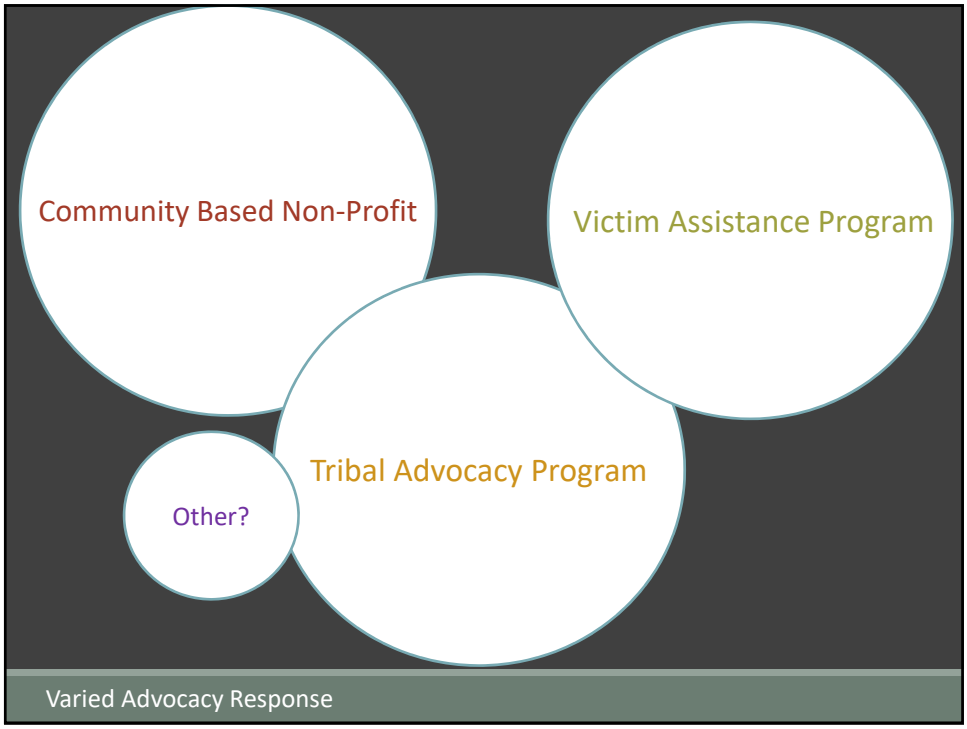

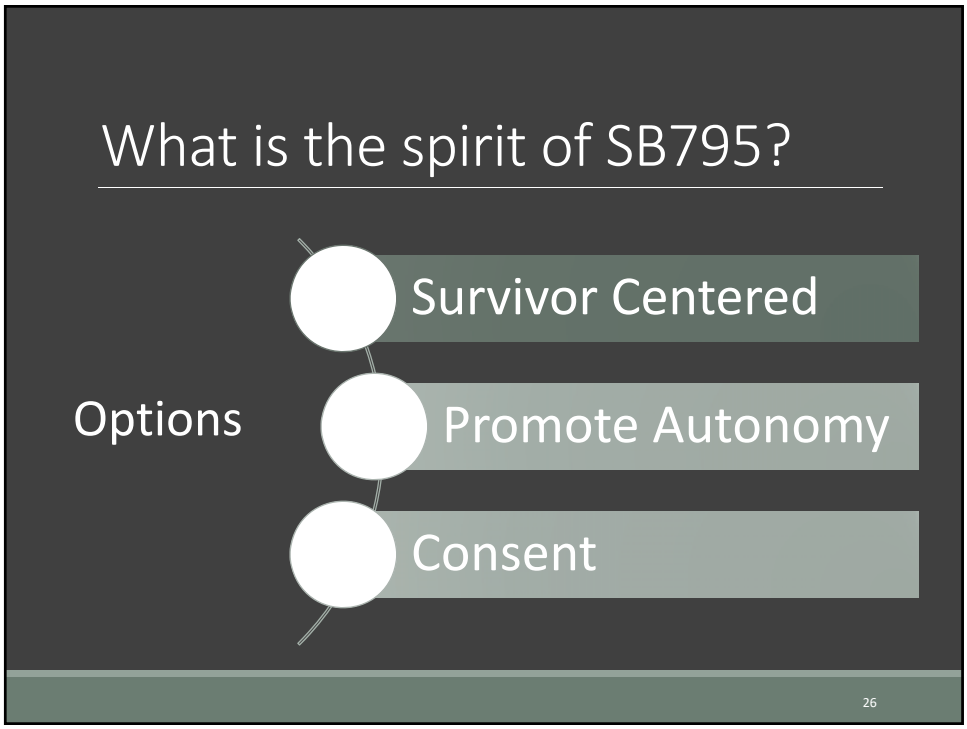

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SAVE Fund and Other Legislation

This project was supported by Grant No. 2015-WR-AX-0007 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

ORS 147.395-425

147.395 Definitions

147.397 Payment of costs; form; provider reimbursement; rules

147.399 Sexual Assault Victims' Emergency Medical Response Fund

147.403 Policies, guidelines and training requirements for providers of medical care to sexual assault patients

147.425 Personal representative

Oregon Association of Hospitals and Health Systems

147.399 SAVE Fund

Oregon Department of Justice, Crime Victim Services Division

Valerie Smith runs the SAVE Fund

- 503-378-5348
- save@doj.state.or.us

https://www.doj.state.or.us/crime-victims/for-medical-providers/save-fund-information-for-medical-providers/

Intended to make medical assessments available to patients who have experienced sexual assault in Oregon

SAVE Fund

Available to any patient who was sexually assaulted in Oregon

- Patients assaulted outside of Oregon must go through that state's CVC and other victims services

Available regardless of insurance status

- Covered services will not be billed to insurance
- Other services (i.e. labs, imaging, wound care, off-site prescriptions) may be billed to insurance

Available regardless of reporting status

Separate from Crime Victims Compensation

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Within 168 hours (1 week), covers:

- Medical assessment
- STI prophylaxis (does not include HIV nPEP)
- Pregnancy test
- Emergency contraception
- Antiemetic
- Five counseling sessions

Within 120 hours (5 days), covers:

- All services on previous page
- Evidence collection

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Oregon Association of Hospitals and Health Systems

147.397 Anonymous Kits

(2) The department may not deny payment under this section for any of the following reasons:
(a) The victim of a sexual assault has not reported the assault to a law enforcement agency.
(b) The identity of a victim of a sexual assault is not readily available to the department because forensic evidence has been collected from the victim and preserved in a manner intended to protect the victim's identity.

(5) Providers of medical assessments that seek reimbursement under this section shall:
(a) **Maintain records of medical assessments that protect the identity of victims of sexual assault and keep confidential the identity of victims who have not reported the sexual assault to a law enforcement agency**;
(b) Store forensic evidence collection kits and transfer custody of the kits to a law enforcement agency having jurisdiction over the geographic area where the provider is located; and
(c) **Cooperate with law enforcement agencies to develop and implement procedures that protect the identities of victims while allowing retrieval and assessment of evidence collection kits and related evidence.**

*Important: Anonymous kits will not be tested unless the patient makes a report to police.

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Capacity

People

Materials

Resources

24 HOUR CRISIS & SUPPORT LINE/LÍNEA DE 24 HORAS PARA CRISIS Y APOYO

To speak with an advocate, call our Hope Line

My Sisters' Place

SASS
Supporting Survivors and Advocating for Change

Protocol

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Oregon Association of Hospitals and Health Systems

SART Protocol - Make a plan!

- Get to know your partners
- Attend SART meetings
- Invite your local advocacy program to staff meetings
- Develop protocols for facility to include patient care and transfer
- Familiarize yourself and key partners with the statutes covered today

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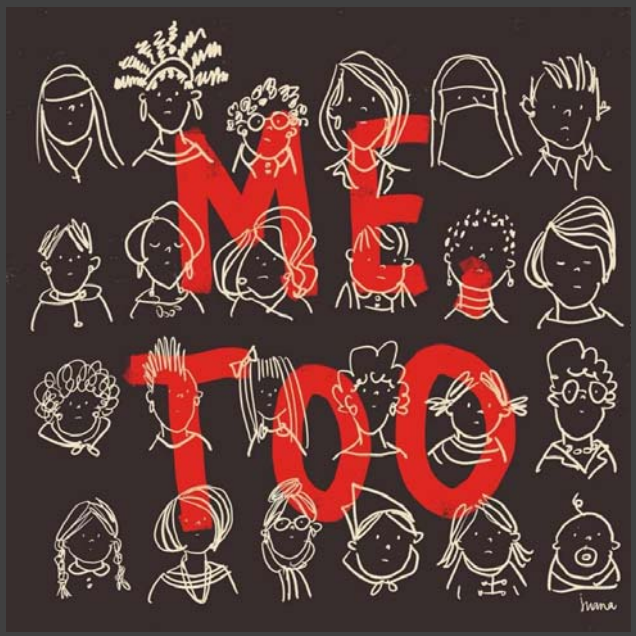

Photo credit: Lab/Shul

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Oregon Association of Hospitals and Health Systems

SANE Training Opportunities

Register at oregonsatf.org

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Questions?

Nicole Broder nicole@oregonsatf.org

Michele Roland-Schwartz michele@oregonsatf.org

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4) List of Oregon hospitals that have a SANE program or affiliation

Oregon SANE Programs	Oregon Providers paid by SAVE	Employers listed by Oregon-certified SANEs	Oregon SANE Certified
Salem Hospital	Asante Ashland Community Hospital	Asante Rogue Regional Medical Center	144
Good Shepherd	Asante Rogue Regional Medical Center	Baker County Health Department	
Samaritan Sarah's Place	Asante Three Rivers Medical Center	Bay Area Hospital	
Providence Medford (Jackson County SART)	Bay Area Hospital	CHI Mercy Health	
Asante Rogue (Jackson County SART)	Columbia Memorial Hospital	Legacy Emanuel	
Asante Ashland (Jackson County SART)	Good Samaritan Regional Medical Center	Good Samaritan Med Center	
Legacy Good Samaritan (RSI-PDX)	Good Shepherd Medical Center	Good Shepherd Hospital	
Legacy Emanuel (RSI-PDX)	Kaiser Permanente	Jackson County SART	
Legacy Mt Hood (RSI-PDX)	Legacy Emanuel Hospital	Kaiser Permanente Westside Med Ctr	
Adventist (RSI-PDX)	Legacy Good Samaritan Hospital & Medical Center	Lebanon Community Hospital	
OHSU (RSI-PDX)	Legacy Meridian Park Hospital	Legacy Health	
Providence Portland (RSI-PDX)	Legacy Mt Hood Medical Center	Maxim Healthcare	
Providence St. Vincent (RSI-PDX)	Legacy Silverton Hospital	McKenzie Willamette Hospital	
Providence Milwaukie (RSI-PDX)	McKenzie Willamette Medical Center	Mercy Medical Center	
Providence Willamette Falls (RSI-PDX)	Mercy Medical Center	Mid-Columbia Medical Center	
Providence Newberg (RSI-PDX)	Mid Columbia Medical Center	OHSU	
Kaiser Sunnyside (RSI-PDX)	Oregon Health & Science University	One Community Health	
Kaiser Westside (RSI-PDX)	Peace Harbor Medical Center	OSU Student Health Services	
Silverton (RSI-PDX) not 24/7	Portland Adventist Medical Center	Peace Harbor Hospital	
Providence Hood River (RSI-PDX) not 24/7	Providence Hood River Memorial Hospital	Peacehealth Sacred Heart	
Providence Seaside (RSI-PDX) not 24/7	Providence Medford Medical Center	Portland State University	
St. Charles Prineville (RSI-Central)	Providence Milwaukie Hospital	Providence Health	
St. Charles Redmond (RSI-Central)	Providence Newberg Hospital	Providence Hood River Memorial	
St. Charles Bend (RSI-Central)	Providence Portland Medical Center	Providence Medford	
	Providence Seaside Hospital	Providence Milwaukie Hospital	
	Providence St Vincent Medical Center	Providence Portland Medical Center	
	Providence Willamette Falls Medical Center	Sacred Heart Riverbend	
	Sacred Heart Medical Center	Salem Hospital	
	Sacred Heart Riverbend	Samaritan Albany General Hospital	
	Salem Hospital	Samaritan North Lincoln Hospital	
	Samaritan Albany General Hospital	Samaritan Pacific Communities Hospital	
	Samaritan Lebanon Community Hospital	Silverton Hospital	
	Samaritan North Lincoln Hospital	Sky Lakes Medical Center	
	Samaritan Pacific Communities Hospital	St. Alphonsus Baker City	
	St Charles Medical Center (Bend)	St. Charles Medical Center	
	St Charles Medical Center (Redmond)	St. Alphonsus Med Ctr Ontario	
	St Charles Medical Center (Prineville)	Tillamook Co General Hospital	
	St Charles Medical Center (Madras)	Willamette Valley Medical Center	
	Tuality Community Hospital		
	Wallowa Memorial Hospital		

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Joseph L. Amaral
R. William Jonas, Jr.

Louis Hammerschmidt (1880 - 1966)
Bruce C. Hammerschmidt (1919 - 2000)

March 26, 2018

Greg Walden, Chairman
Gregg Harper, Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
Congress of the United States, House of Representatives
MargaretTucker.Fogarty@mail.house.gov

VIA PDF E-MAIL

Re: Letter of March 13, 2018, to Memorial Hospital of South Bend

Dear Messrs. Walden and Harper,

My office serves as General Counsel for Memorial Hospital of South Bend. I have been asked to respond to your letter of March 13, 2018. Memorial Hospital of South Bend is in the process of preparing the answers you requested. However, it will not be able to complete its response by March 27, 2018. Consequently, I am writing to request that the response date be extended by fourteen (14) days to Tuesday, April 10, 2018. Thank you for your time and anticipated cooperation and I shall await your response.

Yours truly,

Joseph L. Amaral
jla@hajlaw.com

JLA:lp
cc: L. Tracy

Memorial Hospital of South Bend®
BEACON HEALTH SYSTEM™ Care Partner

Policy /Procedure Document	
Manual:	0.70 Department Area Manual Emergency Care Center Policies
Origination Date:	8/22/2006
Last Review Date:	12/21/2015
Next Review Due:	12/21/2018
Policy Owner:	Director, Emergency Care Center
Required Approvals: ***Committee:***	Professional Practice Research Council
Leadership/Board:	Hospital Leadership

TITLE:	**Patient Sexual Assault Evaluation and Management**
SCOPE:	ECC patients
DOCUMENT TYPE:	Policy
PURPOSE:	To establish guidelines in the care and treatment of the sexually assaulted patient. To identify and treat injuries, assess and treat medical conditions, assess risk for pregnancy and sexually transmitted disease and to provide prophylaxis for sexually transmitted diseases and emergency contraception when appropriate and indicated.
PHILOSOPHY:	Sexual assault is a serious crime that creates significant challenges to healthcare professionals who create an overall plan to treat the medical, emotional, physical safety, and legal needs of the patient. The sexual assault response team (SART) model is used in this community hospital to enhance public safety by increasing public awareness, increasing reporting, and facilitating investigation. SART creates a plan that addresses issues pertaining to the immediate response to sexual assault. Our goals are: 1) to provide care to the sexual assault patient that protects their privacy, integrity and legal rights; 2) to provide the patient with information regarding the Sex Crime Victim Application for Benefits; 3) to meet legal requirements for the collection of forensic evidence and; 4) To maintain chain of custody.
DEFINITIONS:	NA
PROCEDURE:	

Preservation of Evidence

The patient is instructed by the triage nurse not to engage in activities that may destroy important evidence that can be used to identify the perpetrator including eating, smoking, drinking, undressing, gargling, bathing, showering, brushing teeth, chewing gum, washing/cleaning the genital area, urinating and/or defecating before the forensic exam. If the patient absolutely needs to urinate, collect at least 100cc of urine for a drug screen. Mark the specimen with time of collection, who collected it (remembering to instruct the patient not to

wipe the genital area with toilet paper or a wipe). The RN/SANE will later determine if the urine specimen needs to be analyzed in the case of a drug-facilitated sexual assault.

Triage

1. The triage nurse will take the vital signs (except for temperature), allergies, medication history, LMP, demeanor, tetanus status, and notes obvious injury or complaints of pain.
2. Do not ask any questions about sexual assault at this time.
3. Notify Charge Nurse of this patient.
4. With the patient's consent, the triage RN will call SOS advocate (289-HELP) immediately.
5. The patient should be asked if they have notified Law Enforcement. If they have not and wish to make a report, notify Law Enforcement at this time. (See Law Enforcement section).
6. Upon arrival, patient will be taken to a closed room or to the meditation/consultation room (if no room is available). The only exception is if the patient has a physical injury that warrants emergent medical attention.
7. The admitting clerk should be notified to register the patient as "SANE" if it is a known SANE case. If at any time the patient does not meet the requirements of the Sexual Assault Victims Crime Fund, notify registration to obtain further billing information.
8. For patient confidentiality identify the patient as a privacy patient and mark '*OTHER*' as the chief complaint when registering the patient. On the triage assessment, please note that "Rape" is a legal term, not a diagnosis. Assessment throughout the chart, beginning at Triage, should be "History of Sexual Assault," "Report of Sexual Assault," or "Concern of Sexual Assault." Do **NOT** use the term "Alleged Sexual Assault."

Notification

The charge nurse will assign the sexual assault nurse examiner (SANE). If a SANE is not available, a designated trained RN will proceed with the patient's care. The charge nurse will inform the ED physicians that the patient is in the ED. Ideally, the patient should not be left alone. If the patient consents, the chaplain can be notified and will stay with the patient until the SOS advocate arrives.

Reporting of Sexual Assault to Law Enforcement:

If patient reports sexual assault to law enforcement, evidence for crime lab is transferred to appropriate law enforcement agency. This is appropriate if assault occurred within prior 96 hours.

If patient does not wish to report sexual assault to law enforcement agency, they are offered the option of having an anonymous kit collected, if assault occurred within prior 96 hours. (See policy referring to anonymous sexual assault kit collection). These kits are kept in storage for one year. Patients qualify for the Sex Crime Victim Fund Application for Benefits if the assault is reported within 96 hours.

Law Enforcement Notification

In Indiana it is the patient's right to decide if law enforcement will be notified unless a weapon was used; then it must be reported to the appropriate law enforcement agency. Law enforcement may be notified that a sexual assault has occurred but the patient chooses not to report the crime. Law enforcement is to be available and may be utilized as a resource when questions arise regarding the legal process.

If the patient wants law enforcement notified, and notify the appropriate agency.*

Indiana State Police	1-574-233-1123
St. Joseph County Police	1-574-235-9611
South Bend Police Department	1-574-235-9361 (or red phone)
Michigan State Police	1-269-683-4411

Notre Dame Security	1-574-631-5555
St. Mary's College Security	1-574-284-5000
Mishawaka Police Department	1-574-258-1678

*Notify the agency that covers the exact location where the sexual assault occurred.

Providing the patient does not need emergent medical care, the patient is placed in a closed room with the advocate (if the patient consents to having the advocate). Law enforcement may interview the patient briefly at this time.

If the patient does not want a police report completed, or law enforcement notified of the crime, the patient is offered the opportunity to have an anonymous sexual assault kit collected. (See attached protocol for Anonymous Sexual Assault Kit Collection) The patient has the right to refuse collection of a sexual assault kit. Consequences of the patient's decision are explained, and a sexual assault kit is not collected. The medical exam would then be performed, pregnancy test done, medications given, diagnostic tests done, and the appropriate follow-up given

History and Initial Evaluation: (SANE/ER Registered Nurse Function)

Initial Contact:

1. Assess the patient's
    - Desire for support person of choice including partner and/or advocate.
    - Emotional state/mental health status.
    - Disabilities: physical, emotional, developmental.
    - History of psychosocial dysfunction *relevant* to sexual assault evaluation.
    - Psychosocial support.
2. Discuss and allow for questioning regarding:
    - Anticipated medical procedures.
    - Sexual Assault exam procedures.
    - Reporting options.
    - Consents: Obtain signatures on Sexual Assault forms.
    - Sex Crime Victims Services Fund/Application for Benefits.

History of Assault:

Facts about assault:

1. Source of information (patient or accompanying person).
2. Time and place of assault.
3. Hours since assault.
4. Number of assailants.
5. Name of assailants.
6. Record narrative history of assault (to include "excited utterance", defined as "a sudden statement caused by the speaker having seen a surprising, startling or shocking event…" (Webster's, 2008). This should include direct quotes from the patient.
7. Nature of force used:

- Patient had impaired or loss of consciousness
- Known or suspected drug or alcohol ingestion.
- Verbal threats.
- Use of physical force.
- Use or threat with a weapon and type.
- Physical injuries and areas of pain.

8. Details of sexual assault:
    - Which orifices assaulted.
    - By what (finger, penis, foreign object).
    - If a condom was used.
    - If assailant may have ejaculated, and where.
9. Post assault activity:
    - If patient showered or bathed.
    - If patient douched.
    - If patient changed clothes.
    - If patient ate, drank, brushed teeth or flossed.
    - If patient urinated, defecated.
10. Risk factors of assailant, if known, regarding Hepatitis B, syphilis, and HIV:
    - IV Drug Use.
    - Man who has had sex with men
    - Assailant from and endemic country

Past Medical History:

1. Medical history, especially active medical problems and current medications.
2. OB-GYN history, history of sexually transmitted diseases, use of contraception, and risk of pregnancy.
3. Patient's own history of Hepatitis vaccine or illness.

Discussion with Patient (or Parent/Legal Guardian, if minor):

1. Discuss medical forensic procedures.
2. Discuss reporting to law enforcement (CPS, if minor).

Evidence Collection: (SANE/ER Registered Nurse Function)

A. Equipment located on Sexual Assault cart:

1. Sexual Assault Resource Binder.
2. Forensic Drug forms and envelopes for SBMF.
3. Folder with Sexual Assault assessment, consents, sex crime application form, discharge forms and pamphlets.
4. Sexual Assault Collection Kit (check expiration dates on blood tubes).

5. Plastic speculum.
6. Black permanent marker.
7. Extra envelopes for debris (one piece of debris is placed in each envelope).
8. Extra swabs.
9. Wood's lamp.
10. Swab Dryer.
11. Numbered plastic locks for swab dryer.
12. Plastic Packing Tape.

B. Additional equipment needed but not found on cart:

1. 30cc Normal Saline vials
2. 40 patient labels.
3. Clean sheet.
4. Digital Camera (found in Pyxis).
5. Supplemental Nurses Notes.
6. Additional Paper bags (found in CDU closet, if needed).

Lab Draw

Call the lab to draw a HCG and to fill the purple top tube in the sexual assault evidence collection kit. Remember: The patient has the right to decline the collection of any and all specimens and medications.

NOTE: Once the sexual assault kit has been opened, it may not be left unattended by the RN collecting the evidence.

NOTE: Regarding children, obtain blood last after all other samples are collected and only if other blood tests for medical purposes are indicated.

Date Rape Panel

This is a urine screen to test drug levels if drug facilitated sexual assault is suspected. This panel should be used, if ordered, for any sexual assault patient or anyone requesting this panel for legal reasons. This panel is NOT ordered in Cerner and NOT collected by lab personnel. The RN will use the Chain of Custody form (COC) in the sexual assault cart.

The date rape panel includes:

- Benzodiazapines
- Barbituates
- Alcohol
- MDMA (Ecstasy)
- GHB
- Funictrazetame (Rohypnol)
- Ketamines

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Consents

Explain and complete consents for the examination and treatment, photography, and release of information, which is found on the front sheet of the Sexual Assault Assessment. Complete the Sex Crime Victim Fund Application for Benefits. Both are found in one of the folders in the sexual assault cart.

Wood's Lamp

The Wood's Lamp is an ultraviolet light that is used in the dark to examine for fluorescent areas. The lamp should be used wherever the patient indicates semen or other fluid deposits resulting from the assault may be found.

1. Explain the procedure to the patient
2. Turn on Wood's lamp
3. Turn off overhead lighting
4. Allow several seconds for visual adaptation
5. Scan the body approximately 2-3 inches above the body
6. Swab fluorescent areas in accordance with secretions protocol

Photography

At the nurse's discretion, photographs of the general appearance of the victim - torn clothing, blood, dirt or stains on body or clothing can be taken. Bite marks and injuries should be photographed. Bite marks are best photographed with the digital camera found in the Pyxis. If needed, consult the investigating officer for additional photography. Colposcopic photography (not currently available at Memorial Hospital) may be done to document external genitalia and cervical injury – refer to SJRMC if injury is profound and colposcopy is deemed absolute.

Indiana State Protocol

Follow the Indiana State Protocol in collecting the forensic evidence remembering to maintain *chain of custody*.

**The following is a replication of the papers found in the sexual assault kit.

STATE OF INDIANA
ADULT/CHILD SEXUAL ASSAULT EVIDENCE KIT INSTRUCTIONS
Please review before each evidence collection

NOTE: This kit is for the collection of the crime laboratory evidence only. All medical samples processed by the hospital lab should be handled in their routine manner. Medical samples to be considered for collection are listed at the appropriate junctures. At each step of sample collection, forensic evidence must be collected prior to any necessary medical samples.

CHILD SEXUAL ABUSE MUST BE REPORTED TO LOCAL CPS OR LAW ENFORCEMENT AUTHORITIES.

Check all items collected.
Complete the chain of custody form on outside of box.
Refer to complete protocol for details.

THE PATIENT MAY REFUSE AT ANY TIME TO GIVE ANY SAMPLE.
ANY REMAINING EVIDENCE POSSIBLE SHOULD STILL BE COLLECTED.

1. ALWAYS PERFORM AND DOCUMENT A COMPLETE VISUAL INSPECTION TO DETERMINE SITES OF INJURY OR POSSIBLE EVIDENCE:
    a) Bite marks
    b) Cuts/lacerations
    c) Patterned injuries
    d) Contusions
    e) Bruising
    f) Fingernails
    g) Abrasions
    h) Edema

2. FORENSIC SPECIMENS TO COLLECT: (to show association of victim, suspect and crime scene through biological stains, hairs, fibers, and other debris).

A. If assault within 24 hours:

1. Oral, anal, and vaginal swabs and smears
2. Foreign stains or debris
3. Current underwear and other damaged or stained clothing
4. Head and pubic hair combings
5. Known patient blood and hair standards for comparison purposes

B. If assaulted within 24-96 hours: (for children - within 72 hours)

1. Vaginal swabs and smears (not oral; not anal)
2. Foreign stains or debris
3. Collect current underwear
4. Head and pubic hair combings
5. Known patient blood and hair standards for comparison purposes

3. MEDICAL CONSIDERATIONS

A. STIs - GC, Chlamydia, trichomonas, HIV, hepatitis, etc.
B. Infection prophylaxis
C. Pregnancy prophylaxis

4. PACKAGING AND LABELING

A. All items except washings and blood standards MUST BE AIR DRIED (use swab dryer) prior to packaging. While drying, protect swabs from cross-contamination.
B. The healthcare providers collecting evidence MUST label each container to identify contents. Tape seals. MUST BE INITIALED AND DATED.
C. NEVER LICK SEALS. Use tape to seal.
D. The sealed kit and small clothing bags must be signed and dated by person(s) packaging the evidence.
E. The completed kit, including the blood standard, should be stored in a locked container/area until released to a law enforcement agency to maintain chain of evidence.

5. **CHILDREN - See special instruction notes contained within this document prior to conducting the exam.**

AUTHORIZATION FOR COLLECTION AND RELEASE OF EVIDENCE AND INFORMATION FORMS

Fill out all information requested on the Application for Benefits Form. Have patient (or parent/guardian, if applicable) and witness sign where indicated.

The patient may refuse at any time to give a certain specimen. All of the remaining specimens should still be collected.

FORENSIC SPECIMEN COLLECTION NOTE: Hospital-Clinical specimens may be collected at points indicated by (*).

Anonymous Kit
See Anonymous Sexual Assault Kit Collection Policy for instructions if patient chooses to complete an anonymous kit.

SEE GENERAL INSTRUCTIONS INCLUDED IN STATE OF INDIANA SEXUAL ASSAULT EVIDENCE COLLECTION KIT FOR COLLECTION PROTOCOL

FINAL INSTRUCTIONS

Seal all evidence. Return all samples and copy of this instruction sheet to kit. Seal kit with evidence tape provided. Store kit and any extra bags of clothing in secured area until released to appropriate authority.

Complete chain of custody on kit lid (box top) being sure patient's name and medical personnel initials and signatures are present. Affix biohazard label (found in the sexual assault kit) to lower right hand corner on the top of the evidence collection kit.

Medical Screening Exam:

The ED physician will perform the medical screening exam. If SANE present, after the forensic evidence is collected, the SANE will collaborate with the ED physician concerning the sexual assault and any injury identified in the SANE nursing assessment. Appropriate medical care will be explained to the patient and offered. Physician will order all medications.

Medical care may include:

1. Pregnancy testing (unless patient has had a hysterectomy or is post menopausal)

2. Prophylaxis treatment for STDs (gonorrhea, Chlamydia, and trichomonas)
    a. Common drug recommendations for gonorrhea include one of the following:
        1. Cipro 500 mg p.o. (only if patient is 18 years or older)
        2. Rocephin 250 mg IM

    b. Common drug recommendations for Chlamydia include on of the following:
        1. Zithromax 1 gm p.o. (likely to cause nausea)
        2. Doxycycline 100 mg b.i.d. x7-10 days

    c. Common drug recommendations for trichomonas include one of the following:
        1. Flagyl 2 gm one p.o.
        2. Flagyl 500 mg b.i.d. for 7 days

3. Hepatitis B immunization
    a. Current recommendations for vaccination of Hepatitis B include:

1. Recombivax HB Adult dose (10mcg/ml) 1cc IM in deltoid (safe in pregnancy)
2. HBIG

    b. Anonymous HIV testing and counseling (may be done at the St. Joseph County Health Department at no charge 572-235-9781)

    c. Emergency contraception (exception: patient with hysterectomy or is post menopausal or the sexual assault has been greater than 24 hours ago) Follow current recommendations.

    d. Wet mount for trichomonas. If vaginal discharge or malodor is evident the wet mount also should be examined for evidence of bacterial vaginosis and yeast infection.

    e. Tetanus booster if greater than 5 years since last booster.

3. Reference CDC guidelines and recommendations for further information. CDC phone number 404-639-6413 if any questions.

Counseling and Resources:
The advocate or RN/SANE will discuss counseling options and community resources for follow-up.

Safety considerations should include:
1. Is the perpetrator nearby or in police custody?
2. Does the patient need a safe place to stay?
3. Encourage the patient not to be alone at home.
4. Where will you go when you leave here? Who will be with you?
5. Offer woman's shelter if needed.

A prescription for counseling will be signed by the physician and copied x2. The original prescription is given to the patient. One is sent with Applications for Benefits, and one remains with the chart. Counseling is available through SOS or patient choice**.**

Discharge Information:
Verbal and written instructions will be given to the patient upon discharge. Specifically, the front sheet of the Sex Crime Victim Application for Benefits and aftercare information with discharge instructions and referrals, and the folder of pamphlets will be given to the patient. If the patient received a Hepatitis B immunization the CDC handout should also be given. If the patient consents, a friend/relative should also be given the instructions to later reinforce with the patient. Remember patients who have experienced a traumatic event will generally have difficulty focusing and mentally processing all of the follow-up information given to them.

Follow-up and Examinations:
Follow-up care may be obtained through the Family Justice Center Sexual Assault Clinic, St. Joseph County Health Department, or the physician referral.

a. Repeat pregnancy testing (unless patient has had a hysterectomy or is post menopausal) 2-3 weeks after being seen in the ED.
b. Exam for STD should be done 2-3 weeks after the sexual assault.
c. Complete Hepatitis vaccinations at 1 month and 6 months (not offered for anyone greater than 18 at the health department) and give CBC handout.
d. Anonymous HIV testing and counseling available at the St. Joseph County Health Department free of charge, 572-235-9781. Testing needs to be done baseline, then at 3 months and 6 months after assault.
e. Other medical follow-up needs as directed by the physician.

Law Enforcement Notification for Kit:
After all the specimens are collected, air dried, and labeled appropriately, the sexual assault kit is sealed, and the clothes are collected and bagged - each piece separately in a paper bag. The law enforcement agency is notified, and the kit, clothes and paperwork is turned over to a law enforcement officer. The clothes and paperwork are secured Sexual Assault cart. If a nurse was called in to do the exam and leaves before the kit, clothes and paperwork are picked up, it is the responsibility of the charge nurse to turn the kit, clothes, and paperwork over to the law enforcement officer. (*The officer gets the yellow copy of the Sex Crime Victim Application for Benefits, a Xeroxed copy of the Sexual Assault Assessment, the clothes, and the kit). USE RED PHONE FOR SOUTH BEND KITS, CALL ST JOSEPH COUNTY POLICE FOR OTHER JURISDICTIONS.

Filing of Sex Crime Victim Application:
Place the Sex Crime Victim Application for Benefits Form (white copy) on the front sheet of the ER chart, a copy of the dictation, and the Sexual Assault Assessment information on the Social Worker's desk. She will send this information with the patient's bill to Indianapolis (302 W. Washington St., Room E203, Indianapolis, IN 46204-2767 - telephone #317-232-0157). This information has to be sent in within 90 days of the sexual assault.

Definition of Sexual Assaults:

A. Rape-IC35-42-4-1-(Class B felony) A person who knowingly and intentionally has sexual intercourse with a member of the opposite sex when:

1. The other person is compelled by force or the imminent threat of force;
2. The other person is unaware that the sexual intercourse is occurring, or:
3. The other person is so mentally disabled or deficient that consent to sexual intercourse cannot be given.

B. Sexual Intercourse-An act that includes any penetration of the female sexual organ (labia majora) with the male organ**.**

C. Criminal Deviate Conduct-IC35-42-4-2(Class B felony) A person knowingly or intentionally causes another person to perform or submit to deviant sexual conduct when:

1. The other person is compelled by force or the imminent threat of force;
2. The other person is unaware that the sexual intercourse is occurring, or:
3. The other person is so mentally disabled or deficient that consent to sexual intercourse cannot be given.

D. Child Molesting-IC35-42-4-3(Class B felony) A person who with a child under 14 years of age, performs or submits to sexual intercourse or deviate sexual conduct.

MEMORIAL HOSPITAL

April 10, 2018

The Honorable Gregg Harper
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Harper,

Pursuant to your request of March 13, 2018, the following information is provided by Memorial Hospital of South Bend (Indiana) (hereafter referred to as MHSB) to your inquiry regarding how our hospital treats patients seeking treatment and evidence collection following a sexual assault:

1. Does the Memorial Hospital of South Bend employ SANEs or SAFE-certified medical professionals? **No.**

2. If the Memorial Hospital of South Bend does employ SANEs,
   a. When did the Memorial Hospital of South Bend begin employing SANEs? **N/A**
   b. How many SANE or SAFEs does the Memorial Hospital of south Bend employ? **N/A**
   c. How were SANEs trained? **N/A**
   d. During what days and hours are SANEs available at the Memorial Hospital of South Bend? **N/A**
   e. Is the Memorial Hospital of South Bend listed on the IAFN database? **N/A**
   f. What is the annual cost of administering the SANE program at the Memorial Hospital of South Bend? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015. **N/A**
   g. What grants, if any, has the Memorial Hospital of South Bend applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims? **N/A**

3. If the Memorial Hospital of South Bend does not employ SANEs, does the Memorial Hospital of South Bend provide rape kits by non-SANEs? **Yes.**
   a. If so, who conducts those kits? **MHSB has 48 Emergency Room Registered Nurses (ER-RNs) trained in sexual assault/rape kit collection.**
   b. How are these medical professionals training to collect those kits? **MHSB ER-RN's are validated through internal training to complete a rape kit and on evidence collection. See attached document titled "Sexual Assault Class Agenda."**

MEMORIAL HOSPITAL

4. If a sexual assault victim comes to the Memorial Hospital of South Bend requesting treatment and/or a rape kit following an assault, what procedures are in place at the Memorial Hospital of South Bend to treat that victim? If the Memorial Hospital of South Bend does not conduct a rape kit, SAFE certified or not, please include whether the Memorial Hospital of South Bend has a relationship or agreement with another facility that does provide those services. **See attached document, MHSB policy titled "Patient Sexual Assault Evaluation and Management Policy."**

5. Does the Memorial Hospital of South Bend track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed? **No.**

Please advise if you require any additional information or if we can assist your inquiry further.

Respectfully submitted,

Larry A. Tracy, Jr., FACHE
President

cc: Majority Staff in Room 316 of the Ford House Office Building
Minority Staff in Room 564 of the Ford House Office Building

Providing Care for a Sexual Assault Patient

Training Agenda

ECC Classroom

Welcome and overview

- Folder overview

Tour

- Introduction to SA Cart

Caring for the Sexual Assault Patient

- Triage
- Sexual Assault Packet Review
- Equipment Needed for Exam
- Exam/Forensic Collection
  - -Kit Review
- Chain of Custody
- Medical Considerations
- Follow up care
- Discharge information
- Documentation

Skills Validation-

Documentation of Sexual Assault Exam-Review/Document Scenario in folder

Documentation and handling of photos

Familiarity with sexual assault kit

Correct collection and handling of forensic evidence/specimens

Knowledge of supplies needed for physician exam

Correct collection of vaginal/cervical swabs/washings

Correct collection of pediatric cultures

Correct collection of lab specimens/chain of custody

Identification of outside referrals/agencies

Knowledge of Application of Benefits form

Knowledge of discharge instructions/documentation

Restocking of SA cart

Providing Care for a Sexual Assault Patient

Training Agenda

ECC Classroom

Welcome and overview

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Documentation of Sexual Assault Exam-Review/Document Scenario in folder
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Correct collection of lab specimens/chain of custody
Identification of outside referrals/agencies
Knowledge of Application of Benefits form
Knowledge of discharge instructions/documentation
Restocking of SA cart

Penn Medicine

Administration

Hospital *of the* University *of* Pennsylvania

Regina Cunningham, PhD, RN, NEA-BC, FAAN
Chief Executive Officer

March 26, 2018

VIA ELECTRONIC MAIL

The Honorable Greg Walden
Chairman, House Committee on Energy and Commerce
U.S. House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Gregg Harper
Chairman, Subcommittee on Oversight and Investigations
U.S. House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Chairmen Walden and Harper:

Thank you for contacting the Hospital of the University of Pennsylvania as part of your inquiry into the availability of sexual assault forensic exams at hospitals across the United States. The following are our responses to the committee's questions.

Question 1

Does the Hospital of the University of Pennsylvania employ SANEs or SAFE-certified medical professionals?

Response to Question 1

Sexual Assault Nurse Examiners (SANEs) are available 24 hours a day, 365 days a year at the Hospital of the University of Pennsylvania (HUP) through a contract with the Philadelphia Sexual Assault Response Center – a city-wide, non-profit center that provides forensic rape examinations and evidence collection to both females and males. The SANEs that provide the aforementioned services to patients at HUP are employed by the Philadelphia Sexual Assault Response Center. *Please see Appendix A for the contract between HUP and the Philadelphia Sexual Assault Response Center.*

While HUP does not directly employ SANEs, HUP does employ a nurse who is masters-prepared in forensic medicine and SANE-trained who serves as a forensic consultant and liaison to the Philadelphia Sexual Assault Response Center. Additionally, two HUP nurses currently work at the Philadelphia Sexual Assault Response Center in a secondary role and also serve as liaisons.

Question 2

If the Hospital of the University of Pennsylvania does employ SANEs,

a. *When did the Hospital of the University of Pennsylvania begin employing SANEs?*

Silverstein, Suite 120 | 3400 Spruce Street | Philadelphia, PA 19104 | 215.662.3227 | Fax: 215.349.5864 | regina.cunningham@uphs.upenn.edu

b. *How many SANE or SAFEs does the Hospital of the University of Pennsylvania employ?*
c. *How were SANEs trained?*
d. *During what days and hours are SANEs available at the Hospital of the University of Pennsylvania?*
e. *Is the Hospital of the University of Pennsylvania listed on the IAFN database?*
f. *What is the annual cost of administering the SANE program at the Hospital of the University of Pennsylvania? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.*
g. *What grants, if any, has the Hospital of the University of Pennsylvania applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?*

Response to Question 2

As indicated in the response to question one, the Hospital of the University of Pennsylvania (HUP) does not directly employ SANEs. The SANEs who conduct rape examinations and evidence collection at HUP are employed by the Philadelphia Sexual Assault Response Center. However, the following information is relevant to some of question two's sub-questions.

SANEs are available at HUP 24 hours a day, 365 days a year through the Philadelphia Sexual Assault Response Center.

HUP is not listed on the International Association of Forensic Nurses (IAFN) database; however, the Philadelphia Sexual Assault Response Center is listed on the database.

The Philadelphia Sexual Assault Response Center is funded through grants and philanthropy. There is currently no cost to HUP.

HUP has not applied for any grants related to training SANEs.

Question 3

If the Hospital of the University of Pennsylvania does not employ SANEs, does the Hospital of the University of Pennsylvania provide rape kits by non-SANEs?

a. *If so, who conducts those kits?*
b. *How are these medical professionals trained to collect those kits?*

Response to Question 3

The Hospital of the University of Pennsylvania (HUP) does not provide rape kits by non-SANEs.

Question 4

If a sexual assault victim comes to the Hospital of the University of Pennsylvania requesting treatment and/or a rape kit following an assault, what procedures are in place as the Hospital of the University of

Pennsylvania to treat that victim? If the Hospital of the University of Pennsylvania does not conduct a rape kit, SAFE certified or not, please include whether the Hospital of the University of Pennsylvania has a relationship or agreement with another facility that does provide those services.

Response to Question 4

The Hospital of the University of Pennsylvania (HUP) has a written policy and patient care protocol for sexual assault victims.

If a patient at HUP has reported or is suspected of being a victim of sexual assault, the patient's health care provider or nurse will notify the Nursing Administrative Coordinator (NAC). The NAC will conduct the appropriate notifications outlined in the policy, including notifying the Philadelphia Sexual Assault Response Center. A SANE will respond to the hospital within two hours of notification. The SANE will: 1.) obtain consent from the patient, 2.) perform a forensic rape examination and evidence collection, 3.) provide a written recommendation to the health care provider for sexually transmitted infection prophylaxis, pregnancy prophylaxis, and HIV prophylaxis per CDC guidelines, 4.) provide written instructions for follow-up care and counseling, and 5.) transfer forensic evidence to the appropriate police agency. *Please see Appendix B for the Inpatient and Out-Patient Sexual Assault-Forensic Examinations Policy and Appendix C for the Sexual Assault Patient Care Protocol.*

As indicated in question one, HUP has a contract with the Philadelphia Sexual Assault Response Center. The Center is under the auspices of the Drexel University College of Medicine. HUP has had a contract with the Philadelphia Sexual Assault Response Center since December 3, 2015. *Please see Appendix A for the contract.*

Question 5

Does the Hospital of the University of Pennsylvania track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

Response to Question 5

The Hospital of University of Pennsylvania (HUP) does not currently track data on sexual assaults. However, HUP is currently working with the Philadelphia Sexual Assault Response Center to create a formal tracking report. Real-time feedback is provided on an as needed basis and a regularly scheduled conference call between HUP and the Philadelphia Sexual Assault Response Center is conducted every six months.

Appendices

Accompanying this letter are three appendices:

- Appendix A – University of Pennsylvania Health System and Philadelphia Sexual Assault Response Center contractual agreement

- Appendix B – University of Pennsylvania In-patient and Outpatient Sexual Assault Policy
- Appendix C – University of Pennsylvania Sexual Assault Protocol

* * *

The Hospital of the University of Pennsylvania (HUP) appreciates the committee contacting us about this important issue and welcomes the opportunity to serve as a resource to policy-makers. If there is any further information we can provide, or if our responses do not fully answer your questions, please feel free to contact Patrick Norton, Vice President for Public Affairs, at Patrick.Norton@uphs.upenn.edu or (215) 615-0064.

Sincerely,

Regina Cunningham, PhD, RN, NEA-BC, FAAN
Chief Executive Officer
Hospital of the University of Pennsylvania

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachments

PennSANEAgreement CLEAN 09-18-15 bsa 11 05 15 tmd CLEAN.docxFinal

AGREEMENT
BETWEEN
DREXEL UNIVERSITY FOR ITS COLLEGE OF MEDICINE
AND
UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM.

THIS AGREEMENT (the "Agreement") is made and executed as of December 1, 2015 ("Effective Date") by and between **DREXEL UNIVERSITY FOR ITS COLLEGE OF MEDICINE** ("DUCOM"), on behalf of its Department of Emergency Medicine Philadelphia Sexual Assault Response Center (the "Department"), and THE TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA, AS OWNER AND OPERATOR OF THE **UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM** ("PENN" or "UPHS")

RECITALS

WHEREAS, DUCOM employs various health care professionals, including Sexual Assault Nurse Examiner ("SANE") trained nurses ("DUCOM Personnel");

WHEREAS, DUCOM desires permission to offer and provide sexual assault examinations by DUCOM Personnel for UPHS patients at the Hospital of the University of Pennsylvania ("HUP"), Penn Presbyterian Medical Center ("PPMC") Pennsylvania Hospital ("PAH"), and facilities of UPHS (the "Services").

NOW, THEREFORE, in consideration of the mutual agreements and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound, it is mutually agreed and covenanted by the parties to this Agreement, as follows:

1. **Sexual Assault Examinations.** Subject to the terms of this Agreement, DUCOM will be permitted to perform sexual assault examinations at PENN's HUP, PPMC and PAH campuses. DUCOM shall obtain each patient's written consent and perform such examinations in accordance with Schedule A, and all applicable legal requirements and professional standards. DUCOM shall ensure that each and every DUCOM Personnel shall be in compliance with DUCOM, HUP, PAH, PPMC and UPHS policies for working in clinical practices and the UPHS hospitals.

2. **Supplies, Facilities and Personnel.** PENN will provide the following at its own expense:

A. Designated parking without charge.
B. Accompaniment of the SANE nurse to the unit where the patient is located.
C. Assistance with the patient as reasonably requested by the SANE.

D. Patient stickers/labels for the labeling of evidence.
E. Copy of patient demographic or face sheet.

3. **Term and Termination.**

A. The parties agree that this Agreement will be in effect for one year from the Effective Date (the "Term"), and thereafter from year to year for five (5) years, unless either party gives the other party notice pursuant to Section 2(C)..

B. Either party may terminate the Agreement if the other party breaches a material provision of the Agreement and does not correct such breach within thirty (30) days of receipt of written notice of such breach to be delivered by the non-breaching party.

C. Either party may terminate the Agreement upon twenty (20) days written notice, with or without cause.

D. The provisions of Sections 4, 5 and 6 of this Agreement shall survive the termination of this Agreement.

4. **Compensation.** DUCOM shall bill the Pennsylvania Victims Compensation Assistance Program of the Pennsylvania Commission on Crime and Delinquency per their Forensic Rape Examination Billing Procedures, and PENN shall have no obligation with respect to payment to DUCOM for such examinations.

5. **Insurance.**

A. In connection with the performance of this Agreement, DUCOM, at its own cost and expense, shall obtain and maintain in force during the term of this Agreement, and where claims made insurance coverage applies, for a period of five (5) years after such Agreement has terminated or ended, the following insurance coverage:

i. A policy of workers' compensation insurance, in amounts required by law, covering all officers and employees of DUCOM who are in any way engaged in or connected with the Agreement and employer's liability insurance in an amount of not less than Five Hundred Thousand Dollars ($500,000). DUCOM shall require its agents who are in any way engaged in or connected with the performance of this Agreement to maintain similar insurance.

.ii. A policy of commercial general liability insurance including products, completed operations and infringement of intellectual property rights coverage, in an amount not less than Two Million Dollars ($2,000,000) per occurrence. The limit requirements of this paragraph may be satisfied by a combination of primary and excess liability coverage. The commercial general liability insurance policy shall name PENN as an additional insured.

iii. A policy of errors and omissions insurance, including professional liability coverage as may be customary and appropriate given the nature of DUCOM's and UPHS' business, in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. If the policy is a claims-made policy, the policy must have a "tail".

iv A policy of professional liability insurance in the amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate, covering all officers, employees or agents of DUCOM's who are in any way engaged in or connected with the performance of the Services of a professional medical or direct patient care nature, provided, however, that if DUCOM is a "Health Care Facility" as defined under Section 103 of the Pennsylvania Health Care Facilities Act 35 P.S.§448.101, et seq., such policy limits shall be in the amount of One Million Dollars ($1,000,000) per occurrence and Four Million Dollars ($4,000,000) in the aggregate. Such professional liability insurance limits may be inclusive of the Pennsylvania Medical Care Availability and Reduction of Error Fund ("MCare"), or coverage equivalent to that provided by MCare if coverage thereunder should cease to be available or should no longer be required. If the professional liability policy is a claims-made policy, the policy must have a "tail".

v. A policy of comprehensive automobile liability insurance covering the operation of all automobiles used in connection with the performance of this Agreement, affording protection in an amount of not less than One Million Dollars ($1,000,000) covering the operation of all automobiles to be used by DUCOM or any of its officers, employees or agents in connection with the performance of this Agreement. The limit requirements of this paragraph may be satisfied by a combination of primary and excess liability coverage.

B. In connection with the performance of this Agreement, PENN, at its own cost and expense, shall obtain and maintain in force during the term of this Agreement, and where claims made insurance coverage applies, for a period of five (5) years after such Agreement has terminated or ended, the following insurance coverage:

i. A policy of workers' compensation insurance, in amounts required by law, covering all officers and employees of PENN who are in any way engaged in or connected with the Agreement and employer's liability insurance in an amount of not less than Five Hundred Thousand Dollars ($500,000). PENN shall require its agents who are in any way engaged in or connected with the performance of this Agreement to maintain similar insurance.

ii. A policy of commercial general liability insurance including products, completed operations and infringement of intellectual property rights

coverage, in an amount not less than Two Million Dollars ($2,000,000) per occurrence. The limit requirements of this paragraph may be satisfied by a combination of primary and excess liability coverage.

iii. A policy of errors and omissions insurance, including professional liability coverage as may be customary and appropriate given the nature of PENN's and DUCOM's business, in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. If the policy is a claims-made policy, the policy must have a "tail".

iv A policy of professional liability insurance in the amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate, covering all officers, employees or agents of PENN who are in any way engaged in or connected with the performance of the Services of a professional medical or direct patient care nature, provided, however, that if PENN is a "Health Care Facility" as defined under Section 103 of the Pennsylvania Health Care Facilities Act 35 P.S.§448.101, et seq., such policy limits shall be in the amount of One Million Dollars ($1,000,000) per occurrence and Four Million Dollars ($4,000,000) in the aggregate. Such professional liability insurance limits may be inclusive of the Pennsylvania Medical Care Availability and Reduction of Error Fund ("MCare"), or coverage equivalent to that provided by MCare if coverage thereunder should cease to be available or should no longer be required. If the professional liability policy is a claims-made policy, the policy must have a "tail".

v. A policy of comprehensive automobile liability insurance covering the operation of all automobiles used in connection with the performance of this Agreement, affording protection in an amount of not less than Two Million Dollars ($2,000,000) covering the operation of all automobiles to be used by PENN or any of its officers, employees or agents in connection with the performance of this Agreement. The limit requirements of this paragraph may be satisfied by a combination of primary and excess liability coverage.

Each of these insurance policies shall be issued by insurance companies each with an AM Best Rating of "A" or its functional equivalent and shall be licensed or permitted to conduct business in the Commonwealth of Pennsylvania. Prior to the commencement of this Agreement, and on each policy renewal date as long as the Agreement is in effect, the parties shall furnish to each other a current certificate of insurance and policy endorsements required by this section for each of the policies required above. Insurance coverage(s) provided under this Agreement shall not limit or restrict in any way liability arising under or in connection with this Agreement. Such insurance shall not be canceled or terminated by either party unless the other party shall have received thirty (30) days prior written notice of any such cancellation or termination.

6. **Indemnification**

A. DUCOM agrees to defend, indemnify and hold PENN, its trustees, officers, employees and agents harmless from any and all liability, loss, damage, claim, fine or expense, including court costs and reasonable attorneys' fees ("Claims") to the extent such arise due to the negligent or intentional acts or omissions of DUCOM, its employees and agents.

B. PENN agrees to defend, indemnify and hold DUCOM, its trustees, officers, employees and agents harmless from any and all Claims to the extent such arise due to the negligent or intentional acts or omissions of PENN, its employees and agents.

C. However, neither party shall settle any Claim for which the other party is seeking indemnification hereunder without the other party's consent which shall not be unreasonably withheld or delayed.

7. **Proprietary Information; Confidential Information; HIPAA Compliance.** The parties recognize that each of their business interests require a confidential relationship between them and the fullest practical protection and confidential treatment of their trade secrets, business plans, contracts, agreements, internal reports, patient rates and charges or any other pricing information, patient information, management systems, utilization review methodologies, security systems, auditing procedures, policies, techniques, concepts, programs, innovations, inventions and improvements (hereinafter collectively termed "information") which will be received or learned by DUCOM Personnel or PENN employees during the term of this Agreement. Accordingly, the parties agree both during and after the term of this Agreement, to keep secret and to treat confidentially all PENN and DUCOM information, whether patentable, patented or not, and not to use or aid others in using any such information in competition with PENN or DUCOM.

8. **Business Associate.** As UPHS's Business Associate, DUCOM shall be bound by the terms and conditions of the Business Associate Agreement attached hereto as Exhibit A, and to the extent not previously executed, the parties shall execute the same simultaneously with this Agreement.

9. **Independent Contractor**. In performing the sexual assault examinations herein specified, DUCOM is acting as an independent contractor and not as the agent or employee of PENN and shall not have right to any benefits afforded by PENN to its employees, including without limitation, workers' compensation insurance. Nothing in this Agreement shall be construed to create a partnership or joint venture between DUCOM and PENN or to authorize either to act as an agent of the other party in any respect.

10. **Notices.** All notices and other communications pertaining to this Agreement shall be in writing and shall be deemed duly to have been given if personally delivered to a party, sent by facsimile or if sent by the United States Postal Service certified mail, return receipt requested, postage prepaid or by Federal Express, United Parcel or other nationally recognized overnight carriers. All notices or communications between PENN and DUCOM pertaining to this Agreement shall be addressed as follows:

If to DUCOM:

Drexel University College of Medicine
245 N. 15th Street, Mail Stop 1011
Philadelphia, PA 19102-1192
ATTN: Chair, Department of Emergency Medicine

With a courtesy copy to:

Drexel University College of Medicine
Office of the General Counsel
1601 Cherry Street, Suite 10627
Philadelphia, PA 19102
ATTN: General Counsel

If to PENN:

James Ballinghoff, RN, MSN, MBA, Chief Nursing Officer, PPMC,
PPMC Administration
39th and Market Streets
Philadelphia, PA 19104

With a copy to:

University of Pennsylvania/Penn Medicine
Office of General Counsel
3539 Locust Walk
Philadelphia, PA 19104
Attn: Senior Counsel, Health System Division

Any party may change its notification address by giving written notice to that effect to the other parties in the manner provided herein. Notices shall be effective upon receipt.

11. **DUCOM Responsibilities**.

11.1. For all DUCOM Personnel who are: (a) assigned to provide sexual assault examination Services to UPHS patients; or (b) who are providing Services at UPHS facilities for a period of thirty (30) days or longer, DUCOM shall, at DUCOM's expense, perform:

(a) Criminal background checks in all known counties and states of residence and employment (with the results made available to UPHS only upon and to the extent of UPHS's request), covering a minimum of seven (7) years back from the date upon which each DUCOM personnel was hired by DUCOM or when background check was first performed. To the extent permitted by law, DUCOM must immediately notify UPHS in writing if any DUCOM Personnel subject to the provisions of this paragraph is or has been convicted of any crime.

(b) Child abuse clearances for all DUCOM Personnel as required by and in accordance with Pennsylvania Child Protective Services laws, 23 Pa. CSA 6301 et seq.

(c) Verification of employment history covering a minimum of seven (7) years back from the date upon which each DUCOM Personnel was hired by DUCOM, or four (4) employers back from when each DUCOM Personnel was hired by DUCOM, whichever is greater.

(d) Verification of educational history up to and including the highest degree obtained by each DUCOM Personnel.

(e) Verification and validation of each DUCOM Personnel Social Security number and verification of the identity and work authority of each DUCOM Personnel under United States immigration laws.

(f) at UPHS's expense if requested by UPHS

(g) Primary source verification of licensure, certification and registration, if applicable.

11.2 DUCOM shall provide training to its DUCOM Personnel regarding workplace safety, privacy and other standards, shall establish mechanisms to ensure that its personnel comply with all applicable standards, including but not limited to the requirements of The Joint Commission, shall evaluate the performance of any DUCOM Personnel who are engaged under this Agreement at regular intervals, maintain documentation of primary source verification as required; and shall certify that its DUCOM Personnel meet the requisite qualifications and competencies and are performing such Services in a safe and effective manner.

11.3 **Health Status**. DUCOM shall require that its DUCOM Personnel who provide sexual assault examination Services in patient care areas furnish proof of routine immunizations, including annual influenza immunization and any other vaccinations/immunizations as UPHS may require from time to time, and provide documentation of, or submit to, testing for rubella, hepatitis, chicken pox, measles,

mumps and tuberculosis. Documentation regarding tuberculosis testing must evidence testing annually thereafter.

11.4 If applicable, DUCOM shall comply with all requirements of UPHS' vendor registration program.

12. **Compliance with Laws/UPHS Rules, Regulations and Policies.** DUCOM shall perform and cause its DUCOM Personnel to perform, the sexual assault examination Services required under this Agreement in a manner which is in accordance with applicable federal standards, Joint Commission accreditation standards, quality assurance standards, and other governing policies of UPHS regarding quality and safety of treatment. The parties shall mutually define in writing those indicators for quality and safety of treatment in accordance with Joint Commission standards, and DUCOM shall make the results of those indicators available to UPHS.

Documentation of compliance with Joint Commission requirements shall be: (a) maintained on DUCOM's premises; (b) stored in a format reasonably requested by UPHS; and (c) available in summary report formats reasonably requested by UPHS. In addition, DUCOM shall comply with and cause its DUCOM Personnel to comply with, all applicable rules, regulations, policies and procedures of UPHS as they exist now and as they may be amended from time to time, including, but not limited to, all policies and procedures relating to ingress and egress to and from UPHS' campus and premises, parking, confidentiality of PHI, fraud, waste and abuse, use of the University of Pennsylvania and UPHS names, smoking, safety, waste disposal, and infection control. DUCOM shall perform, and cause its DUCOM Personnel to perform, the Services required under this Agreement in a manner which is in accordance with applicable federal standards regarding the prevention of the transmission of bloodborne pathogens. DUCOM shall cooperate with UPHS in any manner reasonably requested, in connection with any effort undertaken by UPHS to maintain accreditation from the Joint Commission or any other like body.

13. **Medicare access to records**. If Section 1861 (v)(1)(I) of the Social Security Act applies to this Agreement, then, until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, DUCOM shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or their duly authorized representatives, this Agreement, and records of DUCOM that verify the nature and extent of costs incurred under this Agreement. If DUCOM carries out any of the duties of this Agreement with a value of $10,000 or more over a twelve month period through a subcontract with a related organization, such contract must contain a clause to the effect that until the expiration of four (4) years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General or any of its authorized representatives, the subcontract, and books, documents and records of the related organization that are necessary to verify the nature and extent of costs. If DUCOM is requested to disclose any books, documents or records relevant to this Agreement for the purpose of an audit or

investigation, DUCOM shall notify UPHS of the nature and scope of such request and shall make available to UPHS, upon request by UPHS, all such books, documents and records.

14. **Advertising and publicity**. Neither party shall use the name, logo or trademark of the other (or of any of the other's affiliates) in any form of publicity or promotional or advertising material, or in any communications with the media without the other's prior written consent to the specific contemplated use. No such use by DUCOM shall state or imply that UPHS endorses DUCOM or the Services and all such use shall comply with applicable PENN and UPHS policies with respect to DUCOM endorsements. UPHS may terminate this Agreement and seek injunctive relief immediately if DUCOM violates this provision.

15. **Miscellaneous.**

A. Waiver of Breach. The parties hereto agree that the waiver by either party of a breach by the other party of any of the provisions contained in this Agreement shall not operate as or be construed to be a waiver of any other breach of this Agreement by any party.

B. Entire Agreement; Binding Effect. This Agreement constitutes the entire understanding among the parties hereto and is intended as the complete and exclusive statement of the agreement among the parties with respect to the subject matter hereof, and supersedes all prior agreements and negotiations thereto. Any term on any document containing terms inconsistent with those contained herein is not valid and will not be binding on any party. The provisions of this Agreement shall be binding upon and inure to the benefit of the respective successors and assigns of the parties hereto.

C. Assignment. This agreement may not be assigned or delegated to any party without the prior written consent of the other party, except to an affiliate or in connection with a reorganization, merger or sale or transfer of substantially all of the assets.

D. Modification. This Agreement may not be modified in any respect other than by an agreement in writing signed by both parties.

E. Change of Law. Notwithstanding anything contained herein to the contrary, either party may notify the other in writing of its intention to terminate this Agreement if at any time any federal, state or local government law, regulation or policy, or the policies of any material third party payor, or interpretations of the foregoing given by a reputable health care attorney, by virtue of this Agreement, cause either party to fail to comply with any such law, regulation, policy or interpretation or shall materially impair (impairment being considered in the legal compliance, operational or financial sense) the continuing validity and/or effectiveness of any material provision hereof.

This termination will become effective only if the parties in good faith are unable to agree, within thirty (30) days after receipt of notice of such impairment, upon a modification to this Agreement that will bring the Agreement into compliance with the law, regulation or policy at issue.

F. **No Obligation to Refer**. The consideration received by either party under this Agreement is not in any way conditioned upon, or shall the terms and conditions of the Agreement vary, based upon the volume or value of business referred between the parties. Neither party is under any obligation to make referrals to or otherwise generate business for the other party.

G. **Construction and Jurisdiction**. This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania (excepting any conflict of laws, provisions which would serve to defeat application of Pennsylvania substantive law). All of the parties hereto submit to the exclusive jurisdiction of the state and/or federal courts located within the County of Philadelphia for any suit, hearing or other legal proceeding of every nature, kind and description whatsoever in the event of any dispute or controversy arising hereunder or relating hereto, or in the event any ruling, finding or other legal determination is required or desired hereunder.

H. **Severability**. If any portion of this Agreement is held invalid, such invalidity shall not affect the validity of the remaining portions of the Agreement, and the parties will substitute for any such invalid portion hereof a provision which best approximates the effect and intent of the invalid provision.

I. **Counterparts.** Provided that all parties hereto execute a copy of this Agreement, this Agreement may be executed in counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument. Executed copies of this Agreement may be delivered by facsimile transmission or other comparable means.

J. **Sanctioned person**. DUCOM represents and warrants that it and any of its agents, employees, officers, and representatives providing sexual assault examination Services under this Agreement: *(a)* are not "*sanctioned persons*" under any federal or state program or law; *(b)* have not been listed in the current Cumulative Sanction List of the Office of Inspector General for the United States Department of Health and Human Services for currently sanctioned or excluded individuals or entities; *(c)* have not been listed on the General Services Administration's List of Parties Excluded from Federal Programs; *(d)* have not been listed on the United States Department of Treasury, Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons List; *(e)* have not been convicted of a criminal offense related to health care; and *(f)* are not a debarred or suspended contractor of the Commonwealth of Pennsylvania. DUCOM shall immediately notify PENN in the event

that it is no longer able to make such representations and warranties. Without limitation to any other rights and remedies under this Agreement, afforded by law, or in equity, PENN may terminate this Agreement with five (5) days written notice, without penalty, in the event that PENN has determined that DUCOM is in breach of this provision.

K. **Compliance**. DUCOM shall comply with applicable: (*i*) federal, state, and local laws, regulations, and executive orders, and amendments thereto, including, but not limited to, OSHA, NRC and CDC regulations, Medicare and Medicaid billing and referral regulations, and the Pennsylvania Department of Health and Pennsylvania Department of Public Welfare regulations; (*ii*) accreditation standards such as those set forth by The Joint Commission; (*iii*) requirements imposed under any city, state, federal, foundation or other award, contract, funding, reimbursement, payments policy, or grant; and (*iv*) PENN's policies and procedures including, without limitation, its anti-discrimination and sexual harassment policies as well as those available at www.PENNhealth.org

L. **Non-discrimination**. In the performance of this Agreement, neither party shall unlawfully discriminate toward any patients, employees, applicants or other persons regardless of their race, color, sex, age, religion, national origin, creed, ancestry, ethnicity, sexual orientation, gender identity or expression, genetic information, socioeconomic status, domestic or sexual violence victim status, source of income, source of payment, veteran status, marital status, familial status disability or any other manner prohibited by law.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and the year first written above by their duly authorized representatives.

DREXEL UNIVERSITY FOR ITS COLLEGE OF MEDICINE
On behalf of its Department of Emergency Medicine Philadelphia Sexual Response Center

By:_____
Name:
Title:
Date:_____

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

By:_____
Name: Garry L. Scheib
Title: Chief Operating Officer, UPHS

PennSANEAgreement CLEAN 09-18-15 bsa 11 05 15 tmd CLEAN.docxFinal

Date:_____

SCHEDULE A

SANE Nurse Examiner shall:

A. Obtain patient consent in accordance with all applicable laws and regulations and shall provide a copy of such consent to PENN.

B. Upon receipt of consent, perform Forensic Rape Examinations and Evidence Collection by SANE trained nurses on patients of PENN in accordance with all applicable standards of care as is usual and customary for such examinations.

C. Provide 24/7 on-call SANE coverage;

D. Timely respond to PENN (within 2 hours of call);

E. Provide Written recommendations to patients for sexually transmitted infection prophylaxis, pregnancy prophylaxis and HIV prophylaxis per CDC guidelines; and

F. Transfer forensic evidence to the appropriate police agency.

EXHIBIT A

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Agreement") is entered into by and between the Trustees of the University of Pennsylvania as owner and operator of the University of Pennsylvania Health System ("UPHS" or "Penn" "Covered Entity") and Drexel University ("Hybrid Entity") for its Covered Entity Component the College of Medicine on behalf of the Department of Emergency Medicine Philadelphia Sexual Assault Response Center ("SARC" or "Business Associate") and is effective as of December 1, 2015("Effective Date").

RECITALS

BUSINESS ASSOCIATE desires to protect the privacy and provide for the security of UPHS' Protected Health Information (as that term is defined herein) used by or disclosed to BUSINESS ASSOCIATE in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the regulations promulgated thereunder by the U.S. Department of Health and Human Services (45 CFR Parts 160, 162 and 164, the "HIPAA Regulations"), the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), and other applicable laws and regulations. The purpose of this Agreement is to satisfy certain standards and requirements of HIPAA, the HIPAA Regulations, including 45 CFR Section 164.504(e), and the HITECH Act, including Subtitle D, part 1, as they may be amended from time to time.

Therefore, intending to be legally bound hereby, the parties agree as follows:

1. **DEFINITIONS**.

1.1 "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA which compromises the security or privacy of PHI, subject to the exceptions set forth in 45 CFR 164.402.

1.2 "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including Section 13400(5).

1.3 "Electronic PHI" means PHI that is transmitted by or maintained in electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including 45 CFR Section 160.103.

1.4 "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including 45 CFR Section 164.304.

1.5 "Protected Health Information" ("PHI") means any information, including Electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present, or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to 45 CFR Section 160.103.

1.6 "Secretary" means the Secretary, Department of Health and Human Services, or his or her designee.

1.7 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an Information System, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including 45 CFR Section 164.304.

1.8 "Unsecured PHI" means PHI that is not secured through the use of an Encryption or Destruction technology or methodology that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals, and shall have the meaning given to such term under guidance issued by the Secretary as may be revised from time to time.

1.8.1 "Encryption" means a technology or methodology that utilizes an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, and such confidential process or key that might enable decryption has not been breached.

1.8.2 "Destruction" means the use of a technology or methodology by which the media on which the PHI is stored or recorded has been shredded, destroyed, cleared, or purged, as appropriate, such that the PHI cannot be read, retrieved, or otherwise reconstructed.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE.

2.1 Permitted Uses and Disclosures of PHI. BUSINESS ASSOCIATE may use, access, and/or disclose PHI received by BUSINESS ASSOCIATE solely for the purpose

of performing the services and/or functions for which UPHS has retained BUSINESS ASSOCIATE, subject to the terms and conditions of this Agreement.

2.1.1 Minimum Necessary. With respect to the use, access, or disclosure of PHI by BUSINESS ASSOCIATE as permitted under section2.1, BUSINESS ASSOCIATE shall limit such use, access, or disclosure, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, access, or disclosure. UPHS shall determine what constitutes the minimum necessary to accomplish the intended purpose in accordance with HIPAA, HIPAA Regulations and any applicable guidance issued by the Secretary.

2.1.2 Documentation of Disclosures. With respect to any disclosures of PHI by BUSINESS ASSOCIATE as permitted under section 2.1, BUSINESS ASSOCIATE shall document such disclosures including, but not limited to, the date of the disclosure, the name and, if known, the address of the recipient of the disclosure, a brief description of the PHI disclosed, and the purpose of the disclosure.

2.1.3 Modification of PHI. Except as permitted under section 2.13.2 below, BUSINESS ASSOCIATE shall not modify any existing PHI to which it is granted access. BUSINESS ASSOCIATE shall record any modification of PHI and retain such record for a period of seven (7) years.

2.1.4 Electronic Transaction Standards. Where applicable, BUSINESS ASSOCIATE shall adhere to the transaction standards as specified in 45 C.F.R. Parts 160 and 162.

2.2 Other Permitted Uses and Disclosures of PHI. BUSINESS ASSOCIATE may, if necessary and only to the extent necessary, use PHI (i) for the proper management and administration of BUSINESS ASSOCIATE's business, (ii) to provide data aggregation services relating to the health care operations of UPHS, or (iii) to carry out BUSINESS ASSOCIATE's legal responsibilities, subject to the limitation in section 2.3, below. BUSINESS ASSOCIATE shall obtain reasonable assurances from the person to whom the PHI is being disclosed that, as required under this Agreement, the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed. BUSINESS ASSOCIATE shall require that any Breaches or Security Incidents be immediately reported to BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall then report the Breach or Security Incident to UPHS in accordance with section 2.7.

2.3 Nondisclosure of PHI. BUSINESS ASSOCIATE is not authorized and shall not use or further disclose UPHS's PHI other than as permitted or required under this Agreement, or as required by law or regulation.

2.3.1 Disclosures Required by Law. In the event BUSINESS ASSOCIATE

is required by law to disclose PHI, BUSINESS ASSOCIATE shall promptly notify UPHS of such requirement. BUSINESS ASSOCIATE shall give UPHS sufficient opportunity to oppose such disclosure or take other appropriate action before BUSINESS ASSOCIATE discloses the PHI.

2.3.2 Legal Process. In the event BUSINESS ASSOCIATE is served with legal process or request from a governmental agency that may potentially require the disclosure of PHI, BUSINESS ASSOCIATE shall promptly, and in any case within five (5) business days of its receipt of such legal process or request, notify UPHS. BUSINESS ASSOCIATE shall not disclose the PHI without UPHS's consent unless pursuant to a valid and specific court order or to comply with a requirement for review of documents by a governmental regulatory agency under its statutory or regulatory authority to regulate the activities of either party.

2.4 Prohibition on Sale of PHI for Remuneration. Subject to the limitations set forth in Section 13405(d)(2) of the HITECH Act, BUSINESS ASSOCIATE shall not directly or indirectly receive remuneration in exchange for any of UPHS's PHI unless BUSINESS ASSOCIATE first obtains authorization from UPHS. UPHS shall not grant such authorization unless the subject of the PHI has granted UPHS a valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the individual's PHI. The foregoing shall not apply to UPHS's payments to Business Associate for Services outlined in the underlying Agreement.

2.5 Security Standards. BUSINESS ASSOCIATE shall comply with the HIPAA Security Rule and take the appropriate security measures including the implementation of the administrative, physical and technical safeguards specified in 45 CFR §§ 164.306, 164.308, 164.310, 164.312 and 164.316 to protect the confidentiality, integrity and availability of UPHS's Electronic PHI that it creates, receives, maintains, or transmits on behalf of UPHS and to prevent any use or disclosure of UPHS's PHI other than as provided by this Agreement.

2.6 Security Documentation. BUSINESS ASSOCIATE shall maintain the policies and procedures implemented to comply with section 2.5 in written form (paper or electronic). If an action, activity or assessment is required to be documented, BUSINESS ASSOCIATE shall maintain a written record (paper or electronic) of the action, activity, or assessment, shall retain the documentation for six (6) years from the date of its creation or the date when it last was in effect, whichever is later, make documentation available to those persons responsible for implementing the procedures to which the documentation pertains, and review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the Electronic PHI.

2.6.1 Security Assessment. During the term of this Agreement, Business

Associate may be asked to complete a security survey and/or attestation document designed to assist UPHS in understanding and documenting BUSINESS ASSOCIATE'S security procedures and compliance with the requirements contained herein.

2.7 Notification of Breaches and Security Incidents. BUSINESS ASSOCIATE shall notify UPHS in writing as soon as possible, but in no event more than five (5) business days, after BUSINESS ASSOCIATE becomes aware of any Breach of or Security Incident involving UPHS's PHI. BUSINESS ASSOCIATE shall be deemed to be aware of any Breach or Security Incident as of the first day on which such Breach or Security Incident is known or reasonably should have been known to its officers, employees, agents or subcontractors. BUSINESS ASSOCIATE shall identify as soon as practicable each individual whose unsecured PHI has been, or is reasonably believed by BUSINESS ASSOCIATE to have been, accessed, acquired, or disclosed during such Breach or Security Incident. BUSINESS ASSOCIATE shall cooperate in good faith, at its own cost and expense, with UPHS in the investigation of any Breach or Security Incident. As between UPHS and BUSINESS ASSOCIATE, UPHS shall have the final authority to determine whether a Breach of unsecured PHI has occurred and whether the breach notification requirements set forth in 45 CFR §§ 164 have been triggered.

2.8 Prompt Corrective Actions. In addition to the notification requirements in section 2.7 above, and with prior notice to UPHS, BUSINESS ASSOCIATE shall take (i) prompt corrective action to remedy any Breach or Security Incident, ii) mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by BUSINESS ASSOCIATE in violation of this Agreement, and (iii) take any other action required by UPHS pertaining to such Breach or Security Incident (e.g. establishment of a toll-free telephone contact number, staff the toll-free telephone contact number, mail individual notifications, etc.).

2.9 Notification of Corrective Action and Provision of Policies. BUSINESS ASSOCIATE will provide written notice to UPHS as soon as possible but no later than twenty (20) business days from the date that BUSINESS ASSOCIATE provided notice to UPHS under section 2.7 of (i) the actions taken by BUSINESS ASSOCIATE to mitigate any harmful effect of such Breach or Security Incident and (ii) the corrective action BUSINESS ASSOCIATE has taken or shall take to prevent future similar Breaches or Security Incidents. Upon UPHS's request, BUSINESS ASSOCIATE will also provide to UPHS a copy of BUSINESS ASSOCIATE's policies and procedures that pertain to the Breach or Security Incident involving UPHS's PHI, including procedures for curing any material breach of this Agreement.

2.10 Indemnification.

The Parties ("Indemnifying Party") shall indemnify, hold harmless and defend each other and each other's respective employees, other members of its workforce, directors, trustees, officers, subcontractors or agents "(Indemnified Party") from and against any and all claims, losses, liabilities, costs, penalties, fines and other

expenses resulting from, or relating to, the acts or omissions of Indemnifying Party or its respective employees, other members of its workforce, directors, trustees, officers, subcontractors or agents, in connection with the duties and obligations under this Agreement, including, without limitation, any expenses Indemnified Party incurs in notifying Individuals of a Breach caused by Indemnifying Party. Section 2.10 shall survive termination of the Agreement.

2.11 Regulatory Compliance. BUSINESS ASSOCIATE shall make its internal practices, books and records relating to the use, disclosure or security of PHI received from UPHS (or created or received by BUSINESS ASSOCIATE on behalf of UPHS) available to any state or federal agency, including the U.S. Department of Health and Human Services, for purposes of determining UPHS's and/or BUSINESS ASSOCIATE's compliance with HIPAA, the HIPAA Regulations, and the HITECH Act.

2.12 Inspection of Records. Within thirty (30) calendar days after UPHS's written request, BUSINESS ASSOCIATE shall make available to UPHS and its authorized agents, during normal business hours, all facilities, systems, procedures, records, books, agreements, policies and procedures relating to the use and/or disclosure of UPHS's PHI for purposes of enabling UPHS to determine BUSINESS ASSOCIATE's compliance with HIPAA, the HIPAA Regulations, and the HITECH Act.

2.13 Rights of Individuals.

2.13.1 Individual's Right to Request Restrictions of PHI. BUSINESS ASSOCIATE shall notify UPHS in writing within five (5) business days after receipt of any request by individuals or their representatives to restrict the use and disclosure of the PHI that BUSINESS ASSOCIATE maintains for or on behalf of UPHS. Upon written notice from UPHS that it agrees to comply with the requested restrictions, BUSINESS ASSOCIATE agrees to comply with any instructions to modify, delete or otherwise restrict the use and disclosure of PHI it maintains for or on behalf of UPHS.

2.13.2 Individual's Request for Amendment of PHI. BUSINESS ASSOCIATE shall inform UPHS within five (5) business days after receipt of any request by or on behalf of the subject of the PHI to amend the PHI that BUSINESS ASSOCIATE maintains for or on behalf of UPHS. BUSINESS ASSOCIATE shall, within twenty (20) calendar days after receipt of a written request, make the subject's PHI available to UPHS as may be required to fulfill UPHS's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526. BUSINESS ASSOCIATE shall, as directed by UPHS, incorporate any amendments to UPHS's PHI into copies of such PHI maintained by BUSINESS ASSOCIATE.

2.13.3 Individual's Request for an Accounting of Disclosures of PHI. BUSINESS ASSOCIATE shall document all disclosures of PHI and, within twenty (20)

calendar days after receipt of a written request, make available to UPHS, and, if authorized in writing by UPHS, to the subject of the PHI, such information maintained by BUSINESS ASSOCIATE or its agents as may be required to fulfill UPHS's obligations to provide an accounting for disclosures of UPHS's PHI pursuant to HIPAA, the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.528, and the HITECH Act, including, but not limited to Section 13405(c).

2.13.4 Electronic Health Records. If BUSINESS ASSOCIATE, on behalf of UPHS, uses or maintains Electronic Health Records with respect to PHI, UPHS may provide an individual, upon the individual's request, with the name and contact information of BUSINESS ASSOCIATE so that the individual may make a direct request to BUSINESS ASSOCIATE for an accounting of disclosures made by BUSINESS ASSOCIATE during the three (3) years prior to the date on which the accounting is requested or as otherwise provided under the HITECH Act Section 13405(c)(4)(A) or Section 13405(c)(4)(B).

2.13.5 Access to PHI by the Individual. If UPHS determines that an individual's PHI is held solely by BUSINESS ASSOCIATE or if BUSINESS ASSOCIATE is acting on behalf of UPHS to provide access to or a copy of an individual's PHI, BUSINESS ASSOCIATE shall, within five (5) business days after receipt of a written request, make available to UPHS, and, if authorized in writing by UPHS, to the subject of the PHI, such information as may be required to fulfill UPHS's obligations to provide access to or provide a copy of the PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.524.

2.13.6 Access to Certain Information in Electronic Format. If BUSINESS ASSOCIATE uses or maintains Electronic Health Records with respect to PHI on behalf of UPHS, BUSINESS ASSOCIATE shall, upon request of UPHS, provide UPHS with the requested Electronic Health Record in an electronic format.

2.14 Compliance with Law. In connection with all matters related to this Agreement, BUSINESS ASSOCIATE shall comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA, the HIPAA Regulations, 45 CFR Parts 160, 162 and 164, and the HITECH Act, Subtitle D, part 1, as they may be amended from time to time.

3 Nothing in this Agreement shall permit the BUSINESS ASSOCIATE or any of its agents or subcontractors to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (e.g. "Offshoring") without express written authorization from the Covered Entity.

4. TERMINATION AND OTHER REMEDIES.

4.1 Notice to Secretary. If a party knows of a pattern of activity or practice by the other party that constitutes a material breach or violation of the other party's obligations under this Agreement, if the breach or violation continues despite the other party's efforts to cure the breach or end the violation, and if termination of this Agreement is not feasible, then the breach or violation shall be reported to the Secretary.

4.2 Material Breach. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

4.2.1 Terminate the Agreement immediately if cure of the breach is not feasible;

4.2.2 Terminate the Agreement unless the other party, within five (5) business days, provides a plan to cure the breach and, within fifteen (15) business days, cures the breach;

4.3 Effect of Termination - Return or Destruction of PHI held by BUSINESS ASSOCIATE or BUSINESS ASSOCIATE's Agents. Upon termination, expiration or other conclusion of the Agreement for any reason, BUSINESS ASSOCIATE shall return or, at the option of UPHS, provide for the Destruction of all PHI received from UPHS, or created and received by BUSINESS ASSOCIATE on behalf of UPHS in connection with the Agreement, that BUSINESS ASSOCIATE or its Agents still maintains in any form, and shall retain no copies of such PHI. Not less than thirty (30) calendar days after the termination of the Agreement, BUSINESS ASSOCIATE shall both complete such return or Destruction and certify in writing to UPHS that such return or Destruction has been completed.

4.4 Return or Destruction Not Feasible. If BUSINESS ASSOCIATE represents to UPHS that return or Destruction of UPHS's PHI is not feasible, BUSINESS ASSOCIATE must provide UPHS with a written statement of the reason that return or Destruction by BUSINESS ASSOCIATE or its Agents is not feasible. If UPHS determines that return or Destruction is not feasible, this Agreement shall remain in full force and effect and shall be applicable to any and all of UPHS's PHI held by BUSINESS ASSOCIATE or its Agents.

4.5 Other Remedies. Notwithstanding the foregoing rights to terminate the Agreement, UPHS shall have such other remedies as are reasonably available at law or equity, including injunctive relief.

4.6 Civil and Criminal Penalties. BUSINESS ASSOCIATE understands and agrees that it is subject to civil or criminal penalties applicable to BUSINESS ASSOCIATE for unauthorized use, access or disclosure of PHI in accordance with the

HIPAA Regulations and the HITECH Act.

5. **CHANGES TO THIS AGREEMENT.**

5.1 Compliance with Law. The parties acknowledge that state and federal laws and regulations relating to electronic data security and privacy are rapidly evolving and that changes to this Agreement may be required to ensure compliance with such developments. The parties specifically agree to take such action as may be necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations, the HITECH Act, and other applicable state and federal laws and regulations relating to the security or confidentiality of PHI.

5.2 Negotiations. In the event of a change in or interpretation of any state or federal law, statute, or regulation which materially affects the rights or obligations of either party under the Agreement, the parties agree to negotiate immediately in good faith any necessary or appropriate revisions to this Agreement. If the parties are unable to reach an agreement concerning such revisions within the earlier of sixty (60) calendar days after the date of notice seeking negotiations or the effective date of a change in law or regulation, then either party may immediately terminate the Agreement upon written notice to the other party.

6. **Intentionally Omitted**

7. **MISCELLANEOUS PROVISIONS.**

7.1 Assistance in Litigation or Administrative Proceedings. BUSINESS ASSOCIATE shall make itself, and any employees or agents assisting BUSINESS ASSOCIATE in the performance of its obligations under the Agreement, available to UPHS at no cost to UPHS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings against UPHS, its directors, officers, agents or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy and arising out of the Agreement.

7.2 No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, any rights, remedies, obligations or liabilities whatsoever upon any person or entity other than UPHS, BUSINESS ASSOCIATE and their respective successors or assigns.

7.3 Survival. The obligations of BUSINESS ASSOCIATE under Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 4.3, 4.4, and 6of this Agreement shall survive the termination of the Agreement.

7.4 Notices. Any notices to be given to either party shall be made via U.S. Mail or express courier to the address given below and/or via facsimile to the facsimile

telephone numbers listed below.

7.5 Entire Agreement. Both parties agree that this Business Associate Agreement represents the entire understanding of the parties with respect to the subject matter covered herein and supersedes and nullifies any previous Business Associate Agreement and/or Addendum that the parties have entered into. For clarification and not limitation, this Business Associate Agreement only applies to the SANE Services performed by SARC for Covered Entity under the separate Services Agreement.

If to BUSINESS ASSOCIATE, to: to:

Edward G. Longazel, M.H.A., C.H.C., C.H.R.C.
Vice President
Chief Compliance, Privacy and Internal Audit Officer
Drexel University
Suite 10666
Three Parkway
1601 Cherry Street
Philadelphia, Pa. 19102-1192
[redacted](voice)
[redacted](fax)
[redacted]

With a copy (which shall not constitute notice) to:

Office of the General Counsel
Drexel University College of Medicine
1601 Cherry Street, Suite 16207
Philadelphia, PA 19102

Attention: _____ Attention: _____

Fax: _____ Fax: _____

If to UPHS, to:

Hospital of the University of Pennsylvania,
Division of Traumatology, Surgical Critical
Care and Emergency Surgery_____
3400 Spruce Street
Philadelphia, PA 19104
Attention: James Ballinghoff
RN, MSN, MBA,Chief Nursing Officer, PPMC
PPMC Administration
Fax: (215)615-4748

With a copy (which shall not constitute notice) :

University of Pennsylvania
Office of the General Counsel
3539 Locust Walk
Philadelphia, PA 19104
Attention: Deputy General Counsel
Fax: (215) 746-5301

Each party may change its address and that of its representative for notice by giving notice in the manner provided above.

IN WITNESS WHEREOF, the parties hereto have duly executed this BUSINESS ASSOCIATE AGREEMENT.

The Trustees of the University of Pennsylvania As owner and operator of the University of Pennsylvania Health System	Drexel University for its College of Medicine
Signature	Signature
Garry L. Scheib Printed Name	Edward G. Longazel, M.H.A., C.H.R.C. Printed Name
Chief Operating Officer, UPHS Title	Vice President Chief Compliance, Privacy and Internal Audit Officer Drexel University Title
12-10-15 Date	Date

	University of Pennsylvania Health System	
Clinical Practice Policy/Procedure	**Inpatient and Out-Patient Sexual Assault-Forensic Examinations**	**Page 1 of 3**

KEYWORDS:

Sexual Assault

Sexual Assault Nurse Examiner(SANE)

Forensic Examination

Evidence Collection

Chain of Custody

Chain of Custody Form

REFER TO:

Sexual Assault Emergency Services 117.51-117.58
Joint Commission LD 04.01.01EP2

Act 28Pa.Code 117.52 (a)

Act 28 PA Code 117.51-117.58

INTRODUCTION

Sexual assault takes many forms, including attacks such as rape or attempted rape as well as any unwanted sexual contact or threats. A sexual assault occurs when someone touches any part of another person's body in a sexual way, even through clothes, without that person's consent. Types of sexual acts which fall under the category of sexual assault include forced sexual intercourse (rape), sodomy (oral or anal sexual acts), child molestation, incest, fondling and attempted rape. Sexual assault in any form is often a devastating crime. Assailants can be strangers, acquaintances, friends, or family members. This policy is designed to assist all HUP, PPMC, and PAH staff in caring for an inpatient who reports being sexually assaulted or if a hospital clinician suspects a patient has been sexually assaulted.

PURPOSE

To provide a specially trained Sexual Assault Nurse Examiner (SANE), provided through contract with Drexel University's Philadelphia Sexual Assault Response Center, to perform a confidential and comprehensive examination for victims of sexual assault who are admitted to HUP, PPMC, or PAH.

SCOPE

This policy applies to all HUP, PPMC, and PAH staff including but not limited to Registered Nurses (RNs), Physicians, and/or Social Workers who are aware of or suspect that an inpatient has suffered a sexual assault. SANE employees contracted through the Philadelphia Sexual Assault Response Center are also under the scope of this policy.

POLICY

Drexel University SANE representatives will:

1. Provide 24/7 on-call SANE coverage
2. Respond to HUP, PPMC, or PAH within two hours of notification
3. Obtain consent, perform a forensic rape examination and evidence collection in accordance with all applicable legal regulations and professional standards
4. Provide written recommendations to the healthcare provider for sexually transmitted infection prophylaxis, pregnancy prophylaxis and HIV prophylaxis per CDC guidelines
5. **Provide written instructions for follow-up care and counseling**
6. Transfer forensic evidence to appropriate policy agency

PROCEDURE

A. NOTIFICATION

1. If an inpatient meets the criteria as described above, the healthcare provider or nurse will notify the Nursing Administrative Coordinator (NAC) on duty (refer to entity-specific phone numbers below).
   a. Referrals may be made within 120 hrs/ 5days days of the alleged event.
   b. The SANE hotline may be consulted for any questions about special victims without making a full referral.
2. The NAC will notify hospital security. Security will notify police (911) per protocol.

3. The NAC will call the SANE hotline (215-425-1625) and document the time of the referral in the electronic log.
4. Upon arrival, the NAC will meet the SANE and escort him/her to the patient's primary nurse. The SANE Nurse will bring consent form and leave copy. The SANE nurse will also come with a consult form and provide copy.

B. CLINICAL CONSIDERATIONS
1. The patient has the right to refuse any/all collection of evidence and medical treatment at any time throughout his/her evaluation and treatment.
2. If the patient declines the forensic exam, the medical exam and treatment will be performed at the request of the patient.
3. It is preferable to leave the patient's clothing on if possible, but if medical treatment requires removing the clothing, save the patient's clothing in a paper bag.
4. Do NOT bathe the patient.
5. Do not provide oral care for the patient.

C. CONSENT AND TREATMENT
1. The SANE will obtain written patient consent for forensic examination, treatment, collection of evidence and release of medical records information to the law enforcement agency that has jurisdiction. A copy of the face sheet and patient labels will be provided to the SANE by the primary nurse.
2. The SANE will explain the examination and evidence collection procedure to the patient.
3. The SANE will provide all necessary equipment for the examination and evidence collection.
4. The primary nurse will assist the SANE during the exam, as reasonably requested
5. The SANE will provide written recommendations to the healthcare provider for sexually transmitted infection prophylaxis, pregnancy prophylaxis, and HIV prophylaxis per CDC guidelines
6. The healthcare provider will enter orders based on SANE recommendations into the patient's electronic medical record
7. The SANE will provide written instructions to patients for follow-up care and counseling
8. The SANE will transfer all forensic evidence to the appropriate police agency

D. DOCUMENTATION
1. The SANE will document on the SANE consult sheet and leave a copy for medical record. The primary nurse will document the following in the patient's electronic medical record:
   a. Time of SANE consult
   b. Time of SANE arrival
   c. Time forensic examination began and ended
   d. Any testing conducted
   e. Any medication administered

ENTITY SPECIFIC INFORMATION

A. HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA (HUP)
1. NAC: [redacted] (contact NM of unit Monday-Friday 7a-3p)
2. Parking: Valet area in front of Ravdin Lobby (34th Street)
3. SANE meets NAC at Emergency Department entrance

B. PENN PRESBYTERIAN MEDICAL CENTER (PPMC)
1. NAC: [redacted]
2. Parking: Rudolphy Lot (across from ED)
3. SANE meets NAC at Emergency Department entrance

C. PENNSYLVANIA HOSPITAL (PAH)
1. NAC: [redacted]
2. Parking: Parking garage on Delancey Street (parking validated by security)
3. SANE meets NAC at hospital main entrance (8th Street)

REFERENCES

Lynch, Virginia A. MSN,RN,FAAN, FAAFS, Forensic Nursing; Mosby Inc. 2006
Texas Office of Attorney General Sexual Assault Prevention & Crisis SANE Training Manual, 2002.

Giardino Angelo MD, PHD., Datner Elizabeth, MD., Asher Janice, MD., Girardin Barbara, RN, PHD., Faugno Diana RN, BSN, CPN, FAAFS, SANE-A., Spencer Mary MD,. Sexual Assault for healthcare, Social Service and Law Enforcement Professionals; G.W. Medical Publishing 2003.

Avegno, Jennifer, MD MA; Mills, Trevor, MD MPH; Mills Lisa MD: Violence, Recognition, Management, and Prevention; Sexual Assault Victims in the Emergency Department: Analysis by Demographic and Event Characteristics
Emerg Med J vol 37, No3, pp 328-334, 2009

Sexual Assault and Abuse and STDs
http: www//cdc.gov/std/tg2015/sexual-assault.htm

ENA Position Statement: Care of the Sexual Assault and Rape Victims in the Emergency department.
Retrieve from ENA. Org 3-1-2016
Pennsylvania Act, 35 P.S. section 10172.1. http://www.pabulletin.com/secure/data/vol38/38-39/1756.html

Girardin Barbara W. RN PHD., Faugno Diana K. RN, BS N,CPN,BCFE., Seneski Patty C. RN,ENP., Slaughter Laura MD, FACR, FACP., Whelan Margaret RN, BSN., Color Atlas of Sexual Assault Mosby 1997.

National Institute of Justice (2009) Rape and Sexual Violence
http://www.ojp.gov/nij/topics/crime/rape-sexu-violence/welcome.htm

REVIEWS/APPROVALS

Supersedes: New
Effective Date: 2015

SEXUAL ASSAULT PATIENT CARE ALGORITHM

HUP Emergency Department

Pt wants evidence collection, STI and/or pregnancy prophylaxis and OK to contact police

- Pt assigned ESI level 2 and placed in private room
- Provide medical screening exam and treat any injuries or medical
- Call 911 and make initial report with PD. Police will contact PSARC and SANE nurse
- Prophylactic treatment to be given at PSARC or in ED
- PD provides transport to PSARC and then to home

Pt wants evidence collection and STI and/or pregnancy prophylaxis but NO police contact

- Pt assigned ESI level 2 and placed in private room
- Provide medical screening exam and treat any injuries or medical conditions
- Contact PSARC to discuss with program director 8a-4p. Contact SANE nurse directly during off-hours
- Prophylactic treatment provided at PSARC or in ED
- Provide cab voucher to PSARC where patient will meet SANE nurse. Pt must provide own ride home

Pt wants only STI and/or pregnancy prophylaxis, NO evidence collection

- Pt assigned ESI level 2 and placed in private room
- Provide medical screening exam and treat any injuries or medical conditions
- Provide prophylactic treatment in ED. Consider pelvic exam by ED clinician
- If patient wants to only file police report, call 911
- Pt to follow-up with PCP/OB/GYN. Provide info for WOAR as needed

Pt medically unstable and to be admitted to inpatient/obs

- Assign appropriate ESI level. Consider trauma
- Consult PSARC at 215-800-1589
- SANE RN will respond to HUP for evidence collection. If patient intoxicated, inquire about evidence collection and consent when clinically sober.
- Provide follow-up for PSARC and WOAR at discharge

CONTACT NUMBERS:

24 Hour PSARC Service/On-Call SANE - 215-625-1425
PSARC Director M-F 8am-4pm – 215-800-1589
Special Victims Unit - 215-685-3251, 52, or 53
Women Organized Against Rape (WOAR) - 215-985-3315
Women in Transition 24 Hour Hotline - 215-751-1111

PSARC Address:

300 East Hunting Park Ave
Philadelphia, PA 19124

UNM HEALTH SCIENCES CENTER

Office of the Chancellor for Health Sciences

March 27, 2018

Honorable Greg Warden, Chairman,
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Honorable Gregg Harper, Chairman
U.S. House of Representatives
Subcommittee on Oversight and Investigations
of the Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

RE: Availability of Sexual Assault Forensic Exams at Hospitals

Dear Congressmen Warden and Harper:

The undersigned are writing in response to your letter dated March 13, 2018, in which you state that the Committee on Energy and Commerce is investigating the availability of sexual assault forensic exams at hospitals across the United States.

This topic is one that we hold very dear. Caring for patients after a traumatic sexual assault requires the highest level of compassion and care. We have made a commitment to respect and support any man or woman who enters our facilities after being assaulted and care for their physical, emotional and mental health. We cannot give them back the security and trust that they once had but we can show them that this very dark day will pass, they will survive and there is a road to recovery and justice.

That said, allow us to introduce to the Committee on Energy and Commerce The University of New Mexico, the UNM Health Sciences Center, the UNM Health System, and UNM Hospitals. The University of New Mexico (UNM) is a state educational institution formed under Article XII, Section 11 of the New Mexico Constitution. UNM is the flagship university of the State of New Mexico, and has approximately 34,000 undergraduate, graduate, and professional students. UNM is one of a few majority-minority research institutions in the United States.

Within the University of New Mexico, there is a designated component unit called the UNM Health Sciences Center. The UNM Health Sciences Center includes UNM's School of Medicine, College of Pharmacy, College of Nursing, and new College of Population Health. At the UNM School of Medicine, we educate medical students in a variety of specialties and concentrations. As New Mexico's only academic health center, in addition to education, we conduct cutting-edge

research and provide superb clinical care to thousands of New Mexicans each year. UNM is a recipient of the prestigious Clinical and Translational Science Award from the National Institutes of Health for its clinical research.

Within the UNM Health Sciences Center is the UNM Health System, which is an integrated health care delivery system consisting of the 525-bed academic teaching hospital known as UNM Hospitals, a 72-bed community teaching hospital known as UNM Sandoval Regional Medical Center, Inc., and UNM Medical Group, Inc. which is the faculty practice organization supporting the clinical practice of the School of Medicine faculty. The UNM Hospitals include the State of New Mexico's only Level I Trauma Center, only designated Children's Hospital, and only National Cancer Institute-designated Comprehensive Cancer Center. Faculty within the UNM School of Medicine serve as the medical staff of the UNM Hospitals, and the UNM Hospitals house a number of residents, fellows, and other healthcare learners. In Fiscal Year 2017, the UNM Hospitals had 78,467 patients visit the Emergency Department. At that same time, the UNM Hospitals had 159,816 primary care outpatient visits, and 362,053 specialty care outpatient visits.

New Mexico is the nation's second-poorest state, with around 45 percent of our population being eligible for and participating in the State's Medicaid program. Health care resources in New Mexico are stretched as well. Other than Bernalillo County (in which the UNM Hospitals are located), virtually every other county of the 33 New Mexico counties is designated as a medically underserved area, in substantially all of the health care professions. Many counties in New Mexico do not have a hospital situated within them and some counties have as little as one to two physicians practicing. Some of the counties that do have hospitals situated within them have seen those hospitals struggle to recruit and retain physicians and surgeons and in some cases have reduced the number of licensed beds to achieve critical access hospital status for financial sustainability purposes.

These challenges in access to health care are due to the State's large rural and frontier areas. Thirty-four percent of the State's 2.1 million residents live in rural and frontier areas. *See 2017 New Mexico Health Care Workforce Committee Annual Report* at 7-10, https://hsc.unm.edu/assets/doc/economic-development/nmhcwc-annual-2017.pdf. All of this is to say that the healthcare workforce is unevenly distributed in New Mexico (*see id.)*, and the demand for high-level emergent, tertiary, and/or quaternary care in New Mexico is significant and is largely focused on the three health systems in Albuquerque, New Mexico: UNM Hospitals, Presbyterian Healthcare Services, and Lovelace Health System. As it relates to specialized quaternary care, virtually all of the focus is on the UNM Hospitals. At the same time, the State of New Mexico is our nation's fifth largest state geographically. Thus, to get to health care, some New Mexicans have to travel several hours.

Because of this history and situation, health care providers in New Mexico have had to be creative in finding alternative ways to create access to health care. The Sexual Assault Nurse Examiner (SANE) programs in New Mexico offer one such creative solution. In 1996, employees of the UNM Hospitals and faculty in the UNM School of Medicine joined with employees and providers at Presbyterian Healthcare Services and Lovelace Health System to create the first SANE program

in New Mexico, the Albuquerque SANE Collaborative (ABQ SANE). These providers and employees recognized that the quality of care that sexual assault patients received in the UNMH Emergency Department was not as comprehensive as could be achieved through a dedicated, SANE program. Additional information about ABQ SANE, including a list of services and program goals, is available at https://abqsane.org/.

Since that time, this program has grown and new independent SANE programs started in other New Mexico communities. Currently, New Mexico has a comprehensive network of SANE programs. These programs are coordinated by the New Mexico Coalition of Sexual Assault Programs (NMCSAP). Among many roles in serving sexual assault survivors in New Mexico, NMCSAP is the fiscal agent that pays for sexual assault evidence kits (SAEKs) used by all SANE programs in New Mexico. A copy of a map showing the SANE program locations in New Mexico is attached. as Document No. UNM-1. Thus, the SANE programs in New Mexico lead the way in collecting SAEKs, as opposed to hospital emergency departments.

We tell you this so you can better understand our answers to the Committee's questions. With this in mind, the UNM Hospitals provides the following responses to your questions. For ease of reference, we have restated each of the Committee's questions (including subparts) and have supplied our institution's response after each such question.

Question No. 1: Does the University of New Mexico Hospital employ SANEs or SAFE-certified medical providers?

Response to Question No. 1: As indicated above, UNM Hospitals works in collaboration with ABQ SANE to ensure victims receive the highest level of care possible. There are UNM Hospitals providers who are SANE certified and provide SANE services outside of their UNM Employment as well. We do not directly employ SANE OR SAFE certified providers to provide SANE or SAFE services.

Question No. 2: If the University of New Mexico Hospital does employ SANEs,

a. When did the University of New Mexico Hospital begin employing SANEs?

b. How many SANE or SAFEs does the University of New Mexico Hospital employ?

c. How were SANEs trained?

d. During what days and hours are SANEs available at the University of New Mexico Hospital?

e. Is the University of New Mexico Hospital listed on the IAFN database?

f. What is the annual cost of administering the SANE program at the University of New Mexico Hospital? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.

g. What grants, if any, has the University of New Mexico Hospital applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?

Response to Question No. 2: Our responses to the various subparts of Question No. 2, are as follows:

As we do not employ SANE providers to provide SANE services, most of this question does not apply to the UNM Hospitals. However, we can state that ABQ SANE strongly prefers its providers see patients at their facility. If determined to be medically necessary, ABQ SANE providers will come to the UNM Hospitals to see a patient. This is rare. If this occurs, the ABQ SANE providers will bring a SAEK with them for evidence collection purposes.

Additionally, the UNM Hospitals is not, as far as we know, listed on the IAFN database.

The UNM Hospitals has not since 1996 applied for or funded any programs related to the training of SANEs or treatment of sexual assault victims. Additional information about the provider of these services, ABQ SANE, including a list of its services and program goals, is available at https://abqsane.org/.

Question No. 3: If the University of New Mexico Hospital does not employ SANEs, does the University of New Mexico Hospital provide rape kits by non-SANEs?

a. If so, who conducts those kits?

b. How are these medical professionals trained to collect those kits?

Response to Question No. 3: No, the UNM Hospitals nurses and providers do not provide sexual assault evidence kits (SAEKs). Since 1996, all SAEKs in the greater Albuquerque area have been collected by specially-trained SANEs at ABQ SANE. Attached as Document Nos. UNM-2 to UNM-130 is a copy of a technical report to the United States Department of Justice authored by two UNM School of Medicine faculty members that summarizes a comprehensive evaluation of ABQ SANE's impact on sexual assault care and criminal justice outcomes in this area.

Question No. 4: If a sexual assault victim comes to the University of New Mexico Hospital requesting treatment and/or rape kit following an assault, what procedures are in place at the University of New Mexico Hospital to treat that victim? If the University of New Mexico Hospital does not conduct a rape kit, SAFE certified or not, please include whether the University of New Mexico Hospital has a relationship or agreement with another facility that does provide those services.

Response to Question No. 4: The vast majority of sexual assault victims go directly to ABQ SANE. More specifically,

a. ABQ SANE is well known in the community and sexual assault victims can go directly to ABQ SANE without the need for a physician or other referral. ABQ

SANE is located at the ABQ Family Advocacy Center (FAC). The FAC is run by the City of Albuquerque and offers a co-located service delivery model for victims of domestic violence, sexual assault and stalking. In addition to offering medical and forensic services for victims of sexual assault, the various providers at FAC provide the following array of services: civil legal services, rape crisis counseling, court filings, advocacy and counseling, child sexual abuse treatment and testing (Para los Niños) and law enforcement (should a victim choose to report to law enforcement). Notably, the FAC is located less than three miles from the UNM Hospitals Emergency Department, less than a fifteen minute journey by automobile. Greater detail about the workings of the FAC can be found at: https://www.cabq.gov/police/albuquerque-family-advocacy-center.

b. Since October 1, 2000, Bernalillo County EMS has had a protocol in place that permits it to transfer sexual assault patients directly to ABQ SANE. The Bernalillo County EMS System Guidelines are available at: https://www.cabq.gov/fire/documents/abc-ems-protocols-guidelines-feb-26-2018.pdf).

c. Albuquerque Police Department and Bernalillo County Sherriff's Office can similarly take sexual assault victims directly to ABQ SANE.

d. Occasionally, sexual assault patients are brought to the UNM Hospitals Emergency Department by the Albuquerque Police Department (or other law enforcement) or by ambulance. Some sexual assault victims also "walk in." In these circumstances, the Emergency Department responds just as it would with any other patient who presents for care. In other words, we triage, perform a medical screening exam, and stabilize the patient, if necessary. Among the sexual assault patients that come to the Emergency Department, most do not need further stabilization. If stabilization were needed, we would initiate that consistent with our obligations under the Emergency Medical Treatment and Labor Act (EMTALA).

Consistent with our obligations relative to patient privacy and patient choice, only after stabilization (and patient permission) would ABQ SANE be contacted. ABQ SANE strongly prefers that they see patients at their facility within the FAC. If determined to be medically necessary, ABQ SANE providers will come to the UNM Hospitals to see a patient. This is rare. If this occurs, the ABQ SANE providers will bring a SAEK with them for evidence collection purposes.

Prior to contacting ABQ SANE, we explain to the patient the options available. We let patients know about ABQ SANE and the services that ABQ SANE can provide. If the patient agrees, we contact ABQ SANE and speak with the on-call SANE provider. Generally, the SANE provider will speak with the patient over the phone to develop a plan for the patient. While ABQ SANE offers 24/7 services, the unit is not physically staffed 24/7. If several cases are activated at the same time, our experience tells us that ABQ SANE will need to triage services and sometimes set an appointed time to be seen. If the patient agrees to go to ABQ SANE, the Emer-

gency Department arranges transport to ABQ SANE. The patient's choices include: (i) patient's own vehicle, (ii) taxicab to ABQ SANE (paid for either by the UNM Hospitals or by ABQ SANE), or (iii) law enforcement (if law enforcement remains involved).

The UNM Hospitals policies that describe our procedures are our EMTALA/MSE policies. The UNM Hospitals does not have specific policies that address providing treatment to sexual assault victims.

New Mexico law (Section 24-10D-1 *et seq.*, NMSA 1978, as amended) requires hospitals that provide emergency care for sexual assault survivors to provide information about emergency contraception and that they further provide emergency contraception (EC) upon request. Because of our relationship with ABQ SANE, we generally do not provide EC at the UNM Hospitals but defer this to ABQ SANE if patients elect to be seen there. We inform patients that ABQ SANE can provide post-coital contraception and post-exposure prophylaxis for no charge. If a patient does not want to be seen at ABQ SANE, our practice is to provide this medication. History tells us that this is extremely rare.

Question No. 5: Does the University of New Mexico Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

Response to Question No. 5: No, the UNM Hospitals does not track this data for the reasons articulated above, including the small number of the UNM Hospitals' encounters with sexual assault victims.

* * *

The University of New Mexico, the UNM Health Sciences Center, and the UNM Hospitals are proud of our role serving as the backbone of the health system in New Mexico and to have been involved in founding and supporting the SANE program system in Albuquerque. We are even more proud of how the SANE programs have blossomed into a functioning network of specialized providers serving the needs of sexual assault victims.

We trust that the information we are providing the Committee on Energy and Commerce serves the needs of and informs this investigation.

If you have any further questions, we would ask that you direct those questions to Scot Sauder, Esq., Deputy University Counsel for Health Sciences, at (505) 272-2377 and he will coordinate our responses.

Sincerely,

Paul B. Roth, M.D., MS, FACEP, Executive Vice President and Chancellor for Health Sciences, and Dean, UNM School of Medicine

Michael E. Richards, M.D., MPH, Vice Chancellor for Clinical Affairs, UNM Health System

Michael Chicarelli, DNP, Interim Chief Executive Officer, University of New Mexico Hospital

Cc: The Honorable Frank Pallone, Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

The Honorable Ben Ray Lujan, Member

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Subcommittee on Oversight and Investigations

The Honorable Ben Ray Lujan, Member

New Mexico SANE Programs

SANE Program

Satellite SANE

Deferred Pediatric

An Impact Evaluation of a Sexual Assault Nurse Examiner (SANE) Program

Albuquerque SANE Collaborative
Albuquerque, NM

NIJ Grant # 98-WT-VX-0027

Cameron S. Crandall, MD
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The views are those of the authors and do not reflect the opinions of the National Institute of Justice or the U.S. Dept. of Justice

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Acknowledgments

This project could not have been completed without the diligent participation of a large number of agencies and individuals.

We would like to thank numerous staff in the Department of Emergency Medicine and in the Center for Injury Prevention Research and Education. A number of people have come and gone, all of whom played key roles in getting this project completed. Lenora Olson conceived of this evaluation and nurtured the original grant. Anne Worthington joined the project early on and developed a real energy and expertise in understanding violence against women. She alone interviewed all of the stakeholders and is the repository of important details and insights on how SANE units impact sexual assault. Jonathon LaValley helped wrestle and tame the complex web of databases created by the different medical, law enforcement, prosecution and court agencies. He spent many early and late hours coaxing the project along and in programming the computer to extract the results that are presented in this report. Lisa Cutchen started with this project very early on and helped research the background information on sexual assault and SANE units. We would like to also acknowledge her valiant effort in putting together the victim telephone survey before scooting off to medical school. Thanks also to Kimberly Morgan, Norma Faries, and Lynne Fullerton-Gleason for their help in collecting the data and putting together this report. Special thanks are needed for Laura Banks, who joined our group just recently, but whose fresh keen eyes picked out errors and omissions that we were no longer able to see. Jan Schmidt helped recover the final report document from several crashes. Marta Sherbring developed the flow diagrams. Countless staff members listened to and transcribed the key informant interviews.

Hilary Heyl facilitated the researcher-community meetings that were used to develop the evaluation questions.

Marcia Mikulak and Anne Worthington poured over the key informant interviews with a fine toothed comb and put together a cohesive summary of SANE's impact on our community.

Larry Cook of the Intermountain Injury Control Research Center at the University of Utah conducted the probabilistic linkage.

Several Albuquerque SANE Collaborative staff were very helpful with this project. Pat Schindler and Linda Robinson former Albuquerque SANE Collaborative Directors encouraged the project and provided helpful suggestions on how to improve our study. Very special thanks are reserved for Constance Monahan, current Director of the Albuquerque SANE Collaborative for her insight and clarity on interpreting our results and in reading drafts of the final report.

Julie Altwies, Jolene Altwies, and Mary Helen Wickert were helpful in interpreting the confusing array of law enforcement and prosecution data.

Countless agencies and staff members assisted with the project, including: Albuquerque Police Department, Bernalillo County Sheriff's Department, University of New Mexico Campus Police, Federal Bureau of Investigation, Bureau of Indian Affairs, Second Judicial District Attorney's Office, Second Judicial District Court, Albuquerque Rape Crisis Center, the New Mexico Coalition of Sexual Assault Programs, New Mexico Crime Victims Reparation Commission and of course the Albuquerque SANE Collaborative.

And personal thanks to David Sklar, Gabriel Campos, Bao Pei, Tung Zhu and A. Dobe for encouragement and providing moral support to finish this project.

Abstract

Research Goals and Objectives

Statement of purpose

The purpose of this evaluation was to determine the impact of SANE services on four areas: 1) healthcare, 2) victim services, 3) law enforcement and 4) prosecution.

Research subjects

The experiences of women who sought services at the University of New Mexico Health Sciences Center in the two years prior to the inception of SANE (n=242) (1994–1996) were compared to the experiences of women who sought services at the Albuquerque SANE Collaborative after inception (October 1996) through the end of 1999 (n=715). Key informants (n=28) from the four areas of impact participated in the research.

Research Design and Methodology

Methods

A quasi-experimental design comparing data pre- and post-SANE was used. Ten qualitative and quantitative data collection methods were used. Qualitative methods included: an advocate focus group, victim services interviews, healthcare interviews, law enforcement interviews, and prosecution interviews. Quantitative methods included reviews of pre-SANE medical charts, SANE medical charts, law enforcement and court records, and a victim telephone survey.

Data Analysis

Qualitative data were tape recorded, transcribed, coded, and summarized; content analysis was undertaken. Exploratory and descriptive analyses were used to summarize quantitative data. Chi-square tests were used to compare categorical data and t-tests were used to compare continuous data pre- to post-SANE.

Research Results and Conclusions

Results

Demographic characteristics were similar in the pre- and post-SANE medical, police, district attorney and court records. Post-SANE victims received more medical services for sexual assault, including STD treatment, pregnancy testing and prophylaxis. Post-SANE victims received a greater number and more comprehensive type of referrals to victim services compared to pre-SANE victims (4.0 vs. 1.7 referrals/patient, $p<0.0001$). More SANE victims reported to police (72% vs. 50%, $p<0.0001$) and had sexual assault evidence kit collected than did pre-SANE victims (88% vs. 30%, $p<0.0001$). Police filed more charges post-SANE compared to pre-SANE (7.0 vs. 5.4 charges/perpetrator, $p<0.0001$). Post-SANE charges had a higher conviction rate (69% vs. 57%, $p=0.001$) and a longer average sentence (5.1 vs. 1.2 years, $p<0.0001$) compared to pre-SANE cases.

Conclusions

The data strongly suggest that a SANE unit greatly enhances the healthcare quality of women who have been sexually assaulted, improves the quality of forensic evidence, improves law enforcement's ability to collect information and to file charges, and increases the likelihood of successful prosecution. While SANE units significantly impact the collection of forensic data and improve prosecution, additional resources are needed for victims services (*e.g.*, follow up and counseling), training of law enforcement, and improved communication across all service providers.

Summary

Overview

This report details the findings of the University of New Mexico Hospital Emergency Medicine Department's comprehensive outcome evaluation of the Albuquerque Sexual Assault Nurse Examiner (SANE) Collaborative. Although the proliferation of SANE units in the U.S. suggests an apparent success of this type of program, this is the first coordinated, comprehensive evaluation of SANE.

Our outcome evaluation addresses four areas: 1) healthcare, 2) victim services, 3) law enforcement, and 4) prosecution. We measured SANE's impact using a variety of techniques including face-to-face interviews, telephone interviews, and analysis of medical, police and court records. While we addressed each of the four areas separately, each is so intertwined with one another that we have attempted to link the components so as to comprehensively evaluate SANE. Our evaluation uses a pre-, post- comparison design, comparing responses that reflect on conditions before and after the implementation of the Albuquerque SANE Collaborative.

Our findings strongly suggest that the establishment of the Albuquerque SANE Collaborative in October 1996 significantly and positively impacted healthcare, victim services, law enforcement, and prosecution.

SANE victims received more consistent and broad healthcare services, including STD treatment, pregnancy testing and prophylaxis and a greater number and more comprehensive type of referral to medical and victim services providers compared to pre-SANE victims. More post-SANE victims reported to police (72% vs. 50%) and had sexual assault evidence kit collected than did pre-SANE victims (88% vs. 30%). Police were able to file more charges post-SANE compared to pre-

SANE and these charges ultimately had a higher conviction rate (69% vs. 57%) and a longer average sentence (5.1 vs. 1.2 years) compared to pre-SANE cases.

Community leaders and service providers were overall very pleased with SANE. In all areas of the evaluation, SANE contributed positively to service delivery and the quality of professional's work.

The Albuquerque SANE Collaborative

Until 1996, sexual assault victims in Albuquerque were seen at the emergency departments (ED) of several hospitals. This was perceived to be less than ideal by many, including emergency physicians and nurses, the Albuquerque Rape Crisis Center, the Albuquerque Police Department and the local District Attorney. After two years of planning and fund raising, the Albuquerque SANE Collaborative opened its doors on October 16, 1996. Our evaluation concentrates on the Albuquerque SANE Collaborative and the impact that this unit has had. To better understand our findings, we provide an overview of the typical flow of services prior and subsequent to the startup of SANE.

Typical Pre-SANE Emergency Department Patient Flow

Prior to SANE, sexual assault victims typically sought care at an ED of a local hospital. Upon arrival at the medical facility, the victim would state the reason for their visit to the clerical staff. Often, a patient would not initially state the primary reason for their visit. The patient was triaged by an ED nurse. A history of sexual assault was often elicited at this point and a rape crisis advocate was contacted and requested to come to the ED. Depending upon the patient's severity of illness and injury, the patient would be placed in the ED waiting room for an available exam room. When an exam room became available, the patient would wait for physician evaluation. The physician would assess the patient and would manage any immediate illness or injury. If the patient desired to have a forensic evidence exam, the exam was conducted when resources were available. A physician,

nurse, and rape crisis advocate all needed to be simultaneously available to conduct the exam. Following completion of the exam, the patient would be offered treatment for sexually transmitted diseases, emergency contraception, and definitive treatment for any injuries. If the patient desired to speak with police, a law enforcement officer would be dispatched to interview the patient.

Typical SANE Patient Flow

Since SANE, patients are seen for sexual assault either at a specialized unit at a centrally located hospital in Albuquerque or at another hospital facility if the severity of their injuries do not permit them to go to the SANE unit directly. SANE can be activated through several mechanisms, including the healthcare facility, emergency medical services, police, rape crisis, or by contacting the SANE unit directly. If the victim has injuries that require medical attention, the victim is referred to a local ED for treatment. If the patient needs hospital admission or requires a prolonged ED stay, SANE is contacted for onsite evaluation/forensic evidence exam. If the patient is medically cleared, the SANE nurse and rape crisis advocate are dispatched to meet the patient at the SANE unit. The SANE nurse provides treatment for sexually transmitted diseases and emergency contraception.

Methods

An advisory board of local sexual assault community stakeholders helped us develop the evaluation questions. We convened two working groups of community practitioners: one for healthcare and victim services and one for law enforcement and prosecution. Each of the researcher-practitioner teams met several times during the first six months of the project to develop the evaluation questions and the objective criteria that would be used to assess impact.

We then gathered data from several existing databases, including SANE medical records, University of New Mexico Health Sciences Center (UNMHSC) medical records, Albuquerque

Police Department and Bernalillo County Sheriff's Department data, Second Judicial District (Bernalillo County) prosecution data, and New Mexico Second Judicial District Court data. Pre and post-SANE designations were assigned by the date of service in the medical records, or, in the law enforcement, prosecution and court datasets, by incident date. Those cases initiated or whose date of service preceded October 16, 1996 were designated as pre-SANE individuals, cases initiated after this date were designated post-SANE individuals.

We also collected data from key informant interviews and an advocate focus group. We conducted 28 interviews with representatives from the four target areas: 1) healthcare, 2) victim services, 3) law enforcement, and 4) prosecution. Participants were selected by the advisory board and through referrals from interviewees. The criteria for inclusion were both pre- and post-SANE participation in sexual assault services. We sought to achieve a variety of perspectives—both positive and negative—from the key informants in each of the four areas of impact.

To ensure consistency, a single researcher conducted all the face-to-face interviews. Each interview took 1 to 2 hours. Interviews were tape recorded and later transcribed for analysis.

The interview questions on:

- Nature of the participants' duties as they related to sexual assault services;
- Pre-SANE experience;
- Post-SANE experience;
- Comparison of pre- and post-SANE impacts on the community; and
- Respondents' perception of the SANE unit and suggestions for improvement of sexual assault services.

We interviewed ten law enforcement representatives from the Albuquerque Police Department, the Bernalillo County Sheriff's Department, the New Mexico State Police, University of New Mexico Campus Police and the Bureau of Indian Affairs.

We interviewed six healthcare providers, including ED nurses and physicians, SANE nurses, a physician expert in child sexual assault, and a family practice physician who had experience in seeing sexual assault cases.

We interviewed six victim service stakeholders including therapists, staff and advocates from the Albuquerque Rape Crisis Center (ARCC), the Director of the victim impact program at the DA's office, and the Executive Director of the New Mexico Coalition of Sexual Assault Programs for New Mexico. We also conducted a focus group with five victim advocates from ARCC who had both pre- and post-SANE experience.

Finally Judges and attorneys served as key informants for the prosecution section. Attorneys at the Bernalillo County District Attorney's Office (Violent Crimes Division), Juvenile Court, and the New Mexico State Attorney General's Office were interviewed. Three judges from the District Court were also interviewed. Public defenders and defense attorneys were informally interviewed but no attorney could be identified who had experience with both pre- and post-SANE clients.

Results

The characteristics of sexual assault victims seen in the emergency department (ED) before SANE and those seen at SANE were similar. In both groups, most were Anglo (43% before, 44% after), Hispanic (38% before, 41% after), or American Indian (10% before, 10% after). Among both study groups, victims were of similar age (mean age 27.2 years before, mean age 29.1 years after, $p=0.195$). Most sexual assault victims knew their offender. There were significantly more intimate partner assaults (6% before vs. 11% after, $p=0.0433$), more date and acquaintance assaults (33% before vs. 41% after, $p=0.037$), but fewer family member assaults (11% before vs. 2% after, $p<0.0001$).

Healthcare and Victim Services

Sexual assault victims seen at SANE received a greater variety and depth of medical services for sexual assault compared to victims seen in the ED. Pregnancy testing, pregnancy prophylaxis, and STD treatment were more often reported as provided at SANE than before SANE. Pregnancy testing increased from 79% before SANE to 88% at SANE ($p=0.005$). Likewise, pregnancy prophylaxis was accepted more often (66% before vs. 87% after, $p<0.0001$). Treatment for sexually transmitted diseases (STD) also was accepted more often (89% before vs. 97% after, $p=0.015$). The quality and quantity of referrals also increased. The average number of documented referrals increased significantly from 1.7 referrals per victim before SANE to 4.0 referrals per victim after SANE ($p=0.0237$). Victims seen at SANE received a greater variety of referrals compared to victims in the ED; these referrals included rape crisis (41% before vs. 76% after; $p<0.0001$), social services (13% before vs. 48% after; $p<.0001$), and an STD clinic (9% before vs. 15% after; $p<0.0001$).

Not only did SANE victims receive more services, the time that victims spent at SANE was less than the time that victims spent at the ED. Before SANE, the average time from check-in to discharge was 4 hours and 16 minutes After SANE, the average time from dispatch to discharge time was 3 hours and 26 minutes. Thus, on average, the time spent at SANE was 49 minutes less compared to the ED ($p<0.001$).

Law Enforcement and Prosecution

A greater proportion of victims seen at SANE had forensic evidence collected as well as reported to police. More victims consented to evidence collection (47% before vs. 98% after, $p<0.0001$). Also, vaginal photography was not routinely performed before SANE but after SANE, it was a routine component of the forensic evidence exam (8% before vs. 88% after, $p<0.0001$).

According to medical record data, more victims reported to police (46% before vs. 67% after, $p<0.0001$). The increased reporting coincided with a greater percentage of unfounded cases (4%

before vs. 12% after, p=0.0004) , however, more cases were cleared by arrest (4% before vs. 8% after, p=0.0189).

The number of charges per case (5.4 before vs. 7.0 after, p<0.0001), the proportion of cases presented to the grand jury (38% before vs. 50% after, p=0.0164) and the proportion of charges resulting in an indictment (65% before vs. 70% after, p<0.0001) all increased significantly. Conviction rates also increased. Criminal sexual penetration charge conviction rates increased from 59% before SANE to 69% after SANE (p=0.001). Significantly fewer charges ended with a *nolle prosequi* (28% before vs. 17% after, p<0.0001). There was no difference in the number of dismissals or acquittals. Similar results were observed among charges for criminal sexual contact. A significantly greater percentage of cases received jail time (46% before vs. 55% after, p=0.049). On average, sexual assault cases before SANE were sentenced to 1.2 years versus 5.1 years of incarceration after SANE (p<0.0001).

Discussion

Our findings strongly suggest that the establishment of the Albuquerque SANE Collaborative in October 1996 significantly and positively impacted healthcare, victim services, law enforcement, and prosecution. The statistical data and stakeholder interviews show that SANE has overall increased efficiency by bringing services for sexual assault victims into a unified and central location within a medical setting.

SANE's impact on healthcare was striking. By concentrating previously scattered sexual assault services into one program and one location, a victim receives specialized and sensitive care by professionals who are aware of the physical and psychological affects of sexual assault. Patient care has improved and is more consistent; sexual assault victims are uniformly offered sexually transmitted disease treatment, pregnancy prevention, referrals, and follow-up care.

SANE increased the comfort level of sexual assault victims and provided an environment that offers privacy, safety, and security during their treatment for sexual assault. An increased level of comfort appears to correlate with a greater likelihood to report to police, to undergo forensic evidence collection, and to be willing to cooperate with prosecution.

The improved forensic evidence is perhaps SANE's most important contribution with respect to law enforcement and prosecution. SANE units are able to collect a greater quantity and quality of evidence while saving about an hour of time, on average, compared with the ED. The shorter waiting times may yield better recovery of time-dependent material such as DNA or urine for suspected drug-facilitated sexual assault.

Law enforcement's knowledge of sexual assault issues has increased and their perceptions about and treatment of victims have greatly improved. Better forensic evidence and an improved chain of custody have led to more successful prosecution of sexual assault. DNA, colposcopic photography of vaginal injuries/tears and other injuries, and injury body maps were acknowledged as important contributions to the treatment of sexual assault victims and the prosecution of their offenders. Recent studies have shown that the ability to document injury correlates with successful prosecution (McGregor *et al.*, 2002).

Because the SANE units provide a calmer, less hectic atmosphere to administer services for sexual assault victims, law enforcement officers stated they were able to interview victims who were less stressed and who were more willing to cooperate with law enforcement. Many believed that this has assisted in building more trusting relationships between the victim and law enforcement. This has resulted in an increase in successful prosecution due to more coherent and consistent interviews.

Finally, law enforcement officers stated that another benefit of SANE was an atmosphere where they could 'bond' and develop sympathetic relationships with sexual assault victims. This has

helped law enforcement gain an increased awareness and knowledge of sexual assault issues, which may prevent re-victimization. Prosecutors have increased confidence in forensic evidence and in the interview process. The chain of custody is now rarely challenged by the defense. Prior to SANE, the defense was far more likely to use documentation procured from medical records to infer that the victim 'changed her story.'

Most care providers thought that SANE improved their jobs. Rape crisis advocates and SANE nurse examiners were, however, sometimes at odds. Role clarification of the rape crisis advocate and the nurse examiner appear important steps towards the elimination of stress between these two important components of the acute sexual assault response. All stakeholders reported that SANE has improved the working relationships of SANE medical personnel with law enforcement and prosecution. SANE nurses are available for pre-trial interviews, court appearances, and to give explanations of medical findings. Consistent, familiar faces among the service providers have promoted the exchange of ideas and the opportunity to solve commonly recognized problems.

Prior to SANE, medical providers and prosecutors did not collaborate well. Improved collaboration has eliminated much of the frustration of trying to get medical professionals to participate in the legal process and by providing reliable and factual evidence. While some informants felt that physician testimony might carry more weight, they preferred the consistency and ease with which they were able to use SANE nurse testimony.

Prosecutors were able to bring a greater number of charges forward and they uniformly received indictments for the charges sought. SANE has increased the number of guilty pleas obtained from defendants, thereby avoiding the need for the victim to testify directly. Courts have issued significantly greater sentences for sexual assault crimes.

Our ability to describe the impact on victims was limited. Despite repeated efforts with different modalities, we were unable to solicit the input from the victims of sexual assault to determine their perspective on the services they received. Because of this, we have no direct corroboration from the victim's perspective that SANE has positively impacted them. Uniformly, stakeholders believe that the victim experience is better.

A potential alternative explanation to our findings is that other system changes occurred coincidentally with SANE's startup. Stakeholders do not believe that there were any other significant events or system changes during the study period that impacted sexual assault service delivery.

While not all communities will have the capacity or readiness to implement a SANE-style program, we believe that many of the components of a SANE program might be successfully incorporated into smaller or less ready communities. Intermediate steps to improve services include implementing on-call forensic examiners who can respond to a variety of healthcare locations, and multi-disciplinary or cross-trainings to achieve some of the success of a SANE unit. Having one point person at an emergency department or hospital who can communicate regularly with law enforcement and prosecution might significantly improve problem solving. Healthcare facilities should review their chain of custody procedures and consult with law enforcement on ways to improve and standardize evidence collection.

Finally, the success of SANE begs the question of whether this service delivery model might successfully be applied to similar medical/criminal justice interfaces such as domestic violence or non-intimate battery. SANE in many ways is a highly specialized emergency department—one that combines the expertise of many disciplines to efficiently deliver a high quality product to a somewhat reluctant clientele.

In summary, we find strong and compelling evidence that SANE has positively impacted healthcare, victim services, law enforcement and prosecution. Communities without SANE programs should investigate the possibility of starting a comprehensive program. There is clear evidence that the quality and quantity of services will improve while increasing the likelihood of successful prosecution.

Detailed Final Report

Project Goals and Objectives

This report details the findings of the University of New Mexico Health Sciences Center (UNMHSC) Emergency Medicine Department's comprehensive outcome evaluation of the Albuquerque Sexual Assault Nurse Examiner (SANE) unit in the areas of healthcare, victim services, law enforcement, and prosecution. Although the proliferation of SANE units in the U.S. suggests an apparent success of this type of program, this is the first coordinated, comprehensive evaluation of SANE.

Our outcome evaluation plan addresses four areas: 1) healthcare, 2) victim services, 3) law enforcement, and 4) prosecution. We measured the impact of SANE using a variety of techniques, including face-to-face interviews, telephone interviews, and analysis of police and court records. While we address each of the four areas of interest separately, each area interacts with one another and we have therefore linked the components so as to comprehensively evaluate SANE. Our evaluation uses a pre-, post- comparison design, comparing responses that reflect on conditions before and after the implementation of the Albuquerque SANE Collaborative. Our evaluation meets the research recommendations outlined in the National Research Council publication *Violence in Families* including willingness of service providers to collaborate with researchers, availability and appropriateness of data, and use of satisfactory measures to assess program process and impact (Chalk and King, pg. 8-9).

Statement of Problem

National Data

The problem of violence against women in the United States has gained increasing attention in the past 25 years and has recently become a focus of research and intervention. The National

Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC) have joined together in a collaborative effort to sponsor a research program on violence against women. This evaluation is a response to their joint solicitation for Research and Evaluation on Violence against Women. In particular, this evaluation addresses the identified goal to understand better how to increase the effectiveness of legal and healthcare interventions.

In the past 25 years, perceptions of violence against women have changed tremendously. In particular, domestic violence and sexual assault are now viewed as crimes. Due largely to the efforts of victims' and women's advocates in the 1970s, the myths about crimes against women (*e.g.*, 'battered women would leave if they wanted to,' 'rape victims are asking to be raped') have begun to be dispelled, and funds have been allocated for crisis shelters and services for victims (Zorza, 1994; Hofford and Harrell, 1993; Frisch, 1992; and Bowman, 1992).

The changes in the public's perceptions of sexual violence mirror changes in the legal definition of sexual assault. The definition of what constitutes rape varies from state to state, but generally refers to forced sexual penetration of a victim by an offender. Because the legal definition of rape can be restrictive, the term *sexual assault* has been used to cover a wide range of crimes including attempted rape, indecent assault, and battery (Rosenberg, 1991). Inconsistencies in the definitions of rape and sexual assault make it difficult to estimate the incidence of these crimes. Further still, victims' failure to report due to the perceived social stigma of sexual assault, fear of the criminal justice system, or belief that reporting will do no good also affect the accuracy of prevalence estimates (Bachman and Saltzman, 1995). Despite these limitations, studies have demonstrated that rape and other forms of sexual assault are not rare events.

Sexual assault has been shown to have a severe psychological impact on victims resulting in post-traumatic stress disorder, depression, and suicide (Rosenberg 1991). Other effects include problems with family and friends, including divorce and fear of future assault that limits the victims' re-integration and mobility in the community.

Studies have variously estimated that as few as 2% and as many as 50% of women in the U.S. have experienced rape. Most estimates fall between 13% and 25% (National Research Council, 1996, p. 23). Furthermore, more than half of all rapes occurred during childhood or adolescence: 29% when the victim was less than 11 years old, and 32% between the ages of 11 and 17 (Kilpatrick, Edmunds, and Seymour, 1992). Koss reports that 40% of college women and 44% of women surveyed in community studies report being victims of either attempted or complete rape (Koss, 1990).

Although prevalence estimates vary, studies consistently document that younger women are much more likely to be victimized than older women. In addition, most sexual assault victims know their assailants (p. 39). The National Crime Victims Survey found that only 18% of rapes and sexual assaults against women are committed by strangers; 26% are by a current or former husband or boyfriend, and 56% are by an acquaintance.

The rate of forcible rape reported to the police increased 54.9% between 1974 and 1993. It must be expected that social and cultural changes in the last 25 years would have had an encouraging effect on victims' willingness to report. Still, despite rape laws, reforms, and changes in perception, prosecution rates are very low. According to the Senate Judiciary Committee (1993), only 38% of the approximately 100,000 rapes reported annually to the police result in arrest; as few as 2% of rape victims see their assailant jailed.

These studies and others demonstrate that sexual assault/rape is one of the most under-reported of violent crimes. One reason often cited for lack of reporting is the poor treatment victims receive from the criminal justice system. Improved treatment of victims could increase victim cooperation in both reporting crimes and in providing testimony, which in turn could help prevent criminals from re-offending.

In the last few years, promising policy and procedural changes to improve the law enforcement, prosecutorial, and healthcare responses to victims of sexual assault have been implemented in many states. It should be noted that these improvements in the treatment of sexual assault victims may function as a method of crime prevention. Without victim cooperation in both reporting of crimes and prosecution of offenders, the criminal justice system functions less effectively and in turn, leaves offenders free to re-offend. Examples of system improvements include the use of victim and witness advocates, DNA typing, measures to protect victim privacy to encourage reporting and prosecution (Epstein and Langenbahn, 1994) and sexual assault nurse examiner (SANE) programs or units. The establishment of SANE units provides sexual assault victims a safe and confidential setting for the exam procedures necessary to gather evidence against the offender. It also connects victims to support services and a network of advocates to guide them through the justice system if they choose to prosecute.

SANE programs have demonstrated effectiveness as a community method to case-manage victims of sexual assault (Ledray, 1997). The first SANE units were developed in the late 1970s and were designed to address deficiencies in the delivery of services to victims of sexual assault while providing a caring, supportive environment. Management of sexual assault victims is complex because many agencies are involved in the process of treatment, referral, and prosecution. These agencies include healthcare, law enforcement, judicial, volunteer support

agencies, and others. Prior to the development and implementation of SANE units, most victims of sexual assault were treated in local emergency departments (EDs), subjected to long waiting times in public areas, treated by healthcare providers who were not specifically trained in evidence collection procedures, and received inadequate follow-up care.

The mission of the SANE unit is to prevent further trauma to sexual assault victims in the healthcare environment by providing comprehensive, timely and coordinated treatment. In a SANE unit, healthcare facilities, community agencies, law enforcement and other legal agencies ideally work together to provide the best service to victims of sexual assault. SANE units provide a safe, non-threatening environment where specialized medical/forensic evidence examinations are conducted with privacy. Safety and confidentiality are stressed throughout the interview and examination process. This should allow for better and more timely evidence collection for the criminal justice system—evidence that is tailored toward investigation and prosecution of the perpetrator. The medical records are reinforced in court by professional testimony from the nurse who performed the forensic evidence examination. Thus, SANE units pledge to enhance not only the sexual assault victim's treatment and experience but also the legal community's ability to address this crime. The question of whether or not this goal is met is the subject of this evaluation.

New Mexico and Albuquerque Area Data

Estimating the incidence of rape and other sexual assault in New Mexico is difficult for many of the same reasons cited nationally: inconsistent definitions, under-reporting, and fear of the criminal justice system. Despite these barriers, there are several agencies in the state that track the incidence of sexual assault. Data from recent Uniform Crime Reports consistently show that the New Mexico forcible rape rate is among the highest in the U.S. In 1996, there were 1,088

forcible rapes reported to the criminal justice system in New Mexico but only 85 arrests were made (FBI, 1996). The New Mexico Coalition of Sexual Assault Programs tracks sexual assaults from a sample of rape crisis and mental health centers. From July 1995 to June 1996, 1,625 individuals reported a sexual assault in New Mexico, of which the majority (62%, n=1,014) involved sexual penetration. Most sexual assaults were perpetrated using physical force or manipulation but others involved verbal threats, use of knives, firearms or other weapons.

The Albuquerque SANE Collaborative

Until 1996, sexual assault victims in Albuquerque were seen at the ED of several hospitals. This was perceived to be less than ideal by many, including emergency physicians and nurses, the Albuquerque Rape Crisis Center, the Albuquerque Police Department and the local District Attorney. After two years of planning and fund raising, the Albuquerque SANE Collaborative opened its doors on October 16, 1996. Our evaluation concentrates on the Albuquerque SANE Collaborative and the impact that this unit has had.

To better understand our findings, we provide an overview of the typical flow of services prior and subsequent to the inception of SANE. The paragraphs below summarize a prototypical experience. The flow diagram (Exhibit 1) presents the text in diagrammatic form.

Typical Pre-SANE Emergency Department Patient Flow

Prior to SANE, sexual assault victims typically sought care at an ED of a local hospital. Upon arrival at the medical facility, the victim would state the reason for their visit to the clerical staff. Often, a patient would not initially state the primary reason for their visit. The patient was triaged by an ED nurse. A history of sexual assault was often elicited at this point and a rape crisis advocate was contacted and requested to come to the ED. Depending upon the patient's severity of illness and injury, the patient would be placed in the ED waiting room for an available

exam room. When an exam room became available, the patient would wait for physician evaluation. The physician would assess the patient and would manage any immediate illness or injury. If the patient desired to have a forensic evidence exam, the exam was conducted when resources were available. A physician, nurse, and rape crisis advocate all needed to be simultaneously available to conduct the exam. Following completion of the exam, the patient would be offered treatment for sexually transmitted diseases, emergency contraception, and definitive treatment for any injuries. If the patient desired to speak with police, a law enforcement officer would be dispatched to interview the patient.

Typical SANE Patient Flow

Since SANE, patients are seen for sexual assault either at a specialized unit at a centrally located hospital in Albuquerque or at another hospital facility if the severity of their injuries do not permit them to go to the SANE unit directly. SANE can be activated through several mechanisms, including the healthcare facility, emergency medical services, police, rape crisis, or by contacting the SANE unit directly. If the victim has injuries that require medical attention, the victim is referred to a local ED for treatment. If the patient needs hospital admission or requires a prolonged ED stay, SANE is contacted for onsite evaluation/forensic evidence exam. If the patient is medically cleared, the SANE nurse and rape crisis advocate are dispatched to meet the patient at the SANE unit. The SANE nurse provides treatment for sexually transmitted diseases and emergency contraception.

Scope and Methodology

Development of Evaluation Questions

Researcher-Community Collaboration

Our evaluation strategy for each area of interest was designed to be able to: 1) match each method to the appropriate research question and data type, 2) operationalize outcome measures to achieve an in-depth understanding of the results, 3) collect data from a variety of sources, and 4) triangulate data. We convened two advisory groups of community practitioners to develop evaluation questions: one for healthcare and victim services and one for law enforcement and prosecution. For the topics of healthcare and victim service, we brought together key staff from the Albuquerque SANE Collaborative, the New Mexico Coalition of Sexual Assault Programs, the Albuquerque Rape Crisis Center, the New Mexico Crime Victims Reparation Commission, a sexual assault survivor, and several emergency physicians. For the law enforcement and prosecution work group, we met with members of the Office of the District Attorney, victim advocates, Albuquerque Police Department, Bernalillo County Sheriff's Department, and the Bureau of Indian Affairs. Each of the researcher-practitioner teams met several times during the first six months of the project. An outside facilitator solicited input from the teams in two areas: 1) outcome questions of interest to their stakeholder group and their profession and 2) benchmarks to develop criteria for the proposed outcome questions. For example, the law enforcement and prosecution group wondered whether or not SANE improved the quality of their work. Objective criteria for an improved quality of work would include whether their work was time efficient, whether paperwork was streamlined, whether they had a cooperative witness, whether they had confidence in the evidence and whether the prosecution was successful. If the researchers determined that an evaluation question proposed by the stakeholders could not be

adequately answered from existing or new data sources, then the evaluation question was eliminated.

Following these meetings, the researchers identified appropriate data collection strategies, developed specific measures of effectiveness, and operationalized the indicators for measuring effectiveness. Data collection tools were reviewed by the advisory group.

A complete listing of the evaluation questions, criteria, and data sources used to answer the evaluation questions is found in Exhibit 2

The Research Team

The research team was composed of both faculty and staff. Cameron Crandall, MD, Research Director in the Department of Emergency Medicine coordinated the overall project and directed the quantitative analysis. Deborah Helitzer, ScD, Director of the Office of Evaluation at the UNMHSC directed the qualitative analysis. Drs. Crandall and Helitzer were responsible for the final report.

Shelly Wright abstracted and entered the medical record data.

Anne Worthington, MPH was the project coordinator. She was responsible for the day to day aspects of the project. In addition, she conducted all the stakeholder interviews. Marcia Mikulak, PhD, along with Ms. Worthington, coded and analyzed the stakeholder interviews.

Jonathon LaValley, BS, coordinated the quantitative aspects of the project, managed the databases, and conducted and programmed the statistical analysis in SAS.

Data Collection

Quantitative Methods

From the researcher and community collaboration discussed above, evaluation questions were generated and pertinent quantitative data sources were identified from the sexual assault

service providers. The databases collected for analysis included: medical service provider, police, district attorney, and court data. Two series of quantitative analyses were performed on these data to evaluate the impact of the SANE unit. The first set of analyses compared all datasets by pre- or post-SANE designations. Pre- and post-SANE designations were assigned by date of service or, in the law enforcement and prosecution data sets, by incident date. Those cases initiated or whose date of service preceded October 16, 1996, were designated as pre-SANE individuals; cases initiated after this date were designated post-SANE individuals. The second set of analyses involved the probabilistic linkage of UNMHSC and SANE medical records to police records, district attorney records, and finally court records to make comparison between pre- and post-SANE service outcomes possible. Details of the data linkage procedures are found under the section titled Data Linkage on page 23. Due to difficulties in linking across datasets, only the results from the first analysis are included in this report.

Prior to linkage or analysis, data were collected, checked and cleaned for errors, and aggregated. Victims of sexual assault who were female and 18 years of age or older on January 1, 2000 were included. The wide variety of data sources and formats resulted in a variety of data quality and completeness. In the sections below, we describe each of the datasets that were used for the quantitative analyses. Exhibit 3 below summarizes the source and sample size of the datasets that were used in the analysis.

Medical Service Provider Data

Medical service provider data were collected from the UNMHSC medical records through abstraction of charts for those patients who had a diagnosis of sexual assault in the hospital discharge and billing database. SANE medical record data on all sexual assault victims presenting to SANE during the study period were provided in Microsoft Access format by the

Albuquerque SANE Collaborative. Data elements that were analyzed in the SANE (n=715) and UNMHSC (n=242) medical record data included: demographics of each victim population, medical services provided, referrals made to other victim services, assault characteristics, forensic evidence examination and evidence collection, law enforcement involvement and victim-offender relationship information.

Police Data

Data were collected from the Albuquerque Police Department and the Bernalillo County Sheriff's Department for police cases that involved criminal sexual activity during the study period. Police data were obtained for 1995-1999, which included 6,112 observations representing 1,430 unique suspects and 2,891 charges. The case number identified unique incidents of sexual assault reported to the police. The overall quality of the police data file was limited; eight of the 21 variables provided by the Albuquerque Police Department had greater than 75% of the data missing. Data elements that were analyzed included victim and offender demographic information, case disposition and status, crime/statute violated, drug and alcohol involvement, evidence of previous domestic violence and involvement of domestic violence, weapons use and victim/offender relationships.

District Attorney Data

Data were collected from the Office of the District Attorney in the Second Judicial District regarding cases of felony criminal sexual assault. The district attorney database is comprised of three smaller data sets: a victim data set (n=498) which contained one entry for each victim name, a case data set (n=705) which contained case characteristics and charges, and a charges data set (n=6,285) which identified the description of each charge. Only cases that had at least one felony criminal sexual charges were included in the prosecution data set. Each component of

the district attorney database was indexed by a unique district attorney case number. More than 35 fields contained in this database had 90% or more missing data. Data elements that were analyzed included victim and defendant demographic information, charge definition, sequence (initial charges and final charges) and number, law enforcement case information, charge and case status, and a limited amount of information regarding case outcome and sentencing.

Court Data

The New Mexico Second Judicial District Court provided a database consisting of court record of felony sexual offenses. The database for this project was comprised of five data sets linked by a unique court case number, these datasets include the case data set (n=448) which described the party or individuals involved in the case including defendants, witnesses, prosecutors, etc.; a charge data set (n=3,480) which described the charges associated with each case; and three sentence data sets (community service (n=104), incarceration (n=133), and probation (n=175)) which described court case outcomes and the community service, jail time, or probation that resulted from each case. Thirty-three (33) fields found in the Court database had 90% or more missing data. Data elements analyzed include case disposition and status, defendant characteristics, initial and final charges, trial outcomes and sentencing.

Data Linkage

Two different protocols were used to attempt to merge UNMHSC medical records and SANE records with the police, district attorney, and court datasets. The initial attempt involved the linkage of victims to the police data via personal identifying information such as name, incident date, social security number, and date of birth. These linked records were then matched to district attorney and court data using suspect personal identifying information such as name, incident date, social security number, and date of birth. The first data linkage protocol

successfully linked only 66 records from pre- and post-SANE eras, as many of the databases lacked important personal identifying information or the information that was available was inconsistent. For example, there are multiple ways of spelling many last names, often addresses are no longer accurate, medical records and police records may have conflicting dates of incident, etc. A second protocol based upon probabilistic matching across databases was developed with assistance from Larry Cook, statistician from the Intermountain Injury Control Research Center in Utah. This second attempt at merging victim records across datasets utilized the LinkSolv (Strategic Matching, Inc., Version 2.3.436) probabilistic merge matching software. The first merge linked UNMHSC and SANE medical records to police data by using personal identifiers such as first and last name, date of birth, date of incident, date of medical/SANE service, race, city, zip code, quadrant, and street. Only records that merged with a match probability of greater than 95% were included in the linked data. These merged files were then linked to district attorney records using both the defendant and victim information. Other merge criteria used to link medical and police records to District Attorney records included: defendant/suspect first and last name, victim first and last name, defendant birth date, defendant race, and incident date. Only those records with a match probability of 95% were included. Finally, the merged records were linked to the court database using defendant first and last name, social security number, and case number. The resultant dataset consisted of 31 pre-SANE victims and related suspects and 227 post-SANE victims and related suspects. These data were then analyzed and compared. Because only 31 pre-SANE cases linked across the dataset, we have decided not to include these findings in the report. In nearly every case, the probabilistic linkage analyses provided the same inference as the binary pre-/post-SANE comparison.

Victim Telephone Survey

To solicit opinions from sexual assault victims about their experiences with medical care, victim services, law enforcement, and prosecution, we attempted to survey all pre-SANE UNMHSC patients and SANE clients. We used procedures that stressed patient confidentiality. The contact lists were provided from the billing data for sexual assault services at the UNMHSC or from the SANE client database. From this information, Albuquerque SANE Collaborative staff attempted to contact the sexual assault victim via telephone to determine if they would be interested in participating in a telephone survey. The SANE staff explained to the victim that if they agreed to participate that a researcher from the university would contact them to conduct the survey. The Albuquerque SANE Collaborative staff was instructed to attempt to call at least three times, on different days and at different times during the day. Victims were told that the survey would take approximately 30 minutes and that it was preferred if they could provide a date and time when they would be uninterrupted. Victims were informed that they would be compensated for their participation with a $15 certificate good at a local store.

The response rate for both the pre-SANE and post-SANE groups was very poor. The response rate for the UNMHSC group was lower than that of the SANE group (0.4% versus 1.8%). Most of the extremely low response rate was due to refusal to participate (16% pre-SANE, 9% post-SANE), incorrect and disconnected phone numbers (41% pre-SANE, 38% post-SANE) and no answers (43% pre-SANE, 51% post-SANE). In many instances, the victim told the SANE personnel that they would participate, but despite repeated attempts, the UNM personnel could not reach the victim. However, 13 telephone interviews were conducted. The telephone survey contact protocols and the survey instrument are provided in .

Statistical Analysis

The quantitative data were analyzed using standard techniques of exploratory and confirmatory data analysis. After the data were cleaned (for out-of-range values, etc.), frequencies of variables were examined. Wherever appropriate, categories were collapsed. After cleaning and removing non-qualified records, the resultant data sets were analyzed and compared. Basic frequencies and population characteristics were computed for both pre- and post-SANE groups.

The data were analyzed using a quasi-experimental approach. The primary comparison for all analyses was between pre- and post-SANE periods. The incident date contained within each of the datasets relative to the inception date of SANE (October 16, 1996) defined the pre- and post-SANE periods. All comparisons are based upon this binary division.

For the medical data, we used a standard of "not documented—not done" in our analysis. For example, if there was no documentation that the victim had a pregnancy test or was provided sexually transmitted disease treatment, we assumed that it did not occur.

At the time that the data were collected, some post-SANE cases had not had sufficient time to be adjudicated. Hence, to correct for this, we examined only post-SANE cases with greater than six months of time following the grand jury indictment, allowing for the time allotted under New Mexico's 'speedy trial' provisions. This correction eliminated 51 defendants with 143 charges who were removed from the post-SANE group in all analyses involving charge outcome.

Prosecution outcome was analyzed in two ways: 1) at the charge level and 2) at the defendant level. At the charge level, the units of analysis were the individual charges themselves. At the defendant level, the unit of analysis was the defendant. For the defendant level, we concentrated on the highest level charge that applied to their case.

Sentencing time was calculated as the sum of the time sentenced less time credited. Credited time includes both suspended and deferred sentence time.

We compared the distribution of categorical variables against the chi-square distribution and normally distributed continuous variables against the t-distribution for statistical inference. When continuous variables were not normally distributed (*e.g.*, many time interval data points were highly skewed), we used nonparametric methods. Whenever an expected cell frequency was less than 5, we used Fisher's Exact Test. In all cases, we used a two-tailed Type I error rate of 5% to determine statistical significance. SAS statistical software (version 8.2, Cary, NC) was used to conduct all of the quantitative analyses.

Qualitative Methods

We collected original data from key informant interviews and an advocate focus group. We conducted 28 interviews with representatives from the four target areas: 1) healthcare, 2) victim services, 3) law enforcement, and 4) prosecution. Participants were selected by the advisory board and through referrals from interviewees. The criteria for inclusion were both pre- and post-SANE participation in sexual assault services. We sought to achieve a variety of perspectives—both positive and negative—from the key informants.

To ensure consistent data collection, a single researcher conducted all the face-to-face interviews. The researcher explained the interview process, answered questions, and obtained informed consent from the key informant. Each interview took from 1 to 2 hours. The interview was tape recorded and later transcribed for review and coding.

The interview questions were developed by the evaluation team and revised by the advisory board. All interview tools included five general sections:

- Nature of the participants' duties as they related to sexual assault services;

- Pre-SANE experience;
- Post-SANE experience;
- Comparison of pre- and post-SANE impacts on the community; and
- Respondents' perception of the SANE Collaborative and suggestions for improvement of sexual assault services.

In addition to the general questions, each target area interview contained questions devised to capture information relevant to the participant's area of expertise (Appendix B.). The questionnaire was constructed in a "gap" format. The "gap" methodology asks interviewees to describe the ideal service delivery then to rate their experience. Researchers then measure the "gap" between experience and expectation. The researcher, rather than the respondent, makes the analytic comparisons. A codebook was developed from the interviews, and all interviews were coded and entered into the Atlas Ti program (version 4.2, Scientific Software Development, Berlin, 1997), a software program used to facilitate qualitative data analysis. A matrix of responses was compiled and data were analyzed by the researchers. The analysis of these data is summarized below in the Detailed Findings cross-reference section.

Interview process

Law Enforcement

Researchers conducted ten law enforcement interviews with representatives from the Albuquerque Police Department, the Bernalillo County Sheriff's Department, the New Mexico State Police, UNM Campus Police and the Bureau of Indian Affairs. Four of the law enforcement interviews were with Albuquerque Police Department sex crimes detectives who had investigated the majority of recent sexual assault cases in Albuquerque. Because field officers are often the first to respond to a crime scene, we attempted to interview two such officers. Only one officer was interviewed, despite efforts over six months to make contact with a second officer.

Division heads of the Bernalillo County Sheriff's Department and the New Mexico State Police Department were interviewed both for their personal experience and also to summarize the experience of those they supervise. A detective from the Bureau of Indian Affairs who had the most experience investigating sex crimes on Indian land was interviewed, as was an officer from the campus police at the University of New Mexico. A former Albuquerque Police Department sex crime detective who now serves as a liaison to the local District Attorney's office was also interviewed.

Healthcare

We interviewed six healthcare providers, including ED nurses from UNMHSC, ED physicians from UNMHSC and other local hospitals, SANE nurses, a physician expert in child sexual assault, and a family practice physician who had experience in treating sexual assault cases. All of the healthcare providers had several years experience in each of their respective fields and represented UNMHSC as well as other Albuquerque area hospitals. One of the ED nurses was also a SANE nurse.

Victim Services

Victim services programs were represented through six stakeholder interviews with therapists, staff and advocates from the Albuquerque Rape Crisis Center (ARCC), the Director of the victim impact program at the local District attorney's office, and the Executive Director of the New Mexico Coalition of Sexual Assault Programs for New Mexico.

A researcher-facilitated focus group was conducted with five victim advocates from the ARCC who had both pre- and post-SANE experience. Information from the ARCC advocate focus group has been incorporated into the analysis. As with the stakeholder interviews, the focus group was tape recorded and transcribed for later review and analysis.

Because of our inability to conduct the telephone survey, we elected to conduct a victim focus group so that we might at least obtain qualitative data on the victim's experiences and satisfaction with services. For the victim focus group, we placed advertisements in local newspapers and at the ARCC asking for women who experienced sexual assault and who received services at either UNMHSC or SANE. We also contacted the few women who had agreed to participate in the telephone survey to see if they would be willing to participate in a focus group. While several individuals did contact us, none of the women who responded to the advertisements had received services at UNMHSC or at SANE. None of the women who had agreed to the telephone survey would agree to participate in the focus group. Thus, we were unable to hold the focus group. As a consequence, we caution that any statements about the victim's experience with the system do not come from the perspective of the victim stakeholders themselves. While we were able to conduct 13 telephone surveys, we are concerned about the generalizability of their responses. We have decided to not include their responses in the report.

Prosecution

Judges and attorneys served as key informants for the prosecution section. Attorneys at the Bernalillo County District Attorney's Office (Violent Crimes Division), Juvenile Court, and the New Mexico State Attorney General's Office were interviewed. Three judges from the District Court were also interviewed. Public defenders and defense attorneys were informally interviewed but no attorney could be identified who had experience with both pre- and post-SANE clients. The comments of the public defenders/defense attorneys have been incorporated into the analysis of the prosecution data. Attorneys and staff at the United States Attorney's Office were interviewed regarding prosecution of cases on Indian land. Their experience was limited to one

case within the scope of our study. An attorney from the US Attorney's Office was interviewed by telephone and these comments were included in the data analysis.

Stakeholder quotations are provided as examples of statements about a particular topic. These examples were chosen because they were typical of the larger dataset. Stakeholder interviews are cited by number (Example: [HC#4]) in this report. We do not identify any of the stakeholder interviewees in this report.

All aspects of the study design and data collection were approved by the University of New Mexico Health Sciences Center Human Subjects Institutional Review Board.

Detailed findings

The findings below are organized to mirror the chronological experience of a sexual assault victim as she moves through the continuum of sexual assault services. We first begin by describing the study population, and then we describe the healthcare and victim services from the perspective of the healthcare and victim service providers. Next, we describe the outcomes reported by law enforcement and prosecution. Finally, we describe areas of impact that cross through all four areas of evaluation.

Demographics and Characteristics of the Study Population

Demographic characteristics of sexual assault victims are presented in Exhibit 4. Pre- and post-SANE sexual assault populations were similar with respect to age, ethnicity, geographic area of referral, and victim/offender relationship. Because of human subject considerations, we only examined cases where the victim was 18 years or older. Among the pre-SANE sexual assault victims who sought services, the mean age was 27.2 years of age. Post-SANE victims who sought services were on average slightly but not significantly older (mean age 29.1 years, p=0.195).

Most sexual assault victims knew their offender both pre- and post-SANE. The proportion of unspecified/missing relationship information between victim and offender was lower in the post-SANE group (pre-SANE: 36.2%, post-SANE: 13.0%, p<0.0001). While several miles (~5 miles) separate the UNMHSC and the Albuquerque SANE Collaborative, pre- and post-SANE sexual assault victims still came from similar areas of the city. Both pre- and post-SANE groups included individuals referred from correctional facilities, New Mexico tribal reservations, and from out-of-state areas in the Navajo reservation. For the purposes of comparison and because of the limited number of these out-of-state individuals (n=2), these records were omitted. The majority of the victims in the pre-SANE and post-SANE groups were from the Albuquerque metropolitan area. The distribution of zip codes within Albuquerque was compared pre- and post-SANE and was not found to be significantly different.

Pre-and post-SANE victims arrived at the site of medical care or examination using similar transportation methods; most frequently victims arrived alone. The majority of pre- and post-SANE victims arrived at the medical care facility by ambulatory means (Exhibit 4). More sexual assault victims arrived by ambulance in the pre-SANE sample. A slightly greater but not significantly different number of post-SANE victims were documented as accompanied by law enforcement (29.8%) than pre-SANE (24.1%) (p=0.25). A significantly greater percentage of post-SANE victims (27.3%) were accompanied by a spouse or a significant other compare to pre-SANE (7.4%) (p=<0.0001).

Characteristics of the sexual assault are in Exhibit 5. Post-SANE records contained information about alcohol, drug use, and domestic violence; however, no comparison data were available pre-SANE. The location of the assault was more commonly known in the post-SANE data than pre-SANE. Both pre-and post-SANE victims were assaulted on similar days of the

week and similar times of day. Saturday and Sunday represent the largest percentages of assaults by day of week. Assaults for pre- and post-victims generally occurred at night between midnight and 4 AM. Most pre and post-SANE victims were assaulted by one assailant (pre-SANE 89.1%, post-SANE 86.2%). Weapon data were not typically recorded in the pre-SANE medical record which precluded a pre- and post-SANE comparison. From the police data, weapon use was similar pre-and post-SANE.

Healthcare and Victim Services

Continuity of Care, Unified Services, and Uniform Communications

Stakeholders reported that prior to SANE, sexual assault victims were seen in a variety of care and service facilities. Treatment was fractured and inconsistent. Post-SANE, the data suggest that all cases of sexual assault that did not involve major injuries went directly to SANE. Informants perceive that now there is one facility instead of many agencies, which provides a greater continuity of care within both the medical system and entire sexual assault system. Informants concur that SANE provides comprehensive services including medical exam interview, treatment, forensic evidence exam, medical documentation for prosecution, police interview, STD treatment, pregnancy prevention, emotional support, referrals, follow-up, sexual assault information, and legal services. They believe that all services are provided with confidentiality, safety, and privacy.

> "Their [SANE] services are more personable, more private, [and] more comfortable. I think that the police like it better also...you know, ideally, the SANE situation is set up... so that everything goes smoothly, medical to law enforcement to legal...I think it's a lot better that a survivor can have a police interview at the SANE location. It's a much better atmosphere, I think both for survivors and a better atmosphere to advocate." [VS#4]

Improved Training in Sexual Assault Treatment and Evidence Collection for Healthcare Providers

With fewer medical providers involved and standardized healthcare provider training, informants perceive that SANE brings consistency into the treatment and care of sexual assault victims and establishes a standard of care. The data show that all SANE nurses receive the same sexual assault treatment training and use the same terminology and reporting structures. SANE providers reported that they are trained to use a protocol, unlike ED healthcare providers, where training is inconsistent and a standard protocol is often not followed.

> "...some of the frustration that the ED staff would feel, too, is that we would spend a lot of time with sexual assault victims and never really saw any benefit." [HC#5]

Prior to SANE, ED nurses reported that they were often fearful of doing forensic evidence exams—afraid that they were not collecting all the evidence. Pre-SANE, ED doctors were also unfamiliar with rape kits and how to use them. SANE nurses are forensic nurses who receive mandatory training in how to conduct rape exams, collect evidence, take photos of injuries, and detect and photograph microscopic tears using a colposcope. SANE nurses report that they are comfortable and confident conducting forensic evidence exams because of their training and because they are now specialists in evidence collection.

> [Pre-SANE] "We pretty much dreaded doing sexual assault exams [and were] a little uncomfortable that we were doing something wrong, that we were collecting the evidence wrong and it wouldn't be worthwhile to the victim...we always had this feeling that since we did the exams rarely, we weren't doing them correctly, or the fear that we wouldn't do them correctly, wouldn't gather the evidence correctly, so we would do it pretty much cookbook. You know, we'd get the list out, make sure we did it. We wouldn't quit until we were completely done. So each exam, just the collection part would take maybe a half-hour or so. So I would always feel like I would have to have everything else in the ED cleared up before I even went into the room to talk to the victim" [HC#5]
>
> [Pre-SANE] "The physician would be really frustrated because they didn't even know what a rape kit was, this would be maybe [a community

> hospital] type, where very few rape cases were brought, and here's a physician who's had to call somebody to get a rape kit cause they didn't have any more in their hospital...and then, he's frustrated, because he doesn't know exactly how to do it." [VS#3]

Informants reported that the training SANE nurses receive has led to increased medical provider understanding of physiological and psychological affects of sexual assault. SANE nurses are trained to know what questions to ask patients, and are able to make decisions regarding what forensic evidence to collect. SANE nurses, having a greater understanding of sexual assault combined with more time to spend with victims, are better able to include the patient in choosing options during medical forensic evidence exams, and are more able to give complete explanations of exam procedures.

> "...we as [victim service agency] are in training with the SANE nurses more so that we can talk a little more about the emotional dynamics of sexual assault...PTSD, sexual rape trauma syndrome..." [VS#1]
>
> "The training made forensic exams successful and gave confidence to nurses." [HC#4]

Increased Efficiency, Decreased Workload and Improved Job Satisfaction for ED Staff

Informants reported that pre-SANE, healthcare professionals in ED settings dreaded attending to sexual assault victims because of the length of time required for exams, the emotional trauma of the victim, lack of training in collection of sexual assault evidence, and the stress of the ED. Now, SANE nurses do not feel over-extended and stressed by external service delivery demands while they serve sexual assault victims. Healthcare informants reported that SANE was "more of a non-medical unit that provides more security, comfort, and homey environment—not a clinical environment" [HC#4] making it possible to work in a calmer atmosphere.

Informants reported that SANE provides a better sense of job satisfaction for nurses by providing a specialized service in an atmosphere that is created to support victims of sexual

assault. Healthcare providers no longer feel isolated and alone. In the post-SANE era, when patients are badly hurt and require treatment at an ED, those medical providers reported that they really appreciated having SANE nurses help them collect the evidence from victims in the ED. Better yet, most of the victims go immediately to SANE, bypassing the ED altogether.

> "In terms of the medical community, they know about SANE, they are glad to have SANE. This has been a good addition for them." [HC#3]
>
> "It helped us because it got them [assault victims] out of the ED. That stress wasn't there anymore. I think any ED nurse will agree with me. It was the best thing that happened to the ED." [HC#4]

Healthcare informants reported that SANE has freed-up ED medical personnel. There is a more efficient use of healthcare provider time, because at SANE, scheduling of forensic evidence exams can occur. However, a downside is that residents in emergency medicine, family medicine, and obstetrics and gynecology do not get the required training in forensic evidence examinations and medical management of sexual assault, as these exams are now held offsite at SANE.

> "[Pre-SANE,] no one really enjoyed doing it. I mean that was the thing we didn't like; we really just didn't enjoy doing it. It was lengthy, the kit had to be precise, [there were] probably ten to twenty envelopes of different things you had to collect, so it was a very lengthy procedure. So if you were busy, if you had other patients that were bad, you know it took a lot of time, to be away from your other four or five patients. You know you need to do this, you need to go, you need to get the medicine, you need to do this you need to that, and you can't really do all that and stay there with the girl. I mean you would go in and out, you know you had to draw the blood, give the medicine, you had to do the procedure, and you had to hold the evidence until either the police showed up, or security took you down to the locked area in the basement." [HC#6]
>
> "I'm the expert [a SANE nurse]. [The ED providers] call me for every rape that comes in now." [HC#4]

Improved Healthcare Provider Attitudes Toward Victims and Decreased Use of Stereotypes About Sexual Assault Victims

Informants report that pre-SANE, stereotypes about sexual assault victims were common among healthcare providers. Attitudes about sexual assault victims were relatively negative because of the time and attention they required compared to other patients. The SANE Collaborative has helped debunk negative cultural stereotypes regarding rape: who's responsible, who's to blame, and how a victim is to be treated after the trauma of rape.

Informants report that forensic evidence exams are perceived as uncomfortable for the victim. The collection of forensic evidence takes a long time and required a different type of care than the ED providers' normal routine. There is very little, if any, privacy in the ED, and if they weren't physically hurt, sexual assault victims would have to wait a long time to be seen. ED providers avoided the victims—they avoided the work.

> "Before SANE it was very frustrating and time consuming for an emergency room nurse. I think it almost left us with a feeling of guilt because of the way they [victims] were treated in the ED." [HC#4]
>
> "It [healthcare provider attitudes] varied all the way from empathy to anger…depending on how busy we were…we kind of took it out on the patient, you might say…In the ED there was more of an attitude of blaming the victim" [HC#1]
>
> "There is always that preconceived notion, that stereotypic view that was held by providers. If it was a date rape or something, and they [doctors] didn't take time to really explore the story it was like they [victims] weren't really raped" [HC#2]
>
> "They [ED staff] avoided those patients and they avoided the work. Really what they were doing was avoiding the work. The time, the staffing, and the documentation. I bet in there too, it's just that they are uncomfortable. There are lots of people out there that have been hurt in a sexual way either as a child or as an adult and cases like this are very difficult for them." [HC#3]
>
> "I think dealing with medical personnel that really understood the whole dynamics of sexual assault [was important]. You know, you had to do a lot of brushing over or mediating to make sure that the survivor didn't take things wrong or feel like she was being blamed. I had one doctor come in

> and say, 'Well, you might have been sexually assaulted but I only found one sperm underneath the microscope' implying that, well I only found one so it couldn't be so bad but if I had found fifty then it would have been bad." [VS#1]

Improved Relations with Law Enforcement and Prosecution Communities

Informants perceived that the prosecution and legal community are more accessible to the medical community since SANE. SANE nurses understand law enforcement procedures better. Law enforcement stated that there is increased rapport with victim services and with nurses since SANE.

Prosecution staff found that the quality of evidence gathering has improved. Prosecution staff found medical reports more reliable, easier to read, more efficiently transferred into their domain, and more effective in court.

Informants report that pre-SANE, there was little consistent contact between healthcare providers and the District Attorney's Office. The ED and healthcare providers often didn't know what the outcome was for sexual assault victims. Since SANE, follow-up is more thorough.

> "[Pre-SANE,] it depended on whether we spoke to the staff during previous cases and had built a relationship with those individuals and they could help us out in whatever way they could. Otherwise, there was no relationship; it was difficult to communicate with them [healthcare providers]." [LE#10]

> "I don't know if you really had a chance to establish rapport with the medical personnel at all the different hospitals [pre-SANE]...there wasn't a chance to establish long term friendships or work habits." [LE#5]

> "We [healthcare, victim services, law enforcement and prosecution] worked together but it wasn't a close working relationship...actually you got four different points of view. Now there's a lot less stress...you get to know them on a first name basis. You even have a better atmosphere where you can have more casual conversations getting to know the person and being more relaxed. Therefore there's a lot more interaction between everybody." [LE#3]

Improved Relations with Victim Services/Advocacy Community

Informants report that SANE nurses participate in community events, go to conferences, and participate in trainings with other organizations. Pre-SANE difficulties for advocacy services included waiting for doctors, concerns about security and safety, and making sure an advocate would be available. Advocates often stated they were in a position of having to challenge stereotypes within the legal and medical venue and hence they were in an adversarial position. Advocates stated that they had to "brush over" events in order to make sure victims didn't take inconsiderate healthcare provider statements about their rape in the wrong way. Also pre-SANE, advocates stated that there was less support and contact with legal services and law enforcement. Post-SANE, some victim service interviewees stated with mixed emotions that perhaps SANE nurses felt they could now do the advocates' job. Advocates felt that while their role was valued in the ED by the staff, sometimes the SANE nurses acted as if the were in the way. This was especially true for the younger, less experienced advocates.

Interestingly, healthcare informants provide an alternative perspective. Prior to SANE, healthcare professionals at times stated that rape crisis advocates were in the way and annoying.

> "[Pre-SANE,] with the advocates, that there were a lot of them that had agendas or issues...they were an annoyance." [HC#2]

Post-SANE, healthcare providers often stated that rape crisis was a source of help and support for rape victims. However, one advocate reported significant strife between SANE nurses and the rape crisis advocates. This informant felt that the SANE nurses were not properly trained to function as a victim advocate.

> "...This is a very typical complaint to both early SANE directors: is that they did not respect the Rape Crisis Centers for knowing something. The felt that they were the medical profession, they had this going on, they had the best training in the country to become a SANE nurse, and therefore nobody could tell them anything. And here are Rape Crisis advocates, and Rape Crisis staff coming in saying, 'No actually we do know a little—and

> we know that this will need prosecution, and this one needs the law enforcement, [etc.].' And, while they have good training as a SANE nurse, they were trained as a nurse, they're trained as evidence collectors, and as medical providers—not as a Rape Crisis advocate and they thought that they could take on way more than they should. They wanted to be both the advocate, and the SANE nurse, and I can't tell you how typical this is. They give 'zero' respect to their crisis." [VS#3]

Improved Quality and Standard of Healthcare

Both quantitative and qualitative data strongly suggested that the quality and standard of healthcare received by the sexual assault victim improved with the advent of the Albuquerque SANE Collaborative. Healthcare services were more consistently documented as provided post-SANE than pre-SANE. Pregnancy testing, pregnancy prophylaxis, and STD treatment were more often reported as provided in the post-SANE than the pre-SANE group. In addition, the quality and quantity of referrals also increased.

Post-SANE, pregnancy testing was completed significantly more often compared to pre-SANE (87.6% vs. 79.2%, $p=0.005$). Likewise, pregnancy prophylaxis was accepted more often post-SANE compared to pre-SANE (87.1% vs. 66.1%, $p<0.0001$). Treatment for sexually transmitted diseases was accepted significantly more often post-SANE than pre-SANE (97.0% vs. 89.0%, $p=0.015$).

A colposcope was unavailable in the ED, but was documented as used in the exam in 8.3% of the pre-SANE cases (cases seen in a UNMHSC clinic—not in ED). Post-SANE, a colposcope was used 87.6% of the time to obtain microscopic photographic evidence of injury ($p<0.0001$).

Informants' statements perceived that pre-SANE follow-up care was inconsistent and required heavily upon the victim's initiative. Post-SANE, follow-up is coordinated within SANE with the help of reminder phone calls and motivation.

> "[Pre-SANE, follow-up] was inconsistent. It was inconsistent kinds of care; people who didn't know much about the issues would end up seeing

them. There wasn't good follow-up. There wasn't a coordinated kind of response." [HC#3]

"[Pre-SANE] the quality of medical services was good to excellent, the quality of the forensic exam and follow-up were fair to poor depending" [HC#3]

The overall time that elapsed from initial contact until discharge from the facility differed significantly pre- versus post-SANE. Pre-SANE, the average time from check-in to discharge was 4 hours and 16 minutes. Post-SANE, the average time from dispatch to discharge time was 3 hours and 26 minutes. Thus, on average, the SANE experience saved sexual assault victims 49 minutes compared to the ED experience ($p<0.001$).

ED and SANE models of service delivery are fundamentally different; therefore, the time periods pre- and post-SANE are inherently different. Exhibit 7 on page 93 compares roughly similar time intervals experienced by women in the pre-SANE era compared to the post-SANE era graphically on the flow diagram. Exhibit 8 on page 94 displays these times in tabular form. During each phase of care, sexual assault victims experienced significantly shorter times compared to the pre-SANE era.

Pre-SANE, informants believed that victims were re-victimized by the ED process. That perception appears to have diminished significantly as informants consistently reported a perception that post-SANE victims had universally positive experiences at SANE.

[Pre-SANE] "Most of them were just walking out, weren't waiting, the majority of people that we would call. [We would ask,] 'Why didn't you [stay]? Oh I wasn't going to wait, I wasn't going to go through that, and I didn't want to go through that.' Many of them walked out of the hospital during the wait. If the officer didn't remain with them they would just walk out and they would never go back, they just didn't want to deal with that, the whole atmosphere of the emergency room, the whole re-victimizing of them sitting there being looked at, if it was a Hispanic male that raped them and there were four or five that looked just like her attacker in the emergency room bleeding, everybody reminded her of her attacker in the emergency room so they were just walking out." [LE#9]

> "Instead of complaints about anything with the medical exam I'm having victims who bring it up saying that it was really amazing. That is was a horrible thing to go through but everybody was so nice and it was quiet and she felt safe and just grateful" [PS#2]

SANE decreased the trauma of going to the healthcare facility for victims.

> "The fact that there is a SANE unit is a statement itself; that you are welcome here and you are important, and what has happened to you is a significant thing and this is where you're going to get care." [VS#4]

An analysis of a different dataset, the UNMHSC ED patient tracking system (an ED computer system that tracks patient's arrival, chief complaint, diagnosis and disposition), documented 37 patients with a complaint of sexual assault who left without being seen by a physician between February 1994 and December 1999, representing 4.3% of all patients with a chief complaint related to sexual assault from the same time period. While the number of patients who presented to the ED with a complaint of sexual assault has declined since the inception of SANE, the proportion that leaves without being seen has not changed. The number of sexual assault victims that were "lost to excessive wait time" or "left without being seen" was not available from the SANE records but it is believed to be a lower number since nurses are dispatched to meet the patient at an appointed time. The "no show" rate was also not available. Anecdotally, the SANE Collaborative estimates that about 7 to 10 patients per year leave without completing their care (Constance Monahan, Director, Albuquerque SANE Collaborative, personal communication, January 31, 2003). Consequently, the data suggest that fewer adult women sexual assault victims leave without being seen in the post-SANE era.

Referrals

Exhibit 6 provides the number of sexual assault victims who had documented post-care follow-up. Documented referrals increased in both number and comprehensiveness post-SANE compared to pre-SANE, including a greater proportion of referrals to rape crisis, social services,

and to STD clinics. The average number of documented referrals pre-SANE of 1.7 referrals per victim increased significantly post-SANE to 4.0 referrals per victim (p=0.0237).

Pre-SANE, healthcare providers stated that follow-up procedures were inconsistent or inadequate.

> "Well, that's the problem with the nature of the Emergency Room is those results come back a couple days later, when many times I am not there. So they would get, you know, put in with the regular cultures from the other patients, and the nurse or the doctor on duty at that time would follow through on contacting patients about the results of positive cultures. And so the staff on duty at the time had no connection with the patient, may not even know what was going on, and they would find themselves calling patients to give them the results of tests. Where confidentiality was a problem, they would call them and say, 'We have your test results. Come back to the Emergency Room and get them.' So none of those were good answers—you know, I'm sure a patient who has just spent two or three hours in the ED doesn't want to come back to see their results, and they also don't want the results given over the phone. So follow-up, I think, was a big problem." [HC#5]

The SANE Collaborative has a formal procedure for follow-up services. This appears to be insufficient, however, because a commonly re-occurring subject among stakeholders was the need for even more comprehensive and thorough follow-up services for victims. These follow-up services should include medical, mental health, prosecution advisement, access to and communication with law enforcement and extended contact with advocates throughout the legal and prosecution system. Stakeholders also stated that follow-up and intervention services should be linked.

> "I think there needs to be more follow-up [post-SANE]. Being raped is a big deal, but the way we treat it is just by doing a rape kit, giving them their medicine and then good-bye. They have a follow-up clinic but it's hard to get people to come back in. So I think that needs to be worked on." [HC#3]
>
> "I guess maybe there should be some sort of some way to try to impact the victim to assure a greater response by the victim on secondary follow-ups such as counseling, medical exams things like that." [LE#1]

> "[Talking about areas for improvement post-SANE] the thing that we are working on, you can do some intervention afterwards that is medical and if you can hook the medical and mental health piece together instead of having it be separate, people can see that." [HC#3]

Improved Patient Confidentiality

Informants believe that patient confidentiality has been greatly improved through SANE.

> "The victim's dignity would be taken away even more because you walk in and you have to tell the doctor that this person is in because she was raped. Everyone hears about that and the victim knows that they are going to be victimized again in the hospital, so then there is no confidentiality there at all." [LE#2]

> "[Now] the victims know about the SANE unit and they know it's going to be kept confidential and they can go there and they don't have to be embarrassed like in the ED" [LE#3]

Improved Atmosphere for Sexual Assault Victims Improves Psychological Well-Being

Informants perceive that SANE provides more privacy and more personalized care for patients than is possible in the ED. They state that SANE has increased the comfort level of sexual assault victims because treatment and interviews are now conducted in a private, quiet, "non-clinical," and secure environment. Informants report that SANE gives nurses a sense of authority and place so that they are able to better control the environment for victims. It allows them to focus their attention on the victims of sexual assault, thus enabling them to attend to the victim's emotional as well as physical needs.

> "I think, overall, it affects their whole healing process, if that is positive, it facilitates their healing, if that is negative I think it decreases their ability to heal quickly and effectively. Because you know if they had a bad experience, are they going to associate that with our advocacy and then not come to us, I think as a whole experiences are pretty good at the SANE unit." [VS#1]

Victim Satisfaction

A substantial amount of effort by the researchers was devoted to obtaining the input of sexual assault victims who had received services at either UNMHSC or SANE. Despite numerous efforts, we were only able to reach an extremely small number of victim informants.

We were only able to interview one of the several hundred victims in the pre-SANE era and 12 from the 715 in the post-SANE era. As a consequence, we do not feel that we can reliably gauge the comments from these few respondents. The opinions from the very few victims who agreed to participate in the telephone interviews were varied and at times conflicted with the perceptions of the stakeholders. The varied victim responses may reflect on where they are in the continuum of healing from the assault. Victims also have little comparison—their experience was traumatic, period.

Since researchers were able to speak to only a few victims directly, the information on victims' satisfaction comes largely from informant's perception of victim attitudes.

Stakeholder informants reported that SANE has had an overall positive effect on the satisfaction of victims and had improved the coordination of services that they now receive. Informants perceive that victims heal better; they are not shamed as they once were, and law enforcement is more effectively involved.

Informants perceived that SANE affected a change in atmosphere, degree of privacy, and level of confidentiality for victims. Informants perceived the ED as a hurried environment that lacked privacy and confidentiality for victims. In contrast, informants felt that SANE provides a better, more confidential, environment for victims.

> "We could direct them to the EDs but they weren't as inclined to go there. You can't say 'go to the ED, it's quiet, it's private, you won't have all these people walking by looking at you and you can talk about your sexual assault'" [VS#1]
>
> "[SANE] is more of a non-medical unit. That provides more security, comfort, and homey environment. Not a clinical environment. Couches and stuff like that." [HC#4]
>
> "Because [SANE] is a self contained unit, the rooms have doors on them and people are aware of confidentiality. People become very aware of confidentiality, as opposed to seeing kids running around with their gowns

> on and half undressed and all that. It gets a lot easier to maintain confidentiality; you only see one kind of patient with one type of problem." [HC#3]

Prior to SANE, informants perceive that victims were not getting complete explanations of each procedure nor the risks associated with them.

> "[The victims] would sit around in rooms that were bare-bones at best, typical emergency room cubicles and wait for somebody to come in to tell them what was going on and what they were waiting for. None of them know what was going to occur for an exam. They were not apprised of risks." [HC#2]

Informants reported that victims are re-victimized in the ED, especially in the waiting room, but at times also by the ED provider. By contrast, the informants perceive that SANE increased the likelihood that victims felt less re-victimization both because of the "homey" environment of SANE as well as by the medical and law enforcement personnel.

> "The victims would loose more dignity in the Emergency Room because they were victimized again by the physicians and the nurses. They would feel like their crime was not as serious as someone who was stabbed or shot." [LE#2]

> "I think there are so many different things that are all so important [about SANE]. The decrease in shaming the individual, how they are treated, the fact that law enforcement gets involved, we have trained medical personnel, there's a place for them to go. I think, overall, it affects their whole healing process, if that is positive, it facilitates their healing, if that is negative I think it decreases their ability to heal quickly and effectively." [VS#1]

Law Enforcement and Prosecution

Law enforcement and evidence collection

Comments on Overall Improvement

Informants reported that SANE vastly improved evidence collection, storage, and chain of custody. Informants believed that the environment of SANE was more conducive to cooperation with law enforcement.

> "It's 99.9% positive [SANE]. It's documented and preserved evidence that we use to support the victim's story and because we have SANE we have victims not pissed off with that part of the process right away. They are more willing to talk with us, talk with law enforcement. And then when we are able to proceed on a case we are not in that weakened position [as we were pre-SANE] that well 'the medical evidence is lost' and we somehow look bad because we can't get the cooperation, we can't get the evidence, we can't use it, it wasn't sealed properly, it wasn't collected properly. All of that has put our cases in a stronger position because evidence is collected. Things are documented and we have the witness available for the whole process and that has put us in a stronger position to get better pleas, to go to trial." [PS#2]

Informants also perceived that SANE has increased the ability of the victim to give reliable statements to law enforcement, increasing the efficacy of the legal process.

> "It was hard to conduct an interview [in the ED]. You would...conduct your interview behind a curtain and it was a lot more difficult for the victim to talk to you about what happened to her. Then you have to have photographs taken because then you have the right instruments to take photographs there like you [now] do at SANE. So a Field Investigator would come out to take overall photographs and usually they are male. And the female victims would feel uncomfortable...[At SANE,] we [are] able to talk to the victim in an atmosphere that is not so threatening like the ED." [LE#2]

Reporting to police

According to medical record data, a greater proportion of victims reported to police post-SANE compared to pre-SANE (66.6% vs. 45.7%, $p<0.0001$).

Perpetrator Type

Post-SANE, the victim-perpetrator relationship differed somewhat from the pre-SANE period. There were significantly more intimate partner assaults (5.9% vs. 11.0%, $p=0.0433$), more date and acquaintance assaults (33.0% vs. 41.4%, $p=0.037$), but fewer family member assaults (11.3% vs. 2.4%, $p<0.0001$) pre-SANE compared to post-SANE. Some of this difference may be explained by a significantly fewer number of unknown victim-offender relationships post-SANE compared to pre-SANE (12.0% vs. 21.7%, $p<0.001$) (Exhibit 4).

Increased Efficiency of Evidence Collection

Informants reported that the efficiency of evidence collection has vastly improved since the advent of SANE.

> "You could accomplish in an hour there [SANE] what would take you three hours to accomplish in an emergency room." [LE#3]
>
> "SANE is fantastic. They collect the evidence, they seal the evidence, they store the evidence, and they transport it down here and tag it into evidence that has freed up so much available time." [LE#5]
>
> "The collection of evidence, our ability to get medical records from SANE and understand them is night and day difference. So there are a lot of things in the process of prosecution that are so much easier now." [PS#2]

Increased Quality of Forensic and Examination Evidence Collection, Storage, and Results

A greater percentage of sexual assault victims consented to sexual assault evidence collection post-SANE compared to pre-SANE (Exhibit 6, 98.0% s. 47.0%, $p<0.0001$). Also, use of a colposcope was not routinely performed pre-SANE; post-SANE it is a routine component of the forensic evidence exam and includes photography (Exhibit 6, 8.3% vs. 87.6%, $p<0.0001$).

Informants perceive that pre-SANE, the quality of the forensic evidence exam and follow-up were fair to poor. They report that post-SANE, the quality of the forensic evidence exam improved markedly.

> [Post-SANE,] "the forensic evidence was excellent. It was useful because it was clear that the evidence had been collected very carefully and very meticulously. Just the thoroughness of the documentation of even the most minor injury or scratch on the body was thorough." [PS#1]
>
> "They [SANE] do good forensic medical collection consistently on the patients that go there, whereas before it was real spotty." [HC#3]
>
> "Things like the photography, interior photos of the vagina, things like that have taught me a lot more about evidence, about the body itself and the injuries and how things work." [PS#2]

Decrease in lost or damaged forensic evidence

Informants report that pre-SANE, evidence was lost because the health providers were not consistently giving out the correct information to the victims about what they could and couldn't do with regards to maintaining forensic evidence.

> [Pre-SANE] "From the forensic standpoint, nobody told them not to go to the bathroom, not to eat, and not to change their clothes, so a lot of evidence was lost." [HC#2]

Informants said that SANE has standardized the collection of evidence in sexual assault exam kits, assisting law enforcement officers in evidence reading.

> "[Pre-SANE, the quality of written medical documentation] was fair, but not as good as it is now. You didn't have a complete coherent statement of what had happened medically. We had to try to decipher doctor's notes that were often not legible." [PS#3]
>
> [Pre-SANE] "There were so many different doctors and different hospitals that a lot of them would only take what they thought was going to be relevant to the case. They would make their own determination of what was relevant and that wasn't always helpful to us, and that's an understatement." [PS#2]
>
> [Post-SANE,] "when the evidence is brought from them to our criminalistics people they already know what its going to look like. It isn't foreign to them. They don't have to guess like: 'what did this doctor do?' It's standard for each one, so they know what they are dealing with." [LE#2]
>
> [Post-SANE,] "the quality of the documentation or history is much improved because again it is more standardized and they are trained specifically for this. They are not putting things in the report that are inflammatory and their own synopsis of what the victim said because they are trained how to take these particular reports. The records that we are getting are more detailed than they used to be from an ED." [PS#2]

Informants consistently stated that the quality of the evidence collected, including photos, has improved greatly since the advent of SANE. The improved communication among law enforcement, prosecution and SANE has enhanced the understanding of the photographic evidence.

> "[Pre-SANE,] the quality of evidence was difficult because, it was difficult for the DA to have adequate evidence in front of them to proceed with prosecution because they had to rely on testimonial evidence, and that's sometimes pretty difficult." [LE#9]
>
> "With SANE we now have the photographs to document the close up genital photos which clearly document injuries that otherwise would not have been documented." [PS#1]
>
> "[Post-SANE,] now it's more than just looking for bruises or cuts. We can prove it happened on the basis of body fluids and hairs." [PS#4]

Law enforcement and prosecution informants reported that SANE created a system that helped ensure a high quality of evidence preservation.

> "The great thing about SANE is that they can preserve the evidence for us." [LE#2]
>
> "[SANE] has put our cases in a stronger position because evidence is [better] collected. Things are documented and we have the witness available for the whole process and that has put us in a stronger position to get better pleas, to go to trial." [PS#2]

With SANE, informants believe that the chain of custody of evidence has been maintained much better than before SANE.

> "[Pre-SANE]…for us to try to find somebody and bring them back just to get the chain of custody so we could use whatever forensic evidence we had, it was a huge struggle in almost every case it was a nightmare." [PS#2]
>
> "Like I said, [post-SANE] it was a lot more efficient, a lot more thorough. And when it got to trial, you had a lot easier time explaining your chain of evidence. It was a lot easier to say that it went straight from SANE to evidence, versus you sitting on the stand and them going, 'What happened there?' 'I don't know.' You know, it [SANE] made a big difference with that…I think a lot easier for our forensic, to have that consistency. The chain of [custody] going straight from SANE to evidence alleviates a lot of the doubt." [LE#3]
>
> "In the early years of my practice, defense attorneys challenged the chain of evidence frequently but now chain of evidence isn't challenged." [PS#1]

In addition, informants reported that the method by which evidence is collected is of highest standard.

> "[Pre-SANE, doctors] weren't looking for particular things, they weren't as careful with the internal exams in noting things like redness, stiff neck, if someone had been choked. So these things frequently [didn't] get documented because they weren't observed." [PS#2]

Informants also believe that the privacy and safety of the SANE atmosphere makes it easer for the witness to relax and tell the whole story. This makes the witness statements more likely to be reliable.

> "In the ED, you were, 'let's go, let's get this done while we can.' There [SANE] you can say, 'Do you want to take a break? Do you need to get a drink of water? If you don't feel real good just take a break.' And then they can gather their thoughts and they can come back more of a whole person. The statements were usually a lot more accurate...In a relaxed atmosphere [like SANE] you have a much more reliable witness statement. No matter what, the situation is going to be uncomfortable, but if you make it more relaxed, they are more relaxed and tell you more." [LE#3]

Prosecution informants stated that prior to SANE the written evidence was not good, nor consistent. It was attacked in court by the defending counsel, making it seem that the victim changed her story.

> [Pre-SANE] "The doctors weren't noticing that if they put something different down, or if they re-interpreted it as they were writing that could be a really bad thing for the prosecution. It made the victim seem like she changed her story, when in fact she didn't. They just heard it wrong, wrote it down differently, [and] paraphrased it. The defense tried to use that as evidence that the victim changed her story." [PS#2]

Quality of law enforcement work

Informants stated that the quality of the law enforcement officer's job related to sexual assault had changed for the better since the advent of SANE.

> "The atmosphere at SANE, I found to be very supportive; it plays a positive role in my job." [LE#4]

Informants reported that job satisfaction among law enforcement officers improved as a result of improved communications with healthcare providers. Pre-SANE, it was difficult to communicate with healthcare providers because working relationships lacked consistency. Under

SANE, new protocols in evidence collection increased communication and collaboration between law enforcement and medical personnel. SANE also facilitates the ability to have regular meetings with consistent attendees to provide ongoing quality improvement.

> "Much nicer, a lot more quiet, a lot more relaxed, a lot more bonding. *Interviewer:* With the victim? *Respondent:* Yes. Actually, just about anybody there. You know - I shouldn't say it like this, but my phrase that comes to mind all the time is those little things, like when it's two o'clock in the morning and you've been up all night and you're tired and you have brain farts and you forget things, SANE nurses are going, 'Do you remember that?' You know, you've just got this set pattern that it's just so much easier to be organized, and it was a lot less often that you'd forget to do something like that and a lot easier to get reports later. But there was a lot more bonding. Rape Crisis advocates I got to know more on a first-name basis who they were, and the nurses that were performing the medical tests. It made a difference." [LE#3]

Informants report that one important benefit of the direct communication between SANE nurses and law enforcement is that officers are now able to more quickly and accurately identify trends in similar assaults and perpetrator types. Informants reported that SANE helped them to identify pattern rapists.

> "We had a medium where if the officers were frustrated with a certain part of a case, especially medical, we went to SANE or Rape Crisis. They were kind of our neutral zone and they could answer the questions for us. It's what we call identity patterns in a suspect." [LE#3]
>
> "I think a factor that helped that SANE has noted or we have noted is that if they see a common type of situation occurring in rapes they will report this trend to us." [LE#1]
>
> "Have SANE in place for example, the SANE personnel is really alert to what is going on. We had a pattern rapist that hit the southeast and I was just talking to the secretary about that. And she said we had another case that came in yesterday morning similar to your case. Well I put the two together." [LE#2]

Informants perceive that SANE increased the efficiency of every task performed by law enforcement officers. Waiting time for victims' medical exams is greatly reduced, and police are able to attain medical records in a timely manner. Overall law enforcement time at the medical

facility is greatly reduced. Time spent on evidence collection and processing is also greatly reduced, freeing up officers for investigations of sexual assault.

> "The case load didn't change really, but your efficiency was a lot better. You could do more cases and get them completed a lot quicker, a lot more thorough." [LE#3]

Law enforcement officers now state that they have the ability to contact and/or interview witness and family members in a centralized location where the atmosphere is calm and comforting, confidentiality is now strictly maintained, and victims feel safer. Prior to SANE, the ED atmosphere was chaotic, impersonal, unsafe, de-humanizing, and lacked privacy for victims. With SANE, police were better able to establish a positive rapport with victims, which increased the quality of witness statements. Law enforcement officers feel that they are better able to determine validity of witness statements post-SANE, and because they are getting more accurate interviews, they are able to identify perpetrators more easily. Informants reported that SANE has provided a positive and supportive atmosphere for law enforcement: private space for interviews, cooperation with nurses, less time spent waiting, and support for personal needs (coffee, snacks, and telephones). The SANE atmosphere provided an opportunity for breaks and 'down time' to relieve tension. Officers are now able to focus their attention on victim interviews and the investigation of perpetrators.

> "That is if the police officer handled it appropriately, then we had somebody that was more cooperative. If the police officer didn't handle it appropriately, then we had somebody that didn't want to have anything to do with us or the system, feeling like that, you know, if there's not going to be any understanding at all in the course of the prosecution of the case, why bother? Post-SANE, the police are better prepared to deal with that in a better way." [PS#4]
>
> [Pre-SANE] "It was very uncomfortable because you were dealing with doctors and nurses coming in and out; the victim feeling very, very out of place...But with SANE, it's a lot easier to be more understanding and more patient and understand that their [victim] confusion is more the

incident or act that happened to them and not just their surroundings." [LE#3]

Informants reported an overall efficiency of the work environment allowed law enforcement more time to investigate cases of sexual assault.

> "Everything is done for us. They free up a lot of time for us so we can investigate our cases. So we can put in more quality time in to our cases." [LE#2]

Informants also reported improved communication with healthcare providers since the advent of SANE. Informants reported that the number of healthcare facilities and the turnover of staff made it difficult to establish working relationships in the pre-SANE era.

> "[Pre-SANE,] it depended on whether we spoke to the staff during previous cases and had built a relationship with those individuals and they could help us out in whatever way they could. Otherwise, there was no relationship; it was difficult to communicate with them." [LE#10]
>
> "Before SANE, there was a high turnover rate in all the agencies making it difficult to establish working relationships." [LE#4]
>
> "I don't know if you really had a chance to establish rapport with the medical personnel at all the different hospitals [pre-SANE] there wasn't a chance to establish long term friendships or work habits." [LE#5]
>
> "They [medical professionals] would cooperate as much as they could, but we were obviously in the way." [LE#3]

Change in the number of unfounded cases of sexual assault and number of cases cleared by arrest.

There was a greater percentage of unfounded cases (a case determined by law enforcement to not have merit) in the post-SANE era compared to pre-SANE (post-SANE: 11.6% vs. pre-SANE: 3.8%, p=0.0004). However, a greater percentage of cases in the post-SANE era were cleared by arrest compared to pre-SANE (post-SANE: 8.4% vs. pre-SANE: 3.8%, p=0.0189).

Seriousness of charges filed

Compared to pre-SANE, in the post-SANE era a significantly lower proportion of the charges in the district attorney data were for 1st degree criminal sexual penetration (CSP) (17.9% pre- vs. 12.2% post, p=0.0088), there was a non-significant increase in the relative proportion of

2nd degree CSP (31.1% pre vs. 35.5% post, p=0.1327) and a substantial and significant increase in the proportion of 3rd degree CSP (15.1% pre vs. 33.5% post, p<0.0001).

Law enforcement informants reported that the quality and consistency of the forensic evidence made for more consistent filing of charges.

> "I think there's a change in the consistency of them, in the charges filed. I mean, the seriousness I don't think is ever going to change, but I mean, like I said, putting together a better case, having a better statement, so filing charges are a lot more consistent." [LE#3]

Grand Jury and District Court Charges

Proportion of charges and cases moved forward

Exhibit 10 lists the progression of charges moved forward from law enforcement to grand jury and to district court. A greater proportion of charges were presented to the grand jury in the post-SANE era compared to pre-SANE (70.3% vs. 65.2%, p<0.0001). Likewise, a greater proportion of sexual assault cases were presented to the grand jury post-SANE compared to pre-SANE (49.5% vs. 37.7%, p=0.0164).

Change in the number of charges assigned per defendant

Exhibit 11 provides the number of charges per case resulting from grand jury indictment. The number of charges per case post-SANE was significantly larger than the number of charges per case pre-SANE (7.0 vs. 5.4, p<0.0001).

Judgment and sentence

Conviction rates

Exhibit 12 provides the proportion of charges that resulted in a conviction (guilty plea or jury trial) among the sexual assault cases pre-SANE compared to post-SANE. Conviction rates increased in nearly all charge types post-SANE and significant increases occurred for criminal sexual penetration, criminal sexual contact, child abuse, and criminal sexual solicitation.

Change in the percentage of plea agreements

Exhibit 13 specifies the outcome for the charges. The maintenance of the seriousness of the crime was tracked for plea agreements and trials. There is suggestive evidence that post-SANE guilty pleas for criminal sexual penetration maintained the seriousness of the crime compared to pre-SANE (86.8% vs. 80.5%, p=0.0848). A significantly fewer number of charges ended with a *nolle prosequi* (28.3% vs. 16.6%, p<0.0001). There was no difference in dismissals or acquittals. Similar results were observed among charges for criminal sexual contact.

Exhibit 14 lists the outcome at the case level. In contrast to the charge level data, there were no significant differences at the case level in outcome.

Time to case disposition

The average number of days from grand jury indictment to case disposition in district court was over 3 months faster (mean 135.1 days faster, 95% confidence interval: 94.4, 175.9 days) (Exhibit 15).

Sentence

Exhibit 16 provides sentencing outcome for cases pre- and post-SANE with respect to incarceration, probation, and community service. A significantly greater percentage of cases post-SANE received jail time and probation. There was no difference in the proportion who received community service.

Exhibit 17 provides the average sentence time for cases pre- and post-SANE with respect to incarceration, probation, and community service. Post-SANE length of incarceration and probation were significantly longer than pre-SANE; it was not possible to sort out sentencing for collateral charges from the sexual crime in the data.

Exhibit 18 provides the average incarceration time (in years) for both CSP and CSC individually and separately. Based upon a nonparametric analysis, the total incarceration time

was significantly longer in the post-SANE period compared to the pre-SANE era. There is suggestive evidence that longer sentences were made for CSP offenses post-SANE compared to pre-SANE. There was no statistical difference in the length of sentences for CSC offenses.

Victim cooperation with prosecution, willingness to testify

Informants reported that prior to SANE victims had minimal support and understanding of the judicial process and were reluctant to testify.

> "Pre-SANE, victims came through the courtroom reluctantly. It was a place that hadn't been explained to them. It seemed hostile, a hostile environment. Certainly the judge cannot appear to be on their side. The defense attorney certainly cannot appear to be sympathetic to what they're doing. Prosecutors are kind of in a position, once we begin a trial, where they are working and can't really offer much support or guidance to the victim for what they're about to go through, so it was a very imposing sort of system for the survivor or the victim to go through before. Now they've got a support structure in place where what they're going to go through is explained to them, the ramifications of the procedure are explained to them, some preparation is given to them for what they have to do once they get to the stand. And you know, to say that it is a kind or gentle place is wrong, but to say it's kinder and gentler may be appropriate." [PS#4]

More importantly, informants commented that the force of the evidence collected through SANE, especially photographic evidence of injuries, strongly supported the victim's testimony and often obviated the need for the victim to testify at all.

> "*Interviewer:* How about change in the proportion of cases where the suspect was indicted? *Respondent:* It probably increased. Again, the victim doesn't stand alone. And if the victim goes alone to the grand jury and offers her word and he offers his, there's a greater likelihood that the grand jury is not even going to indict. It's surprising how many times juries, grand juries and petit juries, you know, will consider some sort of buyer's remorse, you know, you want it and now you're dissatisfied with it and you complain. With the medical testimony, it doesn't happen." [PS#4]

Expert testimony

Informants reported both positive and negative aspects to relying on the SANE nurses for testimony. On the positive side, the SANE nurses are well trained to testify and they know that

providing testimony is part of their job. They document evidence during the exam that facilitates this role. The informants clearly appreciated the value of how the SANE nurse testimony related to the specific activities of evidence collection, preservation, and recording. On the other hand, informants stated that doctors hold more weight with juries than nurses, even though they may not be as well prepared, do not see testifying as part of their job, and are less cooperative and available. Therefore we might infer that the SANE advantage is that nurses are better prepared as factual witnesses and are better witnesses than ED nurses, but that the lack of MD testimony could be a disadvantage with juries, especially if expert medical testimony is needed.

> "[Pre-SANE,] their duty was to be a doctor treating somebody in an emergency room, and if they had to go to court as a result of this, that was just a burden. Very seldom did I have medical personnel who looked upon testifying, as part of their job." [PS #1]
>
> "We were very frustrated [before SANE]...with getting the doctors to just show up and participate...when they did, it was hit or miss. Either you got one of the few really great doctors or you got the doctor who had an attitude...as one doctor said, 'people are dying because I'm not in the emergency room. This better be important'....and that attitude reflected itself in front of the jury" [PS#2]
>
> "They do a real good job, the [SANE] nurses do testifying. We don't tend to use them as experts because they are not medical doctors or that sort of thing." [PS #2]
>
> "What we need them [SANE nurses] for, the things they do testify about, is so valuable. They are talking about evidence they collected and how they preserved it and collected it and all that. So we are able to say here is what the test showed later. Without that link we can't use it, so that's been a huge difference. And their testimony about the victim's demeanor and things like that have been great, a great help, they are very good at that. They are objective and they are good at it and they care so it all comes across really well." [PS #2]

Quality of the prosecutors' work

Prosecution informants reported that prior to SANE, cases involving sexual assault were frustrating and time inefficient. It was difficult to obtain and interpret medical records. Informants stated that SANE facilitated obtaining records, which contained more understandable

information. Prosecution informants also reported a greater confidence in the forensic evidence post-SANE compared to pre-SANE.

> "[Pre-SANE,] the uniformity wasn't there, so you could have a good doctor who was even very attentive to certain details, but miss other things just from lack of experience of sexual assault...They may have taken a hundred kits but never testified in a courtroom, so they really don't know what some of the issues might be." [PS#2]
>
> "I know in the case I did I could tell it was much better, a very detailed report, photographs of the injuries, she [SANE nurse] provided us with some back-up documentation about the opinions. [PS#6]
>
> "It was clear that the Nurse Examiners were always thinking about collecting evidence as well as treating victims." [PS#1]

They also stated that it was much easier post-SANE to obtain records and to work with medical personnel compared to pre-SANE.

> "[Post-SANE] it is so much easier for us to deal with and understand, and we are getting the records without having to fight with the hospital [like we did pre-SANE]. We are [now] getting them quickly." [PS#2]
>
> "My feeling and the feeling of my colleagues during those 5 or 6 years [before SANE] was that it was very frustrating the amount of time we had to spend in trying to analyze, swapping medical records and the amount of time we spent trying to convince the medical staff and various hospitals to cooperate with us so that we could proceed to trial was frustrating. Knowing how much time that took away from other things, it definitely did. Every hour we had to be dealing with that was an hour we didn't spend on something else. There was a lot of frustration then, a lot of wasted time. Sometimes, many hours of wasted time and still wouldn't get what we needed." [PS#2]

Cross-cutting Issues

Change in the community response to sexual assault

Informants reported that the creation of the SANE unit suggests that the community's response to sexual assault has changed. Rather than leaving the victims to navigate myriad uncoordinated systems, SANE has centralized services for victims of sexual assault, increased

the community awareness of sexual assault, improved education about sexual assault, and improved working relationships between agencies serving sexual assault victims.

The creation of the Albuquerque SANE Collaborative coincided with an increased community wide effort to combat sexual assault, including specialized training for law enforcement and prosecution, increased staffing in the prosecutor's office, and a general increase in community education.

> "I think awareness has definitely grown...well, a perfect example would be SANE. That was an awareness that people became aware that we needed this to exist, and awareness definitely brought SANE about." [LE#5]
>
> "Obviously community groups are aware. That's why we have the SANE unit now...people are recognizing the need to make a better facility in order to preserve evidence and privacy for the victim, trying to make the victims as comfortable as possible." [LE#8]
>
> "The fact that we are out there and we have set up a place called SANE for sexual assault expresses to the community that we have a problem with rape and there is a place you can come to, to help you with that." [VS#1]
>
> "I think, the public is better educated, I think initially, when SANE started and there was a blitz about 'here we are, this is what we do,' I think that really helped, and of course the Rape Crisis Center and community education efforts and SANE was part of that, all of that has helped to better educate. [VS#2]
>
> "Post-SANE working relationships between agencies... are much better...better all over...it all builds, it all relates." [VS#2]
>
> "Actually pre-SANE community education at Rape Crisis consisted of one person. Post-SANE we have three full-time educators, a violence against women coordinator. That's got to have an impact on community. We did 912 sexual assault presentations in 1999, reaching approximately 27,000 audience members, not including audience that you can't count that are so big like media audience, but specific presentations 912, reaching 27,000 people. In addition to 27 years of training volunteers, who then go out into the community and educate and become part of their life. So, I do feel that there's been a shift, that at least we're part way there." [VS#2]

Coordination of services

Informants consistently and repeatedly commented that one of the most significant aspects of SANE was to coordinate care. Prior to SANE, care was "very disjointed and fractionalized" [HC#2].

> "[Pre-SANE,] there were services out there but they weren't as trained, you know, it's like OK, you have this injury, you can go to a medical facility and you know, they kind of limped through it because it's not something they do everyday and so I think there were medical services, there were legal services, there were our services, I just don't think there was that continuity." [VS#1]

With the advent of SANE, service delivery is less chaotic. It is now centralized and communication has improved between agencies and with victims.

> "As I have said earlier SANE centralized the whole process for everybody, so it does cut out a huge chaotic piece that was never able to be brought to the table because it was so big...it centralizes the advocacy pieces, the beginning of the legal process, the medical treatment, and then consequently the therapeutic process. The potential is greater." [VS#2]

> "I think the best piece of SANE has been clearly the survivors experience in getting medical care, and then the advocacy that can happen there, and the communication with all the providers." [VS#2]

Collaboration between healthcare, victim services, law enforcement and prosecution

Informants reported that since SANE their working relationship with the variety of agencies involved with sexual assault has improved. They perceive that communication has improved and overall, stress has been reduced. SANE has created a focus where four different areas of service delivery come together. One informant commented that while at times strife between parties existed, there was now a mechanism to resolve conflict—out of ear shot of the victim.

> "[Pre-SANE,] we worked together but it wasn't a close working relationship...actually you got four different points of view. Now there's a lot less stress...you get to know them on a first name basis. You even have a better atmosphere where you can have more casual conversations getting to know the person and being more relaxed. Therefore there's a lot more interaction between everybody." [LE#3]

> "If there is any friction, it is not with the survivor there present. That's why we have our meetings that we do, we have a process that we call. All of us supervisors have pagers so if something is going on that's not going right at the SANE unit they page up the line to get us and we take care of it on this level so that the survivor and these people aren't involved and we deal with those issues separately from at that precise moment. Big difference" [VS#1]

Opportunities for improvement

Despite the overwhelmingly positive impact of SANE, there remain some opportunities for improvement. Follow-up, communication and training remain challenges.

Provision of care beyond the initial SANE visit remains challenging. While service providers acknowledge the importance of more support services, such as medical and mental health and social services, the SANE Collaborative has not yet effectively addressed this problem. While many informants suggested that follow-up has improved, additional strides are needed. One area identified as needing attention was the link between acute and convalescent care, especially for mental health and women's health.

> "What they need a lot of times, especially in the teenage group is psycho-social support, and because they are minors and they are dependent on families they really need that for families too...So really what I think is still missing...there is still not really a mental health component there [SANE]." [HC3]

> "There should be some sort of way to try to impact the victim to assure a greater response by the victim on secondary follow-ups such as counseling, medical exams, things like that...We need to try to look at the strategies that we have seen if there is anyway that we can improve, maybe raising the number of victims that come back, because once they don't come back, probably nothing occurs for them as far as medically, psychologically, or even prosecution wise. And that's a big problem, and I'm not sure I have the answer to that." [LE#1]

Additionally, now that services are more formal and less haphazard, ironically, the increased formalization and structure may have negatively affected collaborative relationships. For example, when the forensic evidence exam was conducted in the ED, the rape crisis advocate

was seen as being helpful. Now, the rape crisis advocate role is less defined and possibly perceived as duplicative with the SANE nurse.

> "Well I think we had a more important role prior to SANE, you know. Because we were the experts, now I think for the most part because of the collection of the forensic evidence the SANE nurse is [the expert]." [AFG][1]

> "There was more of a handshake at that time between the Rape Crisis Center and, and walking that person through, and 'Who's going to deal with the sentencing?' or, 'this person needs this' and that's not happening any more. They're [LE] not doing a whole lot of advocacy, they're either focusing on homicide high impact cases, and admittedly they have an overwhelming case load, by the same token they don't call us and say, 'we have a sexual assault survivor who needs some support, could you come to their services?' There just isn't that kind of give and take any more, it's become more territorial." [VS#2]

> "I have had really mixed experiences with SANE nurses, those that I've been able to have a really good relationship with and we can work together for the survivor and I have had other experiences where I have not been able to do that, where I really felt that my role was undermined...we were the experts in the past and now the medical personnel is more the expert and so I've felt that I am not seen as being at an equal level with this person because I'm just an advocate." [AFG]

> "[When I was working before SANE, I was getting more respect from the doctors and nurses,] because these people [doctors and nurses] didn't have a clue and the survivors they needed somebody to stand up to these people and tell them to get off their butt and get going and these people have been sitting here for four hours and obviously they don't need me to do that anymore because we've got a SANE nurse and we're in a completely different environment. [AFG]

> "But one of the other things too that I feel is missing as part of that collaboration is just kind of communication among the staff people and the volunteers with the staff people from the SANE unit as well as even training because I know we used to be a part of the training for the nurses, Rape Crisis used to be a part of that training and right now we're not, or we haven't been very much at all." [AFG]

While training has provided some of the most notable improvements in services to sexual assault victims, it is also an area that shows room for further enhancement. Prosecutors often

[1] AFG: Albuquerque Rape Crisis Center, advocate focus group participant

stated that the only training they've had has been on-the-job training, personal readings, and a few workshops. Victim service providers also stated that prosecutors might benefit from better training in how to interview victims, including child victims of sexual abuse. Some law enforcement interviewees also stated a lack of, or even a decrease in, training in working with sexual assault victims. Some healthcare providers stated that since SANE, although they have receive good training in exam and documentation procedures, they have not received any training in how to work with sexual assault victims. Victim services stakeholders confirmed this, stating a need to conduct more training sessions with healthcare providers in order to discuss the dynamics of working with sexual assault victims and to clarify the role of the advocate.

> "The law enforcement actually only as far as the academy goes only allows an hour or an hour and a half for the new officers that are coming on out of a four month training, so it's almost negligible." [AFG]
>
> "Yeah, and I know SANE is now doing like another hour but it's relatively small [and] it's relatively limited as far as an on-going basis with all of the first response, on line officers." [AFG]
>
> "The training component really not changed drastically, it's not like we're talking another 40 hours or anything like that." [AFG]

Discussion and Implications of Findings

Both the quantitative and qualitative data suggest that the establishment of the Albuquerque SANE Collaborative in October 1996, significantly and positively impacted healthcare, victim services, law enforcement, and prosecution.

Impact on Healthcare and Victim Services

The impact of SANE on healthcare and victim service providers has been striking. A common theme from all of the healthcare stakeholders was the invaluable service that SANE provided. SANE concentrates all services for sexual assault victims into one program and one location with the goal of meeting the immediate physical, emotional, and legal reporting needs of

the victim. The victim receives specialized and sensitive care by professionals who are more aware of the physical and psychological affects of sexual assault on victims. The chain of custody for evidence is more consistent and secure. Patient care has achieved a level of consistency in the standard of care for sexual assault victims who now are uniformly offered treatment for sexually transmitted disease, pregnancy prevention, referrals, and follow-up care. Another benefit provided by SANE is the introduction of a uniform common language regarding sexual assault. This has helped to unify healthcare providers in their triage and treatment of sexual assault victims. Finally, SANE has significantly reduced the workload of healthcare providers in the ED and has allayed their attendant concerns about treating sexual assault victims within the ED setting.

SANE has increased the comfort level of sexual assault victims, providing an environment that offers privacy, safety, and security during their treatment for sexual assault. Patient confidentiality has been greatly improved because the SANE unit provides a physically more secure environment for the patients to disclose information and to receive notification of their laboratory test results. SANE records are kept separate from traditional medical records offering increased victim confidentiality regarding insurers and third party payers. The SANE unit consistently provides a greater number and breadth of patient referrals. The SANE unit also has the capacity to provide follow-up care to sexual assault victims, but getting clients to return for follow-up remains difficult.

Sexual assault victims spent about an hour less time at SANE compared to the ED. Beyond this time savings, SANE provides a higher quality and comprehensiveness of services while streamlining service delivery. Waiting times are usually decreased—women no longer have to wait in a crowded ED waiting room. The time is spent collecting a greater quantity and quality of

evidence. The shorter waiting times may also improve the collection of time-dependent material such as oral DNA or urine for suspected drug-facilitated sexual assault.

While some tensions between victim service providers and the SANE unit were noted, victim service providers clearly stated that SANE has been an extremely positive force within the sexual assault community. The SANE unit has created some stress between traditional patient advocates (such as rape crisis advocates) and the forensic nurse examiners. Many respondents noted that the specific roles of the rape crisis advocates and the nurses needed clarification. Some of these challenges at the Albuquerque SANE Collaborative may have been specific to the staff personalities at these agencies. Nonetheless, the opportunity to clarify the roles of the forensic nurse examiner and the rape crisis advocate with respect to the patient and each other will be an ongoing process. The SANE units should recognize the value of having two distinct roles and personnel: one SANE, one rape crisis advocate. Each person has different priorities and strengths for the victims. The two also reduce the threat of system abuse, improve quality assurance, and assuage many risk management concerns.

SANE nurse examiners also potentially walk a thin line between being a detached healthcare provider and functioning as an agent of law enforcement. It remains uncertain how this new role of a healthcare provider affects patient autonomy, especially with respect to accepting or declining invasive examinations, medical treatments, and laboratory tests.

SANE units can collect consistent and high quality epidemiologic data about sexual assault, affording the opportunity to monitor the incidence and trends of sexual assault. SANE units can help identify new collaborative partners, *e.g.*, college campuses, domestic violence providers, and assisted living centers for the elderly and disabled. An expanded base of referral organizations combined with reliable and accurate sexual assault incidence data can provide the

basic data that advocates can use to motivate community and legislative leaders to recognize and address sexual assault.

Finally, all stakeholders recognized the need to improve the inclusion of psychological treatment for victims. Currently, these services are offered through follow-up services, but are often not used by victims. Psycho-social issues were a common theme among stakeholders who felt that families, teenagers, and victims of all ages need more support and counseling services to more effectively deal with the psychological and emotional after-effects of surviving sexual assault.

Impact on law enforcement and prosecution

At the front end, SANE units improve healthcare delivery. SANE's greatest impact, however, may be on improving law enforcement and prosecution services. SANE programs deliver a higher quality of forensic evidence to law enforcement and prosecution. This significantly increases the success of sexual assault crime prosecution while simplifying criminal justice work.

SANE units introduce and systematize the concept that there are two crime scenes with a physical assault: 1) the physical location/environment where the assault occurred and 2) the human body. Because of the special nature of sexual assault, evidence collection at the human body scene is difficult and intrusive. SANE and law enforcement each respond to the two different scenes with their unique expertise. They collaborate and combine their work to corroborate the victim's story.

Improved forensic evidence is perhaps SANE's most important contribution with respect to law enforcement and prosecution. SANE nurses are specifically trained in sexual assault forensic evidence exams, photographic techniques for the documentation of injuries, and using a

colposcope. The utility of forensic evidence only becomes apparent after the victim is willing to provide forensic evidence and to report to police. Most informants noted an increase in the number of women reporting sexual assaults within the Albuquerque area. This observation was corroborated by the difference in reporting to police that was observed in the pre- and post-SANE medical records. Another significant impact has been the ability of law enforcement to track trends within perpetrator types. This may be due to the increased consistency of evidence collection and an increase in contact and communication with SANE nurse examiners and law enforcement.

Because the SANE units provide a calmer, less hectic atmosphere to provide services for sexual assault victims, law enforcement officers stated they were able to interview victims who are less stressed and who were more willing to cooperate with law enforcement. According to the stakeholders, this aspect alone has assisted in building less stressful and more trusting relationships between the victim and law enforcement. Hence, there is an increase in successful prosecution due to more coherent and consistent interviews. Finally, law enforcement officers stated that another benefit of SANE was an atmosphere where they could 'bond' and develop sympathetic relationships with sexual assault victims. This has helped law enforcement gain an increased awareness and knowledge of sexual assault issues, which may help them prevent re-victimization.

A potentially concerning observation is the increase in unfounded cases in the post-SANE period compared to the pre-SANE period. Whether this may be attributed to the changes in willingness to report to law enforcement that may resulted by pressures created by SANE or due to the ease from which patients can be seen at SANE is unclear and deserves further clarification.

Not only are victims more likely to report, stakeholders reported a decrease in lost or damaged forensic evidence and an increase in the type and quality of forensic and interview evidence collected. The collection of photographic documentation of injuries and colposcopic evidence has increased the recognition of sexual assault as a violent crime by providing evidence for prosecution. The consistent standards of collection by SANE has maximized the effect of DNA and forensic evidence when cases go to trial.

SANE has assumed the responsibility of managing the chain of custody, from labeling, tagging, storage, and transport of forensic evidence. Indeed, SANE has established a significantly higher standard of forensic evidence collection for sexual assault victims and routinely includes colposcopic examination for evidence of injury. Recent studies have shown that the ability to document injury correlates with successful prosecution (McGregor, *et al.* 2002).

SANE programs are better equipped to respond to changes in forensic technology. For example, within the past decade, photography has advanced from Polaroid to digital technology. Whatever the advance, SANE units serve as the bridge between medical science, healthcare, law enforcement and prosecution. Because of their centrality, SANE units may be an ideal place to introduce and evaluate new technologies. SANE programs may need to proceed cautiously, however, and in full cooperation with law enforcement and prosecution as new technologies are being advanced without completely understanding how such techniques will be viewed in the courtroom or understood by juries.

Post-SANE, prosecution has increased confidence in forensic evidence and in the interview processes. The chain of custody for evidence is less often challenged by the defense. In addition, prior to SANE, the defense was far more likely to use documentation procured from medical records to infer that the "victim changed her story."

Equally important has been the increased consistency in the working relationships of SANE personnel with law enforcement and prosecution. SANE nurses are available for pre-trial interviews, court appearances, and to give explanations of medical findings. Law enforcement and prosecutors found it difficult to obtain information about victims from medical personnel, especially from ED doctors and nurses who often have rotating shifts, making contact difficult. Consistent and familiar faces among all service providers promote the exchange of ideas and the opportunity to solve commonly recognized problems. Finally, prosecutors' ability to read, understand, and work with medical records has vastly improved because of SANE data collection procedures and the increased contact and communication between prosecutors and SANE nurses.

Prior to SANE, this kind of collaboration between doctors and prosecutors did not exist. This alone has increased the efficiency of the prosecution by eliminating the frustration of trying to get medical professionals to participate in the legal process and by providing reliable and factual evidence. While some informants felt that physician testimony might carry more weight, they preferred the consistency and ease with which they were able to use SANE nurse testimony.

Prosecutors are able to bring a greater number of charges to grand jury where they have uniformly received indictments for the charges sought. There is evidence at the charge level that SANE has increased the number of guilty pleas from defendants, thereby obviating the need of the victim's testimony. The increased quality of evidence, availability of expert witness testimony, and a proven track record with the grand jury and the courts has improved the successful prosecution of sexual assault cases.

Crosscutting Issues

Training

All agencies benefit from cross-training related to sexual assault. Inter-agency training has focused on debunking popular myths about sexual assault victims. Law enforcement educates SANE on what to (and not to) ask and the reasoning or intent behind police investigation. Prosecution trains SANE on laws and courtroom demeanor, judicial process and building credibility. Training has improved for all areas of impact. Although pre-SANE training did exist, many law enforcement, prosecution, and healthcare providers reported that they had not received formal training, only informal 'on-the-job' experience and 'mentorship.' Many healthcare providers stated that they didn't receive any training to work with sexual assault victims prior to SANE, and some ED nurses stated that prior to SANE they were afraid of missing key evidence in the rape exam. Law enforcement officers confirmed this stating that pre-SANE the lack of training for healthcare providers led to improper evidence collection and tagging which could affect a victim's legal case.

Healthcare providers stated that training in rape exam procedures by SANE has greatly improved their confidence in forensic evidence exam procedures and in evidence collection overall.

The SANE Collaborative has trained both law enforcement and prosecution on frequently used medical terms and procedures used by healthcare providers that were previously not well understood by law enforcement and prosecution, greatly facilitating their understanding of medical issues. In addition, SANE has trained other providers on the types of physical trauma that sexual assault creates. SANE has facilitated the contact of medical providers with prosecution. SANE nurses have proven to be extremely informative and helpful in providing information about the medical aspects of sexual assault.

Collaboration

A multidisciplinary approach is the preferred approach to address problems and concerns with healthcare, victim services, law enforcement and prosecution. Multidisciplinary teams (MDT) not only improve relationships, but also assist in the training of new forensic evidence collection procedures, changes in technology, specialized training in sub-specialty areas, and interview and documentation guidelines. Derhammer *et al.* (2000) has also noted that a SANE unit improved the collaboration between law enforcement and medical providers in their region.

The impact of the SANE unit on cooperation and communication between agencies has been impressive. MDT meetings have greatly facilitated communication between agencies (which was poor prior to SANE) and problem-solving techniques have been successfully applied. As a result, stakeholders reported better communication and working relations between agencies, particularly with victim service organizations. The centralized location of SANE has facilitated building personal relationships between members of organizations and has facilitated developing positive interpersonal communications. There is now the capability of establishing long-term relationships between SANE and law enforcement; detectives report better communication with medical personnel. SANE units have brought healthcare to the table with law enforcement and prosecution.

Limitations

We looked only at women ages 18 years and older, thus we cannot comment on the impact that the Albuquerque SANE Collaborative may have had on male sexual assault or on adolescent sexual assault. A recent evaluation of sexual assault evidence collected by physicians in Florida showed that documentation of weapon use and traumatic injuries correlated with successful prosecution, especially among adolescents (Gary-Eurom *et al.* 2002). We cannot confirm this observation with our data.

We did not conduct a cost-benefit analysis of SANE. While the overall costs associated with ED care can be costly, the marginal cost of one additional patient in an ED (who might have been sexually assaulted) is quite low. A freestanding SANE unit needs to cover overhead expenses, including facility costs and personnel. EDs do not have this problem. SANE programs that manage patients in EDs can avoid some of these expenses. But the lack of a separate centralized location may not offer many of the convenience, privacy and confidentiality benefits that were noted in our evaluation.

It is not too surprising that stakeholders view SANE's impact as positive. Inherent to the SANE model is the alleviation of many of the difficult aspects of providing sexual assault services. SANE provides the time and place to provide compassionate healthcare, support for the victim in deciding whether or not to report to law enforcement or to undergo a forensic examination and collection of forensic evidence away from stakeholder agencies. This positive view is from the agency stakeholders. It is uncertain if the SANE model is viewed positively by victims.

Despite repeated efforts with multiple modalities, we were unable to solicit the input from the victims of sexual assault. We caution that the findings on victim satisfaction reported in this report are from the perspective of the service providers themselves. From the few victims with whom we were able to communicate, we found evidence of disconnect between the victim's stated experiences and the providers perception. We believe that it is very important to obtain the impact on the victims from the victims themselves. Because of the difficulty that we experienced in trying to reach this group, we believe that it is necessary to prospectively survey sexual assault victims soon after they have received services. Given the mobility of our patient population, we do not suggest that researchers attempt to contact sexual assault victims much beyond the assault

itself. Victim participation will depend upon each individual's readiness to talk about their experiences. Programs will need to balance readiness to speak about their experiences against the practical aspects of contacting a mobile population after the fact. If contact is desired, then permission to do so should be obtained at the time of the SANE evaluation.

We were unable to successfully link across the various datasets. Healthcare records clearly identify the victim but do a poor job in identifying the offender. Likewise, court records identify the offender (in the subset of cases that are adjudicated) but do a poor job in identifying the victim. Unfortunately, we found the quality of the law enforcement and prosecution records limited. We had hoped to link healthcare records to court records through this bridge. We were unable to do so. Even the probabilistic linkage strategy proved inadequate, largely because of the quality of the pre-SANE medical record identifying information. Nonetheless, we are confident that there was a clear difference in outcome measures as we were able to identify the pre- and post-SANE records in each of the datasets on the basis of the incident date which was found in all of the datasets. A common case identification number system across all of these data systems is needed to facility data linkage.

An inherent weakness to a pre-/post-intervention comparison is the difficulty in accounting for the potential that other system changes may have explained observed differences. While stakeholders did not feel that there were significant temporally related factors that would otherwise explain SANE's impact, there may have been some changes in the police administration or in the district attorney's office that impacted decisions on how sexual assault cases were prioritized. In the Albuquerque area, federal VAWA and VOCA funding has increased the number of community educators and victim advocates. This may have effected the

community's perception of sexual assault as a significant criminal justice problem and have increased the number of women who were willing to prosecute.

Our findings are for a small metropolitan area. Our findings might not hold for smaller communities whose magistrate court judges often do not have formal legal training.

Conclusion and implications of findings

The Albuquerque SANE Collaborative has universally had a positive impact on healthcare, victim services, law enforcement and prosecution. Both quantitative and qualitative data suggest that SANE has increased the efficiency of medical services by bringing services for sexual assault victims into a unified and central location within a hospital setting, and significantly reducing the stress associated with caring for sexual assault victims. All stakeholders stated that law enforcement's knowledge of sexual assault issues has increased and hence, law enforcement's perceptions about and treatment of victims has been greatly improved. SANE has increased the quality and quantity of forensic evidence and improved the chain of custody of forensic evidence, which in turn has led to more successful prosecution of sexual assault. DNA, colposcopic photography of vaginal tears and other injuries, and injury body maps were universally acknowledged as important contributions to the treatment of sexual assault victims and the prosecution of their offenders.

Our findings strongly suggest that a SANE unit can positively impact the prosecution of sexual assault while providing a higher standard of care to the patient. In addition, SANE centralizes sexual assault reporting and can improve our understanding of the magnitude of the problem. This may be especially useful for defining the problem in pockets of populations that are difficult to identify but who may be at increased risk, such as adolescents, the elderly and

vulnerable adults. SANE data can be used to show sleepy or ignorant communities the importance of sexual assault.

Centralization of sexual assault services might inhibit the delivery of services in some communities. This includes rural communities where services are not available and in communities whose members are distrustful of the 'system' and law enforcement. Loss of expertise in providing sexual assault services by emergency and women's health physicians may exacerbate this problem. Physicians must maintain basic skills in managing sexual assault to assist SANE units that are 'overcrowded' (when SANE units cannot respond to the volume of patients) and to provide services in communities without a SANE unit.

Not all communities will have the capacity or readiness to implement a SANE-style program. Nonetheless, we believe that many of the components of the SANE program might be incorporated into smaller or less ready communities. Intermediate steps to improve services include implementing on-call forensic examiners who can respond to a variety of healthcare locations, and multi-disciplinary trainings to achieve some of the success of a SANE unit. Having one point person at an emergency department or hospital who can communicate regularly with law enforcement and prosecution might significantly improve problem solving. Healthcare facilities should review their chain of custody procedures and consult with law enforcement on ways to improve and standardize evidence collection.

While not all existing SANE programs can undergo an extensive outcome evaluation, observations made in this evaluation may be useful. Areas of likely improvement include better follow-up for victims of sexual assault for both physical and mental health, and minimizing the impact of giving multiple interviews (to healthcare, law enforcement, etc.) by following a child sexual abuse model of videotaping or tape recording the interview. Intensive case management

may also be a successful strategy to improve post-care follow up. As the SANE unit coordinates a multiphase response to acute sexual assault, so might a SANE unit be able to coordinate follow-up services by providing a single contact phone number and a patient care coordinator. Follow-up is needed for a wide variety of services, including women's health, mental health (*e.g.*, PTSD and family support), and future sexual health.

Finally, the success of SANE begs the question of whether this model might successfully be applied to analogous situations, such as domestic violence or non-intimate battery. SANE in many ways is a highly specialized emergency facility—one that combines the expertise of many disciplines to deliver a high quality product to a somewhat reluctant clientele who did not plan on needing these services. The parallels with domestic violence are obvious.

Despite all the positives, there are some negative consequences that need to be considered. SANE units have decreased the opportunity to train resident physicians in emergency medicine and other specialties on how to provide sexual assault services. With the increase of SANE units nationwide and the decrease in physician experience with sexual assault, many residency training programs are beginning to recognize this lack of training as a significant problem. Residency training programs, including ours in Albuquerque, are working with SANE programs to train resident physicians in the principles of forensic evidence collection and sensitive treatment of the sexual assault victim.

Because of their intimate environment and highly specialized care, SANE units may lack the flexibility of providing 'volume' services for sexual assault. Whenever multiple cases of sexual assault present at the same time, a SANE unit may not be able to handle the volume of patients in a timely matter. At the Albuquerque SANE Collaborative, when multiple patients present at once, some clients are scheduled for a later time. This might pose negative consequences for the

collection of time dependent forensic data. This may be less of an issue in an ED, where more staff may be available to provide services.

Communities need to consider carefully the size and number of SANE units that their community can support. Unregulated services for sexual assault patients between competing SANE programs may undermine their effectiveness, ultimately diminishing the SANE impact. The specialization of a SANE program requires hospitals, criminal justice agencies, and community leaders to collaborate.

In summary, we find strong and compelling evidence that SANE has positively impacted healthcare, victim services, law enforcement and prosecution. Communities with access to SANE programs are better equipped to respond to the crime of sexual assault. Communities without a SANE program can start a coherent response by implementing incremental steps as presented in this report. There is clear evidence that the healthcare and victims services will improve while increasing the apprehension and conviction of sexual assault offenders.

Endnotes

Bachman, Ronet and Linda E. Saltzman. Violence Against Women: Estimates from the Redesigned Survey. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. August 1995.

Bowman, Cynthia G. The Arrest Experiment: A Feminist Critique. *The Journal of Criminal Law and Criminology*, 83(1), Spring 1992.

Chalk, Rosemary and Patricia A. King (eds.). *Violence in Families: Assisting Prevention and Treatment Programs.* Washington, DC: National Academy Press. 1998.

Crandall, Cameron S., Lenora M. Olson, Lynne Fullerton, David P. Sklar, and Russ Zumwalt. Guns and Knives in New Mexico: Patterns of Penetrating Trauma in New Mexico, 1978–93. *Academic Emergency Medicine,* 4:263–267, 1997.

Crowell, Nancy A. and Ann W. Burgess, Eds. *Understanding Violence Against Women.* Washington, DC: National Academy Press. 1996.

Derhammer F, Lucent V, Reed JF, Young MJ. Using a SANE interdisciplinary approach to care of sexual assault victims. *The Joint Commission of Quality Improvement,* 26(8):488–496, 2000.

Epstein, Joel, and Stacia Langenbahn. *The Criminal Justice and Community Response to Rape.* Washington, DC: U.S. Department of Justice, National Institute of Justice. May 1994.

Frisch, Lisa A. Research that succeeds, policies that fail. *The Journal of Criminal Law and Criminology*, 83(1), Spring 1992.

Frost, Floyd J., Joan I. Sandvig, Kristine Tollestrup, Muree Larson, Hans V Petersen, Cameron S. Crandall, Barbara L. Rader, and David P. Sklar. Healthcare Charges Attributable to Intimate Partner Violence in a New Mexico HMO. Submitted *American Journal of Preventive Medicine*, June 1998.

Fullerton, Lynne, Lenora M. Olson, Cameron S. Crandall, and David P. Sklar. Occupational-related Mortality in New Mexico, 1980–1991. *Annals of Emergency Medicine*, 26 (4):447–454, 1995.

Fullerton, Lynne, Lenora M. Olson, Cameron S. Crandall, M. Jack Lee, and David P. Sklar. Relationship between Ambulance Transports for Alcohol Intoxication and Assault. *Academic Emergency Medicine,* 5(4):325–329, 1998.

Fullerton, Lynne, M. Jack Lee, Lenora M. Olson, and David P. Sklar. 20th Century Alchemists: Generating Research Data from a Billing Database. *Proceedings: 25th Public Health Conference on Records and Statistics*. Washington, DC: U.S. Dept of Health & Human Services, 1995; p.267–272.

Gary-Eurom K, Seaberg DC, Wears RL. The prosecution of sexual asasult cases; correlation with forensic evidence. *Annals of Emergency Medicine*, 39(1):39–46, 2002.

Hargarten, Steve, Lenora M. Olson, and David P. Sklar. Emergency Medicine and Injury Control Research: Past, Present and Future. *Academic Emergency Medicine*, 4:243–244, 1997.

Hofford and A. Harrell. *Family Violence: Interventions for the Justice System*. Washington, DC: U.S. Department of Justice, Bureau of Justice Assistance. 1993.

Kilpatrick, Dean G., Christine N. Edmunds, and Anne K. Seymour. *Rape in America: A Report to the Nation*. Arlington, VA: National Victim Center. April 1992.

Koss, M. P. Violence Against Women: A Research Agenda. *American Psychologist*, 45:374–380, 1990.

Ledray, Linda E. and Kathy Simmelink. Efficacy of SANE Evidence Collection: A Minnesota Study. *Journal of Emergency Nursing*, 23(1):75–77, 1997.

McGregor MJ, Du Mont J, Myhr TL. Sexual assault forensic medical examination : is evidence related to successful prosecution ? *Annals of Emergency Medicine*, 39:639–647, 2002.

Olson, Lenora M., Carolyn Anctil, Lynne Fullerton, Judith Brillman, Justin Arbuckle, and David P. Sklar. Increasing Emergency Physicians' Recognition of Domestic Violence. *Annals of Emergency Medicine*, 27:741–746, 1996.

Rosenberg, Mark L. and Mary Ann Fenley. *Violence in America: A Public Health Approach*. New York: Oxford University Press. 1991.

Tollestrup, Kristine, David P. Sklar, Floyd J. Frost, Lenora M. Olson, JoElla Weybright, Joan I. Sandvig, and Muree Larson. Verbal and Physical Aggression by Intimate Partners of Women who are Members of a Health Maintenance Organization. Submitted, *American Journal of Public Health*, June 1998.

U.S. Department of Justice, Federal Bureau of Investigation. *Crime in the United States, 1996*. Washington, DC: U.S. Government Printing Office. 1997.

Zorza, Joan. Must We Stop Arresting Batterers? Analysis and Policy Implications of New Police Domestic Violence Studies. New England Law Review, 28(929), Summer 1994.

Appendices

Appendix A. Victim telephone survey contact protocols and survey instrument.

Appendix B. Qualitative data collection instruments.

List of Exhibits

Exhibit 1. Flow diagram of acute sexual assault services in Albuquerque at University of New Mexico Health Sciences Center (pre-SANE) or at the Albuquerque SANE Collaborative (post-SANE).

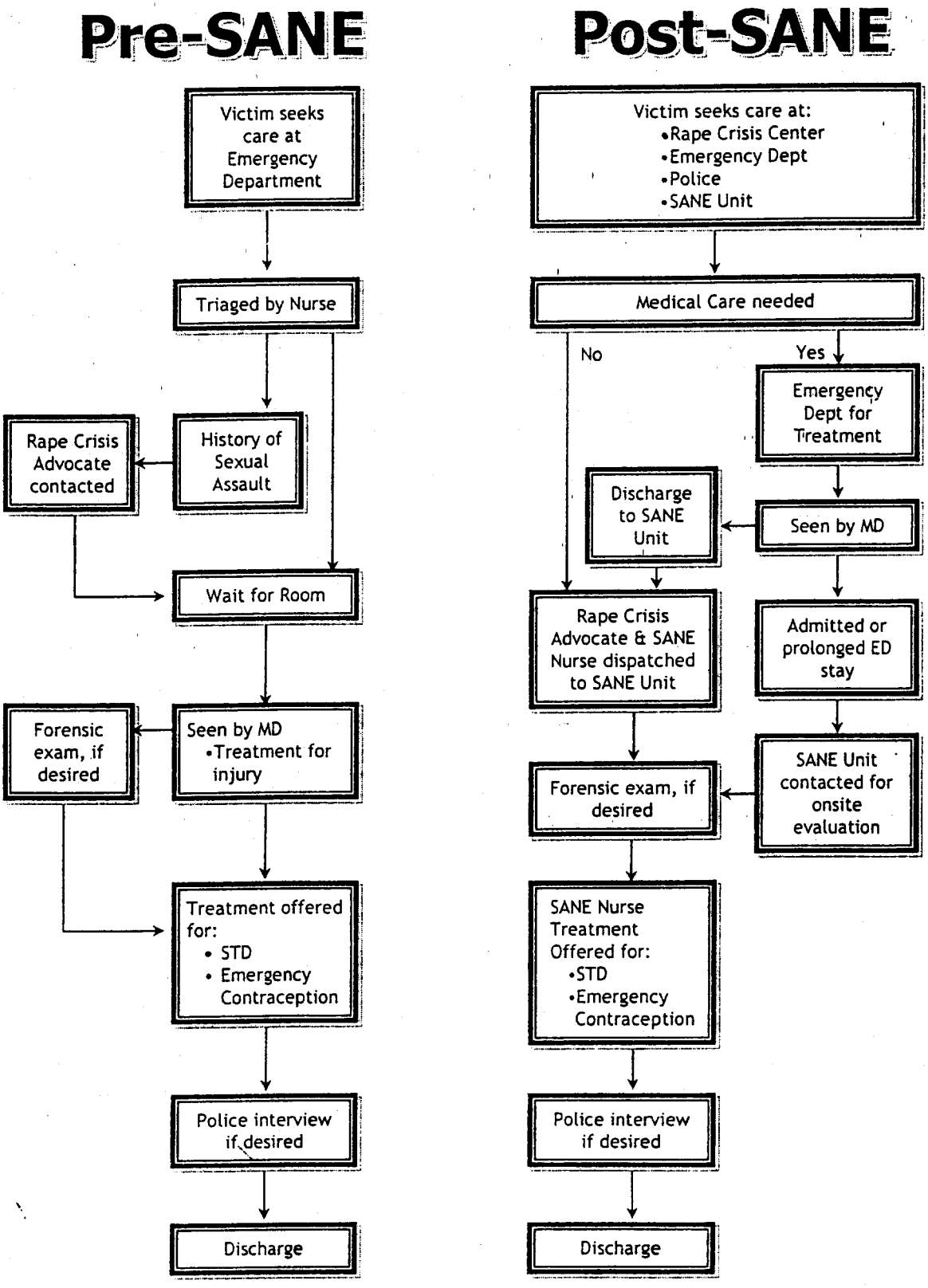


Exhibit 2. Matrix of evaluation questions, criteria, and data collection tools. Principal evaluation questions are numbered; criteria provided by stakeholders are in italics. Check marks indicate evaluation data source.

Questions	Data Collection Sources & Tools										
	Victim phone survey	Victim focus group	Advocate focus group	Victim services interview	Law Enforcement SA records	Law Enforcement Stakeholder Interviews	Court record review	Prosecution Stakeholder Interviews	Medical record review	Healthcare Stakeholder Interviews	SANE records
A. SANE's Mission and Goals											
1. Change community response				✓		✓				✓	
2. Increase coordination of services			✓	✓		✓		✓	✓	✓	
3. Decrease the trauma of the forensic exam for victims	✓	✓									
4. Decrease waiting time for victims *Change in length of time of exam* *Show up–d/c time* *Forensic exam* *Waiting to be seen by provider* *After exam to d/c*	✓								✓	✓	✓
5. Increase proportion of victims who consent to forensic exam *Is there a change in the % of forensic exams done?*	✓								✓		✓
6. improve quality of evidence *Change in the quality of evidence collected (including photos)* *Admissible* *Proves what you want proved* *Visualizes what you want to show* *Variety of evidence* *Chain of custody of evidence has been maintained* *Method by which evidence is collected is of highest standard* *Document evidence from collection to courtroom* *No question about the "real evidence"* *Evidence is not attacked in court* *High quality of preservation of evidence* *High quality evidence preservation—refrigerated, tagged, sealed, not allowed to mold* *Change in the process of collecting evidence (If so, what is the effect of that change on pleas, prosecution, etc.)*						✓		✓	✓		✓
7. Improve quality of expert testimony *Change in effectiveness of expert witness* *Defense attorney stipulates to nurse testimony* *No need for further action* *No questions by judge* *DA confidence in nurse testimony, ability* *Good witness, knowledgeable & confident* *Jury believes nurse, understands her, no attack from defense*								✓			
8. Increase conviction/plea offer rates							✓	✓			

Abbreviations: ED: emergency department, SA: Sexual Assault, SANE: Sexual assault nurse examiner, DA: District attorney

(Exhibit 2 Matrix continued)

Questions	Data Collection Sources & Tools										
	Victim phone survey	Victim focus group	Advocate focus group	Victim services interview	Law Enforcement SA records	Law Enforcement Stakeholder Interviews	Court record review	Prosecution Stakeholder Interviews	Medical record review	Healthcare Stakeholder Interviews	SANE records
B. Victim Satisfaction											
1. Change in the level of victim satisfaction in services? *Pre-exam interviews* *Exam by medical provider* *Advocacy/support* *Police* *Prosecution*	✓	✓	✓								
2. Change in atmosphere, degree of privacy, level of confidentiality due to the environment?	✓		✓			✓		✓		✓	
3. Change in (quality of, depth of, clarity of) explanation of purpose & procedures *Ability to refuse any services* *Victim perception of control* *Storage & disposal of evidence* *Consent*	✓									✓	
4. Change in access and utilization (are there cultural difference)		✓	✓	✓		✓			✓	✓	✓
5. Change in the way information is given to victims regarding reporting and prosecution? If so, how has it changed?		✓	✓								
6. Change in the pressure exerted on the victim to prosecute and/or testify?	✓	✓						✓			
7. Change in victim's perceptions toward law enforcement attitude (respect of victims, choice to prosecute or not)	✓	✓									
C. Recovery											
1. Change in length of time until victim returns to basic functioning (work, social, family)?		✓									
2. Change in the proportion of clients who have been seen for previous SAs?									✓		✓
3. Is there a change in re-victimization for victim (law enforcement & prosecution process)?	✓	✓									
D. Referrals											
1. Change in the proportion of referrals made (by medical provider)?	✓								✓		✓
2. Change in the comprehensiveness of referrals (scope of referrals from physical to emotional needs, alternative resources, etc.)?	✓								✓		✓
3. Change in victim's follow-through on referrals?	✓										
E. Quality of Service Delivery											
1. Change in quality of each aspect of service delivery (change in response)? *Police response* *Advocacy services* *Emotional support* *Collection of forensic evidence* *Legal advocacy by sex crimes detectives* *% of charges by DA's office*	✓			✓		✓	✓	✓		✓	

Abbreviations: ED: emergency department, SA: Sexual Assault, SANE: Sexual assault nurse examiner, DA: District attorney

(Exhibit 2 Matrix continued)

Questions	Data Collection Sources & Tools										
	Victim phone survey	Victim focus group	Advocate focus group	Victim services interview	Law Enforcement SA records	Law Enforcement Stakeholder Interviews	Court record review	Prosecution Stakeholder Interviews	Medical record review	Healthcare Stakeholder Interviews	SANE records
F. Prosecution											
1. Change in the number of prosecutions?							✓	✓			
2. Change in victim cooperation with prosecution? *Willingness to go forward with prosecution to testify*	✓						✓	✓			
3. Change in the number of pleas?							✓	✓			
4. Change in conviction rates?							✓	✓			
5. Change in the seriousness of charges filed?						✓	✓	✓			
6. Change in the quality of the prosecutors' work? *Time efficient* *Paperwork streamlined* *Only have to do something once* *Cooperative witness* *Confidence in evidence* *Successful prosecution*								✓			
G. Law Enforcement											
1. Change in ability of law enforcement and prosecution to identify and prosecute suspects?						✓	✓	✓			
2. Change in law enforcement's job? *Privacy and security for interview* *Accessibility of phones, supplies, equip.* *Victim attitude/preparedness to give statement* *Evidence collection procedure* *Quality and consistency of information* *Convenience* *Efficiency (less time)* *Attitude of nurse/rape crisis advocate regarding law enforcement* *Comfort in "female" atmosphere*						✓					
3. In what ways has SANE changed the quality of law enforcement work life? *Time efficient* *Paperwork streamlined* *Only have to do something once* *Cooperative witness* *Confidence in evidence* *Successful prosecution*						✓					
4. Change in the amount of time that law enforcement spends at the hospital?						✓					
5. Change in the types of offenders prosecuted?						✓	✓	✓			
6. Change in the number of false reports involving SA?						✓	✓				

Abbreviations: ED: emergency department, SA: Sexual Assault, SANE: Sexual assault nurse examiner, DA: District attorney

(Exhibit 2 Matrix continued)

Questions	Data Collection Sources & Tools										
	Victim phone survey	Victim focus group	Advocate focus group	Victim services interview	Law Enforcement SA records	Law Enforcement Stakeholder Interviews	Court record review	Prosecution Stakeholder Interviews	Medical record review	Healthcare Stakeholder Interviews	SANE records
H. Forensic Exam/Evidence/Documentation											
1. Change in the physical discomfort of the exam for victims?	✓	✓									
2. Change in provider attitudes toward exam?										✓	
3. Change in the amount of evidence lost due to procedure (chain of evidence)?						✓	✓	✓	✓		✓
4. Change in effectiveness of written medical documentation? *Is it used and understood by all* *Understood by all* *If it adds to closed case* *Corroborates other testimony (not conflicting)* *Does not include info that could damage case: prior sexual history, prior psychologivcal history, opinions about the character of the victim*								✓			
5. Difference between medical provider's notes (MD vs. SANE) with regard to notations that may call into question victim believability?								✓	✓		✓
6. Increase in DNA testing, colposcopy exam, photos?									✓		✓
7. Change in the percent of cases that use forensic evidence for trial?							✓	✓			
8. Change in the effectiveness of oral history taking? *Accurate and believable?*								✓			
I. Testimony/Expert Witness											
1. Difference in jury credibility between MD and nurse?								✓			
J. Collaboration											
1. Change in the quality of working relationships between all collaborative agencies *Respect between different parties/genders* *Good communication—memos, meetings, speaking face-to-face* *Written communication summarizes understandings* *Collaborators/players know one another, able to identify people* *Being on the same page about what the mission of SANE is* *Understanding of philosophical differ- ences between different service areas* *Level of trust/confidence among service orgs*				✓		✓		✓		✓	
2. Change in attitude of law enforcement toward medical facility?						✓					
3. Change in the types and numbers of law enforcement agencies that use SANE vs. EDs?						✓			✓		✓

Abbreviations: ED: emergency department, SA: Sexual Assault, SANE: Sexual assault nurse examiner, DA: District attorney

(Exhibit 2 Matrix continued)

Questions	Data Collection Sources & Tools										
	Victim phone survey	Victim focus group	Advocate focus group	Victim services interview	Law Enforcement SA records	Law Enforcement Stakeholder Interviews	Court record review	Prosecution Stakeholder Interviews	Medical record review	Healthcare Stakeholder Interviews	SANE records
K. Training											
1. Changes in the training process of law enforcement, rape crisis, medical professionals or prosecutors regarding sexual assault, issues of cultural diversity and disabilities, and dealing with the emotional issues of victims?				✓		✓		✓		✓	
L. Provider Attitudes/Characteristics											
1. Change in provider attitudes/treatment toward victims? *Medical, Advocate, Law enforcement. Prosecution, Other support services What would you attribute this change to (from providers'perspective)?*	✓		✓							✓	
2. Difference for victims in being treated by MDs vs. nurses?	✓		✓								
M. Outreach/Community awareness											
1. Change in level of community awareness regarding sexual assault services?				✓		✓				✓	
N. Healthcare											
1. Change in the demands on the medical community, specifically EDs?										✓	
2. In what way has SANE changed the quality of work lives of medical providers"?										✓	
3. Change in medical treatment for injuries?	✓										
O. Demographics											
1. Are there established procedures which standardize treatment (EDs vs. SANE)?										✓	
2. Change in the demographics of women who are seen either in the ED or at SANE for sexual assault *Age, Ethnicity, Geographic area, Victim/suspect relationship*									✓		✓
3. How many women lost to excessive wait in ED—leave before they are seen in ED for SA?									✓		✓
4. Change in the number of victims who report?	✓				✓				✓		✓

Abbreviations: ED: emergency department, SA: Sexual Assault, SANE: Sexual assault nurse examiner, DA: District attorney

Exhibit 3. Sample sizes for healthcare, law enforcement, prosecution and court data sources, by pre- and post-SANE periods, Bernalillo County, NM, 1994–1999.

Unit of observation	Pre-SANE N	Post-SANE N	Comment
Healthcare			
Medical records	242	715	Pre-SANE are UNMHSC medical records, Post-SANE are SANE records
Law Enforcement			
Police Suspects	384	1,046	Data from Albuquerque Police Department and Bernalillo County Sheriff's Department
Police Charges	673	2,218	
Prosecution			
Prosecution suspects	291	412	Data from the Second Judicial District Attorney's Office for Bernalillo County, NM
Prosecution charges	2,304	3,981	
Court			
Court Cases	194	273	Data from the Second Judicial District Court for Bernalillo County, NM
Court Defendants	194	275	
Initial Charges	707	1,542	
Final Charges	271	960	
Total Charges	978	2,502	
Suspect Sentenced	114	208	

Exhibit 4. Demographic characteristics of sexual assault victims. Data are from medical and law enforcement records, by pre- and post-SANE periods, Bernalillo County, NM, 1994–1999.

	Pre-SANE Medical		Post-SANE Medical		Pre-SANE Police		Post-SANE Police	
	N	(%)	N	(%)	N	(%)	N	(%)
Victim Characteristics								
Age group (in years)								
18 - 25	98	(43.2)	321	(44.9)	82	(44.3)	204	(46.3)
26 - 35	68	(30.0)	219	(30.6)	56	(30.3)	136	(30.8)
36 - 45	45	(19.8)	134	(18.7)	35	(18.9)	94	(21.3)
46 - 65	16	(7.0)	26	(3.6)	9	(4.9)	6	(1.4)
66 and older	0	(0.0)	12	(1.7)	3	(1.6)	1	(0.2)
Missing	15	(26.9)	3	(0.4)	0	(0.0)	198	(23.7)
Victim Ethnicity								
Anglo/Caucasian	25	(29.4)	302	(42.7)	93	(50.3)	224	(48.2)
Hispanic	22	(25.9)	285	(40.3)	70	(37.8)	169	(36.3)
American Indian	6	(7.1)	72	(10.2)	14	(7.6)	35	(7.5)
African American	4	(4.7)	24	(3.4)	3	(1.6)	21	(4.5)
Other	1	(1.2)	5	(.7)	1	(0.5)	3	(0.6)
Unknown	27	(31.8)	20	(2.8)	4	(2.2)	13	(2.8)
Missing	157	(64.9)	7	(1.0)	0	(0.0)	0	(0.0)
City of Residence								
Albuquerque	142	(93.4)	572	(82.4)	169	(88.0)	430	(91.5)
Other	14	(9.2)	60	(8.6)	16	(8.3)	30	(6.4)
Los Lunas	7	(4.6)	23	(3.3)	1	(0.5)	5	(1.1)
Belen	2	(1.3)	16	(2.3)	2	(1.0)	2	(0.4)
Rio Rancho	0	(0.0)	16	(2.3)	3	(1.6)	2	(0.4)
Bernalillo	2	(1.3)	7	(1.0)	1	(0.5)	1	(0.2)
Victim - Perpetrator Relationship								
Acquaintance	67	(33.0)	264	(37.3)	87	(40.5)	318	(50.1)
Stranger	57	(28.1)	234	(33.1)	9	(4.2)	31	(4.9)
Unknown	44	(21.7)	85	(12.0)	30	(14.0)	48	(7.6)
Spouse/Significant Other	12	(5.9)	78	(11.0)	2	(0.9)	8	(1.3)
Family Member	23	(11.3)	17	(2.4)	87	(40.5)	230	(36.2)
Date	0	(0.0)	29	(4.1)	0	(0.0)	0	(0.0)
Missing	39	(16.1)	8	(1.1)	0	(0.0)	4	(0.6)
Mode of Arrival to Medical Facility								
Ambulatory	101	(50.5)	620	(90.1)	-		-	
Ambulance	72	(36.0)	62	(9.0)	-		-	
Unknown	25	(12.5)	3	(0.4)	-		-	
Other	2	(1.0)	3	(0.4)	-		-	
Missing	42	(17.4)	27	(3.8)	-		-	
Who Victim Arrived With								
Law Enforcement	39	(18.9)	198	(29.8)	-		-	
Significant Other	12	(5.8)	181	(27.3)	-		-	
Self	54	(26.2)	170	(25.6)	-		-	
EMS	31	(15.0)	66	(9.9)	-		-	
Friend	19	(9.2)	20	(3.0)	-		-	
Family	7	(3.4)	24	(3.6)	-		-	
Other	0	(0.0)	5	(.8)	-		-	
Not documented	44	(21.4)	0	(.0)	-		-	

Exhibit 5. Assault characteristics for sexual assaults from medical and police data, by pre- and post-SANE periods, Bernalillo County, NM, 1994–1999.

	Pre-SANE Medical		Post-SANE Medical		Pre-SANE Police		Post-SANE Police	
	N	(%)	N	(%)	N	(%)	N	(%)
Assault Characteristics								
Location of Assault								
Other	61	(28.5)	192	(27.1)	-		-	
Victim's Home	34	(15.9)	184	(26.0)	-		-	
Unknown	77	(36.0)	98	(13.8)	-		-	
Perpetrator's Home	37	(17.3)	131	(18.5)	-		-	
Vehicle/Park/Street	5	(2.3)	101	(14.2)	-		-	
Other	0	(0.0)	3	(0.4)	-		-	
DV Related Assault								
No	-		526	(74.3)	95	(67.9)	53	(41.4)
Yes	-		93	(13.1)	45	(32.1)	75	(58.6)
Unknown	-		89	(12.6)	0	(0.0)	0	(0.0)
Day of Assault								
Sunday	19	(9.4)	135	(19.1)	-		-	
Saturday	31	(15.3)	130	(18.4)	-		-	
Wednesday	14	(6.9)	95	(13.4)	-		-	
Thursday	15	(7.4)	89	(12.6)	-		-	
Monday	18	(8.9)	84	(11.9)	-		-	
Friday	18	(8.9)	76	(10.7)	-		-	
Tuesday	16	(7.9)	69	(9.7)	-		-	
Unknown	71	(35.1)	30	(4.2)	-		-	
Time of Assault								
12 AM to 4 AM	98	(56.6)	253	(39.4)	-		-	
8 PM to 12 AM	26	(15.0)	140	(21.8)	-		-	
4 AM to 8 AM	14	(8.1)	71	(11.1)	-		-	
4 PM to 8 PM	9	(5.2)	69	(10.7)	-		-	
12 PM to 4 PM	11	(6.4)	61	(9.5)	-		-	
8 AM to 12 PM	15	(8.7)	48	(7.5)	-		-	
Weapons								
None - Hands, Feet, etc.	-		454	(64.0)	167	(90.8)	369	(92.9)
Unknown	-		130	(18.3)	0	(0.0)	0	(0.0)
Cutting Instrument	-		53	(7.5)	12	(6.5)	13	(3.3)
Gun	-		56	(7.9)	3	(1.6)	7	(1.8)
Blunt Instrument	-		7	(1.0)	2	(1.1)	2	(0.5)
Other	-		9	(1.3)	0	(0.0)	6	(1.5)

Exhibit 6. Medical and forensic services documented as provided by pre- and post-SANE groups, UNMHSC and the Albuquerque SANE Collaborative, 1994–1999.

	Pre-SANE		Post-SANE	
	N	(%)	N	(%)
Medical Services				
Pregnancy Test				
Yes	160	(77.3)	557	(80.6)
No	28	(13.5)	42	(6.1)
Declined	14	(6.8)	37	(5.4)
Not applicable	5	(2.4)	55	(8.0)
Not documented	35	(14.5)	24	(3.4)
Pregnancy Prophylaxis				
Yes	109	(60.9)	575	(83.7)
No	41	(22.9)	42	(6.1)
Declined	15	(8.4)	43	(6.3)
Not applicable	14	(7.8)	27	(3.9)
Not documented	63	(26.0)	28	(3.9)
STD Treatment				
Yes	146	(60.3)	586	(85.8)
No	18	(7.4)	33	(4.8)
Not applicable	17	(7.0)	64	(9.4)
Not documented	61	(25.2)	32	(4.5)
Referral to Rape Crisis Documented	99	(40.9)	544	(76.1)
Referral to Social Services Documented	31	(12.8)	342	(47.8)
Referral to STD Clinic Documented	22	(9.1)	105	(14.7)
Forensic Services				
Assault Reported to Police				
Yes	115	(47.5)	470	(66.6)
No	22	(9.1)	180	(25.5)
Not documented	105	(43.4)	56	(7.9)
Forensic Exam				
Yes	49	(21.4)	684	(97.2)
No	19	(8.3)	20	(2.8)
Not documented	174	(76.0)	11	(1.6)
Evidence Collected				
Yes	39	(47.0)	673	(98.0)
No	44	(53.0)	14	(2.0)
Not documented	159	(65.7)	28	(3.9)
Colposcope Used				
Yes	20	(8.3)	626	(87.6)
No	22	(9.1)	80	(11.2)
Not documented	200	(82.6)	9	(1.3)

Exhibit 7. Flow diagram of acute sexual assault services in Albuquerque at University of New Mexico Health Sciences Center (pre-SANE) or at the Albuquerque SANE Collaborative (post-SANE), with time interval descriptions and mean times (in minutes) observed, 1994–1999.

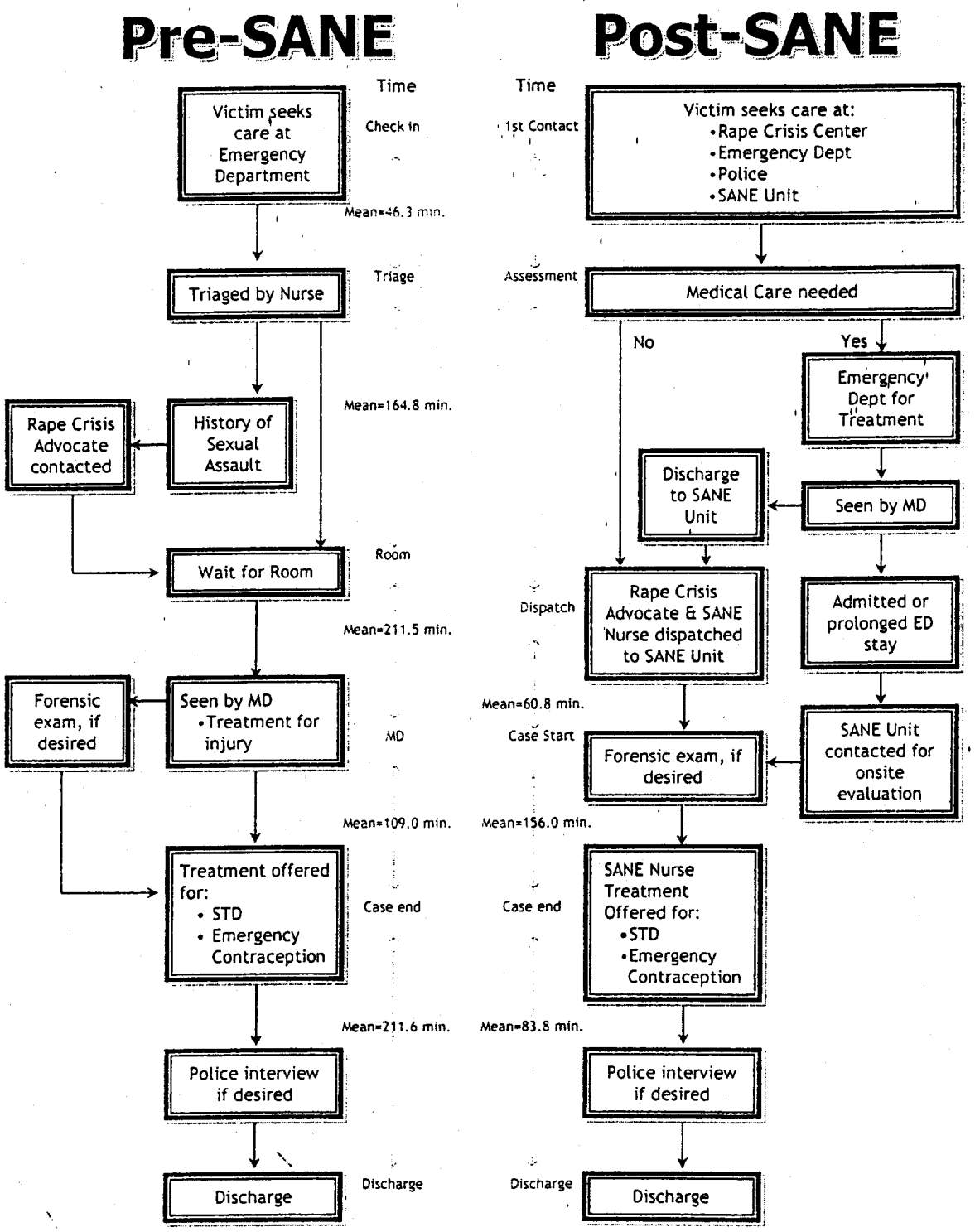


Exhibit 8. Comparable time intervals experienced by sexual assault victims pre- and post-SANE, 1994–1999.

		Time Intervals (in minutes)				
Pre/Post	**Time interval**	**N**	**Median**	**Mean**	**SD**	**p value**
Pre	Check in time to MD Time	117	118	139.5	97.8	<.0001
Post	Dispatch to Case Start	650	38	60.8	120.4	
Pre	MD to Case Completion	96	90	107.3	107.2	<.0001
Post	Case Start to Case Completion	630	137	156.0	101.6	
Pre	Case Completion to Discharge	86	5	226.3	511.1	<.0001
Post	Completion to Discharge	596	60	83.8	118.9	

Exhibit 9. Suspect characteristics and sexual assault case characteristics, by pre- and post-SANE periods, law enforcement, prosecution, and court data. Bernalillo County, New Mexico, 1994–1999.

	Pre-SANE Police		Post-SANE Police		Pre-SANE Prosecution		Post-SANE Prosecution		Pre-SANE Court		Post-SANE Court	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Suspect Characteristics												
Male	338	(90.4)	927	(88.6)	—		—		—		—	
Age group (in years)												
18 - 25	88	(24.1)	184	(17.8)	39	(23.5)	89	(33.1)	25	(23.1)	52	(17.7)
26 - 35	111	(30.4)	372	(35.9)	101	(60.8)	97	(36.1)	27	(25.0)	103	(35.0)
36 - 45	96	(26.3)	251	(24.2)	6	(3.6)	48	(17.8)	32	(29.6)	71	(24.1)
46 - 65	61	(16.7)	218	(21.0)	19	(11.4)	32	(11.9)	17	(15.7)	60	(20.4)
66 and older	9	(2.5)	11	(1.1)	1	(0.6)	3	(1.1)	7	(6.5)	8	(2.7)
Missing	19	(4.9)	10	(1.0)	27	(14.0)	22	(7.6)	10	(8.5)	34	(10.4)
Perpetrator Ethnicity												
Anglo/Caucasian	165	(43.0)	404	(38.6)	39	(23.2)	59	(43.7)	—		—	
Hispanic	128	(33.3)	407	(38.9)	101	(60.1)	38	(28.1)	—		—	
American Indian	61	(15.9)	123	(11.8)	7	(4.2)	15	(11.1)	—		—	
African American	25	(6.5)	83	(7.9)	19	(11.3)	21	(15.6)	—		—	
Oriental	5	(0.8)	29	(2.8)	2	(1.2)	1	(0.7)	—		—	
Other	—		—		—		1	(0.7)	—		—	
Unknown	—		—		25	(13.0)	156	(53.6)	—		—	
Domestic Violence Related												
Yes	114	(30.1)	213	(44.9)	89	(46.1)	125	(43.0)	—		—	
No	265	(69.9)	261	(55.1)	104	(53.9)	166	(57.0)	—		—	
Missing	5	(1.3)	572	(150.9)								
Alcohol Related												
Yes	120	(82.8)	—		72	(37.3)	96	(33.0)	—		—	
No	25	(17.2)	—		121	(62.7)	195	(67.0)	—		—	
Missing	239	(62.2)	—									
Drug Related												
Yes	20	(14.6)	123	(36.8)	37	(19.2)	65	(22.3)	—		—	
No	117	(85.4)	111	(33.2)	156	(80.8)	226	(77.7)	—		—	
Missing	247	(64.3)	830	(78.0)								
Habitual Offender												
Yes	—		—		3	(1.6)	7	(2.4)	—		—	
No	—		—		190	(98.4)	284	(97.6)	—		—	

Exhibit 10. Charges and cases moved forward to grand jury and district court, by pre- and post-SANE periods, Second Judicial District Court, Bernalillo County, NM, 1994–1999.

	Pre-SANE		Post-SANE		p value
	N	(%)	N	(%)	
Total number of initial charges	2,304		3,483		
Total number of cases					
Charge level					
Charges presented to Grand Jury	1,501	(65.2)	2,461	(70.3)	<0.0001
Charges filed in District Court	1,501	(65.2)	2,448	(70.7)	<0.0001
Case level					
Cases presented to Grand Jury	58	(37.7)	149	(49.5)	0.0164
Cases filed in District Court	58	(37.7)	149	(49.5)	0.0164

Exhibit 11. Number of charges assigned per defendant, pre- and post-SANE, Second Judicial District Court, Bernalillo County, NM, 1994–1999.

	Charges Assigned per Case					p value
Period	**N**	**Mean**	**SD**	**Min**	**Max**	
Pre-SANE	194	5.4	4.1	1	17	<.0001
Post-SANE	273	7.0	7.3	1	44	

Exhibit 12. Percentage of convictions resulting from grand jury indictment, by charge type, pre- and post-SANE, Second Judicial District Court records, Bernalillo County, NM, 1994–1999.

	Pre-SANE		Post-SANE		p value
Charge Type	**N convicted / N charges**	**%**	**N convicted / N charges**	**%**	
Criminal Sexual Penetration	211 / 360	58.6	541 / 781	69.3	0.0010
Criminal Sexual Contact	109 / 213	51.2	440 / 714	61.6	0.0082
Child Abuse	66 / 120	55.0	169 / 217	77.9	<0.0001
Kidnapping	32 / 60	53.3	100 / 202	49.5	0.7086
Assault	16 / 48	33.3	77 / 159	48.4	0.0935
Interfering with investigation	30 / 54	55.6	54 / 100	54.0	0.9877
Attempted felony	31 / 39	79.5	36 / 47	76.6	0.9516
Burglary/Property Damage	8 / 15	53.3	27 / 55	49.1	1.0000
Drug/Alcohol Abuse	5 / 10	50.0	12 / 23	52.2	1.0000
Firearm Posession/Enhancment	1 / 4	25.0	3 / 16	18.8	1.0000
Criminal Sexual Solicitation	17 / 34	50.0	59 / 75	78.6	0.0052
Violation of Protective order	2 / 2	100.0	2 / 8	25.0	0.1330
Habitual Offender	1 / 1	100.0	6 / 6	100.0	—
Motor Vehicle Violation	4 / 7	57.1	2 / 4	50.0	1.0000

Exhibit 13. Charge outcome by highest applicable initial charge filed pre- and post-SANE. Bernalillo County, NM, 1994–1999.

	Pre-SANE		Post-SANE	
	N	(%)	N	(%)
Total CSP Charges	360		781	
Charge Outcome				
Convicted	211	(58.6)	541	(69.3)
Guilty Plea	193	(90.6)	524	(96.9)
Same degree CSP	*157*	*(80.5)*	*455*	*(86.8)*
Lesser degree CSP	*35*	*(17.9)*	*67*	*(12.8)*
Other Felony	*1*	*(0.5)*	*2*	*(0.4)*
Jury trial	18	(8.5)	17	(3.2)
Same degree CSP	*16*	*(88.9)*	*16*	*(94.1)*
Lesser degree CSP	*2*	*(11.1)*	*1*	*(5.9)*
Other Felony	*0*	*(0.0)*	*0*	*(0.0)*
Nolle Prosequi	102	(28.3)	130	(16.6)
Dismissal	39	(10.8)	91	(11.7)
Acquittal	7	(1.9)	18	(2.3)
Other	1	(0.3)	1	(0.0)
Total CSC Charges	213		714	
Charge Outcome				
Convicted	109	(51.2)	440	(61.6)
Guilty Plea	95	(87.2)	401	(91.1)
Same degree CSC	*72*	*(75.8)*	*352*	*(87.8)*
Lesser degree CSC	*18*	*(18.9)*	*47*	*(11.7)*
Other Felony	*5*	*(5.3)*	*2*	*(0.5)*
Jury trial	14	(12.8)	39	(9.7)
Same degree CSC	*13*	*(92.9)*	*37*	*(94.9)*
Lesser degree CSC	*1*	*(7.1)*	*1*	*(2.6)*
Other Felony	*0*	*(0.0)*	*0*	*(0.0)*
Nolle Prosequi	73	(34.3)	171	(23.9)
Dismissal	23	(10.8)	80	(11.2)
Acquittal	8	(3.8)	12	(1.7)
Other	0	(0.0)	1	(0.1)

Abbreviations:
CSP: Criminal sexual penetration
CSC: Criminal sexual contact

Exhibit 14. Case outcome, by highest applicable charge per case, pre- and post-SANE, Bernalillo County, NM, 1994–1999.

	Pre-SANE		Post-SANE	
	N	(%)	N	(%)
Total Cases with Highest Case Charge: CSP	141		209	
Charge Outcome				
Convicted	70	(49.6)	111	(53.1)
Guilty Plea	61	(87.1)	99	(89.2)
Same degree CSP	*52*	*(85.2)*	*85*	*(85.9)*
Lesser degree CSP	*5*	*(8.2)*	*9*	*(9.1)*
Other Felony	*2*	*(3.3)*	*5*	*(5.1)*
Jury trial	9	(12.9)	12	(10.8)
Same degree CSP	*8*	*(88.9)*	*9*	*(75.0)*
Lesser degree CSP	*1*	*(11.1)*	*3*	*(25.0)*
Other Felony	*0*	*(0.0)*	*0*	*(0.0)*
Nolle Prosequi	37	(26.2)	54	(25.8)
Dismissal	29	(20.6)	39	(18.7)
Acquittal	4	(2.8)	5	(2.4)
Other	1	(0.7)	0	(0.0)
Total Cases with Highest Case Charge: CSC	88		148	
Charge Outcome				
Convicted	41	(46.6)	73	(49.3)
Guilty Plea	35	(85.4)	61	(83.6)
Same degree CSC	*26*	*(74.3)*	*48*	*(78.7)*
Lesser degree CSC	*7*	*(20.0)*	*10*	*(16.4)*
Other Felony	*2*	*(5.7)*	*3*	*(4.9)*
Jury trial	6	(14.6)	12	(19.7)
Same degree CSC	*4*	*(66.7)*	*7*	*(58.3)*
Lesser degree CSC	*2*	*(33.3)*	*4*	*(33.3)*
Other Felony	*0*	*(0.0)*	*1*	*(8.3)*
Nolle Prosequi	24	(27.3)	41	(27.7)
Dismissal	18	(20.5)	25	(16.9)
Acquittal	5	(5.7)	9	(6.1)
Other	0	(0.0)	0	(0.0)

Abbreviations:
CSP: Criminal sexual penetration
CSC: Criminal sexual contact

Exhibit 15. Average time from grand jury indictment to district case disposition, pre- and post-SANE, Bernalillo County, NM, 1994–1999.

Period	Time to case disposition (in days)*					
	N	Mean	SD	Min	Max	p value
Pre-SANE	118	469.7	219.6	4	1,167	<0.0001
Post-SANE	213	334.6	154.6	8	1,274	

*Average number of days between Grand Jury indictment and case disposition.

Exhibit 16. Sentencing outcome of sexual assault cases, pre- and post-SANE, Second Judicial District Court records, Bernalillo County, NM, 1994–2000.

	Pre-SANE		Post-SANE		p value
	N	(%)	N	(%)	
Total	194		274		
Incarceration Time					
Yes	89	(45.9)	151	(55.1)	0.0490
No	105	(54.1)	123	(44.9)	
Probation					
Yes	111	(57.2)	184	(66.9)	0.0324
No	83	(42.8)	91	(33.1)	
Community Service					
Yes	16	(8.2)	17	(6.2)	0.3890
No	178	(91.8)	258	(93.8)	

Exhibit 17. Sentence times imposed on convicted sexual assault offenders, pre- and post-SANE, Second Judicial District Court records, Bernalillo County, NM, 1994–2000.

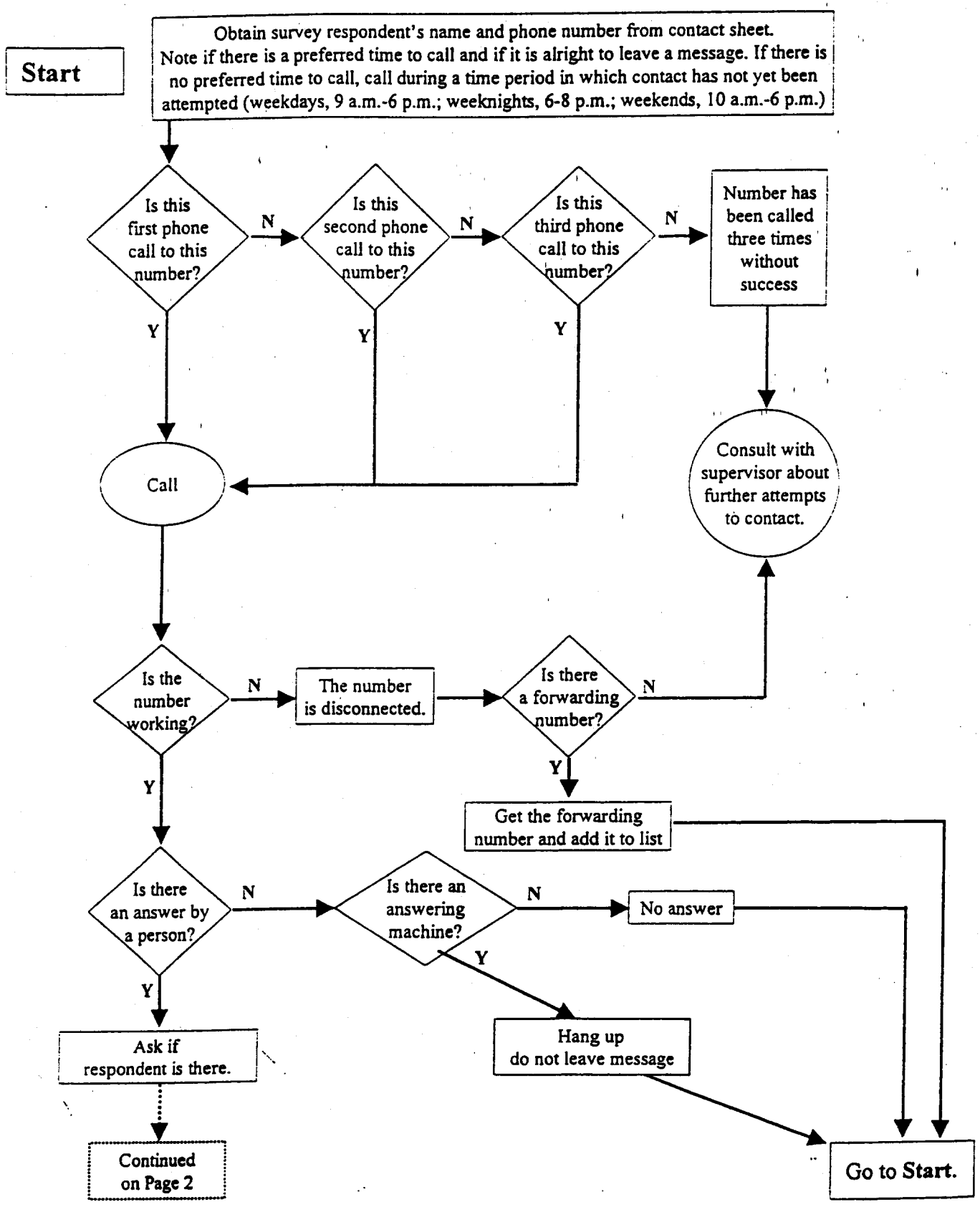
Period	Sentence	Sentence Time					p value
		N	Mean	SD	Min	Max	
Pre-SANE	Incarceration time (Years)	55	1.2	13.8	364 days	72.0	
Post-SANE	Incarceration time (Years)	78	5.1	22.1	364 days	164.0	<0.0001
Pre-SANE	Probation time (Years)	41	3.6	1.4	1.0	5.0	
Post-SANE	Probation time (Years)	39	4.0	2.5	364 days	16.9	<0.0001
Pre-SANE	Hours of community service	16	12.5	50.0	0.0	200.0	
Post-SANE	Hours of community service	2	75.0	35.4	50.0	100.0	0.2048

Exhibit 18. Sentence imposed on convicted sexual assault offenders for any charge and by CSP and CSC as highest sexual assault charge, pre- and post-SANE, Second Judicial District Court records, Bernalillo County, NM, 1994–1999.

Period	Sentence (in years, for all charges)	Sentence Time					p value
		N	Mean	SD	Min	Max	
Pre-SANE	Total Incarceration Time	55	1.2	13.8	0	72.0	<0.0001
Post-SANE	Total Incarceration Time	78	5.1	22.1	0	164.0	
Pre-SANE	CSP Incarceration Time	21	4.3	7.5	364 days	72.0	0.0925
Post-SANE	CSP Incarceration Time	30	8.5	18.4	364 days	164.0	
Pre-SANE	CSC Incarceration Time	34	1.1	17.5	0	17.0	0.1658
Post-SANE	CSC Incarceration Time	48	15.2	16.0	0	22.0	

Sentence time is adjusted for credited or deferred sentence time. Times reflect the sentence for all charges associated with the case.
For CSP and CSC breakdown, CSP was the highest sexual offense; CSC was the highest sexual offense.
CSP = Criminal sexual penetration
CSC = Criminal sexual contact

University of New Mexico Department of Emergency Medicine
Impact Evaluation of a SANE Unit in Albuquerque, New Mexico
Flowchart for Survivor Telephone Survey—Survey Contact



University of New Mexico Department of Emergency Medicine
Impact Evaluation of a SANE Unit in Albuquerque, New Mexico
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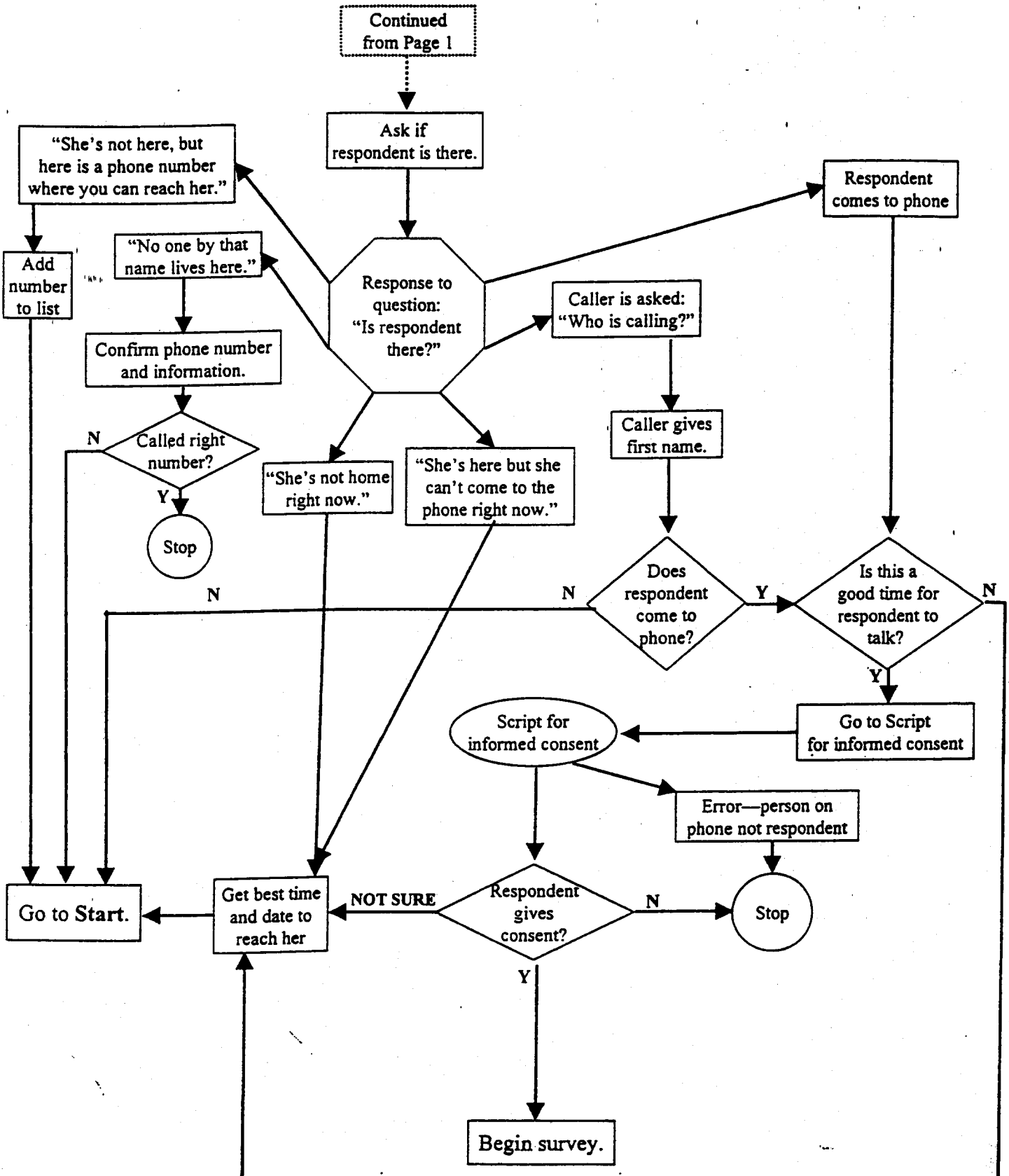

THE UNIVERSITY OF NEW MEXICO • HEALTH SCIENCES CENTER
SCHOOL OF MEDICINE

Department of Emergency Medicine
David P. Sklar, M.D., Chair
David Doezema, M.D., Vice-Chair

Name Date
Address
City, State, Zip

Dear Ms. _____:

The University of New Mexico Health Sciences Center and the Sexual Assault Nurse Examiner Collaborative (SANE) are working together to improve services for sexual assault treatment and prevention. This project, which is funded by the National Institute of Justice, will help us to understand what kinds of medical, legal, and support services are most beneficial. As part of this project, we are collecting information by telephone from female sexual assault survivors to find out which services were most helpful to them.

Your name was chosen from a list of women who were seen for sexual assault at University Hospital or the Albuquerque Sexual Assault Nurse Examiner (SANE) Collaborative. A woman from SANE called you and got your permission to have us contact you. We are confirming that you agreed to complete a short telephone interview. A woman interviewer from the University of New Mexico Center for Injury Prevention Research and Education will call you to conduct the interview, which will last approximately 20 minutes. If she calls at a time that is not good for you to talk, you may ask her to call back another time.

The interviewer will ask about your opinion of the healthcare and legal services you received. Your answers to the questions will be kept private. We will not report your name or any of your individual responses. Instead, we will combine your answers with those of the other participants for an overall report.

Your participation is totally voluntary. Your decision will not affect any future services you receive at University Hospital or the UNM Health Sciences Center. You may refuse to answer any of the questions in the survey, and you may end the survey at any time.

If you choose to participate you will receive a $10.00 gift certificate from Target to compensate you for your time.

You may not benefit directly from this research. We believe that this study will help us improve services for sexual assault survivors in the future. You may feel good about participating in a process that will help other sexual assault survivors. There may also be risks, however, to participating in this research. You may feel that you are re-experiencing the trauma by talking to the interviewer about your experiences with

HRRC 98-244

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the health care and legal system. We do not know how often people will benefit from participating in this telephone survey, or how often they may become distressed by it. If you find the interview process upsetting and would like to talk to someone, the Albuquerque Rape Crisis Center 24-hour hotline (266-7711) is available for support.

Only you can decide if you should participate in this study. If you have questions about it, please call me at (505) 272-5062. I will be happy to answer any of your questions. We thank you in advance for your assistance in completing this important survey. With your help, we hope to improve the services available for sexual assault treatment and prevention.

Sincerely,

Cameron Crandall, MD
UNM Center for Injury Prevention Research and Education

Hello, I'm _____ calling from the University of New Mexico. I would like to speak with (respondent).

(WHEN ON-LINE, REINTRODUCE.) I am with the UNM Health Sciences Center Department of Emergency Medicine. We are conducting a research study about ways to improve services for sexual assault survivors. I understand that you have already been contacted by _____ and that you may be interested in helping us by answering some questions about the care and services that you received. Is that right? Did you receive the letter from us explaining the study? *If "NO"*, ask: would you like me to send you one? If "YES", ask: What is your address? (Verify address on form). In a moment I will be giving you some numbers. Do you have a pen or pencil ready? This interview should take about 20 to 30 minutes. Is this a good time for me to talk to you?

IF SHE ANSWERS YES, CONTINUE.

IF SHE ANSWERS NO: Is there another time when it would be more convenient for us to talk? IF YES, RESCHEDULE INTERVIEW. IF NOT INTERESTED, THANK HER FOR HER TIME AND END CALL.

Let me remind you again about the purpose of this study and how it works. As part of this study, we are collecting information by telephone from women who were seen at (SELECT ONE):

- University Hospital
- the Albuquerque SANE Collaborative

As one of these women we want to know what made your experience easier, and what made it more difficult, so that we know how to improve services for sexual assault survivors.

The questions in this telephone survey will only ask for your opinions of the medical and legal services you received. If you choose to participate in the survey, your answers will be kept private. We will not report your name or any of your individual responses. Instead, the answers that we receive from all of the participants will be combined for an overall report.

You may not benefit directly from this research; however, you may feel good about participating in a process that will improve services for other sexual assault survivors. Only you can decide if you should participate. You may refuse to answer any of the questions in the survey, and you may end the survey at any time. There may also be risks to your participation. Even though we will not ask you to talk about the assault, you may feel you are re-experiencing the trauma by answering questions about your opinion of the health care and legal system. We do not know if people may benefit from participating in the telephone survey, or if they may become distressed by it.

If you feel distressed by the interview and you would like to talk to someone, the Albuquerque Rape Crisis Center hotline is available for support 24 hours a day at 266-7711. If you have any questions or concerns about the survey, you may contact the study's principal investigator, Dr. Cameron Crandall, through the University Hospital Emergency Department during office hours at 272-5062 or after hours at 272-2411. If you choose not to participate, we will respect your decision and will not attempt to contact you again. Your decision will not affect any future services you receive at University Hospital or the UNM Health Sciences Center. Your participation is totally voluntary. As is customary with surveys like this we offer $10. 00 for you time and help

Do you have any questions about the survey? ANSWER QUESTIONS. Would you like to participate in the survey?

IF YES, BEGIN INTERVIEW. IF NO, THANK HER FOR HER TIME

LIST OF CONTACT NAMES AND TELEPHONE NUMBERS
University of New Mexico SANE Impact Evaluation

Principal Investigator, Cameron Crandall, MD
Questions re: Patient confidentiality, protocol, study design and purpose
272-6521 (w), 272-5062 (w). 561-0478 (pager)

Co-Investigator, Deborah Helitzer, ScD
Questions re: protocol, study design and purpose
272-1601 (w)

Project Coordinator, Anne Worthington
Questions re: protocol, scheduling
272-1209 (w), (505) 984-2013 (h)

Research Coordinator, Jonathon LaValley
Questions re: data and forms
272-8670

Albuquerque Rape Crisis Center
Referral for survivors
266-7711

Commonly Asked Questions

1). How did you get my name?

Your name was chosen from a list of people served by SANE and the University of New Mexico Health Sciences Center.

2). I have never been assaulted. Why are you calling me?

Am I speaking to _____(name of patient) who was born in ____(year of birth on contact sheet)? (if she answers no) or (if she answers yes that is her name and birth year but she wasn't assaulted) **I'm sorry, we must have made a mistake.**

3). Who is Dr. Crandall?

The principal investigator on this project.

5). Why is the University of New Mexico doing this?

To evaluate sexual assault services for women and find out if services need to be improved. SANE is not doing the project because we want an independent evaluation.

6.) When will the confidential data be destroyed?

At the end of the study. The study should be finished the beginning of next year.

7). How many questions are on the survey?

The number of questions depends on individual responses. However, the survey takes about 15 to 20 minutes.

8). When will this project be finished?

The beginning of next year.

9). Can you fax or email me the letter?

Yes. Can I have your fax or e-mail address?

10). How do you get to the Emergency Department?

The letter will be available at the administrative office of the Emergency Department which is open 9 to 5 Monday through Friday. You need to call first at 272-5062 to get directions.

Interviewer_____ start time _____ end time _____ Study ID#_____

An Impact Evaluation of a SANE Unit in Albuquerque, New Mexico
UNM Center for Injury Prevention Research and Education
Sexual Assault Survivor Telephone Survey

1. I'm going to ask you a series of questions to find out what—in your opinion—would make an **ideal** service for women who have been sexually assaulted. I'll ask you about medical, law enforcement, and legal services. Before we talk about your own experience, I would like you to imagine what would make up an ideal service for survivors. If you could create an ideal **medical** service, how would you rate the importance of the following factors on a scale from 1 to 5, with 1 being "very unimportant", 2 being "somewhat unimportant", 3 being "neutral", 4 being "somewhat important" and 5 being "very important."

	1 VERY UNIMPORTANT	2 SOMEWHAT UNIMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY IMPORTANT	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
a. The patient is seen by a medical provider in a reasonable amount of time.								
b. The patient receives any medical treatment that is necessary due to the assault.								
c. The patient feels safe in the medical facility.								
d. The medical provider is understanding.								
e. The medical provider is competent.								
f. The patient feels comfortable talking about the incident to the medical provider.								
g. The information the patient provides to the medical provider is kept confidential.								
h. The patient's privacy is respected.								
i. The physical environment of the medical facility is soothing.								

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Interviewer_____ Study ID#_____

	1 VERY UNIMPORTANT	2 SOMEWHAT UNIMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY IMPORTANT	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
j. The patient is made as physically comfortable as possible during the rape exam.								
k. The rape exam is conducted by a specially trained nurse. *(if they ask – SANE)*								
l. The rape exam is conducted by a doctor.								
m. It is important to collect physical evidence, even though it might make the patient feel more uncomfortable.								
n. The patient has a rape crisis advocate available to her.								

Now I'm going to ask you some questions about police and legal services. If you could create ideal police and legal services, how would you rate the importance of the following factors on a scale from 1 to 5, with 1 being "very unimportant", 2 being "somewhat unimportant", 3 being "neutral", 4 being "somewhat important" and 5 being "very important."

	1 VERY UNIMPORTANT	2 SOMEWHAT UNIMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY IMPORTANT	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
o. The survivor has access to police at the medical facility.								
p. The police are thorough in their investigation of the case.								
q. The survivor feels respected by the police.								
r. The survivor receives support for either wanting or not wanting to prosecute her offender.								
s. The district attorney's office is competent in the prosecution of the offender.								
t. The survivor is kept informed about the prosecution process.								

UNM-118

Interviewer _____ Study ID#_____

- In your opinion, what is a reasonable amount of time in which a sexual assault survivor should be seen after they arrive at the medical facility. *(Record response here)* _____
- Are there things that are not on this list that you think would be ideal for services for sexual assault service? ___Yes___No
- *If "YES", obtain supplemental factor page. If " NO", go to Question #2.*

2. Now I'm going to ask you a different kind of question with a different rating scale. These questions will be based on your own experience with sexual assault services. The first set of questions is about medical services.

a. Did you seek medical treatment after the assault?
_____Y _____N _____Don't know _____Not applicable _____Refused to answer

- *If "NO" ask the following question and proceed to Question #3.*

Can you tell me why?_____

- *If "YES" continue below. For all other responses, mark "not applicable" for items b through p and proceed to Question #3.*

b. Was a rape crisis advocate present for you at the medical facility?
_____Y _____N _____Don't know _____Not applicable _____Refused to answer

Please rate how strongly you agree or disagree with the following statements on a scale from 1 to 5, with 1 being "strongly disagree" , 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

	1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
c. I was seen by a medical practitioner in a reasonable amount of time.								
d. My needs for medical treatment were fully met.								
e. I felt safe while at the medical facility.								
f. The medical provider was understanding.								
g. The medical provider was competent.								
h. I felt comfortable talking to the medieal provider about the incident.								

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Interviewer_____ Study ID#_____

	1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
i. I felt that the information collected by the medical provider would be held in confidence.								
j. My privacy was respected.								
k. The physical environment of the medical facility was soothing to me.								

➘If respondent gave additional factors on the Supplemental Factor Page, go to Part II (on the 2nd page of the SFP) and ask questions.

l. There are a number of reasons why people seek medical treatment after an assault. The following is a list of possible reasons. Was it?

For an exam to collect physical evidence	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
For possible pregnancy prevention	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
For injuries requiring treatment	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
For sexually transmitted disease prevention	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Because you were encouraged to go by police	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Because you were encouraged to go by family	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Because you were encouraged to go by a friend	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Were you forced to seek medical treatment?	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused

If so, by whom?_____

Was there another reason I have not mentioned?

Other _____

m. Where did you seek treatment? *If not SANE unit skip to item o.*

_____University Hospital
_____SANE unit at St. Joseph NE Heights Hospital
_____Other hospital
_____Private doctor's office
_____Other_____
_____Don't know
_____Not applicable
_____Refused to answer

n1. Did you go directly to the SANE unit, or did you go to the emergency room and then to SANE?

_____Went directly to SANE *If "YES", go to item o.*
_____Went to emergency room first, then referred to SANE from there

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n2. Were you treated at the emergency room and then sent to SANE, or did the ER refer you to SANE immediately?

_____First treated at ER, then sent to SANE
_____Referred directly to SANE from the ER
_____Other _____
_____Don't know
_____Refused to answer

o. About how many times not including this visit, since you were fifteen years old have you been a patient in a hospital emergency room?

_____times as a patient in a hospital emergency room

_____Don't know
_____Not applicable
_____Refused to answer

p. How soon after the assault did you seek medical care?

_____Right away
_____Within 24 hours
_____2-3 days after
_____4-7 days after
_____More that 1 week but less than 1 month after
_____After 1 month
_____Don't know
_____Not applicable
_____Refused to answer

3. Did a medical provider perform a special exam to collect physical evidence of a rape?
_____Y _____N _____Don't know _____Not applicable _____Refused to answer

➘ *If "NO" ask the following question and proceed to Question #4 on page 7.*

a. Can you tell me why you did **not** have the exam?

Too uncomfortable	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Too traumatic	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Concerns about chain of evidence	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Concerns about handling of evidence	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Did not want legal evidence taken	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused

Was there another reason that I haven't mentioned?_____

➘ *If "YES"continue on next page.*

➘ *For all other responses, proceed to Question #4 on page 7.*

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Interviewer_____ Study ID#_____

Please rate how strongly you agree or disagree with the following statements on a scale from 1 to 5, with 1 being "strongly disagree" , 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

		1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
b.	I was made as physically comfortable as possible during the exam.								
c.	I expected the exam to be conducted by a nurse. (if they ask - SANE)								
d.	I expected the exam to be conducted by a doctor.								
e.	It was important to collect the physical evidence, even though it might have made me feel uncomfortable.								
f.	The medical provider asked for my consent to do the rape exam.								
g.	The medical provider explained the procedures of the rape exam.								
h.	I understood why the procedures of the rape exam were necessary.								
i.	I understood how the physical evidence would be stored and disposed.								
j.	I felt that I could refuse part or all of the rape exam.								

		1 NOT AT ALL TRAUMATIC	2	3	4	5	6	7	8	9	10 VERY TRAUMATIC	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
k.	On a scale from 1-10, can you tell me how the rape exam was for you, with 1 being "not at all traumatic" and 10 being "very traumatic,"?													

l. Who did your exam?

_____MD
_____SANE nurse
_____Other_____

_____Don't know
_____Not applicable
_____Refused to answer

UNM-122

Interviewer_____ Study ID#_____

4. These next questions are about police services.

a. Did you report your assault to the police?
_____Y _____N _____Don't know _____Not applicable _____Refused to answer

➘ *If "NO" ask the following question and proceed to Question #5 on page #9.*

b. Can you tell me why you did **not** report your assault to the police? Was it because you *(read statement)*...

Were afraid	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Distrusted police	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Were concerned about privacy	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Didn't want anyone to know	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer

Are there other reasons I have not mentioned?_____

➘ *If "YES" continue below. For all other responses proceed to Question #5 on page #9.*

Based on your experience with police services, please rate your agreement or disagreement with the following statements on a scale from 1 to 5, with 1 being "strongly disagree" , 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

	1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
c. I had access to police at the medical facility.								
d. The police were thorough in their investigation of my case.								
e. I felt respected by the police.								
f. I received support for wanting or not wanting to prosecute my offender.								

UNM-123

I'm now going to ask you some more questions about your experience with the police.

g. First, who reported the incident to the police?

_____Self reported
_____Medical facility reported
_____Rape crisis center reported
_____Family member reported
_____Friend reported
_____Other_____
_____Don't know
_____Refused to answer

h. How soon after the assault were the police notified?
Write in number of hours, days, etc.

_____Hours
_____Days
_____Weeks
_____Months
_____Other_____
_____Don't know
_____Refused to answer

i. Were you interviewed by a uniformed officer or by a sex crimes detective?

_____Uniformed officer
_____Sex crimes detective
_____Both uniformed officer and sex crimes detective
_____Other_____
_____Not interviewed
_____Don't know
_____Refused to answer

j. On how many different occasions did the police interview you?

_____ times
_____Not interviewed
_____Don't know
_____Refused to answer

Interviewer_____ Study ID#_____

5. Did the district attorney's office try to prosecute your offender?

_____Y _____N _____Don't know _____Not applicable _____Refused to answer

➘ *If "NO" ask item a below and then proceed to item g.*

a. Why do you think that was? *Do not prompt respondent.*

_____I didn't want to
_____No identified assailant
_____Insufficient evidence
_____Chain of evidence disrupted
_____Insufficient police investigation
_____I signed a waiver not to prosecute
_____Other_____
_____Don't know
_____Refused to answer

➘ *If "YES", continue below. For all other responses, proceed to item g..*

Please rate your agreement or disagreement with the following statements on a scale from 1 to 5, with 1 being "strongly disagree", 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

	1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
b. The district attorney's office was competent in the prosecution of my case.								
c. I was kept informed about the prosecution process.								
d. I supported the district attorney's decision to pursue prosecution.								

The following questions also relate to your experience with the district attorney's office.

e. Did you feel pressured to prosecute?

☐ Yes, I felt pressured
☐ Neutral, neither pressured nor not pressured
☐ No, did not feel pressured
☐ Other response_____

➘ *If "YES", felt pressured, continue on Page #10. For all other responses proceed to ~~Question #6~~.* item h on page 10

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Interviewer_____ Study ID#_____

f. By whom did you feel pressured? Did you feel pressure from *(read statement)*...?

Medical provider	☐ YES ☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Rape crisis advocate	☐ YES ☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Police	☐ YES ☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Prosecutor	☐ YES ☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused to Answer
Other_____				

g. We are interested in whether or not you supported the decision **not** to prosecute. Please rate your agreement or disagreement with the following statement on a scale from 1 to 5, with 1 being "strongly disagree", 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

	1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER
I supported the district attorney's decision not to pursue prosecution.								

h. Did you feel pressured **not** to prosecute?

Felt pressured	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Neutral, neither pressured nor not pressured	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Did not feel pressured	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Other response_____					

➘ *If "YES", continue below. For all other responses, skip to Question 6.*

i. By whom did you feel pressured? Did you feel pressure from the *(read statement)*...?

Medical provider	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Rape crisis advocate	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Police	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Prosecutor	☐ YES	☐ NO	☐ DON'T KNOW	☐ N/A	☐ Refused
Other_____					

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Interviewer_____ Study ID#_____

6. Now I'm going to ask you some questions about follow-up services. We're interested in the types of services people go to following a sexual assault. I'll read a list of possible services and ask which ones you used.

a.	Did you use the rape crisis center?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
b.	Were you referred by a medical provider to the rape crisis center?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
c.	Did you use legal services?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
d.	Were you referred by a medical provider to legal services?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
e.	Did you use the battered women's shelter?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
f.	Were you referred by a medical provider to the battered women's shelter?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
g.	Did you use services for incest survivors?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
h.	Were you referred by a medical provider to the services for incest survivors?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
i.	Were you referred by a medical provider to other health services (STD, HIV, family planning)?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
j.	Did you use the Crime VictimReparation services?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
k.	Were you referred by a medical provider to the NM crime ~~survivor~~ victim reparation services commission?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
l.	Did you use the alcohol/drug treatment center?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
m.	Were you referred by a medical provider to the alcohol/drug treatment center?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
n.	Did you use counseling, therapy services?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
o.	Were you referred by a medical provider to counseling or therapy services?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused
p.	Were there services that you needed that you did not receive?	☐ Y	☐ N	☐ DN	☐ N/A	☐ Refused

If "YES", write response below. For all other responses, go to question # 7.

If so, what were they?_____

_____

_____

UNM-127

Interviewer_____ Study ID#_____

We're nearly at the end of the survey.

7. For statistical purposes, can you tell me how you describe your ethnicity? *Do not prompt respondent.*

_____African American/Black _____Hispanic
_____American Indian _____Other_____
_____Asian/Pacific Islander _____Don't know
_____Caucasian/White _____Refuses to answer

8. Before we stop, do you have anything to add, or any suggestions for improving services for sexual assault survivors?

_____

_____

_____

Thank you very much for taking the time to complete this survey. Your participation is very important to us and helps us to better understand the issues facing women who have been sexually assaulted.

Please remember that the Albuquerque Rape Crisis Center hotline is available for support 24 hours a day. That number is 266-7711. You are welcome to call if you'd like to talk to someone.

Are you alright? As part of this research project we are going to conduct a focus group with sexual assault survivors sometime in the next few months. If you are interested, it will be an opportunity to talk further about the services available for sexual assault survivors. Participation in the focus group is completely voluntary. We don't yet know exactly when it will be scheduled but, if you would like to be included, we will call you when we know the date and time of the meeting.

Would you be willing to participate in the focus group? _____Yes _____No

If yes: Is this phone number the correct number to reach you? *Note to interviewer: Write her phone number on the contact sheet. Do not write any identifying information on the survey.*

Thank you again for participating.

END OF INTERVIEW

UNM-128

Interviewer _____ Study ID# _____

Sexual Assault Survivor Telephone Survey
Supplemental Factor Page

What factors are not on the list that you think would be important for an ideal sexual assault service? (Can you list them please.)

Factor 1: _____

Factor 2: _____

Factor 3: _____

Part I.

If you could create an ideal service, how would you rate the importance of these factors on a scale from 1 to 5, with 1 being "very unimportant", 2 being "somewhat unimportant", 3 being "neutral", 4 being "somewhat important" and 5 being "very important."

F1. *Rephrase Factor 1 as a statement and write in:* _____

1 VERY IMPORTANT	2 SOMEWHAT IMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

F2. *Rephrase Factor 2 as a statement and write in:* _____

1 VERY IMPORTANT	2 SOMEWHAT IMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY IMPORTANT	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

F3. *Rephrase Factor 3 as a statement and write in:* _____

1 VERY IMPORTANT	2 SOMEWHAT IMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 VERY IMPORTANT	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

UNM-129

Interviewer _____ Study ID# _____

Part II.

Based on your own experience with sexual assault services, please rate how strongly you agree or disagree with the following statements on a scale from 1 to 5, with 1 being "strongly disagree", 2 being "somewhat disagree", 3 being "neutral", 4 being "somewhat agree" and 5 being "strongly agree."

F1. *Rephrase Factor 1 as a statement and write in:* _____

_____

_____

1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

F2. *Rephrase Factor 2 as a statement and write in:* _____

_____

1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

F3. *Rephrase Factor 3 as a statement and write in:* _____

_____

1 STRONGLY DISAGREE	2 SOMEWHAT DISAGREE	3 NEUTRAL	4 SOMEWHAT AGREE	5 STRONGLY AGREE	DON'T KNOW	NOT APPLICABLE	REFUSED TO ANSWER

UNM-130

Supplemental factor page

July 20, 2018

Chairman Walden
Chairman Harper

Dear Chairmen Walden and Harper:

On behalf of the 104 hospitals represented by the Alabama Hospital Association (AlaHA), the following is provided as a response to the request for information on resources and the availability of SANE programs contained in your letter of June 21, 2018.

Alabama is a state with large medically underserved areas with limited financial resources. Because of these limitations, it is important to maximize collaboration and cooperation among involved entities. The Alabama Crime Victim's Compensation Commission, created by the legislature in 1984, provides some payment to hospitals and other community providers for sexual assault examinations. The Alabama Department of Forensic Science makes evidence collection kits available to hospitals at no cost.

As a membership organization, AlaHA does not determine the services provided by our member hospitals, nor suggest standards of care for any medical procedure, test, or exam. As a consequence, the Alabama Hospital Association does not maintain a statewide data base on programs such as SANE.

In response to your inquiry, AlaHA reached out to many of our member hospitals. During those conversations, we learned that SANE programs, SAK Kits, and other resources for victims of sexual assault are available throughout our state. In some cases, services may be provided directly through hospitals, in other instances through outside contracts with other entities or by referral to other providers.

Importantly, significant challenges were identified in the provision of sexual assault services. While not a comprehensive list, the following represent many of the concerns:

- A shortage of staff available to provide 24/7 coverage by SANE trained medical personnel.
- Severe financial challenges, especially in rural areas which limit the ability to hire staff.
- Difficulties in maintaining the chain of custody of evidence collected.

- Insufficient training opportunities.
- Lack of access to contractors or resources willing to provide services in rural areas.
- A significant shortage of medical professionals trained to perform pediatric sexual assault exams.
- A profound shortage of health care providers (physicians and nurses) in Alabama's HPSAs.

The combination of financial instability of many rural hospitals, a severe shortage of health care personnel, and the lack of training make the direct provision of SANE services problematic for many hospitals. It is important to note that increasing access to training without improved financial resources for hospitals is unlikely to significantly lessen the challenge.

Thank you for the opportunity to provide input.

Sincerely,

Donald E. Williamson, MD
President/CEO
Alabama Hospital Association

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

March 13, 2018

Mr. W. Russell Tyner
President and Chief Executive Officer
Baptist Medical Center South
2105 E South Boulevard
Montgomery, AL 36116

Dear Mr. Tyner:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is investigating the availability of sexual assault forensic exams at hospitals across the United States.

In 2016, the U.S. Government Accountability Office (GAO) published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." According to the GAO, a sexual assault forensic exam, also known as a "rape kit," may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training ("SAFE rape kits") "may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates."[1] The GAO found that in each of the six states examined, the number of SANEs "does not meet the need for exams within their states."[2]

Not all hospitals employ SANEs or provide SAFE rape kits to patients,[3] and there are no federal requirements regarding the availability of SANEs in health care facilities.[4] According to the GAO, a Joint Commission accreditation standard requires that hospitals "establish policies

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[1] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 1-2.
[2] *Id.* at 23.
[3] *What is a Rape Kit?*, RAINN, https://www.rainn.org/articles/rape-kit
[4] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 8.

for identifying and assessing possible victims of sexual assault and to train staff on those policies, [but] each hospital is responsible for determining the level of specificity of such policies, including the minimum level of training required of its medical staff that performs exams."[5] In other words, hospitals may simply choose not to provide these services.

Indeed, according to recent news reports, victims of sexual assault often have trouble obtaining a rape kit.[6] Moreover, GAO found that the lack of SANEs can be particularly acute in rural areas, where there may be just one SANE or one SANE program to serve multiple counties, and a patient may have to travel several hours to reach a facility that offers SAFE rape kits.[7] However, the issue is not isolated to rural areas.[8] In some metropolitan areas, including Washington, DC and Las Vegas, NV, there may be only one facility that provides SAFE rape kits.[9] As such, a rape victim must go to that specific hospital to get the most appropriate treatment.

Data on the availability of SANEs and SAFE rape kits nationwide is limited.[10] According to the Department of Justice, the most comprehensive database on SAFE facility locations is administered by the International Association of Forensic Nurses (IAFN). However, this database is based on self-reporting by facilities with SAFE programs, and as such, is incomplete. The IAFN database lists as few as two locations in some states, including Connecticut, Hawaii, Mississippi, South Dakota, and Wyoming. IAFN estimates that between 13 and 15 percent of hospitals in the United States provide SAFE rape kits. It is not clear what happens to a victim of sexual assault if he or she visits one of the roughly 85 percent of hospitals that do not provide these vital services.

Accordingly, the committee is interested in learning more about how hospitals treat patients seeking treatment and evidence collection following a sexual assault. Please provide written answers to the following questions by March 27, 2018.

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[5] *Id.* at 9.
[6] *At Least Half of Rape Victims in SC Aren't Seen by a Sexual Assault Nurse*, GREENVILLE NEWS (July 20, 2017), https://www.greenvilleonline.com/story/news/2017/07/20/sexual-assault-nurses-short-supply/492935001/; *Lawmakers Want Easier Access to Rape Kits*, COLUMBIA BASIN HERALD (Jan. 29, 2018), http://www.columbiabasinherald.com/local_news/20180129/lawmakers_want_easier_access_to_rape_kits; *Why Did It Take Nine Hours and Three Emergency Rooms For This Woman to Get a Rape Kit?*, COSMOPOLITAN, http://www.cosmopolitan.com/politics/a58941/dinisha-ball-rape-kit-texas-emergency-room/.
[7] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 23. *See also, You have to drive an hour for a rape kit in rural America*, The Washington Post, https://www.washingtonpost.com/news/wonk/wp/2016/04/19/you-have-to-drive-an-hour-for-a-rape-kit-in-rural-america/?utm_term=.29e3af0fe722 (April 19, 2016); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[8] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 24.
[9] *Why Are There No Rape Kits at the George Washington University*, WJLA, http://wjla.com/news/education/rape-kits-at-the-george-washington-university-9776 (March 25, 2011); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[10] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 21.

1. Does the Baptist Medical Center South employ SANEs or SAFE-certified medical professionals? No

2. If Baptist Medical Center South does employ SANEs,

   a. When did Baptist Medical Center South begin employing SANEs? N/A

   b. How many SANE or SAFEs does the Baptist Medical Center South employ? N/A

   c. How were SANEs trained? N/A

   d. During what days and hours are SANEs available at the Baptist Medical Center South? N/A

   e. Is the Baptist Medical Center South listed on the IAFN database? N/A

   f. What is the annual cost of administering the SANE program at the Baptist Medical Center South? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015. N/A

   g. What grants, if any, has the Baptist Medical Center South applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims? N/A

3. If the Baptist Medical Center South does not employ SANEs, does the Baptist Medical Center South provide rape kits by non-SANEs? We stock the kits, but do not do the rape kits.

   a. If so, who conducts those kits? N/A

   b. How are these medical professionals trained to collect those kits? N/A

4. If a sexual assault victim comes to the Baptist Medical Center South requesting treatment and/or a rape kit following an assault, what procedures are in place at the Baptist Medical Center South to treat that victim? If the Baptist Medical Center South does not conduct a rape kit, SAFE certified or not, please include whether the Baptist Medical Center South has a relationship or agreement with another facility that does provide those services. see below

5. Does the Baptist Medical Center South track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed? No

Thank you for your prompt attention to this matter. If you have any questions regarding this request, please contact Brighton Haslett with the Majority Committee staff at (202) 225-2927.

4. We contact SANE and make arrangements for patient. If patient is stable, patient is directed to Sane clinic/office for kit to be performed. If patient is unstable, SANE RN comes to hospital and performs kit with MD.

Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

Ernie W. Sadau
President and Chief Executive Officer

March 27, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U. S. House of Representatives
Washington, DC 20515

The Honorable Gregg Harper
Chairman
Subcommittee on Oversight and Investigations
U. S. House of Representatives
Washington, DC 20515

Re: Request for Information regarding the availability of sexual assault forensic exams and sexual assault nurse examiners at CHRISTUS Spohn Health System hospitals

Dear Chairman Walden and Ranking Member Pallone:

I am writing in response to your inquiry dated March 13, 2018, which requested information regarding the availability of sexual assault forensic exams and sexual assault nurse examiners (SANEs) at CHRISTUS Spohn Health System hospitals. CHRISTUS Spohn Health System is comprised of the following six-hospital locations:

- Memorial (Corpus Christi, TX)
- Shoreline (Corpus Christi, TX)
- South (Corpus Christi, TX)
- Beeville (Beeville, TX)
- Kleberg (Kingsville, TX)
- Alice (Alice, TX)

The responses noted below are representative of each facility.

1. **Does CHRISTUS Spohn Memorial Hospital employ SANEs or SAFE-certified medical professionals?**
   Response: CHRISTUS Spohn Health System does not have a SANE/SAFE program.

2. **If CHRISTUS Spohn Memorial Hospital does employ SANEs,**
   a. **When did CHRISTUS Spohn Memorial Hospital begin employing SANEs?**
   Response: Not applicable.

   b. **How many SANE or SAFEs does CHRISTUS Spohn Memorial Hospital employ?**
   Response: Not applicable.

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Ernie W. Sadau
President and Chief Executive Officer

c. **How were SANEs trained?**
Response: Not applicable.

d. **During what days and hours are SANEs available at CHRISTUS Spohn Memorial Hospital?**
Response: Not applicable.

e. **Is the CHRISTUS Spohn Memorial Hospital listed on the IAFN database?**
Response: No.

f. **What is the annual cost of administering the SANE program at CHRISTUS Spohn Memorial Hospital? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.**
Response: Not applicable.

g. **What grants, if any, has CHRISTUS Spohn Memorial Hospital applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?**
Response: CHRISTUS Spohn has not applied for, nor received any funds related to SANE training or treatment of sexual assault victims.

3. **If CHRISTUS Spohn Memorial Hospital does not employ SANEs, does the CHRISTUS Spohn Memorial Hospital provide rape kits by non-SANEs?**
Response: It is the policy of the CHRISTUS Spohn Health System that all patients presenting or identified as victims of sexual assault will receive care in accordance with the hospital's capabilities. Specifically, medical staff will seek to stabilize the patient for transportation to the nearest forensic site for the evidentiary examination. There have been rare occasions when a rape kit was performed at a CHRISTUS Spohn facility; for example, when the patient did not give consent to be transported to another facility, or the patient required other trauma-related services that prevented transport.

   a. **If so, who conducts those kits?**
   Response: In the rare instances noted above, the exam was performed by a medical doctor.

Ernie W. Sadau
President and Chief Executive Officer

b. **How are these medical professionals trained to collect those kits?**
Response: The performing medical doctor follows the *Texas Evidence Collection Protocol*. As noted in its preamble, the protocol provides "recommendations to medical, legal, law enforcement, advocacy and forensic science professionals on the identification, collection and preservation of physical evidence and the minimization of physical and psychological trauma to the victims/survivors of sexual assault and requirements of ECP kits as designated by Chapter 420, Government Code".

4. **If a sexual assault victim comes to the CHRISTUS Spohn Memorial Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at CHRISTUS Spohn Memorial Hospital to treat that victim? If CHRISTUS Spohn Memorial Hospital does not conduct a rape kit, SAFE certified or not, please include whether CHRISTUS Spohn Memorial Hospital has a relationship or agreement with another facility that does provide those services.**
Response: In accordance with our hospital policy, adults and children will have a medical screening exam and stabilization of emergent conditions. Once a patient is stabilized, adult patients will be transferred to the [redacted], and children will be transferred to [redacted] for a SANE Exam.

   As noted in 3b above, in the event the patient refuses transport, a medical doctor may perform the sexual assault evidentiary exam.

5. **Does CHRISTUS Spohn Memorial Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?**
Response: No, this information is not tracked.

CHRISTUS Health appreciates the Committee's interest in these issues and welcomes the opportunity to provide related information. Please do not hesitate to contact me if you have any additional questions.

Sincerely,

Ernie W. Sadau
President & Chief Executive Officer
CHRISTUS Health

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c|h|a
Colorado Hospital Association

July 5, 2018

Greg Walden, Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC

Gregg Harper, Chairman
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, DC

Sent via email to: Samantha Bopp | Staff Assistant
U.S. House Committee on Energy and Commerce

Dear Chairmen Walden and Harper:

Thank you for your recent inquiry of Colorado Hospital Association (CHA) regarding sexual assault and SANE care in Colorado health care facilities. We agree that this is an important and sensitive topic. While CHA serves a statewide coordinating role and as a resource in many areas of health care within our state and on a wide variety of topics, we currently are not actively involved with the state's SANE program. That said, Colorado is fortunate as a state to have been historically focused on this issue and does have many resources in place to help care for victims of sexual assault.

We provide below answers to the questions you posed to us in your letter and identify resources available to Colorado hospitals and patients.

1. **How many hospitals in Colorado is Colorado Hospital Association aware of that have a SANE program?**

   The Colorado Department of Public Safety's Division of Criminal Justice maintains a website with resources for victims including a current list of SANE facilities (http://cdpsdocs.state.co.us/ovp/sexual-assault-programs/SANELocations2018.pdf). That list indicates that there are 34 facilities across the state. The facilities are hospitals, freestanding emergency departments and victim assistance organizations.

2. **Does Colorado Hospital Association maintain a database of hospitals and/or other entities across Colorado that have a SANE Program? If so, is it publicly available?**

   CHA does not maintain a database of hospitals and/or other entities across Colorado that have a SANE Program. The State of Colorado maintains a list, and it is publicly available on its website (http://cdpsdocs.state.co.us/ovp/sexual-assault-programs/SANELocations2018.pdf).

c|h|a
Colorado Hospital Association

3. **What steps, if any, has the Colorado Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals in Colorado? Does CHA partner with law enforcement agencies in any capacity to provide access to SAFE kits?**

CHA currently is not actively involved with the state's SANE program. The State does however, have the benefit of a competitive grant that was awarded in 2013 to UCHealth Memorial Hospital in Colorado Springs. With this grant from the Division of Criminal Justice, UCHealth Memorial Hospital accepted responsibility for overseeing the Colorado SANE/SAFE Project.

Oversight for the Colorado SANE/SAFE Project is conducted by a Board of Directors. Colorado does have the benefit of law enforcement partnerships in that the Colorado Bureau of Investigations provides kits to health care facilities at no charge. Further, law enforcement has no current backlog of analysis and meets a 90-day turnaround, which exceeds the national average.

Since inception in 2013, Colorado SANE/SAFE Project has provided training to more than 400 RN and advanced practice providers. The program often trains site coordinators and providers as well through their Medical Forensic Exam (MFE) course which is for providers who have not completed the 64-hour SANE training. This allows exams to be performed in more areas within Colorado. The project also sends instructors to rural Colorado twice each year to conduct this training.

In addition to the course described above, the Project provides the 64-hour didactic course, (which allows students to sit for the national certification tests), hands-on clinical labs, preceptorship for providers who want further assistance and 24/7 technical assistance. Additionally, a 24-hour Advanced Forensic Nurse Examiner course for SANEs was just released. In addition to classroom-based education and skills labs, these courses are available online and free or charge. This has helped Colorado health care facilities in rural and remote areas of the state offer this important service.

4. **What challenges has Colorado Hospital Association identified that hospitals face in providing access to these services? How is Colorado Hospital Association working with your hospitals to address those challenges?**

CHA currently is not actively involved with the state's SANE program. Member hospitals have not identified to CHA challenges to providing access to SANE services. Generally, Colorado hospitals, like facilities in many western states, face geographic and financial challenges in rural and frontier areas of the state that often impact access to services.
As described above, the UCHealth Memorial Hospital program offers a variety of options for hospitals in remote areas, with and without SANE staff. This program includes training, online assistance and resources and after-hours technical assistance. Here is the link to the program's website: https://www.uchealth.org/professionals/education-programs/colorado-sexual-assault-program/#training-for-professionals. This training commitment and format has helped mitigate many of the geographic and financial challenges often faced by rural health care providers.

c|h|a
Colorado Hospital Association

The Project is in close contact with the programs and hospitals throughout Colorado and tracks inquiries and questions. These are used to trend issues, which in turn is used to develop training.

5. **For hospitals in Colorado that do not have a SANE program, does Colorado Hospital Association provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking a SAFE kit? If so, what is recommended? Please provide copies of such guidance. Do the procedures vary for hospitals in rural and urban areas or based on the availability of local alternatives?**

   CHA currently is not actively involved with the state's SANE program. UCHealth Memorial Hospital offers best practice training for medical professionals in areas where SANE and SAFE kits are not available (https://s3.amazonaws.com/uchealth-wp-uploads/wp-content/uploads/2016/10/28124927/MHS-SAFE-SANE-Medical-Response-to-Sexual-Assault-Patients-2017-Flyer.pdf).

Thank you for the opportunity to provide this information. Please do not hesitate to contact me if you have any additional questions.

Sincerely,

Steven J. Summer
President and CEO

Cc: The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Michelle Greenhalgh & Sahil Chaudhary (via email)
Rep. Diana DeGette Office

CONNECTICUT HOSPITAL ASSOCIATION

June 28, 2018

Greg Walden, Oregon, Chairman
Gregg Harper, Chairman, Subcommittee on Oversight and Investigations
115th Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairmen Walden and Harper:

The Connecticut Hospital Association ("CHA") greatly appreciates the opportunity to respond to the questions posed in a June 21, 2018, letter we received from the House of Representatives Committee on Energy and Commerce regarding both sexual assault rape kits and sexual assault nurse or forensic examiner programs ("SANE/SAFE programs").

Section 19a-112a of the Connecticut General Statutes as amended by Public Act 18-83, mandates that for every individual who presents at a hospital self-identifying as a sexual assault victim, that hospital staff provide information on the availability of a sexual assault evidence collection kit, and with consent from the individual, then perform the forensic exam and evidence collection process.

The same state law establishes the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations ("Commission"), providing it the sole legal authority in Connecticut to set the parameters of the sexual assault forensic exam and evidence collection process. CHA is one of fifteen (15) statutorily appointed members of the Commission. The Commission meets on a quarterly basis and is responsible, under the law, for promulgating and maintaining a set of guidelines for the performance of sexual assault evidence collection kits, also known as the official state of Connecticut *Technical Guidelines for Health Care Response to Victims of Sexual Assault* ("Technical Guidelines"), to ensure that every victim has access to a standardized evidence collection process. The Technical Guidelines, as well as the sexual assault evidence collection kit, are required to be reviewed annually by the Commission to maintain best practices at all hospitals across the state. Both the kit and Technical Guidelines were updated in 2017.

Responses to your enumerated questions are set forth below.

1. How many hospitals in Connecticut is Connecticut Hospital Association aware of that have a SANE program?

   Answer to 1: The state of Connecticut operates one SAFE program under its Office of Victim Services ("OVS") that coordinates response by specially trained Sexual Assault Forensic Examiners (SAFEs), also known as the Gail Burns-Smith SAFE Program. OVS limits the number of hospitals that are able to activate the program response due to scarcity of funding and resource availability. Currently, there are eight (8) acute care hospitals in Connecticut that fall within the state's SAFE program catchment area, with one (1) SAFE on-call to respond to a request for service at any of the eight participating facilities. Long-range, and subject to funding, the number of facilities allowed to participate will be increased with the ultimate goal of having the program be available state-wide.

   By Commission design, any hospital staff in Connecticut are expected to be able to perform a sexual assault evidence collection kit with consent of a victim, at any time, following the precise protocols set forth in the Technical Guidelines and kit, regardless of whether or not they are a trained SANE/SAFE. Many hospitals do employ SANE/SAFEs on staff, at both hospitals that are able to activate the state SAFE Program and those that are not able.

2. Does Connecticut Hospital Association maintain a database of hospitals and/or other entities across Connecticut that have a SANE program?

   Answer to 2: No. OVS maintains its own SAFE Program database.

   a. If so, is that database publicly available?

   Response to 2.a: Not applicable to CHA. OVS's database is not publicly available.

3. What steps, if any, has the Connecticut Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Connecticut?

   Answer to 3: The Commission established that sexual assault evidence collection kits are to be provided directly by OVS to every acute care hospital in Connecticut. There is no shortage of kits. A kit is performed, following the Technical Guidelines, on each individual who consents to an exam and evidence collection.

   a. Does Connecticut Hospital Association partner with law enforcement agencies in any capacity to provide access to SAFE kits?

Answer to 3.a: As noted above, CHA is one of fifteen (15) statutorily appointed members on the collaborative Commission, which also includes representation from the Connecticut Police Chiefs Association as well as the Division of State Police. It also includes representation by other vital stakeholders groups such as the Chief State's Attorney Office, Department of Children and Families, the Division of Scientific Services (state laboratory), the Connecticut College of Emergency Physicians, the Connecticut Nurses' Association, Disability Rights Connecticut, Connecticut Alliance to End Sexual Violence, OVS, and both an OBGYN and pediatrician appointed by the Connecticut State Medical Society among others.

4. What challenges has Connecticut Hospital Association identified that hospitals face in providing access to these services?

Answer to 4: While the core services are available (i.e., performance of a kit on each individual that consents, and the kits are readily available), both OVS and our member hospitals report ongoing difficulty in retaining highly-trained SANE/SAFE personnel. This pool of nurses, as is the trend for many in the nursing field, often seeks additional, advanced degrees or other work opportunities, and as a consequence, leave their SANE/SAFE positions with relative frequency.

   a. How is Connecticut Hospital Association working with your hospitals to address those challenges?

Answer to 4.a: CHA actively works with OVS and other stakeholders on the Commission to broaden the pool of trained SANE/SAFE personnel to offset the high turnover. Through feedback provided by CHA, OVS will soon provide opportunities for interested hospital staff to become a trained SAFE to allow the pool of available SAFEs in Connecticut to increase.

5. For hospitals in Connecticut that do not have a SANE program, does Connecticut Hospital Association provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking a SAFE kit?

Answer to 5: Connecticut law mandates an exam and evidence collection kit be performed following the Technical Guidelines when an individual consents to the kit, without regard to whether there is specifically trained SANE program staff available. OVS controls the state's official SAFE training program. Creation of stand-alone guidance and standards beyond these two state-sanctioned sources is discouraged by the Commission as it could conflict with existing processes and requirements.

CHA works with the Commission and OVS to ensure that all hospital staff are adequately trained on the sexual assault evidence collection kit and Technical Guidelines, and that every hospital has a working understanding of their core requirements. The most recent Commission-sponsored trainings for healthcare providers were held in early June 2018, in which all Connecticut hospitals were represented. CHA assisted in the planning and presentations at the trainings.

CHA also works with the *Connecticut Alliance to End Sexual Violence to improve the coordination and availability of services to victims of sexual assault.

a. If so, what procedures are recommended?

Response to 5.a: Not applicable.

b. If so, please provide copies of such guidance, standards, or best practices.

Response to 5.b: Not applicable.

c. Do the procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center?

Answer to 5.c.: There is no geographic difference to the availability of exams and evidence collection, or the standards and requirements that apply to the exam or evidence collection. All acute care hospitals must perform the kits in a manner consistent with the Technical Guidelines. Additionally, pursuant to state statute, the Connecticut Alliance to End Sexual Violence must be contacted by a hospital to assist every such individual who presents to the hospital seeking services after a sexual assault.

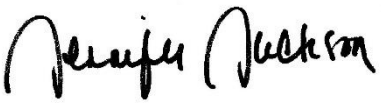
*The Connecticut Alliance to End Sexual Violence (The Alliance) is a statewide alliance of individual sexual assault crisis programs. It works to end sexual violence and ensure high quality, comprehensive and culturally competent sexual assault victim services, in three core areas: victim assistance, community education, and public policy advocacy.

The Alliance offers opportunities to promote social change with national, state and local organizations; procurement and distribution of funds to develop and support its member organizations; a forum for the exchange of skills and information regarding the response to, and prevention of sexual assault; and a mechanism for the development and maintenance of appropriate standards of services for rape crisis centers.

The Alliance provides free and confidential support to all survivors—regardless of age, sex, immigration status, race, ethnicity, nationality, sexual orientation, gender identity or expression, or religious or spiritual beliefs.

Thank you again for the opportunity to respond.

Sincerely,



Jennifer Jackson
President and CEO

JDJ:ljs
By E-Mail

MedStar Georgetown
University Hospital

March 26, 2018

Congress of the United States
House of Representatives
Attn: Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Walden and Committee Members,

Thank you for your letter dated March 13, 2018, requesting information regarding the care of patients seeking treatment and evidence collection following sexual assault. Below we have provided our written response to the five questions enumerated in your letter.

1. Does the MedStar Georgetown University Hospital Center employ SANEs or SAFE-certified medical professionals?

   MedStar Georgetown University Hospital is a member of MedStar Health Inc., the largest healthcare provider in the Maryland and Washington, D.C. region. Our sister hospital, MedStar Washington Hospital Center (110 Irving Street, NW Washington, DC 20010), is the designated home of the DC Sexual Assault Nurse Examiner (SANE) Program for all of D.C. and provides the most comprehensive 24/7 care for victims of sexual assault including: expertise in evidence collection, STI testing and treatment, support services by victim advocates from DC Rape Crisis Center, referrals to counseling and crime victim compensation, and follow-up care. MedStar Georgetown University Hospital coordinates care for victims of sexual assault by working closely with SANEs employed by MedStar Washington Hospital Center, all while providing timely, competent, and compassionate care to these patients in accordance with the protocols recommended by the District of Columbia Sexual Assault Response Team through the Mayor's Office of Victim Services and the Metropolitan Police Department Sexual Assault Unit. Given the expertise available from MedStar Washington Hospital Center, MedStar Georgetown University Hospital does not employ separately SANE or SAFE-certified medical professionals.

2. If MedStar Georgetown University Hospital does employ SANEs,
   a. When did MedStar Georgetown University Hospital begin to Employ SANEs?
   b. How many SANE or SAFEs does the MedStar Georgetown University Hospital employ?
   c. How were SANEs trained?
   d. During what days and hours are SANEs available at the MGUH?
   e. Is the Georgetown Hospital listed on the IAFN database?
   f. What is the annual cost of administering the SANE program at the MGUH? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.
   g. What grants, if any, has the MGUH applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims.

As previously mentioned, while MedStar Georgetown University Hospital does not employ SANEs or SAFE-certified medical professionals, it is the policy of MedStar Georgetown University Hospital to provide timely, competent and compassionate care to these patients either at our hospital or at our sister hospital MedStar Washington Hospital Center, the designated home of the DC Sexual Assault Nurse Examiner (SANE) Program.

3. If the MedStar Georgetown University Hospital does not employ SANEs, does the MedStar Georgetown University Hospital provide rape kits by non-SANEs?
    a. If so, who conducts those kits?
    b. How are these medical professionals trained to collect those kits?

MedStar Georgetown University Hospital does not provide rape kits by non-SANEs. MedStar Georgetown University Hospital utilizes the expertise and advanced care that is available through MedStar Washington Hospital Center's expertise and its designation as a Sexual Assault Nurse Examiner (SANE) Program. MedStar Georgetown University Hospital assists in transporting the patient to MedStar Washington Hospital Center, located 3.4 miles from MedStar Georgetown University Hospital, which has a SANE certified nurse on-call 24/7 to ensure that the highest quality of care is provided. In the event that a patient is not stable for transport, a SANE on-call certified nurse will respond from MedStar Washington Hospital Center to MedStar Georgetown University Hospital to administer the examination utilizing a SAFE-kit.

4. If a sexual assault victim comes to the MedStar Georgetown University Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at the Georgetown Hospital to treat that victim? If the MedStar Georgetown University Hospital has a relationship or agreement with another facility that does provide those services.

It is the policy of MedStar Georgetown University Hospital Emergency Department to provide care to these patients in accordance with the protocols recommended by the District of Columbia Sexual Assault Response Team through the Mayor's Office of Victim Services and the Metropolitan Police Department Sexual Assault Unit.

When a sexual assault victim seeks examination and treatment in the Emergency Department, the patient is triaged as a Level 2 per the Emergency Severity Index. Consent and pre-registration is completed per MedStar Georgetown University Hospital protocol and the patient is placed in a private room with a door, if available. The patient's chart is given directly to one of the Emergency Department attendings. The patient receives a medical screening exam by the Emergency Department attending to determine the need for emergency medical diagnostics and/or treatment. In the interest of preserving any evidence the patient is instructed not to remove any clothing in Emergency Department and should not shower. If a patient must undress the following procedure is used to maintain the chain of potential evidence:

MedStar Georgetown
University Hospital

Excerpt from MGUH ED Protocol #39:

> Place two sheets on the floor or bed and have the patient undress on top of the sheet, fold clothes on top of the sheet, and hold their possessions. Any items, other than clothing, are placed individually by the patient in a brown paper bag. No belongings or clothing, deemed potential evidence, are collected by the MedStar Georgetown University Hospital associate. If the patent needs to void urine, the sample should be collected in a sterile collection container and placed in a biohazard bag by the patient. The MedStar Georgetown University Hospital associate should not handle the patient's urine sample. The associate will document that the patient has maintained the chain of custody for potential evidence.

The Emergency Department attending will coordinate with dispatch at MedStar Washington Hospital Center (at 866-977-SANE) to activate the Sexual Assault Response Team (SART) to coordinate the transfer of the patient to MedStar Washington Hospital Center. If the patient wants to report to Law Enforcement, MedStar Georgetown University Hospital will contact the MPD command Info Center (or another appropriate Law Enforcement jurisdiction), the SANE certified nurse on-call, and the Network for Victim Recovery (NVRDC) advocate. Law enforcement will respond to MedStar Georgetown University Hospital with a sex crimes detective, explain the SANE program to the patient, and notify MedStar Georgetown University Hospital that the law enforcement agent will facilitate the transportation of the patient to MedStar Washington Hospital Center. MedStar Georgetown University Hospital will notify the on-call NVRDC advocate and SANE certified nurse to inform them of the patients transfer and coordinate communication. The Law Enforcement agent will facilitate transfer regardless if law enforcement intends to investigate the assault further. This may include ensuring the patient has his or her own transportation to MedStar Washington Hospital Center, contacting the NVRDC advocate for a free car service, or transporting the patient directly via law enforcement transport.

In the event that a patient does not want to report to law enforcement, the above protocol will be followed except the NVRDC on-call advocate will be dispatched to MedStar Georgetown Hospital Center and coordinate the patient's transportation to MedStar Washington Hospital Center.

In the event that a patient is too unstable to transfer or refuses to transfer to MedStar Washington Hospital Center, the MedStar Georgetown University Hospital Emergency Department attending will coordinate with MedStar Washington Hospital Center to have a SANE on-call certified nurse respond to MedStar Georgetown University Hospital to administer the exam at MedStar Georgetown University Hospital. If a patient presents with more emergent medical conditions that need treatment, the MedStar Georgetown University Hospital team will collect whatever evidence is reasonably practicable given the circumstances. MedStar Washington Hospital Center has a SANE certified nurse on-call 24/7 and the aforementioned protocol will be followed

MedStar Georgetown
University Hospital

once the patient is stabilized. The MedStar Georgetown University Hospital Emergency Department attending will also coordinate with the NVRDC on-call advocate to be dispatched to MedStar Georgetown University Hospital. The NVRDC will coordinate remaining follow-up, facilitate the patient's transport home, Crime Victims' Compensation (CVC) paperwork, notification of law enforcement victim services resource, and any other necessary resources.

The MedStar Washington Hospital Center SANE on-call certified nurse will coordinate if any Drug Facilitated Sexual Assault (DFSA) specimens are collected at MedStar Georgetown University Hospital to be submitted to: 1) the Office of the Chief Medical Examiner if the patient does not want to report to law enforcement, or 2) to the appropriate law enforcement jurisdiction if the patient does want to report to law enforcement. Physical Evidence Recover Kits (PERKS) will be stored by the DC SANE program at MedStar Washington Hospital Center. MedStar Georgetown University Hospital associates are provided clear protocols regarding treatment of patients who are victim of sexual assault to ensure the patient receives timely, competent, compassionate care and maintains a clear chain of potential evidence.

5. Does the MedStar Georgetown University Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

MedStar Washington Hospital Center is the designated Sexual Assault Nurse Examiner center for all of the District of Columbia. Virtually all patients presenting to MedStar Georgetown University Hospital for sexual assault are evaluated by a SANE on-call certified nurse employed at MedStar Washington Hospital Center, unless the patient's clinical condition dictates otherwise. Therefore, the data tracking sexual assault, number of rape kits (Physical Evidence Recover Kits), and the kits themselves are stored and collected at MedStar Washington Hospital Center. MedStar Georgetown University Hospital can access this data on an as needed basis.

Thank you for the opportunity to provide information regarding MedStar Health's SANE program. Please let us know if you have additional questions.

Sincerely,

Michael Sachtleben
President

LEE HEALTH

March 14, 2018

The Honorable Greg Walden, Chairman
Congress of the United States
United States House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Gregg Harper, Chairman
Congress of the United States
United States House of Representatives
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Chairman Walden and Chairman Harper:

Thank you for your letter and inquiry regarding the availability of sexual assault forensic exams at hospitals across the United States. Lee Memorial Hospital appreciates the opportunity to respond to your inquiry. In response to your written questions, Lee Memorial Hospital provides the following:

1. *Does Lee Memorial Hospital employ SANEs or SAFE-certified medical professionals?*

Answer: Lee Memorial Hospital does not employ SANE or SAFE-certified medical professionals.

2. *If Lee Memorial Hospital does employ SANEs,*
   a. *When did Lee Memorial Hospital begin employing SANEs?*
   b. *How many SANE or SAFEs does Lee Memorial Hospital employ?*
   c. *How were SANEs trained?*
   d. *During what days and hours are SANEs available at Lee Memorial Hospital?*
   e. *Is Lee Memorial Hospital listed on the IAFN database?*
   f. *What is the annual cost of administering the SANE program at Lee Memorial Hospital? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.*
   g. *What grants, if any, has Lee Memorial Hospital applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?*

Answer: As provided in Lee Memorial Hospital's answer to the Chairmen's Question Number 1, Lee Memorial Hospital does not employ SANEs or SAFE-certified medical professionals.

3. *If Lee Memorial Hospital does not employ SANEs, does Lee Memorial Hospital provide rape kits by non-SANEs?*
   a. *If so, who conducts those kits?*
   b. *How are these medical professionals trained to collect those kits?*

Answer: Lee Memorial Hospital does not provide rape kits by non-SANEs.

LEE HEALTH

4. *If a sexual assault victim comes to Lee Memorial Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at Lee Memorial Hospital to treat that victim? If Lee Memorial Hospital does not conduct a rape kit, SAFE certified or not, please include whether Lee Memorial Hospital has a relationship or agreement with another facility that does provide those services.*

Answer: If a sexual assault victim is identified in the Emergency Department or Obstetrical Triage at Lee Memorial Hospital, the following procedures are applied:

A. The patient is triaged immediately and taken to a treatment area for a medical screening exam and treatment if indicated.
B. If the patient is an adult, a sexual assault exam will be performed by staff members from the Abuse, Counseling and Treatment Center's (ACT) Rape Crisis Center.
C. If the patient is a vulnerable adult, the rape or sexual assault is immediately reported to the Florida Abuse Registry Hotline at 1-800-96-ABUSE in accordance with Sections 415.1045 and 415.1034(2), Florida Statutes.
D. If the patient is not a vulnerable adult and they present to the Emergency Department with Law Enforcement, the ACT Rape Crisis Center at (239) 939-3112 should also be contacted to ensure that they have been notified.
E. If the adult patient presents without Law Enforcement, the hospital must obtain permission from the patient to notify Law Enforcement and the ACT Rape Crisis Center. The patient has the right to choose to only have the Rape Crisis Center notified but not Law Enforcement.
F. If the patient chooses not to have Law Enforcement and the Rape Crisis Center notified the hospital shall provide the patient with information about the Rape Crisis Center and of their right to examination and evidence collection. The hospital shall provide the patient with the phone number for ACT at discharge. The hospital shall then document in the medical record that the patient did not want Law Enforcement and the Rape Crisis Center notified and that they were provided with information about the Rape Crisis Center.
G. If the patient is under the age of 18, the sexual assault exam will be performed by the Florida Department of Children and Families Child Protective Team (CPT). The hospital shall notify the Florida Abuse Registry Hotline, in accordance with Section 39.201, Florida Statutes, and the Abuse Hotline will notify the CPT and Law Enforcement as indicated. If the child can be discharged the CPT will perform the sexual assault exam at their Facility. Patient consent for reporting is not required when a patient is less than 18 years old.
H. If the patient also has a gunshot wound or other life threatening injury indicating an act of violence, staff shall report the same to the Lee County Sheriff's Office of the county in which said treatment is being administered. Consent from the patient is not necessary for reporting.

5. *Does Lee Memorial Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?*

Answer: Lee Memorial Hospital does not track or collect data on sexual assault victims.

As requested from your correspondence dated March 13, 2018, Lee Memorial Hospital provides the aforementioned responses to your questions. Again, Lee Memorial Hospital appreciates the opportunity to respond to your inquiry and assist in your investigation. Should you have any additional questions regarding our written responses, please feel free to contact me.

LEE HEALTH

Sincerely,

Lisa M. Sgarlata, DNP, MSN, FACHE
Chief Patient Care Officer/Chief Nurse Executive
Lee Memorial Health System
2776 Cleveland Avenue
Fort Myers, FL 33901

LEE HEALTH

March 14, 2018

The Honorable Greg Walden, Chairman
Congress of the United States
United States House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Gregg Harper, Chairman
Congress of the United States
United States House of Representatives
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
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Dear Chairman Walden and Chairman Harper:

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Answer: Lee Memorial Hospital does not provide rape kits by non-SANEs.

LEE HEALTH

4. *If a sexual assault victim comes to Lee Memorial Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at Lee Memorial Hospital to treat that victim? If Lee Memorial Hospital does not conduct a rape kit, SAFE certified or not, please include whether Lee Memorial Hospital has a relationship or agreement with another facility that does provide those services.*

Answer: If a sexual assault victim is identified in the Emergency Department or Obstetrical Triage at Lee Memorial Hospital, the following procedures are applied:

A. The patient is triaged immediately and taken to a treatment area for a medical screening exam and treatment if indicated.
B. If the patient is an adult, a sexual assault exam will be performed by staff members from the Abuse, Counseling and Treatment Center's (ACT) Rape Crisis Center.
C. If the patient is a vulnerable adult, the rape or sexual assault is immediately reported to the Florida Abuse Registry Hotline at 1-800-96-ABUSE in accordance with Sections 415.1045 and 415.1034(2), Florida Statutes.
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F. If the patient chooses not to have Law Enforcement and the Rape Crisis Center notified the hospital shall provide the patient with information about the Rape Crisis Center and of their right to examination and evidence collection. The hospital shall provide the patient with the phone number for ACT at discharge. The hospital shall then document in the medical record that the patient did not want Law Enforcement and the Rape Crisis Center notified and that they were provided with information about the Rape Crisis Center.
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H. If the patient also has a gunshot wound or other life threatening injury indicating an act of violence, staff shall report the same to the Lee County Sheriff's Office of the county in which said treatment is being administered. Consent from the patient is not necessary for reporting.

5. *Does Lee Memorial Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?*

Answer: Lee Memorial Hospital does not track or collect data on sexual assault victims.

As requested from your correspondence dated March 13, 2018, Lee Memorial Hospital provides the aforementioned responses to your questions. Again, Lee Memorial Hospital appreciates the opportunity to respond to your inquiry and assist in your investigation. Should you have any additional questions regarding our written responses, please feel free to contact me.

LEE HEALTH

Sincerely,

Lisa M. Sgarlata, DNP, MSN, FACHE
Chief Patient Care Officer/Chief Nurse Executive
Lee Memorial Health System
2776 Cleveland Avenue
Fort Myers, FL 33901

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City, State, ZIP+4®: Washington DC 20515-6115

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How can I help you?

MASSACHUSETTS Health & Hospital ASSOCIATION

500 District Ave. I Burlington, MA 01803
781-262-6001
swalsh@mhalink.org

Steve Walsh
President & CEO

July 5, 2018

Honorable Greg Walden
Chairman, Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Honorable Gregg Harper
Chairman, Subcommittee on Oversight & Investigations
2227 Rayburn House Office Building
Washington, DC 20515-6115

Dear Congressman Walden and Congressman Harper:

The Massachusetts Health & Hospital Association (MHA), on behalf of our member hospitals and health systems, would like to thank you for the opportunity to provide information on the Massachusetts Sexual Assault Nurse Examiner (SANE) program, which we strongly believe is one of the nation's most effective. We would be happy to provide any additional information about SANE as you and your staff review our responses.

Through leadership in advocacy, education, and information, MHA represents and advocates for the collective interests of hospitals, health systems, physician organizations, and clinical staff throughout Massachusetts for the advancement of the public's health. Our mission includes developing programs and initiatives that focus on the needs of patients, improve the health status of the communities our hospitals serve, and to ensure that clinicians are able to provide timely and high-quality care without increased administrative requirements.

MHA and our members are committed to improving the care and wellbeing for survivors of sexual assaults. In particular, we have worked hard to change the perspective within the provider and patient community that such post-assault programs are not just forensic exams. Instead, our state has developed through the Massachusetts SANE program a public health initiative that provides compassionate, comprehensive, and expert forensic nursing care to sexual assault patients of all ages across the commonwealth. In addition, the program provides resources to alleviate long-term behavioral and physical health effects of assault through collaboration with community-based resources that promote healing.

We believe that the Massachusetts SANE program could be considered the gold standard. Its effectiveness is the result of the following:

- The program is managed by the Massachusetts Department of Public Health (DPH), so there is a statewide agency that ensures standardization of forms, kits, training of clinical staff, and messaging by healthcare providers, law enforcement, and community-based organizations (e.g., rape crisis centers) throughout the commonwealth;
- To ensure that the program is meeting the needs of patients, communities, and providers, there is a multidisciplinary advisory committee composed of clinicians, hospital and law enforcement personnel, various state agencies, and community-based service organizations that meets quarterly to review new challenges or barriers. MHA has been an initial member of this committee and actively works with the state agencies, community based organizations, and law enforcement to ensure any information is coordinated among the hospital and clinician community;
- In an effort to prevent confusion or different practices, the state also developed a separate adult and pediatric Sexual Assault Forensic Evidence (SAFE) kit that is provided to every hospital; and
- To maintain the focus on the needs of the patient, DPH works closely with community-based organizations and hospitals to maintain a program that covers the costs of medical and behavioral health services, as well as connects the survivor with an advocate so that the individual can focus on healing in a supportive environment.

MHA has been and continues to be a committed partner to the Massachusetts SANE program since its inception in 1997. While we include the specific responses to your questions below, we would encourage you to also review the DPH website (www.mass.gov/dph/sane), which provides greater detail on the program.

Attached please find our responses to the proposed questions regarding MHA's participation and contribution to the Massachusetts SANE program to-date. Should you like more information about the program or our attached responses, please do not hesitate to contact MHA's Vice President of Legal and Regulatory Affairs Anuj Goel at (781) 262-6034 or agoel@mhalink.org.

Sincerely,

Steve Walsh
President & CEO
Massachusetts Health & Hospital Association

Massachusetts Health and Hospital Association
Response to Committee on Energy and Commerce
July 5, 2018

1. ***How many hospitals in Massachusetts is the Massachusetts Health and Hospital Association aware of that have a SANE program?***

   Every acute care hospital in Massachusetts (there are 65) participates in the Massachusetts SANE program. Given the structure of the program, there are three different ways that hospitals participate.

   First, the Massachusetts Department of Public Health (DPH), which oversees the SANE program, employs SANE nurses who are under contract with 30 acute care hospitals to directly provide services. When a survivor of a sexual assault arrives in one of these hospital emergency departments, the clinical staff contacts the Massachusetts SANE program, which will send the on-call SANE nurse to this location to conduct the evaluation of the survivor and complete the Sexual Assault Forensic Evidence (SAFE) kit. Second, Massachusetts also has the National TeleNursing Center (NTC) Project that works with the U.S. Navy as well as two Massachusetts hospitals where the DPH on-call SANE nurse provides clinical assistance and guidance for the evaluation and completion of the SAFE kit to staff within the emergency department. Third, for the remaining 33 acute care hospitals, DPH holds routine training for clinical staff regarding trauma informed care, which includes the distribution of SANE protocols, best practices, and clinical training for conducting the evaluation and completing the SAFE kit.

   In addition to the services outlined above, Massachusetts also developed a separate and pediatric-specific SANE program managed by DPH that provides pediatric SANE services to eight hospitals to address this specific problem. Please note that the hospitals that are contracted for the pediatric SANE program are within the group of 30 hospitals that are directly contracted with DPH. However, as part of trauma informed care in Massachusetts, hospitals that are not contracted to provide pediatric SANE services are aware of the availability of this service and, when clinically appropriate, will work to transfer children to one of the eight contracted hospitals to ensure that pediatric-specific medical and behavioral services are available to the child and family members.

   As stated in our cover letter, Massachusetts also developed standardized adult-specific and pediatric-specific SAFE kits that have been distributed to every hospital emergency department in Massachusetts. The state also developed a collaborative process between hospitals and law enforcement to ensure that there is a standard process for maintaining the kits and for notifying a local law enforcement official to coordinate the collection for the District Attorney's office to use in any further legal actions.

As a result, every hospital is aware of the SANE program, has an available supply of kits, and is able to access information and assistance for clinical and operational staff to ensure that the survivors who come to our hospitals are able to receive both the necessary medical and behavioral health assistance to ensure long-term recovery and support.

2. ***Does the Massachusetts Health and Hospital Association maintain a database of hospitals and/or other entities across Massachusetts that have a SANE program? If so, it that database publicly available?***

   As outlined above, the Massachusetts DPH is currently contracted with 32 hospitals to provide direct SANE services. This list is maintained on the DPH public website (www.mass.gov/dph/sane) for anyone to access. However, as described, every acute care hospital with an emergency department also provides SANE services and has a Massachusetts-specific SAFE kit. So in our public messaging, all survivors are encouraged to go to their closest hospital emergency department to ensure that they are able to access the medical and behavioral health services that are needed following this traumatic event.

3. ***What steps, if any, has the Massachusetts Health and Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Massachusetts? Does Massachusetts Health and Hospital Association partner with law enforcement agencies in any capacity to provide access to SAFE kits?***

   We are not aware of any access issues or barriers to SAFE kits within a hospital emergency department in Massachusetts. Massachusetts has a specific SAFE kit subcommittee comprised of state agencies, law enforcement, district attorneys, and hospitals that meets every two years to review and make necessary updates to the contents and information that is within each kit.

   In addition, as outlined above, a Massachusetts-specific kit has been distributed to every hospital emergency department. MHA also works closely with DPH and other state agencies to ensure that hospital staff are aware of how and who to contact if they are running low on supplies of kits. When there are updates made to the kits, MHA works with the hospital community and the state agencies to ensure that providers are aware of the changes and assists with connecting hospitals to DPH to ensure enough kits are provided to the right contact within each hospital emergency department. As part of this process, the state also provides information to each hospital regarding proper handling of kits, including the relevant documentation and paperwork required. Over the years, this work has included webinar trainings, handouts, education materials, and one-on-one conversations with hospitals requiring additional assistance or education. To date, we have not been aware of a

concern raised or identified regarding the lack of access to a SAFE kit within a hospital emergency department.

While MHA does not specifically partner with law enforcement agencies regarding the SAFE kits, we are part of the multi-disciplinary advisory committee which develops standards for the maintenance, notification, and collection of the SAFE kits from hospitals by law enforcement. In our role on the advisory committee, MHA provides feedback and information from hospitals regarding any specific issues relating to law enforcement's collection of the kits. The advisory committee then uses this information to determine if there are local or statewide enhancements that should occur to improve the collaboration between hospitals and law enforcement once a kit is completed.

4. ***What challenges has the Massachusetts Health and Hospital Association identified that hospitals face in providing access to these services? How is the Massachusetts Health & Hospital Association working with its hospitals to address those challenges?***

Prior to 1997, hospitals faced inconsistent messages, lack of coordination with law enforcement, and non-uniform make up of SAFE kits. With the development of the statewide program, those challenges have been removed. However, there are four challenge areas that remain and that could benefit from the federal government's assistance.

First, the major problem is ensuring that there is funding to sustain and expand SANE staff to cover all 65 acute care hospital emergency department location throughout Massachusetts. While the state has maintained a stable level of funding, alternative solutions are needed for additional resources to sustain and expand the program. MHA has met with several member hospitals to explore various options, such as using community benefits and other resources to help fund the program; however, none has been determined to be viable at this time. It would be helpful if there was a mechanism for federal funding to states to help complement existing programs and efforts. In addition, there should be a resource center for sharing best practices around the country so states can learn from each other when developing and maintaining programs.

Second, there should be a focused effort to expand the opportunities for Tele-SANE services, which would ensure consistent evaluation and resources to help survivors. In particular, there are different rules in each state for credentialing contracted SANE services in various hospitals. If the federal government could streamline the regulatory requirements or provide the means for each state to streamline its licensure and credentialing process, it could effectively standardize and expand this critical service to many additional areas around the country.

Third, the federal government could look to develop a standard national SAFE kit to assist law enforcement in taking legal action on these traumatic events. A problem we have encountered involves working with a survivor who suffered a sexual assault in one state, but is seeking law enforcement action in their home state. There continues to be inconsistent approaches for communicating the results from one state to another. In addition, the kits may be different in each state and, as a result, may not contain what law enforcement in the survivor's home state needs to take formal legal action.

Fourth, the federal government can also assist by developing uniform and standard messages and training curriculum for use across the country. Similar to the kits, each state or various hospitals have developed different videos, SANE protocols, training curriculum, patient notices, and more. Standardized practices and information would minimize confusion for both survivors and clinical staff working across state lines. We encourage the federal government to develop standard/template information and resources that states could take and either adopt or add locally available information.

5. ***For hospitals in Massachusetts that do not have a SANE program, does the Massachusetts Health and Hospital Association provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking a SAFE kit?***
    a. ***If so, what procedures are recommended?***
    b. ***If so, please provide copies of any such guidance, standards, or best practices.***
    c. ***Do the procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center?***

As we have outlined above, there is one statewide SANE program in Massachusetts in which every hospital is participating – either directly under a contract with the state or indirectly by having clinical staff trained to follow the protocols and processes developed by the state. Information about the state-specific program is available on the state website (www.mass.gov/dph/sane). However, the training materials are not posted online as they are subject to change. Instead, they are provided directly to the clinical staff at routine trainings.

MHA has been working in conjunction with the state to promote trainings and facilitate meetings across the hospital community. As DPH directly provides specific guidance, standards and best practices on treating patients, there has been no need to date for MHA to separately provide such information.

Mount Sinai SAVI

Sexual Assault and Violence Intervention Program

Lynn M. Frederick Hawley, MA
Executive Director
Mount Sinai SAVI Program
Department of OBGYN and Reproductive Science

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March 27, 2018

Congressman Greg Walden
Chairman
Committee on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Congressman Gregg Harper
Chairman
Energy & Commerce Subcommittee on Oversight & Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairmen Walden and Harper:

I am writing on behalf of Dr. Kenneth Davis in response to your Committee's March 13, 2018 request for information on "how hospitals treat patients seeking treatment and evidence collection following a sexual assault." As the Executive Director of the Sexual Assault and Violence Interventional Program ("SAVI") within The Mount Sinai Hospital ("MSH"), I coordinate these programs at MSH and appreciate the opportunity to respond.

As you will see from our responses below, MSH maintains a comprehensive program to address the needs of sexual assault survivors. Our mission is to provide the highest quality medical care and compassionate, client-centered services to address both the patient's physical and psychological trauma. In fact, MSH is one of the few institutions with a dedicated program exclusively focused on providing outreach, comprehensive training, emergency room advocacy and counseling services to address the needs of past and present victims of sexual assault and domestic violence. Our SAVI program has been designated a "center of excellence" since 2006 by the New York State Department of Health. In addition to the Sexual Assault Forensic Examiner ("SAFE") Program which is the focus of the Committee's questions, SAVI maintains over 150 highly trained volunteer counselors who are on call 24/7 to respond to all instances of sexual assault. The counselors, together with

the trained SAFE clinicians work seamlessly to provide comprehensive services to the sexual assault survivors seeking care at MSH.

Within the context of the above background on our programs, please find the responses to the Committee's questions below. We have listed each question and provided our response directly underneath.

1. *Does the Mount Sinai Hospital employ SANEs or SAFE-certified medical professionals?*

   Yes, The Mount Sinai Hospital and its affiliate medical school the Icahn School of Medicine at Mount Sinai (collectively "Mount Sinai") employ **23** SAFEs. These include ten nurses, seven physician assistants and six physicians. All are employed full time by Mount Sinai. Each of these employees has completed additional training to qualify as a SAFE.

   If the Mount Sinai Hospital does employ SANEs/SAFEs:

   a. *When did Mount Sinai Hospital begin employing Safes?*

      MSH began employing SAFEs in 2006.

   b. *How many SAFEs does the Mount Sinai Hospital employ?*

      MSH currently employs 23 SAFE clinicians.

   c. *How were SAFEs Trained?*

      The SAVI program has an active recruiting and training program for MSH's SAFE clinicians. SAVI distributes program and recruiting information throughout the hospital, clinics and physician practices. All interested clinicians submit applications for screening by the SAFE program coordinator. Approved candidates must complete either a 40-hour certification training administered by the New York City Alliance Against Sexual Assault (the Alliance) or an Advanced Practitioner Training (also administered by the Alliance) which consists of all the elements of the 40-hour training except hands on pelvic practice. The latter training is for medical professionals who perform pelvic exams as part of their regular duties. (MSH pays for these training programs on behalf of its employees). After completing the training, these potential SAFEs then must complete a preceptorship at MSH. As part of the preceptor program, they must perform a complete sexual assault exam on a live model – a certified Gynecology Teaching Assistant who is also knowledgeable about trauma and the evidence collection exam. The preceptorship is observed by the SAFE Program Medical Director or Assistant Medical

Director. Once the candidate successfully completes this final step, they are eligible to participate as a SAFE clinician and take on-call shifts. Continuing education is provided by the SAVI SAFE Program, inclusive of monthly education meetings, guest speakers, field trips relevant to forensics, etc. The SAFE Program Coordinator also monitors and assists with the continuing education for the SAFEs which is required to maintain certification in NY State.

d. *During what days and hours are SAFEs available at the Mount Sinai Hospital?*

SAFEs are on-call 24/7 at MSH. In addition, many of the SAFE trained staff work in the MSH emergency department. They are available to provide services to a patient if the on-call SAFE clinician is unexpectedly unavailable.

e. *Is the Mount Sinai Hospital listed on the IAFN database*?

Mount Sinai, through its SAVI program is a member of and listed on the IAFN database. In addition, many of the Mount Sinai trained SAFEs are individual members of IAFN.

f. *What is the annual cost of administering the SAFE program at the Mount Sinai Hospital* for 2017,2016 and 2015?
The annual direct cost of our SAFE Program primarily includes the on-call stipends paid to the SAFEs (payments are made for 12-hour on-call shifts plus an additional amount when called in for a case) and the employees' training costs. In CY 2015 this cost was $34,396, in CY 2016 the cost rose to $84,565, and in CY 17 this cost was $221,210. The increase reflects both the expansion of the SAFE roster and the expansion of our coverage to a 24/7 program. Additional costs of the Program include SAVI personnel who administer the program. The Advocate and SAFE Program Coordinator manages both the SAFE program and coordinates the volunteer advocates who work closely with the SAFE clinicians to provide care, counseling and services to the survivors. In 2016 the cost was $128,400 which includes hiring and training of the new Coordinator and new upgraded equipment. In 2017 the cost was $73,100. So the totals for 2015, 2016 and 2017 are respectively $34,396, $212,965 and $294,310.

g. *What grants if any has the Mount Sinai Hospital applied for or accepted to fund any programs related to the training of SAFEs or treatment of sexual assault victims?*

The Mount Sinai SAVI Program receives multiple grants from state and city programs. It has a grant through the NYS Division of Criminal

Justice Services that provides funding for coordinating the SAFE Program, training the SAFEs, and purchasing necessary SAFE related equipment. SAVI also receives funding for a broad array of related victim services from the NYS Office of Victim Services, NYS Department of Health, NYS Division of Criminal Justice Services, City Council of New York City, and NYS Coalition against Sexual Assault. SAVI also conducts an annual fundraiser and receives individual grants from grateful patients and interested donors.

2. *If the Mount Sinai Hospital does not employ SAFEs, does the Mount Sinai Hospital provide rape kits by non-SAFEs*

   N/A since we employ our SAFEs.

3. *If a sexual assault victim comes to The Mount Sinai Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at the Mount Sinai Hospital to treat that Victim?*

   Mount Sinai has an extensive protocol for treating survivors of sexual violence who seek care at our Hospital. As an initial matter, MSH has an extensive training program for its clinicians and staff to identify potential survivors of sexual assault. Once a patient discloses sexual assault, they are triaged to a SAFE-equipped room. Both the on-call SAFE and SAVI Advocate are contacted to come to MSH to provide care and treatment to the patient. The Advocate is a certified volunteer who provides counseling, support, information, referral, advocacy and safety planning to the survivor. The Advocate remains with the survivor throughout their stay in the hospital. The SAFE conducts the medical and evidence collection exam, consistent with the patient's consent and wishes. Specific medical protocols and regimens are followed in the event the survivor is a candidate for and chooses a prophylaxis medication. The patient receives detailed discharge instructions and treatment/counseling options including follow- up for any medical care or continued prescription medication. The SAVI counselors follow- up with every patient to provide ongoing support including free therapy, advocacy and referral information. If an evidence collection kit is completed, the survivor can choose whether to report the assault to the New York City Police Department and sign the kit over to them immediately or to have the kit held with MSH Security until they decide if they want to file an official police report. Currently New York State requires preservation of the kit for a minimum of 30 days. However, MSH typically maintains the kits for at least one year, during which time SAVI contacts the survivor to check in on whether they would like us to destroy the kit or continue to hold it.

4. *Does Mount Sinai Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?*

The SAVI program at Mount Sinai tracks the number of sexual assault cases seen in the ED, whether a rape kit was requested and completed, who conducted the kit, demographics on the survivor, services each survivor received in the ED and afterwards, and some data on the assault if it is reported to us by the survivor (where the assault occurred, relationship of perpetrator to survivor, etc.) We provide quarterly reports on SAFE-related services and activities to the NYS DOH and NYS DCJS.

We believe that the above information is fully responsive to the Committee's questions. If you have additional requests or seek clarification, do not hesitate to contact us for additional information. Thank you for taking such an interest in these important programs for our patients.

Sincerely,

Lynn Frederick-Hawley
Executive Director
SAVI Program

cc:

Kenneth L. Davis, M.D.
President and CEO
Mount Sinai Health System

Emma Palmer
VP, Government Affairs and Public Policy
Mount Sinai Health System

March 27, 2018

Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Enclosed you will find the answers for the professionally trained SANE employees we have at our hospital – Nebraska Medicine, Omaha, NE

We included a copy of the questions with our answers because we did not repeat the question with some of our answers.

Thank you,

Suzanne L. Nuss
Chief Nursing Officer
Nebraska Medicine
987400 Nebraska Medical Center
Omaha, NE 68198-7400

Nebraska Medicine

SERIOUS MEDICINE. EXTRAORDINARY CARE.

Sent 3/27/18

SANE Questionnaire

1. Does Nebraska Medicine employ SANE or SAFE- certified medical professionals?
   Yes, Nebraska Medicine ED has a team of nurses trained as Sexual Assault Nurse Examiners.
2. If Nebraska Medicine does employ SANEs,
   a. **We have employed several trained SANE nurses since 2011, however officially began a program to train and staff SANE nurses in 2015.**
   b. **We currently have 7 trained SANE nurses who take call and also staff in the Emergency Department. Additionally, we have 4 nurses in training. Our team also has a emergency Medicine Physician champion who supports training, education, and quality of care, as well as a Pharmacist who researches best practice for emergency prophylaxis and coordinates continuity of care regarding medications and follow-up for HIV prophylaxis.**
   c. **We have used two different methods to obtain the 40 hour training required of SANE nurses. Several have completed the 40hr online training from IAFN (International Association of Forensic Nurses) others have attended a 40hr SANE Training Course. Nurses also, completed pelvic training as well as orientation in the department with another trained SANE nurse.**
   d. **Our SANE Nurses take call shifts. However, our team is not yet large enough to have 24-7 call coverage. Our nurses are also full time ED staff, in our experience if a SANE is not on call the majority of the time a SANE nurse is staffing in the department. If not, the charge nurse will call the ANM and send out a text to the Sexual Assault Nurse team to see if anyone is available to respond. If a SANE nurse is not available, we have an agreement with Nebraska Methodist SANE Team to transfer sexual assault victims after medical screening by Emergency Medicine Physician for SANE care at their facility. This option must be presented to the patient and agreed upon by the patient.**
   e. **Nebraska Medicine is not listed in the IAFN database.**
   f. **The annual cost of the SANE program relates to the call coverage by SANE nurses: Additionally any educational and meeting time that we participate in. There is not a quick way for us to quantify this amount.**
   g. **Nebraska Medicine is not involved in any grant funding currently. However, the Attorney General's Office for the State of Nebraska will reimburse up to $500 per case for forensic services provided to sexual assault patients.**
3. Nebraska Medicine does employ SANE nurses.
4. Upon presentation to the Emergency Department a sexual assault victim is identified as an ESI Acuity 2 and immediately roomed. The SANE nurse is contacted, police are notified, and request is made for advocacy services. The SANE nurse will collect HPI information and is present during the interview with law enforcement. The SANE nurse educates the patient

regarding options for forensic exam and collection of the SA (sexual assault) kit. Consent is obtained from the victim for evidence collection. The contents of the kit are collected by the SANE nurse and chain of custody is maintained by the SANE nurse until turned over to law enforcement. If a SANE nurse is not on call or available, the patient is educated by the staff regarding the SANE services and if stable for transfer offered to transfer to Nebraska Methodist Hospital for SANE care. All transfers are arranged in accordance with EMTALA. If the patient chooses not to transfer the SA kit is completed by the EM physician with assistance of ED nurse.

5. Audits are completed monthly regarding all patients who present to the Nebraska Medicine ED for care related to Sexual Assault. Audits include number of DV patients, SA patients, number of kits completed, number of transfers due to no SANE available, and number of kits completed by SANE nurse. Additionally, Nebraska Medicine participates in a community SART (Sexual Assault Response Team) to work toward continuity of care and best practices for all victims of sexual assault in the greater Omaha area.

For further questions or information regarding Nebraska Medicine SANE team please contact:
Amy Mead RN, BSN, CEN
SANE trained
Associate Nurse Manager Emergency Department
amead@nerbaskamed.com
402-559-9726

1. Does the Nebraska Medical Center employ SANEs or SAFE-certified medical professionals?

2. If the Nebraska Medical Center does employ SANEs,

    a. When did the Nebraska Medical Center begin employing SANEs?

    b. How many SANE or SAFEs does the Nebraska Medical Center employ?

    c. How were SANEs trained?

    d. During what days and hours are SANEs available at the Nebraska Medical Center?

    e. Is the Nebraska Medical Center listed on the IAFN database?

    f. What is the annual cost of administering the SANE program at the Nebraska Medical Center? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.

    g. What grants, if any, has the Nebraska Medical Center applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?

3. If the Nebraska Medical Center does not employ SANEs, does the Nebraska Medical Center provide rape kits by non-SANEs?

    a. If so, who conducts those kits?

    b. How are these medical professionals trained to collect those kits?

4. If a sexual assault victim comes to the Nebraska Medical Center requesting treatment and/or a rape kit following an assault, what procedures are in place at the Nebraska Medical Center to treat that victim? If the Nebraska Medical Center does not conduct a rape kit, SAFE certified or not, please include whether the Nebraska Medical Center has a relationship or agreement with another facility that does provide those services.

5. Does the Nebraska Medical Center track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

Thank you for your prompt attention to this matter. If you have any questions regarding this request, please contact Brighton Haslett with the Majority Committee staff at (202) 225-2927.

Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

March 13, 2018

B. Sue Miss
Can you get to the Right person to complete.
Thx
DMW

Dr. Daniel J. DeBehnke, MD, MBA
Chief Executive Officer
Nebraska Medical Center
4350 Dewey Avenue
Omaha, NE 68105

Dear Dr. DeBehnke:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is investigating the availability of sexual assault forensic exams at hospitals across the United States.

In 2016, the U.S. Government Accountability Office (GAO) published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." According to the GAO, a sexual assault forensic exam, also known as a "rape kit," may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training ("SAFE rape kits") "may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates."[1] The GAO found that in each of the six states examined, the number of SANEs "does not meet the need for exams within their states."[2]

Not all hospitals employ SANEs or provide SAFE rape kits to patients,[3] and there are no federal requirements regarding the availability of SANEs in health care facilities.[4] According to the GAO, a Joint Commission accreditation standard requires that hospitals "establish policies

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[1] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 1-2.
[2] *Id.* at 23.
[3] *What is a Rape Kit?*, RAINN, https://www.rainn.org/articles/rape-kit
[4] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 8.

for identifying and assessing possible victims of sexual assault and to train staff on those policies, [but] each hospital is responsible for determining the level of specificity of such policies, including the minimum level of training required of its medical staff that performs exams."[5] In other words, hospitals may simply choose not to provide these services.

Indeed, according to recent news reports, victims of sexual assault often have trouble obtaining a rape kit.[6] Moreover, GAO found that the lack of SANEs can be particularly acute in rural areas, where there may be just one SANE or one SANE program to serve multiple counties, and a patient may have to travel several hours to reach a facility that offers SAFE rape kits.[7] However, the issue is not isolated to rural areas.[8] In some metropolitan areas, including Washington, DC and Las Vegas, NV, there may be only one facility that provides SAFE rape kits.[9] As such, a rape victim must go to that specific hospital to get the most appropriate treatment.

Data on the availability of SANEs and SAFE rape kits nationwide is limited.[10] According to the Department of Justice, the most comprehensive database on SAFE facility locations is administered by the International Association of Forensic Nurses (IAFN). However, this database is based on self-reporting by facilities with SAFE programs, and as such, is incomplete. The IAFN database lists as few as two locations in some states, including Connecticut, Hawaii, Mississippi, South Dakota, and Wyoming. IAFN estimates that between 13 and 15 percent of hospitals in the United States provide SAFE rape kits. It is not clear what happens to a victim of sexual assault if he or she visits one of the roughly 85 percent of hospitals that do not provide these vital services.

Accordingly, the committee is interested in learning more about how hospitals treat patients seeking treatment and evidence collection following a sexual assault. Please provide written answers to the following questions by March 27, 2018.

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[5] *Id.* at 9.
[6] *At Least Half of Rape Victims in SC Aren't Seen by a Sexual Assault Nurse*, GREENVILLE NEWS (July 20, 2017), https://www.greenvilleonline.com/story/news/2017/07/20/sexual-assault-nurses-short-supply/492935001/; *Lawmakers Want Easier Access to Rape Kits*, COLUMBIA BASIN HERALD (Jan. 29, 2018), http://www.columbiabasinherald.com/local_news/20180129/lawmakers_want_easier_access_to_rape_kits; *Why Did It Take Nine Hours and Three Emergency Rooms For This Woman to Get a Rape Kit?*, COSMOPOLITAN, http://www.cosmopolitan.com/politics/a58941/dinisha-ball-rape-kit-texas-emergency-room/.
[7] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 23. *See also*, *You have to drive an hour for a rape kit in rural America*, The Washington Post, https://www.washingtonpost.com/news/wonk/wp/2016/04/19/you-have-to-drive-an-hour-for-a-rape-kit-in-rural-america/?utm_term=.29e3af0fe722 (April 19, 2016); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[8] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 24.
[9] *Why Are There No Rape Kits at the George Washington University*, WJLA, http://wjla.com/news/education/rape-kits-at-the-george-washington-university-9776 (March 25, 2011); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[10] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 21.

Regional One Health

March 21, 2018

The Honorable Greg Walden
Chairman House Energy and Commerce Committee
&
The Honorable Gregg Harper
Chairman Subcommittee on Oversight and Investigations –
House Energy and Commerce Committee
One Hundred and Fifteenth Congress of the United States
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Congressmen Walden and Harper:

This letter is in response to your request dated March 13, 2018, seeking information on how hospitals treat patients and handle evidence collection when patients seek treatment following a sexual assault. The responses to your inquiry follow.

1. **Does Regional One Health employ SANEs or SAFE-certified medical professionals?**
   Answer: No, Regional One Health does not employ SANE or SAFE-certified medical professionals.

2. **If Regional One Health does employ SANEs,**
   a. **When did Regional One Health begin employing SANEs?**
      Answer: Regional One Health does not employ SANEs.
   b. **How many SANE or SAFEs does Regional One Health employ?**
      Answer: Regional One Health Does Not employ SANEs.
   c. **How were SANEs trained?**
      Answer: Regional One Health does not train SANEs.
   d. **During what days and hours are SANEs available at Regional One Health?**
      Answer: Regional One Health does not employ SANEs. SANEs from the local rape crisis center are available on-call 24/7.
   e. **Is Regional One Health listed on the IAFN?**
      Answer: Regional One Health is not listed on the IAFN.

f. **What is the annual cost of administering the SANE program at Regional One Health? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015**.
Answer: Regional One Health Does not have a SANE program.

g. **What grants, if any, has Regional One Health applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?**
Answer: Regional One Health has not applied for or accepted funds for SANE training or for the treatment of sexual assault victims.

3. **If Regional One Health does not employ SANEs, does Regional One Health provide rape kits by non-SANEs?**
Answer: Regional One Health does not provide rape kits by non-SANEs. Regional One Health staff is trained to notify local law enforcement officers when sexual assault victims present. The law enforcement officials make contact with Rape Crisis to have someone come to the hospital to assess the patient.
   a. **If so, who conducts those kits?**
   Answer: The kits are conducted by professionals from the Shelby County Rape Crisis Center.
   b. **How are these medical professionals trained to collect those kits?**
   Answer: Regional One Health's medical professional do not collect rape kits.

4. **If a sexual assault victim comes to Regional One Health requesting treatment and/or a rape kit following an assault, what procedures are in place at Regional One Health to treat that victim? If Regional One Health does not conduct a rape kit, SAFE certified or not, please include whether Regional One Health has a relationship or agreement with another facility that does provide those services?**
Answer: Regional One Health's procedures direct staff to contact the local law enforcement agency when a victim of sexual assault presents. The local law enforcement agency contacts the local rape crisis center to provide the rape kit. Regional One Health has relationships with the local law enforcement agencies and the Rape Crisis Center.

5. **Does Regional One Health track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested and how many rape kits are completed?**
Answer: Regional One Health does not track data on the number of sexual assault victims treated each year, the number of rape kits requested or the number of rape kits completed each year.

If you have questions or need additional information, please contact Ms. Tish Towns at (901) 545-7176 or by email at ltowns@regionalonehealth.org. Thank you for service to the citizens of the United States.

Sincerely,

Reginald W. Coopwood, MD
President and CEO

Saint Alphonsus Health System

March 22, 2018

U.S. House Committee on Energy & Commerce
ATTN: Rep. Greg Walden, Chairman
and Rep. Gregg Harper, Chairman,
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington DC 20515-6115

RE: Information Request on Availability of Sexual Assault Forensic Exams at U.S. Hospitals

Dear Chairman Walden:

Thank you for inviting Saint Alphonsus Regional Medical Center to provide information to the House Energy & Commerce Committee as they investigate availability of sexual assault forensic exams at hospitals across the United States.

Saint Alphonsus commits significant resources and actively partners with other private & public entities to ensure that victims of sexual assault are treated with utmost dignity and provided compassionate, competent, comprehensive care and additional resources as needed.

Below we provide answers to the questions we received from the Committee:

1. Does Saint Alphonsus Regional Medical Center employ SANE or SAFE certified medical professionals?
    - **Yes. We have a community-based SAFE team that employs nurses from both major hospital systems in Ada County. This means that a victim in our community will have the same level of care offered at any of our four Emergency Departments or the free-standing FACES of Hope victim center.**

2. If Saint Alphonsus Regional Medical Center does employ SANES,
    a. When did Saint Alphonsus Regional Medical Center begin employing SANEs?
        - **2001**

    b. How many SANEs or SAFEs does Saint Alphonsus Regional Medical Center employ?
        - **6-10**

c. How were SANEs trained?

- **Each SANE is required to complete an International Association of Forensic Nurses (IAFN) recognized Sexual Assault Nurse Examiner (SANE) course, which is 40-42 hours. The nurse then follows a preceptor who is already a SANE nurse, and their orientation typically takes 4-6 months. Orientation includes additional classes and training, i.e. domestic violence, trauma-informed care, toxicology, etc. Each nurse is also required to spend time with law enforcement, attend court, and spend time with an advocate. Within 2-3 years our nurses are asked to successfully complete the SANE-A certification exam.**

d. During what days and hours are SANEs available at the Saint Alphonsus Regional Medical Center?

- **The SANE team takes call and is available 24 hours daily, 365 days a year.**

e. Is Saint Alphonsus Regional Medical Center listed on the IAFN database?

- **Yes**

f. What is the annual cost of administering the SANE Program at Saint Alphonsus Regional Medical Center? Please explain what is covered by this cost, such as the cost of SANE Training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.

- **There are no training expenses in the SANE Budget at this time. This budget does includes a full-time SANE Coordinator.**

FY15:	**Wages and Benefits -**	**$177,284.00**
	Supplies & Misc. Costs -	**$ 3,644.00**
	Total Expenses -	**$180,928.00**
FY16:	**Wages and Benefits -**	**$185,899.00**
	Supplies & Misc. Costs -	**$ 3,644.00**
	Total Expenses -	**$189,543.00**
FY17:	**Wages and Benefits -**	**$185,990.00**
	Supplies & Misc. Costs -	**$ 2,582.00**
	Total Expenses -	**$188,572.00**

g. What grants, if any, has Saint Alphonsus Regional Medical Center applied for or accepted to fund any programs related to the training of SANE's or treatment of sexual assault victims.

- **$75,000.00 - Initial grant to start our program came from Saint Alphonsus Women's Philanthropic Healthcare Fund. This provided**

initial training of the first group of SANEs and the cost of the colposcope. (2000)

- **$14,182.00 – Grant received from Idaho Council on Domestic Violence & Victim Assistance (ICDVVA) for training for SANE nurses. This included ongoing and initial training of SANEs.** (2004/2005)

- **$3,833.19 – Grant received from Saint Alphonsus Women's Healthcare Fund to send 3 SANE's to IAFN National Conference.** (2016)

- **$3,122.92 – Funded as part of a Grant to FACES of Hope from ICDVVA. This sent two nurses to IAFN National Conference held in Toronto, Canada. (2017)**

3. If Saint Alphonsus Regional Medical Center does not employ SANEs, does Saint Alphonsus Regional Medical Center provide rape kits by non-SANEs?
    - **Not applicable**

4. If a sexual assault victim comes to Saint Alphonsus Regional Medical Center requesting treatment and/or a rape kit following an assault, what procedures are in place at Saint Alphonsus Regional Medical Center to treat that victim?
    - **We have a policy and protocols in place for this situation. The first priority is ensuring that the victim does not need medical intervention emergently. Medical needs always take priority over forensic needs. Law enforcement and SANE are notified. Options are explained to the victim. Prophylaxis against Gonorrhea and Chlamydia is offered if the victim elects not to have a forensic exam, as well as pregnancy prophylaxis. If a victim chooses to have a forensic exam, the victim may choose to have forensic exam at the hospital Emergency Department or at our off-site facility (FACES of Hope Victim Center). The majority of our exams are at FACES of Hope location.**

5. Does Saint Alphonsus Regional Medical Center track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested and how many rape kits are completed?
    - **Yes – we track all of the above, including information on all SANE calls involving sexual assault. Data points include: (1) Time/day of week; (2) Exam given or declined; (3) If strangulation and/or alcohol involved; (4) Gender and age; (5) Police agency or jurisdiction involved; (6) Insurance status (FACES not reimbursed by government payer sources). (7) Kit number associated with patient. All victims that request a forensic exam will have an exam completed.**

We track the number of victims that decline an exam after options are explained.

Hopefully the above information is helpful to your investigation of this issue. If you have questions or need additional information, please do not hesitate to contact our SAFE Coordinator, Cynthia Cook, RN, BSN, SANE-A, at (208)577-4420 or Cynthia.a.cook@saintalphonsus.org, or contact me at (208)367-7078 or corey.surber@saintalphonsus.org.

Sincerely,

Corey Surber, MHS
Director of State Advocacy
Saint Alphonsus / Trinity Health

cc:
Odette Bolano, CEO, Saint Alphonsus Regional Medical Center
Cynthia Cook, RN, BSN, SANE-A, SAFE Coordinator

March 27, 2018

The Honorable Greg Walden
Chairman, House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515-6115

The Honorable Gregg Harper
Chairman, Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, DC 20515-61

cc: The Honorable Frank Pallone, Jr., Ranking Member, House Energy and Commerce Committee
cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Dear Chairman Walden and Chairman Harper,

Thank you for your interest in care for victims of sexual assault. We share your concern that these patients receive the right care delivered in a compassionate and timely way. In response to your questions about the availability of sexual assault forensic exams at Santa Rosa Memorial Hospital, we are providing the following responses:

1. **Does Santa Rosa Memorial Hospital employ SANEs or SAFE-certified medical professionals?** At Santa Rosa Memorial Hospital, we are committed to providing the best, most appropriate care and services to our communities, especially those who seek treatment for sexual assault. In Sonoma County, the District Attorney has established a forensic contract with the county hospital, Sutter Santa Rosa Regional Hospital, which details procedures on how to properly collect forensic evidence for victims of sexual assault. The contract instructs law enforcement to take patients who need a sexual assault examination directly to the designated facility, Sutter Santa Rosa Regional Hospital.

   Importantly, this contract allows Santa Rosa Memorial Hospital to collaborate with Sutter Santa Rosa Regional Hospital, which employs Sexual Assault Nurse Examiners, Sexual Assault Forensic Examiners and performs rape kits. If a patient needing a sexual assault exam comes to Santa Rosa Memorial Hospital's emergency department, we ensure that person is transported directly to the Sexual Assault Response Team at Sutter Santa Rosa Regional Hospital for timely, expert treatment.

   This collaboration between Santa Rosa Memorial Hospital and Sutter Santa Rosa Regional Hospital has worked well for our communities and has allowed us to serve anyone who is the victim of sexual assault.

2. **If Santa Rosa Memorial Hospital does employ SANEs:**

Questions a through g or not applicable.

3. **If Santa Rosa Memorial Hospital does not employ SANEs, does the Santa Rosa Memorial Hospital provide rape kits by non-SANEs?** No, our hospital does not provide rape kits by non-SANEs. We instead ensure that patients are directly transported to Sutter Santa Rosa Regional Hospital.
   Questions a and b are not applicable.

4. **If a sexual assault victim comes to the Santa Rosa Memorial Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at the Santa Rosa Memorial Hospital to treat that victim? If Santa Rosa Memorial Hospital does not conduct a rape kit, SAFE certified or not, please include whether Santa Rosa Memorial Hospital has a relationship or agreement with another facility that does provide those services.**

   Santa Rosa Memorial Hospital collaborates with Sutter Santa Rosa Regional Hospital, which has been designated by the District Attorney to provide rape kits and services to sexual assault victims. The manner in which most patients come to either facility is determined by law enforcement. Patients who report sexual assault are transported directly to the SART at Sutter Santa Rosa Regional Hospital.

   Santa Rosa Memorial Hospital takes very seriously the treatment of sexual assault and the care of victims who come to us at such a vulnerable time. We have established procedures in our emergency department so that our clinicians can serve as first responders for sexual assault patients:

   - A medical screening exam is done by a physician for every patient and law enforcement is notified of assault if an officer is not already present or aware.
   - If patients are medically cleared, they are discharged and our emergency department notifies the Sheriff's office and arranges to have patients transported to Sutter Santa Rosa Regional Hospital's emergency department. That ED has a specially designated private area for a forensic exam and evidence collection. Patients age 18 and younger or dependent adults are taken to Redwood Children's Center on the second floor of the Family Justice Center located in Redwood City, Calif.
   - If patients' injuries are determined to be traumatic (determined through the county destination guidelines) they would stay at Santa Rosa Memorial Hospital's emergency department. If they are too injured or unstable to discharge, a SANE/SAFE nurse will come to Santa Rosa Memorial Hospital to collect evidence.

5. **Does Santa Rosa Memorial Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?**

Yes, we do track the number of sexual assault victims treated each year. In 2017, 20 sexual assault patients sought treatment at our hospital and were taken to Sutter Santa Rosa Regional Hospital where rape kits were completed.

We hope you found our feedback informative and helpful to your important enquiries. Thank you for your interest in these very vulnerable patients, and we stand ready to work with you on how to improve care even more in the future. If you have additional questions or need more information please contact Jacquelyn Bombard, director of federal relations, at (425) 525-3654 or via email at Jacquelyn.Bombard@providence.org.

Sincerely,

Kevin Klockenga
Executive Vice President
Northern California Region
Providence St. Joseph Health

Texas Hospital Association

1108 Lavaca Street, Suite 700, Austin, Texas 78701
512/465-1000
www.tha.org

July 13, 2018

The Honorable Greg Walden, Chairman
The Honorable Frank Pallone, Jr., Ranking Member
The Honorable Gregg Harper, Chairman, Subcommittee on Oversight and Investigations
The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Re: Letter to Texas Hospital Association Regarding the Availability of Sexual Assault Forensic Exams in Texas Hospitals

Dear Chairman Walden, Chairman Harper, Congressman Pallone, and Congresswoman DeGette:

This letter and the enclosures are sent in response to the U.S. House of Representatives Committee on Energy and Commerce's letter of June 21, 2018 to the Texas Hospital Association[1]. We appreciate and thank you for your inquiry into the process in Texas related to access to sexual assault forensic examiners and forensic medical exams for sexual assault survivors.

The Texas Hospital Association is a statewide leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. THA represents 465 hospitals throughout Texas.

THA has a long history of working with victims' rights organizations, law enforcement, state regulatory agencies and the Texas Legislature in support of increasing access to sexual assault forensic examiners and forensic medical exams.

Stakeholders in Texas, along with THA, have been working since 2005 to develop a process that balances the availability of sexual assault forensic examiners with the geographic size and population of the state. According to the Texas Department of State Health Services (DSHS), there are 648 state-licensed hospitals in Texas. There are 219 state-licensed freestanding emergency care facilities (FEC). This is a total of 867 facilities with an emergency department. According to the Texas Attorney General, there are 360 certified Sexual Assault Nurse Examiners statewide[2].

[1] THA's complete response is comprised of this letter and the accompanying attachments, totaling 25 pages, 001-025.
[2] This information was received in response to a direct inquiry to the Texas Attorney General's Office by THA. To our knowledge, there is no publicly available database or link to this information.

The process in Texas related to the provision of services for survivors of sexual assault is found in the Texas Health and Safety Code, Chapter 323. The state law is applicable to hospitals with an emergency department and to FECs.

A summary of the Texas law can be found in the answer to question number five, below.

ANSWERS TO SPECIFIC COMMITTEE QUESTIONS. THA provides the following information as requested by the Committee:

Question No. 1: How many hospitals in Texas is the Texas Hospital Association aware of that have a SANE program:

> **Response**: The Texas Hospital Association does not maintain this information independently. However, according to the DSHS, 110 facilities in Texas are designated as a SAFE-Ready facility. A SAFE-Ready facility is a facility that employs or contracts with a sexual assault forensic examiner or uses a telemedicine system of sexual assault forensic examiners to provide consultation to a licensed nurse or physician when conducting a forensic medical exam. A copy of the Department's listing of SAFE-Ready facilities is enclosed under ***Tab 1***, 007-009.

Question No. 2: Does the Texas Hospital Association maintain a database of hospitals and/or other entities across Texas that have a SANE program? a. If so, is that database available publicly?

> **Response**: The Texas Hospital Association does not maintain a database of hospitals and/or other entities across Texas that have a SANE program. However, a database of SAFE-Ready facilities is statutorily required and is maintained by the DSHS. That database is available publicly and can be found at:
> http://www.dshs.texas.gov/facilities/sexual-assault-information.aspx.
> A printout of the most current public listing is enclosed under ***Tab 1***, 007-009.

Question No. 3: What steps, if any, has the Texas Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Texas. a. Does THA partner with law enforcement agencies in any capacity to provide access to SAFE kits?

> **Response**: THA has a long history of working with victims' rights organizations, law enforcement, state agencies and the Texas Legislature in support of increasing access to sexual assault forensic examiners and forensic medical exams. THA has actively supported legislation increasing access for sexual assault survivors in emergency departments and has taken an active role in educating hospital members about new and changing statutory requirements. However, in response to the Committee's specific inquiry, other than its general advocacy efforts, THA has not undertaken any steps specifically to increase or address the lack of access to SAFE kits, nor has it partnered with law enforcement agencies to provide access to SAFE kits.

Question No. 4. What challenges has the Texas Hospital Association identified that hospitals face in providing access to these services? a. How is THA working with your hospitals to address those challenges?

Response: Texas hospitals' primary challenge to providing access to sexual assault services lies in the size, geography and population of the state. The cost and intensive requirements of a SANE program can also be a challenge.

There are 867 facilities with an emergency department across the state. There are 360 certified sexual assault forensic examiners. The lack of certified examiners renders it impossible to locate a certified SANE at every Texas emergency department. The intensive nature and upkeep of the SANE certification and the relative infrequency of performing sexual assault forensic exams in remote or rural emergency departments also add to the challenges of ensuring all facilities are SAFE-Ready.

A SANE program is the preferred path for sexual assault forensic exams and evidence collection. THA, through its legislative advocacy and its member education, has worked to ensure that there is an available sexual assault forensic *process* at all emergency departments in Texas while maintaining an emphasis on the importance of having SAFE-Ready facilities available in communities statewide for sexual assault survivors.

Question No. 5: For hospitals in Texas that do not have a SANE program does the Texas Hospital Association provide guidance, standards or best practices on how to treat patients that come to the hospital seeking a SAFE kit?

Response: THA does not provide any guidance, standard or best practices on how to treat patients. THA endeavors to educate its member hospitals on changes in the law by providing summaries of statutory changes to its member hospitals, including summaries of changes to Texas Health and Safety Code chapter 323 related to the provision of emergency services for survivors of sexual assault. Please see the enclosure under ***Tab 2***, 010-012, an excerpt from THA's Health Law Manual containing a summary of HB 3152, legislation passed by the Texas Legislature in 2017 related to SAFE-Ready facilities and access to forensic medical exams. The Health Law Manual is provided to all member hospitals.

Question No. 5a: If so, what procedures are recommended?

Response: N/A

Question No. 5b: If so, please provide copies of any such guidance.

Response: Please see the enclosure under ***Tab 2***, 010-012, an excerpt from THA's Health Law Manual containing a summary of HB 3152, legislation passed by the Texas Legislature in 2017 related to SAFE-Ready facilities and access to forensic medical exams. The Health Law Manual is provided to all member hospitals.

Question No. 5c: Do procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center?

Response: Yes, the statutory requirements vary for emergency department facilities that are designated as SAFE-Ready versus those that are not designated.

Summary of Texas process for emergency services for survivors of sexual assault:

The process in Texas related to the provision of services for survivors of sexual assault is found in the Texas Health and Safety Code, Chapter 323. The state law is applicable to hospitals with an emergency department and licensed FECs.

According to Texas law, every hospital with an emergency department and every FEC must be able to provide a forensic medical exam onsite. The person who performs the exam must have at least basic forensic evidence collection training as approved by the appropriate state licensing board. The facility must have a plan to train personnel on forensic evidence collection.

Additionally, upon request of the DSHS, each facility must submit for approval a plan for providing the statutorily-required services. The required services in the plan include: a private area (if available) to wait and speak with appropriate medical, legal or crisis center staff; access to a sexual assault program advocate (if available); the required DSHS information forms including details on the forensic evidence collection process (see documents enclosed under ***Tab 3***, 013-019, copies of the required information); a private treatment room (if available); if indicated, access to appropriate prophylaxis; and, the name and number of the nearest sexual assault crisis center.

Texas law establishes two levels of facility: facilities that are qualified to provide the basic level of services (described above) and facilities that are self-determined and designated by DSHS to be SAFE-Ready (Sexual Assault Forensic Exam - Ready).

A SAFE-Ready facility is a facility that employs or contracts with a sexual assault forensic examiner or uses a telemedicine system of sexual assault forensic examiners to provider consultation to a licenses nurse or physician when conducting a forensic medical exam. According to DSHS, there are 110 SAFE-Ready facilities in Texas.

If a sexual assault survivor presents to a facility that is not designated as SAFE-Ready, the sexual assault survivor must be informed that the facility is not a SAFE-Ready facility and that the survivor is entitled to received care at that facility or to be transferred to a SAFE-Ready facility. The sexual assault survivor must also receive the standard DSHS form from the initial facility. This form (see documents enclosed under ***Tab 4***, 020-025, copies of the required information) includes: information regarding the benefits of receiving a forensic medical exam conducted by a sexual assault forensic examiner, the DSHS website link to the list and address of SAFE-Ready facilities, information about rape crisis centers and

reporting to law enforcement, and a statement that you have the right to receive the exam at the current ED location. If the patient chooses to transfer to a SAFE-Ready facility, the initial facility must contact the SAFE-Ready facility to confirm a sexual assault forensic examiner is available.

DSHS is authorized to conduct an inspection of any facility to ensure compliance with these requirements.

Again, THA appreciates the opportunity to provide this information to the Committee. Additional information pertinent to the Committee's inquiry can be found at:

Link to Licensed Texas hospitals:
https://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590006976

Link to Licensed Freestanding Emergency Centers:
https://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590006981

DSHS List of SAFE Ready Facilities
http://www.dshs.texas.gov/facilities/sexual-assault-information.aspx

Texas Health and Safety Code Chapter 323
https://statutes.capitol.texas.gov/Docs/HS/htm/HS.323.htm

If you have any questions or need additional information, please contact the undersigned at (512) 465-1000.

Sincerely,

Stephen G. Wohleb, Senior Vice President and General Counsel
Texas Hospital Association

Enclosures

cc *(via email)*: Texas Members of the Committee on Energy and Commerce: The Honorable Joe Barton, The Honorable Michael Burgess, MD, The Honorable Bill Flores, The Honorable Gene Green, The Honorable Pete Olson.

CERTIFICATE OF COMPLIANCE

I hereby certify with respect to the foregoing information and the enclosures contained under Tabs 1, 2, 3 and 4, 007-025 that: (1) a diligent search has been completed of all documents in THA's possession, custody, or control which reasonably could contain responsive documents; (2) documents responsive to the Committee's request have not been destroyed, modified, removed, transferred, or otherwise made inaccessible to the Committee since the date of receiving the Committee's request or in anticipation of receiving the Committee's request, and (3) all documents identified during the search that are responsive have been produced to the Committee, identified in a log provided to the Committee, as described in (17) of the Committee's document entitled "RESPONDING TO COMMITTEE DOCUMENT REQUESTS", or identified as provided in (10), (11) or (12) of the Committee's document entitled "RESPONDING TO COMMITTEE DOCUMENT REQUESTS".

_____

Stephen G. Wohleb, SVP/General Counsel
Texas Hospital Association

Tab 1

STATE OF TEXAS, COMMUNITY-WIDE
SELF DESIGNATED HOSPITALS
FOR THE TREATMENT OF SEXUAL ASSAULT SURVIVORS

HOSPITAL	ADDRESS	CITY	ZIP	COUNTY	TELEPHONE	NOTE:
BAPTIST HOSPITALS OF SOUTHEAST TEXAS	3080 COLLEGE STREET	BEAUMONT	77701	JEFFERSON	4092125000	
BAYLOR MEDICAL CENTER OF CARROLLTON	4343 NORTH JOSEY LANE	CARROLLTON	75010	DENTON	9724921010	
BAYLOR SCOTT & WHITE - COLLEGE STATION	700 SCOTT AND WHITE DRIVE	COLLEGE STATION	77845	BRAZOS	9792070100	
BAYLOR SCOTT & WHITE MCLANE CHILDRENS MEDICAL CENTER	1902 S.W. H. K. DODGEN LOOP	TEMPLE	76502	BELL	8777245437	
BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL	12505 LEBANON ROAD	FRISCO	75035	COLLIN	9729633333	
BAYLOR SCOTT & WHITE MEDICAL CENTER - HILLCREST	100 HILLCREST MEDICAL CENTER BLVD	WACO	76702	MCLENNAN	2542022000	
BAYLOR SCOTT & WHITE MEDICAL CENTER - LAKE POINTE	6800 SCENIC DRIVE	ROWLETT	75088	ROCKWALL	9724122273	
BAYLOR SCOTT & WHITE MEMORIAL HOSPITAL	2401 SOUTH 31ST STREET	TEMPLE	76508	BELL	2547242111	
BAYLOR SCOTT & WHITE THE HEART HOSPITAL - PLANO	1100 ALLIED DRIVE	PLANO	75093	COLLIN	4698143500	
BEN TAUB HOSPITAL (HARRIS HEALTH SYSTEM)	1504 TAUB LOOP	HOUSTON	77030	HARRIS	7138732219	
BIG BEND REGIONAL MEDICAL CENTER	2600 HIGHWAY 118 NORTH	ALPINE	79830	BREWSTER; PRESIDIO	4328373447	
CENTRAL TEXAS MEDICAL CENTER	1301 WONDER WORLD DRIVE	SAN MARCOS	78666	HAYS	5123538979	
CHI ST LUKES HEALTH - MEMORIAL LIVINGSTON	1717 HWY 59 BYPASS	LIVINGSTON	77351	POLK	9363298700	
CHILDREN'S HOSPITAL OF SAN ANTONIO	333 NORTH SANTA ROSA STREET	SAN ANTONIO	78207	BEXAR	210-704-3907	PEDIATRIC
CHILDREN'S MEDICAL CENTER DALLAS	1935 MEDICAL DISTRICT DRIVE	DALLAS	75235	DALLAS	2144567890	PEDIATRIC
CHILDREN'S MEDICAL CENTER PLANO	7601 PRESTON ROAD	PLANO	75024	COLLIN	4693037000	PEDIATRIC
CHRISTUS GOOD SHEPHERD MEDICAL CENTER-LONGVIEW	700 EAST MARSHALL AVENUE	LONGVIEW	75601	GREGG	9033151811	
CHRISTUS ST. ELIZABETH	2830 CALDER STREET	BEAUMONT	77702	JEFFERSON	4098927171	
CHRISTUS ST. MICHAEL	2400 ST. MICHAEL DRIVE	TEXARKANA	75503	BOWIE	9036141000	
CITIZENS MEDICAL CENTER	2701 HOSPITAL DRIVE	VICTORIA	77901	VICTORIA	3615739181	ARE PART OF THE COUNTY SART (SEXUAL ASSAULT RESPONSE TEAM)
COLLEGE STATION MEDICAL CENTER	1604 ROCK PRAIRIE ROAD	COLLEGE STATION	77845	BRAZOS	9797645111	
COOK CHILDRENS MEDICAL CENTER	801 SEVENTH AVENUE	FORT WORTH	76104	TARRANT	6828854340	PEDIATRIC
CORPUS CHRISTI MEDICAL CENTER - DOCTORS REGIONAL	3315 SOUTH ALAMEDA	CORPUS CHRISTI	78411	NUECES	3617611400	
COVENANT CHILDREN'S HOSPITAL	4015 22ND PLACE	LUBBOCK	79410	LUBBOCK	8067250000	PEDIATRIC
COVENANT HOSPITAL PLAINVIEW	2601 DIMMIT ROAD	PLAINVIEW	79072	HALE	8062964265	
COVENANT MEDICAL CENTER	3615 19TH STREET	LUBBOCK	79410	LUBBOCK	8067250000	SHARED PROGRAM W/ UNIVERSITY MEDICAL CENTER, LUBBOCK
COVENANT MEDICAL CENTER - LAKESIDE	24TH STREET	LUBBOCK	79410	LUBBOCK	8067250567	
DELL CHILDREN'S MEDICAL CENTER	4900 MUELLER BLVD	AUSTIN	78723	TRAVIS	5123240101	PEDIATRIC
DENTON REGIONAL MEDICAL CENTER	3535 SOUTH I-35 EAST	DENTON	76210	DENTON	9403843535	
DETAR HOSPITAL NAVARRO	506 EAST SAN ANTONIO STREET	VICTORIA	77901	VICTORIA	3615757441	ARE PART OF THE COUNTY SART (SEXUAL ASSAULT RESPONSE TEAM)
DETAR HOSPITAL NORTH	101 MEDICAL DRIVE	VICTORIA	77904	VICTORIA	3615736100	ARE PART OF THE COUNTY SART (SEXUAL ASSAULT RESPONSE TEAM)
DIMMIT REGIONAL HOSPITAL	704 HOSPITAL DRIVE	CARRIZO SPRINGS	78834	DIMMIT	8308762424	
DOCTORS HOSPITAL OF LAREDO	10700 MCPHERESON ROAD	LAREDO	78045	WEBB	9565232000	
DOCTORS REGIONAL HOSPITAL CORPUS CHRISTI	3315 SOUTH ALAMEDA	CORPUS CHRISTI	78411	NUECES	3617611400	
DRISCOLL CHILDREN S HOSPITAL	3533 SOUTH ALAMEDA	CORPUS CHRISTI	78411	NUECES	3616945027	PEDIATRIC
EDINBURG REGIONAL MEDICAL CENTER	1102 WEST TRENTON ROAD	EDINBURG	78539	HIDALGO	9563886000	
EL PASO CHILDRENS HOSPITAL	4845 ALAMEDA AVENUE	EL PASO	79905	EL PASO	9152428600	PEDIATRIC
GRACE MEDICAL CENTER	2412 50TH STREET	LUBBOCK	79412	LUBBOCK	8067884060	
GUADALUPE REGIONAL MEDICAL CENTER	1215 EAST COURT STREET	SEGUIN	78155	GUADALUPE	8303792411	
HARRIS HEALTH SYSTEM BEN TAUB HOSPITAL	1504 TAUB LOOP	HOUSTON	77030	HARRIS	7138732219	
HARRIS HEALTH SYSTEM LYNDON B JOHNSON HOSPITAL	5656 KELLEY STREET	HOUSTON	77026	HARRIS	7135666874	
HENDRICK MEDICAL CENTER	1900 PINE	ABILENE	79601	TAYLOR	3256702000	
HOPKINS COUNTY MEMORIAL HOSPITAL	115 AIRPORT ROAD	SULPHER SPRINGS	75482	HOPKINS	9038857671	
HUNT REGIONAL MEDICAL CENTER GREENVILLE	4215 JOE RAMSEY BLVD	GREENVILLE	75401	HUNT	9034085000	
HUNTSVILLE MEMORIAL HOSPITAL	110 MEMORIAL HOSPITAL DRIVE	HUNTSVILLE	77340	WALKER	9362914523	
JOHN PETER SMITH HOSPITAL	1500 SOUTH MAIN STREET	FORT WORTH	76104	TARRANT	8179213431	
LIMESTONE MEDICAL CENTER	701 MCCLINTIC DRIVE	GROESBECK	76642	LIMESTONE	2547293281	
MCALLEN MEDICAL CENTER	301 WEST EXPRESSWAY 83	MCALLEN	78503	HIDALGO	9566324000	
MEDICAL CENTER HOSPITAL	500 WEST 4TH STREET	ODESSA	79761	ECTOR	4326406000	
MEDICAL CENTER OF LEWISVILLE	500 WEST MAIN STREET	LEWISVILLE	75057	DENTON	9724201537	
MEDICAL CENTER OF PLANO	3901 WEST 15TH STREET	PLANO	75075	COLLIN	9725191105	
MEMORIAL HERMANN CYPRESS HOSPITAL	27800 NORTHWEST FREEWAY	CYPRESS	77433	HARRIS	3462314000	
MEMORIAL HERMANN HOSPITAL	6411 FANNIN	HOUSTON	77030	HARRIS	7137044000	
MEMORIAL HERMANN KATY HOSPITAL	23900 KATY FREEWAY	KATY	77494	HARRIS	2816447000	
MEMORIAL HERMANN MEMORIAL CITY MEDICAL CENTER	921 N GESSNER DRIVE	HOUSTON	77024	HARRIS	7139323000	
MEMORIAL HERMANN SOUTHWEST HOSPITAL	7600 BEECHNUT	HOUSTON	77074	HARRIS	7134565000	
MEMORIAL HERMANN SUGAR LAND	17500 WEST GRAND PARKWAY SOUTH	SUGAR LAND	77479	FORT BEND	2817255202	
MEMORIAL MEDICAL CENTER-LUFKIN	1201 WEST FRANK	LUFKIN	75904	ANGELINA	9366348111	
METHODIST DALLAS MEDICAL CENTER	1141 N. BECKLEY	DALLAS	75203	DALLAS	2149478181	
METHODIST SPECIALTY AND TRANSPLANT HOSPITAL	8026 FLOYD CURL DRIVE	SAN ANTONIO	78229	BEXAR	2105758110	
MIDLAND MEMORIAL HOSPITAL	400 ROSALIND REDFERN GROVER PARKWAY	MIDLAND	79701	MIDLAND	4326851111	
MISSION REGIONAL MEDICAL CENTER	900 SOUTH BRYAN ROAD	MISSION	78572	HIDALGO	9563239102	
NACOGDOCHES MEMORIAL HOSPITAL	1204 NORTH MOUND STREET	NACOGDOCHES	75961	NACOGDOCHES	9365595156	
NORTH TEXAS MEDICAL CENTER	1900 HOSPITAL BOULEVARD	GAINSVILLE	76240	COOKE	9406651751	
NORTHWEST TEXAS HOSPITAL	1501 S. COULTER	AMARILLO	79106	POTTER	8063541000	
ODESSA REGIONAL MEDICAL CENTER	520 EAST SIXTH STREET	ODESSA	79761	ECTOR	4325828000	
PALESTINE REGIONAL MEDICAL CENTER	2900 SOUTH LOOP 256	PALESTINE	75801	ANDERSON	9037311184	
PARIS REGIONAL MEDICAL CENTER NORTH CAMPUS	865 DESHONG DRIVE	PARIS	75462	LAMAR	9037854521	

STATE OF TEXAS, COMMUNITY-WIDE
SELF DESIGNATED HOSPITALS
FOR THE TREATMENT OF SEXUAL ASSAULT SURVIVORS

PARKLAND MEMORIAL HOSPITAL	5201 HARRY HINES BLVD	DALLAS	75235	DALLAS	2145900356	
PECOS COUNTY MEMORIAL HOSPITAL	387 WEST I-10	FORT STOCKTON	79735	PECOS	4323364201	
PETERSON REGIONAL MEDICAL CENTER	551 HILL COUNTRY DRIVE	KERRVILLE	78028	KERR	8302587366	
PROMISE HOSPITAL OF WICHITA FALLS	1103 GRACE STREET	WICHITA FALLS	76301	WICHITA	9407206633	
PROVIDENCE HEALTH CENTER	6901 MEDICAL PARKWAY	WACO	76712	MCLENNAN	2457514000	
RESOLUTE HEALTH	555 CREEKSIDE CROSSING	NEW BRAUNFELS	78130	COMAL	8305006602	
SCENIC MOUNTAIN MEDICAL CENTER	1601 WEST 11TH PLACE	BIG SPRING	79720	HOWARD	4322631211	
SCOTT & WHITE MEDICAL CENTER - TEMPLE	2401 SOUTH 31ST STREET	TEMPLE	76508	BELL	2547242111	
SEYMOUR HOSPITAL	200 STADIUM DRIVE	SEYMOUR	76380	BAYLOR	9408895572	
SHANNON WEST TEXAS MEMORIAL HOSPITAL	120 EAST HARRIS AVENUE	SAN ANGELO	76903	TOM GREEN	3256536741	
SHRINERS HOSPITAL FOR CHILDREN - GALVESTON	815 MARKET STREET	GALVESTON	77550	GALVESTON	4097706600	PEDIATRIC
ST DAVID'S MEDICAL CENTER	919 EAST 32ND STREET	AUSTIN	78705	TRAVIS	5124767111	
ST DAVID'S ROUND ROCK MEDICAL CENTER	2400 ROUND ROCK AVENUE	ROUND ROCK	78681	WILLIAMSON	5123411000	
ST DAVID'S SOUTH AUSTIN MEDICAL CENTER	901 WEST BEN WHITE BOULEVARD	AUSTIN	78704	TRAVIS	5124472211	
ST JOSEPH REGIONAL HEALTH CENTER	2801 FRANCISCAN DRIVE	BRYAN	77802	BRAZOS	9797763777	
ST JOSEPH REGIONAL REHABILITATION CENTER	1600 JOSEPH DRIVE	BRYAN	77802	BRAZOS	9798217500	
ST. LUKES SUGAR LAND HOSPITAL	1317 LAKE POINTE PARKWAY	SUGAR LAND	77478	FORT BEND	2816377000	
TEXAS HEALTH ARLINGTON MEMORIAL HOSPITAL	800 WEST RANDOL MILL ROAD	ARLINGTON	76012	TARRANT	8179606535	
TEXAS HEALTH HARRIS METHODIST HOSPITAL AZLE	108 DENVER TRAIL	AZLE	76020	TARRANT	8174448600	
TEXAS HEALTH HARRIS METHODIST HOSPITAL CLEBURNE	201 WALLS DRIVE	CLEBURNE	76033	JOHNSON	8176412551	
TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH	1301 PENNSYLVANIA AVENUE	FORT WORTH	76104	TARRANT	8172502000	
TEXAS HEALTH HARRIS METHODIST HOSPITAL HURST-EULESS-BE	1600 HOSPITAL PARKWAY	BEDFORD	76022	TARRANT	8178484602	
TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHWEST FORT	6100 HARRIS PARKWAY	FORT WORTH	76132	TARRANT	8174335000	
TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE	411 NORTH BELKNAP	STEPHENVILLE	76401	ERATH	2549651500	
TEXAS HEALTH PRESBYTERIAN DALLAS	8200 WALNUT HILL	DALLAS	75231	DALLAS	2143456789	
TEXAS HEALTH PRESBYTERIAN HOSPITAL ALLEN	1105 CENTRAL EXPRESSWAY NORTH	ALLEN	75013	COLLIN	9727471000	
TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	3000 I-35	DENTON	76201	DENTON	940898719	
TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO	6200 WEST PARKER ROAD	PLANO	75093	COLLIN	9729818000	
TEXAS HEALTH PRESBYTERIAN KAUFMAN	850 ED HALL DRIVE	KAUFMAN	75142	KAUFMAN	9729327200	
TEXOMA MEDICAL CENTER	5016 SOUTH US HIGHWAY 75	DENISON	75020	GRAYSON	9034164000	
TITUS REGIONAL MEDICAL CENTER	2001 NORTH JEFFERSON	MOUNT PLEASANT	75455	TITUS	9035776000	
TRINITY MOTHER FRANCES REHABILITATION HOSPITAL	3131 TROUP HIGHWAY	TYLER	75701	SMITH	9035107000	
UNITED REGIONAL HOSPITAL	1600 11TH STREET	WICHITA FALLS	76301	WICHITA	9407647000	
UNIVERSITY MEDICAL CENTER	602 INDIANA AVENUE	LUBBOCK	79415	LUBBOCK	8067758200	SHARED PROGRAM W/ COVENANT MEDICAL CENTER, LUBBOCK
UNIVERSITY MEDICAL CENTER OF EL PASO	4815 ALAMEDA AVENUE	EL PASO	79905	EL PASO	9155441200	
UNIVERSITY OF TEXAS MEDICAL BRANCH GALVESTON	301 UNIVERSITY BOULEVARD	GALVESTON	77555	GALVESTON	4097721011	
UT HEALTH EAST TEXAS CARTHAGE HOSPITAL	409 COTTAGE ROAD	CARTHAGE	75633	PANOLA	9036933841	SHARED PROGRAM W/ UT HEALTH EAST TEXAS HENDERSON
UT HEALTH EAST TEXAS HENDERSON HOSPITAL	300 WILSON STREET	HENDERSON	75652	RUSK	9036577541	SHARED PROGRAM W/ UT HEALTH EAST TEXAS CARTHAGE
UT HEALTH EAST TEXAS TYLER REGIONAL HOSPITAL	1000 SOUTH BECKHAM	TYLER	75701	SMITH	9035970351	
VAL VERDE REGIONAL MEDICAL CENTER	801 BEDELL AVENUE	DEL RIO	78840	VAL VERDE; EDWARDS; KINNEY; MAVERICK	8307783658	COVERAGE FOR EDWARDS, KINNEY, MAVERICK, & VAL VERDE COUNTIES
VALLEY BAPTIST MEDICAL CENTER	2101 PEASE STREET	HARLINGEN	78550	CAMERON	9563891674	
WADLEY REGIONAL MEDICAL CENTER	1000 PINE STREET	TEXARKANA	75501	BOWIE	9037988000	

NOTE: The information published herein is based upon facility self reports to HHS. The facility's status may have changed since the time of the publication.
If you are a facility that needs to update your designation or contact information, please email lisa.peers@hhsc.state.tx.us.
updated: May 22, 2018

Tab 2

identified), with patient and provider consent, or for enforcement purposes.

THHSC will develop and publish an annual report aggregating on a statewide basis the complications reported annually.

Not later than Jan. 1, 2018, THHSC will develop the reporting form for reporting complications and publish the forms on the agency's website and will develop the rules to implement this section.

IMPLICATIONS

All hospitals in Texas will be required to comply with this abortion complication reporting requirement.

This requirement will primarily impact a hospital emergency department. Hospitals will need to develop and put in place an emergency department protocol to ensure reporting of any abortion complication diagnosed or treated. Hospital emergency department providers will need to be educated and trained about the reporting requirement, the data requested and the standards on report specificity. Hospital ED staff will need to be aware of the THHSC electronic filing process and the 30-day deadline to file the report. Hospital counsel will need to ensure a timely filing process is developed to ensure repeated violations do not occur, because repeated violations can result in the suspension of a hospital's license.

HOUSE BILL 3152
Sponsors:
Rep. Senfronia Thompson
Sen. Joan Huffman
Effective Date: 9/1/17

Care and Transportation Provided to a Sexual Assault Survivor by a Health Care Facility

ANALYSIS

HB 3152 requires the Texas Department of State Health Services to designate sexual assault forensic exam-ready facilities, which employ or contract with a sexual assault forensic examiner, or use a telemedicine system to provide the consultation. HB 3152 applies to all health care facilities, including freestanding emergency medical care facilities.

Under the bill, a non-SAFE-ready facility must inform a sexual assault survivor of the closest SAFE-ready facility and provide statutorily required information on the benefits of a SAFE exam, information on TDSHS' online SAFE-ready facility list, a statement of rights and the method for obtaining additional information from TDSHS.

A survivor has the option to be transferred to the nearest SAFE-ready facility.

If the survivor elects such transfer, the initial facility must obtain the survivor's written, signed consent to the transfer, then stabilize and transfer the survivor accordingly. Prior to transfer, the initial facility must contact the SAFE-ready facility to confirm that a SAFE examiner is available.

Non-SAFE-ready hospitals and freestanding emergency medical care facilities should keep adequate supplies of TDSHS' information on hand for distribution to survivors and be aware of all disclosure, notification and consent requirements. The nearest SAFE-ready facilities should be identified and contacted to prepare for any future transfers.

IMPLICATIONS

SAFE-ready facilities should ensure compliance with applicable TDSHS requirements and confirm the facility is recognized by TDSHS. SAFE-ready facilities should be aware of any non-SAFE-ready facilities potentially transferring survivors.

Tab 3

Information Sheet for Sexual Assault Patients

If you are a child, an elderly person, or a disabled individual, the law requires any suspected sexual assault to be reported.

If you are age 18 or older, you may choose to report the sexual assault to law enforcement. You may request a medical forensic exam regardless of whether you choose to report the sexual assault.

Informed Consent: You (or your parent or guardian) will be provided information before you are examined or receive treatment. You may ask the medical provider to explain why questions are being asked, why certain evidence is collected or not collected, or which tests or treatments are necessary. You will then be asked to sign a consent form. You may decline to answer any question or decline any portion of the exam or treatment, even after you have provided written consent. A child may be examined and treated without parental consent.

Medical Forensic Exam: During the medical portion of the examination, injuries or other medical conditions are identified and treated. Results from medical testing will be available from this medical facility. Pictures may be taken of body surface injuries or genital injuries during the examination.

During the forensic portion of the examination, evidence is collected. The evidence may be used in an investigation. Depending on the nature of the assault, the following items may be collected during the exam: hair combings, swabs from areas of the body with potential DNA deposits, swabs from areas of genital contact, fingernail swabs/clippings, debris items and clothing.

If you are age 18 or older, medical forensic exams are usually not conducted if more than
96 hours (4 days) have passed since the assault. For children, a medical forensic exam should always be conducted, regardless of how long ago the assault occurred.

You may choose to have a support person (friend, family member, or advocate) in the exam room with you during the medical forensic exam. You may also choose not to have anyone in the exam room except for you and the medical staff. The exam may take several hours.

Reporting and Evidence: If you are age 18 or older and choose not to report the sexual assault now, you may still choose to have evidence collected in case you decide to report later. The Department of Public Safety crime laboratory is required to store the collected evidence for two years. The collected evidence will not be tested unless you report the sexual assault. To report the sexual assault at a later date, contact the law enforcement authority that serves the area where the assault occurred. You may also contact this law enforcement authority for the results of the forensic portion of your examination.

Sexually Transmitted Infections (STIs): The risk of contracting a STI after sexual assault is not known. Emergency treatment for STIs following sexual assault may include a combination of antibiotics designed to prevent most common STIs (gonorrhea, chlamydia, and trichomoniasis). Children and the elderly often do not receive preventive treatment for STIs.

HIV/AIDS: You may be concerned about the risk of HIV/AIDS. If the assault happened within the last 72 hours (3 days), there is a course of medication, called antiretroviral (ARV) therapy that may prevent HIV/AIDS transmission. ARV therapy may be available at the hospital or you may need a prescription to fill at a pharmacy. You may also go to a local health department or community clinic for testing and treatment of HIV/AIDS at a reduced cost. Treatment lasts 28 days and common side effects include feelings of tiredness, diarrhea, nausea, and flu-like symptoms. Talk with your medical provider for more information about the risk and preventive treatment of HIV/AIDS.

Pregnancy: You may be concerned about the risk of pregnancy. If the assault happened within the last 120 hours (5 days), there is medication called emergency contraception that may prevent pregnancy. Emergency contraception may be available at the hospital or you may choose to talk with a pharmacist for emergency contraception that is available without a prescription. The sooner emergency contraception is taken, the more likely it is to be effective. Talk with your medical provider for more information about the risk of pregnancy or emergency contraception. Emergency contraception is not given if you were already pregnant at the time of the sexual assault.

Drug Facilitated Sexual Assault: If you think you may have been drugged within the past 96 hours, immediately notify your medical provider so that she or he can obtain a urine and/or blood specimen as quickly as possible.

Payment: The medical forensic exam results in two bills, one for medical costs and one for forensic costs.

Medical costs, such as medications, x-rays, stitches, facility or provider fees, may be your responsibility. Your medical insurance may cover your medical costs. The attorney general may make a payment to you or on behalf of you for the reasonable costs incurred for medical care provided whether or not the crime is reported.
Forensic costs, such as swabbing for DNA, photographing injuries, or collecting debris, will not be your responsibility. The law enforcement authority you reported to or the Department of Public Safety will pay the forensic costs.

Crime Victims' Compensation: Crime Victims' Compensation may reimburse you for a variety of costs, including medical costs. Learn more about Crime Victims' Compensation by visiting www.oag.state.tx.us/victims/about_comp.shtml or calling 1-800-983-9933.

Advocacy: FREE and confidential information, counseling, and support are available through rape crisis centers. Call 1-800-656-HOPE to be connected to your closest rape crisis center or go to www.taasa.org for more information. Children's Advocacy Centers provide a child-friendly approach to the investigation process and provide services including counseling and support for children and their families. Go to www.cactx.org to find your closest child advocacy center.

Revised April 2, 2018

Folleto de información para pacientes de agresión sexual

Si usted es un menor de edad, una persona mayor o un individuo discapacitado, la ley exige que se denuncie toda posible agresión sexual.

Si tiene 18 años de edad o más, puede elegir denunciar la agresión sexual a la autoridad competente. Puede pedir que se le practique un examen médico forense sin importar si eligió denunciar o no la agresión sexual.

Consentimiento informado: Usted (o su padre o madre o tutor) recibirá la información adecuada antes de que se le practique el examen o reciba tratamiento. Puede pedirle al proveedor médico que le explique por qué se le hacen las preguntas, por qué se recaban o no se recaban ciertas pruebas y cuáles pruebas o tratamientos son necesarios. Después le pedirán que firme un formulario de consentimiento. Puede rehusarse a contestar cualquier pregunta o puede rehusar que se realice cualquier parte del examen o del tratamiento, incluso después de que haya proporcionado su consentimiento por escrito. A un menor de edad se le puede realizar el examen y dar tratamiento sin el consentimiento de los padres.

Examen médico forense: Durante la parte médica del examen, se identifican y tratan las lesiones u otras condiciones médicas. Los resultados de las pruebas médicas estarán disponibles en este centro médico. Es posible que durante el examen se tomen fotos de las lesiones en la superficie del cuerpo o las lesiones genitales.

Durante la parte forense del examen, se recaban las pruebas. Las pruebas se podrían usar en una investigación. Dependiendo de la naturaleza de la agresión, se pueden recoger los siguientes artículos durante el examen: cabellos al pasar el peine, muestras con hisopo de zonas del cuerpo con posibles restos de ADN, muestras con hisopo de las zonas de contacto genital, muestras con hisopo de las uñas o pedazos de uñas, artículos con residuos y ropa.

Si usted tiene 18 años de edad o más, normalmente no se realizan los exámenes médicos forenses si han pasado más de 96 horas (4 días) desde que ocurrió la agresión. En los niños, siempre se debe realizar un examen médico forense, sin importar cuánto tiempo haya pasado desde la agresión.

Puede elegir que una persona de apoyo (amigo, familiar, abogado) esté con usted en la sala de examen durante el examen médico forense. También

puede elegir que no esté presente nadie más en la sala de examen aparte de usted y el personal médico. El examen puede tomar varias horas.

Denuncia y pruebas: Si tiene 18 años de edad o más y elige no denunciar ahora la agresión sexual, todavía puede elegir que se recaben las pruebas por si acaso usted decidiera hacer la denuncia más adelante. La ley exige que el laboratorio de criminalística del Departamento de Seguridad Pública almacene durante dos años las pruebas recabadas. Las pruebas recabadas no serán examinadas a menos que usted denuncie la agresión sexual. Para denunciar la agresión sexual más adelante, comuníquese con la autoridad policial que da servicio al área donde ocurrió la agresión. También puede comunicarse con esta autoridad policial para obtener los resultados de la parte forense de su examen.

Infecciones de transmisión sexual (STI): No se conoce cuál es el riesgo de contraer una STI después de una agresión sexual. El tratamiento de emergencia para STI después de sufrir una agresión sexual puede incluir una combinación de antibióticos diseñados para prevenir las STI más comunes (gonorrea, clamidia y tricomoniasis). Los niños y las personas mayores a menudo no reciben tratamiento preventivo para las STI.

HIV y SIDA: Quizá le preocupe el riesgo de contraer el HIV o el SIDA. Si la agresión ocurrió en las últimas 72 horas (3 días), hay un procedimiento de medicación, llamado terapia antirretroviral (ARV), que puede prevenir la transmisión del HIV y el SIDA. Es probable que la terapia ARV esté disponible en el hospital o que usted necesite una receta para que se la surtan en una farmacia. También puede ir a un departamento de salud local o a una clínica comunitaria para hacerse pruebas y recibir tratamiento contra el HIV y el SIDA a un costo reducido. El tratamiento dura 28 días y entre los efectos secundarios comunes están la sensación de cansancio, la diarrea, la náusea y síntomas parecidos a los de la gripe. Hable con su proveedor médico para obtener más información sobre el riesgo de contraer el HIV o el SIDA o sobre el tratamiento preventivo.

Embarazo: Quizá le preocupe el riesgo de embarazo. Si la agresión ocurrió en las últimas 120 horas (5 días), hay una medicación llamada anticonceptivo de emergencia que puede prevenir el embarazo. Es probable que el anticonceptivo de emergencia esté disponible en el hospital, o usted puede elegir consultar con un farmacéutico sobre el uso del anticonceptivo de emergencia, el cual puede obtener sin receta. Entre más pronto se tome el anticonceptivo de emergencia, más probabilidad hay de que sea eficaz. Hable con su proveedor médico para obtener más información sobre el riesgo de embarazo o el anticonceptivo de emergencia. No se le dará el

anticonceptivo de emergencia si usted ya estaba embarazada en el momento en que ocurrió la agresión sexual.

Agresión sexual facilitada por drogas: Si cree que pudieron haberlo/a drogado en las últimas 96 horas, notifíquelo de inmediato a su proveedor médico para que este pueda obtener una muestra de orina o de sangre tan rápido como sea posible.

El pago: Del examen médico forense se derivan dos facturas, una por los gastos médicos y una por los gastos forenses.
Los gastos médicos, como medicamentos, radiografías, puntos de sutura o cargos del centro o proveedor médicos, es probable que corran bajo su responsabilidad. Su seguro médico podría cubrir sus gastos médicos. Es probable que el fiscal general le pague a usted, o pague de parte de usted, una cantidad razonable que corresponda a los gastos incurridos por la atención médica que se le proporcionó, independientemente de que usted denuncie o no el delito.
Los gastos forenses, como la obtención con hisopo de las muestras para el ADN, las fotografías de las lesiones, la recolección de restos, no correrán a su cargo. Las autoridades policiales ante las que usted puso la denuncia o el Departamento de Seguridad Pública pagarán los gastos forenses.

Compensación a las Víctimas de un Crimen: El Programa de Compensación a las Víctimas de un Crimen (Crime Victims' Compensation) le podría reembolsar diversos gastos, incluyendo los gastos médicos. Para obtener más información sobre la Compensación a las Víctimas de un Crimen, visite www.oag.state.tx.us/victims/index_span.shtml, o llame al 1-800-983-9933.

Apoyo: Tiene a su disposición información, asesoramiento psicológico y apoyo GRATUITOS y confidenciales a través de los centros de crisis por violación. Llame al 1-800-656-HOPE para comunicarse con el centro de crisis por violación más cercano, o vaya a www.taasa.org/about/espanol/ para obtener más información. Los centros de apoyo para menores (Children's Advocacy Centers) proporcionan un enfoque adecuado para el niño en el proceso de investigación, y ofrecen servicios que incluyen el asesoramiento psicológico y el apoyo a los niños y sus familias. Vaya a www.cactx.org/es para encontrar el centro de apoyo para menores más cercano a usted.

Revisado el 2 de abril de 2018

Tab 4

Information for sexual assault survivors at a health care facility that is not a SAFE-ready facility

What is a SAFE-ready facility?

- "SAFE-ready facility" means a health care facility designated as a sexual assault forensic exam-ready facility.
- A SAFE-ready facility uses a certified sexual assault nurse examiner or a physician with specialized training to conduct a forensic medical examination of a sexual assault survivor, or uses telemedicine to consult with a system of sexual assault forensic examiners, regardless of whether a report to law enforcement is made.
- A forensic medical examination is a procedure to assess a victim's health care needs relating to sexual assault and to collect any evidence for possible use in a law enforcement investigation and prosecution.

What are the benefits of a forensic medical examination?

The individual conducting the exam has been specially trained to provide compassionate, sensitive and comprehensive care to sexual assault survivors and is prepared to testify in court proceedings if necessary. This individual has up-to-date information on all aspects of care, is also familiar with the legal system, and can provide accurate information about a survivor's options and what happens if the survivor decides to report the sexual assault.[1]

This facility is not a SAFE-ready facility. The nearest SAFE ready facility is:

NAME:

_____

ADDRESS:

_____

[1] *A Guide for Survivors of Sexual Assault*, Texas Association Against Sexual Assault, Austin TX, available at https://texaslawhelp.org/article/guide-survivors-sexual-assault.

Texas law requires health care facilities give survivors of sexual assault this information form and notify them of their right to choose to have an exam at this facility or to be transferred to another facility.

As a survivor of sexual assault, you have the right to receive a forensic medical examination at this hospital emergency room if you are requesting the examination not later than 96 hours after the assault.

A report to law enforcement is not required, but if you make a report, law enforcement must first authorize the forensic medical examination.

You may call 1-800-656-HOPE (4673) to be connected to a rape crisis center for free and confidential assistance.

The website for the Health and Human Services Commission's list of SAFE-ready facilities: http://dshs.texas.gov/facilities/sexual-assault-information.aspx.

How to Submit a Complaint against a Regulated Health Facility
Complaints may be emailed, faxed, mailed, or delivered by phone via the complaint hotline: http://dshs.texas.gov/facilities/complaints.aspx

Email: hfc.complaints@hhsc.state.tx.us

Fax: (512) 834-6653

Complaint hotline: (888) 973-0022

Mailing address:
Health Facility Compliance Group (MC 1979)
Texas Health and Human Services Commission
P.O. Box 149347
Austin, TX 78714-9347

4/13/2018; form developed under TX HSC 323.0051 *Information form for sexual assault survivors at certain facilities.*

Información para víctimas de agresiones sexuales en centros médicos que no participan en el programa SAFE

¿En qué consisten los centros participantes en el programa SAFE?

- Estos centros médicos han sido designados como centros preparados para realizar análisis forenses en casos de agresión sexual.
- Estos centros contratan a personal médico especializado en agresiones sexuales para realizar análisis forenses a las víctimas o utilizan la telemedicina para consultar con un sistema de médicos forenses especializados en agresiones sexuales, aunque no se haya presentado ninguna denuncia ante las autoridades.
- Un análisis forense es un procedimiento mediante el cual se valoran las necesidades médicas de la víctima relacionadas con la agresión sexual sufrida y reunir cualquier prueba que pueda utilizarse durante la investigación y el proceso penal.

¿Qué ventajas ofrece el análisis médico forense?

La persona que realiza este tipo de análisis ha recibido capacitación especializada para atender con compasión, sensibilidad y de manera integral a las víctimas de agresiones sexuales y está preparada para testificar ante un tribunal en caso necesario. Esta persona dispone de información actualizada sobre todos los aspectos relacionados con estos cuidados y al mismo tiempo está familiarizada con el sistema legal; además, puede informar a los supervivientes de las opciones a su disposición y de lo que sucede cuando una víctima decide denunciar la agresión. [1]

Este centro no participa en el programa SAFE. El centro participante en el programa SAFE más cerca de usted es:

NOMBRE:

_____

DIRECCIÓN:

_____

[1] *A Guide for Survivors of Sexual Assault*, Texas Association Against Sexual Assault, Austin TX, disponible en https://texaslawhelp.org/article/guide-survivors-sexual-assault.

La ley en Texas exige a los centros médicos entregar a las víctimas de agresiones sexuales este formulario e informarles de su derecho a someterse a un examen en este tipo de centros o a solicitar su traslado a otro centro.

Como víctima de una agresión sexual, usted tiene derecho a solicitar un análisis forense en la sala de emergencias del hospital siempre que lo haga antes de que transcurran las primeras 96 horas desde el momento de la agresión.

Aunque no es obligatorio denunciar el incidente ante las autoridades, en caso de presentarse una denuncia, las autoridades deberán autorizar previamente el análisis médico forense.

Para comunicarse con un centro de atención en caso de violación y recibir ayuda gratuita y confidencial, puede llamar al 1-800-656-4673.

Puede encontrar una lista de centros participantes en el programa SAFE de la Comisión de Salud y Servicios Humanos en la siguiente dirección: http://dshs.texas.gov/facilities/sexual-assault-information.aspx.

Cómo presentar una denuncia contra un centro médico regulado
Puede presentar su denuncia por correo electrónico, fax, correo postal o teléfono (a través de la línea directa):
http://dshs.texas.gov/facilities/complaints.aspx

Correo electrónico: hfc.complaints@hhsc.state.tx.us

Fax: (512) 834-6653

Línea directa: (888) 973-0022

Dirección postal:
Health Facility Compliance Group (MC 1979)
Texas Health and Human Services Commission
P.O. Box 149347
Austin, TX 78714-9347

4/13/2018; formulario creado de conformidad con TX HSC 323.0051
Information form for sexual assault survivors at certain facilities (formulario de información para víctimas de agresiones sexuales en ciertos centros).

University Health™ System

March 26, 2018

The Honorable Greg Walden, Chairman
The Honorable Gregg Harper, Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
Congress of the United States
House of Representatives
2125 Rayburn House Office Building
Washington, DV 20515-6115

Dear Representatives Walden and Harper:

This letter is in response to your committee's request for information about how our healthcare facility treats patients and collects evidence following a sexual assault. As your letter states this is an important issue and one that our hospital works very closely with local Sexual Assault Nurse Examiners (SANE) on. The questions contained in your letter with responses from University Health are shown below:

1. Does the University Health Shreveport employ SANEs or SAFE-certified medical professionals?
   Answer – No

2. If University Health Shreveport does employ SANEs,

   a. When did University Health Shreveport beginemploying SANEs?
      Answer – N/A

   b. How many SANE or SAFEs does the University Health Shreveport employ?
      Answer – N/A

   c. How were SANEs trained?
      Answer - Training is coordinated by the Coroner's office.

   d. During what days and hours are SANEs available at theUniversity Health Shreveport?

Answer - They are not employed via UH, but they are available 24/7 through the Forensic Nurse Examiners of Louisiana. A number is provided to access SANEs 24/7.

e. Is the University Health Shreveport listed on the IAFN database?
Answer – No, the program is not managed by University Health but instead is coordinated by the Forensic Nurse Examiners of Louisiana.

f. What is the annual cost of administering the SANE program at the University Health Shreveport? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.
Answer - N/A.

g. What grants, if any, has the University Health Shreveport applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?
Answer - None

3. If the University Health Shreveport does not employ SANEs, does the University Health Shreveport provide rape kits by non-SANEs?
Answer - No

a. If so, who conducts those kits?
Answer – The Caddo Parish Coroner's Office has designated the Forensic Nurse Examiners of Louisiana to collect forensic evidence on victims of sexual assault at all times, 24 x 7.

b. How are these medical professionals trained to collect those kits?
Answer – Only SANEs utilize these kits. All SANES have completed IAFN SANE adult and adolescent training and all SANEs have completed pediatric training.

4. If a sexual assault victim comes to the University Health Shreveport requesting treatment and/or a rape kit following an assault, what procedures are in place at the University Health Shreveport to treat that victim? If the University Health Shreveport does not conduct a rape kit, SAFE certified or not, please include whether the University Health Shreveport has a relationship or agreement with another facility that does provide those services.
Answer – University Health follows the Caddo Parish Coroner's Office / Louisiana Department of Health Region 7 algorithm to initiate the sexual assault response team. The SANEs on call are trained with four being board certified sexual assault nurse examiners.

5. Does the University Health Shreveport track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?
   Answer - All statistics are tracked through the Caddo Parish Coroner's Office and the Nurse Examiners of Louisiana.

I hope that you find this information to be helpful. As you can see the SANE program is important to our community and to our state. Please contact me at 318-626-0974 for any clarification or additional information.

Sincerely,

Captain Daniel J. Snyder
Chief Executive Officer, University Health

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

March 13, 2018

Mr. Mason VanHouweling
Chief Executive Officer
University Medical Center of Southern Nevada
1800 W. Charleston Boulevard
Las Vegas, NV 89102

Dear Mr. VanHouweling:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is investigating the availability of sexual assault forensic exams at hospitals across the United States.

In 2016, the U.S. Government Accountability Office (GAO) published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." According to the GAO, a sexual assault forensic exam, also known as a "rape kit," may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training ("SAFE rape kits") "may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates."[1] The GAO found that in each of the six states examined, the number of SANEs "does not meet the need for exams within their states."[2]

Not all hospitals employ SANEs or provide SAFE rape kits to patients,[3] and there are no federal requirements regarding the availability of SANEs in health care facilities.[4] According to the GAO, a Joint Commission accreditation standard requires that hospitals "establish policies

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[1] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 1-2.
[2] *Id.* at 23.
[3] *What is a Rape Kit?*, RAINN, https://www.rainn.org/articles/rape-kit
[4] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 8.

for identifying and assessing possible victims of sexual assault and to train staff on those policies, [but] each hospital is responsible for determining the level of specificity of such policies, including the minimum level of training required of its medical staff that performs exams."[5] In other words, hospitals may simply choose not to provide these services.

Indeed, according to recent news reports, victims of sexual assault often have trouble obtaining a rape kit.[6] Moreover, GAO found that the lack of SANEs can be particularly acute in rural areas, where there may be just one SANE or one SANE program to serve multiple counties, and a patient may have to travel several hours to reach a facility that offers SAFE rape kits.[7] However, the issue is not isolated to rural areas.[8] In some metropolitan areas, including Washington, DC and Las Vegas, NV, there may be only one facility that provides SAFE rape kits.[9] As such, a rape victim must go to that specific hospital to get the most appropriate treatment.

Data on the availability of SANEs and SAFE rape kits nationwide is limited.[10] According to the Department of Justice, the most comprehensive database on SAFE facility locations is administered by the International Association of Forensic Nurses (IAFN). However, this database is based on self-reporting by facilities with SAFE programs, and as such, is incomplete. The IAFN database lists as few as two locations in some states, including Connecticut, Hawaii, Mississippi, South Dakota, and Wyoming. IAFN estimates that between 13 and 15 percent of hospitals in the United States provide SAFE rape kits. It is not clear what happens to a victim of sexual assault if he or she visits one of the roughly 85 percent of hospitals that do not provide these vital services.

Accordingly, the committee is interested in learning more about how hospitals treat patients seeking treatment and evidence collection following a sexual assault. Please provide written answers to the following questions by March 27, 2018.

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[5] *Id.* at 9.
[6] *At Least Half of Rape Victims in SC Aren't Seen by a Sexual Assault Nurse*, GREENVILLE NEWS (July 20, 2017), https://www.greenvilleonline.com/story/news/2017/07/20/sexual-assault-nurses-short-supply/492935001/; *Lawmakers Want Easier Access to Rape Kits*, COLUMBIA BASIN HERALD (Jan. 29, 2018), http://www.columbiabasinherald.com/local_news/20180129/lawmakers_want_easier_access_to_rape_kits; *Why Did It Take Nine Hours and Three Emergency Rooms For This Woman to Get a Rape Kit?*, COSMOPOLITAN, http://www.cosmopolitan.com/politics/a58941/dinisha-ball-rape-kit-texas-emergency-room/.
[7] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 23. *See also, You have to drive an hour for a rape kit in rural America*, The Washington Post, https://www.washingtonpost.com/news/wonk/wp/2016/04/19/you-have-to-drive-an-hour-for-a-rape-kit-in-rural-america/?utm_term=.29e3af0fe722 (April 19, 2016); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[8] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 24.
[9] *Why Are There No Rape Kits at the George Washington University*, WJLA, http://wjla.com/news/education/rape-kits-at-the-george-washington-university-9776 (March 25, 2011); *Where Are The Rape Kit Nurses?*, New York Times, https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html (June 20, 2017).
[10] U.S. Gov't Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 21.

1. Does the University Medical Center of Southern Nevada employ SANEs or SAFE-certified medical professionals?

2. If the University Medical Center of Southern Nevada does employ SANEs,

    a. When did the University Medical Center of Southern Nevada begin employing SANEs?

    b. How many SANE or SAFEs does the University Medical Center of Southern Nevada employ?

    c. How were SANEs trained?

    d. During what days and hours are SANEs available at the University Medical Center of Southern Nevada?

    e. Is the University Medical Center of Southern Nevada listed on the IAFN database?

    f. What is the annual cost of administering the SANE program at the University Medical Center of Southern Nevada? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.

    g. What grants, if any, has the University Medical Center of Southern Nevada applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?

3. If the University Medical Center of Southern Nevada does not employ SANEs, does the University Medical Center of Southern Nevada provide rape kits by non-SANEs?

    a. If so, who conducts those kits?

    b. How are these medical professionals trained to collect those kits?

4. If a sexual assault victim comes to the University Medical Center of Southern Nevada requesting treatment and/or a rape kit following an assault, what procedures are in place at the University Medical Center of Southern Nevada to treat that victim? If the University Medical Center of Southern Nevada does not conduct a rape kit, SAFE certified or not, please include whether the University Medical Center of Southern Nevada has a relationship or agreement with another facility that does provide those services.

5. Does the University Medical Center of Southern Nevada track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

Thank you for your prompt attention to this matter. If you have any questions regarding this request, please contact Brighton Haslett with the Majority Committee staff at (202) 225-2927.

Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

UMC
UNIVERSITY MEDICAL CENTER

March 26, 2018

RE: Response to letter dated March 13, 2018; Request for information on SANE/SAFE practices at University Medical Center of Southern Nevada

Per your request, please see answers in RED.

1. Does the University medical Center of Southern Nevada (UMCSN) employ SANEs or SAFE-certified professionals? **UMCSN's ER provider group, USACS, contracts with an outside vendor that provides SANE certified professional to conduct rape kit investigations. The vendor, Rose Heart, conducts all sexual assault exams performed at UMCSN.**

2. If the University Medical Center of Southern Nevada does employ SANEs,

   a. When did the University of Southern Nevada begin employing SANEs? **Approximately 1998**
   b. How many SANE or SAFEs does the University Medical Center of Southern Nevada employ? **Rose Heart, the vendor for SANE exams, employs 2 SANE certified nurses**
   c. How were SANEs trained? **SANE nurses are trained according to IAFN curriculum.**
   d. During what days and hours are SANEs available at the University Medical Center of Southern Nevada? **On call 24x7**
   e. Is the University Medical Center of Southern Nevada listed on the IAFN database? **NO**
   f. What is the annual cost of administering the SANE program at the University Medical Center of Southern Nevada? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015. **Unknown**
   g. What grants, if any, has the University Medical Center of Southern Nevada applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims? **NONE**

3. If the University Medical Center of Southern Nevada does not employ SANEs, does the University Medical Center of Southern Nevada provide rape kits by non-Sanes?
    a. If so, who conducts those kits? **N/A**
    b. How are the medical professionals trained to collect those kits? **N/A**

4. If a sexual assault victim comes to the University Medical Center of Southern Nevada requesting treatment and/or a rape kit following an assault, what procedures are in place at the University Medical Center of Southern Nevada to treat that victim? If the University Medical Center of Southern Nevada does not conduct a rape kit, SAFE certified or not, please include whether the University Medical Center of Southern Nevada has a relationship or agreement with another facility that does provide those services. **The victim is checked in through the Emergency Department and taken to a private, quite room. At that point, the SANE nurse is called and they complete the interview, medical and forensic exams. If there are any additional injuries or problems noted during those exams, care can be escalated to an Emergency Department Physician, if necessary. The victim is also given information to the Las Vegas Rape Crisis Center, and the center's resources are available while the victim is still a patient at UMCSN.**

5. Does the University Medical Center of Southern Nevada track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed? **That information is all tracked by Rose Heart, Inc.**

Should you require further assistance, please do not hesitate to contact Hollie Thornton (702) 383-3862.

Sincerely,

Debra Fox, CNO

Deb Fox
Chief Nursing Officer
UMCSN

uchealth

University of Colorado Hospital
Office of the President and CEO

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March 27, 2018

The Honorable Greg Walden, Chairman
U. S. House of Representatives
Committee on Energy and Commerce

The Honorable Gregg Harper, Chairman
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington D.C. 20515-6115

Dear Chairman Walden and Chairman Harper:

Thank you for including University of Colorado Hospital (UCH) in the outreach survey to respond to your questions concerning the availability of sexual assault forensic examinations. We are pleased to participate in your survey.

UCH is the only major teaching hospital in the State of Colorado providing the training and clinical research venues for the University of Colorado's health professions' education programs at the Anschutz Medical Campus in Aurora, CO. UCH is also the "academic anchor" for UCHealth, a major health and hospital system that includes eight additional community based hospitals in Colorado.

UCH proudly provides complete sexual assault forensic examination services in our emergency department. Accordingly, please accept the following as our responses to your questions:

1. Does the University of Colorado Hospital employ SANEs or SAFE-certified medical professionals?

   UCH Response: Yes

2. If the University of Colorado Hospital does employ SANEs,
   a. When did the University of Colorado Hospital begin employing SANEs?

UCH Response: November 2016

b. How many SANE or SAFEs does the University of Colorado Hospital employ?

UCH Response: Currently there are 16 Forensic Nurse Examiners on the team, including the manager.

c. How were SANEs trained?

UCH Response: All SANEs completed the Colorado Statewide 64 online training program, through UCHealth in Colorado Springs (which is grant funded). In addition, all SANEs have gone to the UCHealth two-day live model training in Colorado Springs; performed a minimum of 6 precepted adult exams; performed a minimum of 1 precepted suspect exam; performed a minimum of 10 precepted speculum exams; and observed a minimum of 8 hours of expert witness courtroom training.

d. During what days and hours are SANEs available at the University of Colorado Hospital?

UCH Response: The team is on-call 24 hours a day, 7 days a week.

e. Is the University of Colorado Hospital listed on the IAFN database?

UCH Response: Yes, we are on the IAFN website.

f. What is the annual cost of administering the SANE program at the University of Colorado Hospital? Please explain what is covered by this cost, such as the cost of SANE training, SANE salaries, and victim services. Please provide the cost for 2017, 2016, and 2015.

UCH Response: The cost covers the on-call pay for both orientees and preceptors; call-back pay for both orientees and preceptors; ten hours of on-going yearly training; monthly staff meetings; manager salary; orientation (to

include courtroom observation, live model training, hospital orientation, etc.); monthly journal clubs and peer reviews; and community outreach such as SART meetings. The 2016 cost was $28,052 and the 2017 cost was $158,807.

g. What grants, if any, has the University of Colorado Hospital applied for or accepted to fund any programs related to the training of SANEs or treatment of sexual assault victims?

UCH Response: The University of Colorado Hospital has not yet applied for any grants for our Forensic/SANE program.

3. If the University of Colorado Hospital does not employ SANEs, does the University of Colorado Hospital provide rape kits by non-SANEs?

UCH Response: N/A

4. If a sexual assault victim comes to the University of Colorado Hospital requesting treatment and/or a rape kit following an assault, what procedures are in place at the University of Colorado Hospital to treat that victim? If the University of Colorado Hospital does not conduct a rape kit, SAFE certified or not, please include whether the University of Colorado Hospital has a relationship or agreement with another facility that does provide those services.

UCH Response: All patients are seen through the Emergency Department and have a medical screening exam by an Emergency Physician. If forensic services are needed, the physician notifies the ED call center who will call the on-call Forensic Nurse Examiner (FNE). The FNE will then discuss the patient case with the Physician and determine if an exam is needed. If so, the FNE will come into the hospital and has a one hour response time. The FNE is guided by a SANE pathway, which is a standing order set based on IAFN and CO Statewide SANE education and practices. The SANE pathway includes labs, prophylactic medications for STIs and pregnancy, as well as immunizations in accordance with the CDC guidelines. Community and Law Enforcement Advocates are called for every patient by the FNE. In addition,

uchealth

Emergency Department Social Workers and/or Behavioral Health Evaluators see SANE patients as needed.

5. Does the University of Colorado Hospital track any data on sexual assault, such as the number of sexual assault victims treated each year, how many rape kits are requested, and how many rape kits are completed?

   UCH Response: Yes, the team tracks the following data: Case number, Police Agency (jurisdiction of assault); Mode of Arrival; Victim vs Suspect; Type of Forensic Service (Sexual Assault, Strangulation, Intimate Partner Violence, Elder Abuse, Child Abuse, and/or Human Trafficking); Type of Report (Law, Medical or Anonymous); Patient Age; Patient Gender; Date of week and Time of Day of exam; Length of exam; and if Drugs to Facilitate Sexual Assault (DFSA) was collected.

We hope that our responses to your survey questions are sufficient in meeting your needs. However, if you need any further clarification or additional information we would be pleased to provide such.

Again, thank you for including UCH in this survey and we stand ready to assist your committee and subcommittee in any way as needed.

Sincerely,

Will Cook

Will Cook
President & CEO
University of Colorado Hospital

cc: The Honorable Frank Pallone, Jr., Ranking Member
Committee on Energy and Commerce

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

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July 3, 2018

Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representatives Walden and Harper:

Thank you for the opportunity to respond to your request for information regarding the Utah Hospital Association's work in regard to the availability of sexual assault forensic exams across Utah. Please see the following responses to the questions posed by the Committee:

1. **How many hospitals in Utah is Utah Hospital Association aware of that have a SANE program?** Currently Utah has 19 active Sexual Assault Nurse Examiners (SANE) programs operating throughout the state. This number includes 14 hospital-based programs and five SANE Team regional programs, two of which are based in hospitals. The hospital based and regional SANE programs provide coverage for approximately 39 of the 44 acute care hospitals in Utah. In addition, over 400 nurses and others have been SANE trained, making Utah one of the highest SANE training states per capita as listed in the 2016 GAO report.

2. **Does Utah Hospital Association maintain a database of hospitals and/or other entities across Utah that have a SANE Program?** UHA does not maintain a database of hospitals and/or entities that have a SANE program. It is our understanding that Utah does not have a public database of SANE entities because a patient must come to a hospital or contact law enforcement to obtain care. A patient cannot directly contact a SANE program. However, the Utah Department of Health's Violence and Injury Prevention Program has dedicated a section on their website to Rape and Sexual Assault Resources which includes a listing of Rape Crisis Programs in Utah as well as toll-free phone numbers for the Utah Domestic Violence Link Line and the Rape & Sexual Assault Crisis Line. Additionally, the 2018 Utah State legislature has allocated $50,000 for a statewide electronic medical record for sexual assault exams. This would allow all SANE records to be protected digitally, improve access to law enforcement, allow peer review and enable sexual assault statistics to be more easily maintained by the state. The Utah Coalition Against Sexual Assault (UCASA) in their 2017 report does a good job of listing all SANE programs in Utah.

3. **What steps, if any, has the Utah Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Utah?** Over the years, UHA has had interaction with SANE and SAFE through the work of Wasatch Forensic Nurses (WFN; formerly Salt Lake SANE) and UCASA. Since 2002 it has been the work of WFN and UCASA to offer in-state training for nurses who want to provide these exams. The standard set by the International Association of Forensic Nurses (IAFN) is that each nurse complete 40 class hours of training prior to receiving clinical exam practice. In Utah, UCASA and WFN have been providing two classes a year for more than 10 years. For the last two years the education has been provided at no cost through federal grants. UHA has also teamed up with the Utah Department of Health to remind Utah acute care hospitals of their responsibility to have SAFE kits available at their hospital and most are actively complying.

4. **What challenges has Utah Hospital Association identified that hospitals face in providing access to these services? How is the Utah Hospital Association working with your hospitals to address those challenges?** The greatest obstacle to providing this care in rural and frontier communities is having nurses do an adequate number of exams to achieve and maintain clinical competency. Utah has a number of small hospital who are as much as 70 miles from the next closest hospital. UHA has supported UCASA's efforts to provide onsite education at some Utah rural hospitals, bringing a "model" patient onsite to assist SANEs in rural communities in practicing exam skills, but funding is limited. It is very hard for rural hospitals to prioritize the funds to do these exams when they have so many other healthcare responsibilities to the community. The State of Utah reimburses $750.00 per exam, but if a program conducts only 2-3 exams a year, it is difficult if not impossible to cover the cost of equipment, education, call time, court time and other expenses that go into running and sustaining a SANE program. WFN, which will do approximately 800 exams this year, still requires $50,000 + in grants to meet all expenses. Another major problem is lack a reciprocity to allow nurses who are not part of an independent team to go from one hospital to another. For example, two rural Utah communities, Vernal and Roosevelt, are only 30 minutes apart but they each require their own team of nurses. The independent teams must have MOUs in place with every hospital and they must provide malpractice for their nurses and other administrative costs. Small programs cannot afford to create the infrastructure to respond to additional facilities.

5. **For hospitals in Utah that have a SANE program, does Utah Hospital Association provide guidance, standards or best practices on how to treat patients that come to the hospital seeking a SAFE kit?** The Utah Hospital Association has not specifically provided guidance regarding SAFE kit protocol to members. We have encouraged them to be active on this issue and use the expertise of UCASA and WFN to educate hospitals on best practices and standards. Our statewide SANE Coordinator, Susan Chasson, is currently serving as President of the International Association of Forensic Nurses (IAFN), representing more than 4,000 forensic nurses across the U.S. and Canada. In 2016, IAFN, in partnership with the American College of Emergency Physicians and under the direction of the Office of

Victims of Crime, revised the SANE Program and Operations Guide, available at https://www.ovcttac.gov/saneguide/introduction. This guide provides detailed information and resources for both starting and sustaining SANE programs. These guidelines are followed by WFN and UCASA and the hospital based SANE programs in Utah.

Thank you for the opportunity to provide information on Utah's SANE initiatives. We feel that we have a strong collaborative process in Utah between the hospitals, nurses, UCASA and others involved in this issue. Please feel free to contact me if I can be of further assistance.

Sincerely,

Greg Bell
President/CEO
Utah Hospital Association

Washington State Hospital Association

July 20, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House
Washington, DC 20515

The Honorable Gregg Harper
Ranking Member
Subcommittee on Oversight and Investigations
U.S. House
Washington, DC 20515

Chairman Walden and Ranking Member Harper:

On behalf of our 99 community hospital members, the Washington State Hospital Association (WSHA) appreciates the opportunity to provide information about sexual assault forensic evidence collection and hospital services provided to patients in Washington State.

WSHA supports access to sexual assault forensic evidence collection by trained medical providers
As a membership organization, WSHA advocates for and supports our members in achieving their missions and improving the health of their communities. WSHA actively supports our member hospitals to provide sexual assault forensic evidence collection though well-trained providers as part of a high-quality, sustainable service. Along with our members, WSHA works with advocacy groups, legislators, law enforcement agencies, prosecutors, state agencies, universities, counties, and cities to improve the availability and quality of services for sexual assault survivors in Washington State. WSHA supports and partners with the University of Washington Harborview Center for Sexual Assault and Traumatic Stress, a hospital-based center that provides Sexual Assault Nurse Examiner (SANE) training statewide, to increase SANE training availability. In addition, WSHA staff serve on the Sexual Assault Forensic Examination Best Practices Task Force, a statewide legislatively created task force.

Hospitals face ongoing challenges in hiring and retaining SANEs
Most hospitals in Washington State provide sexual assault forensic evidence exams and collection via trained medical providers, including Sexual Assault Nurse Examiners (SANEs). However, there are significant barriers to providing sexual assault forensic evidence collection services. Access to this service can be limited by provider availability. Due to staffing availability, some hospitals are not able to provide SANE services or provide this service on a 24/7, 365-day basis. In such cases, patients are screened and stabilized and then may be transferred or referred to a hospital that provides this service.

There is significant cost and time associated with specialized training such as SANE training. This can be prohibitive, especially for small, rural, and remote hospitals that already struggle to find sufficient staff members. In addition, this work requires specialized skill and aptitude, making it challenging to retain specially trained providers. Because the work requires advanced skills, some of the SANE providers are also the best nurses to assist in the case of trauma or life-threatening illness. They will first assist with life-saving treatment.

Some providers find they do not want to provide the service or experience vicarious trauma when they do. In addition, some providers decide not to continue to provide forensic evidence collection because of fear of testifying in court proceedings or after having a bad experience before a court.

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Hospitals with low or sporadic case volumes note that it is very difficult to maintain certification requirements, proficiency, and expertise for specially trained staff to provide sexual assault forensic evidence collection. One rural hospital noted that in the past ten years, one sexual assault survivor has come to the hospital seeking a forensic exam. With such low patient volume, it is difficult for specially trained staff to remain competent to perform these forensic exams.

WSHA responses to committee questions
Below are responses to the questions posed in the committee's June 21 letter. Where appropriate, we have provided additional background or contextual information to provide a more comprehensive picture of the work of WSHA and others regarding the availability of sexual assault forensic exams at hospitals across Washington State.

1. *How many hospitals in Washington is Washington State Hospital Association aware of that have a SANE program?*

WSHA surveyed our community hospital members in order to provide accurate information to the committee. The survey did not include specialty hospitals, such as psychiatric and rehabilitation hospitals. WSHA surveyed 90 community hospitals and received information for 88 hospitals. According to this information, 68 hospitals in Washington State provide sexual assault forensic exams and 22 hospitals do not provide these exams.

Some hospitals provide sexual assault forensic exams at all times. At other hospitals, the sexual assault forensic exams are available if a SANE or other trained staff member is available. Some hospitals employ SANE-trained staff, some contract with another entity to provide SANEs, and some have other trained staff perform exams. Because pediatric sexual assault exams require a particularly high level of expertise, most hospitals transfer pediatric patients (minors under the age of 12 or 14) to a location that specializes in serving these patients.

2. *Does Washington State Hospital Association maintain a database of hospitals and/or other entities across Washington that have a SANE program? If so, is that database publicly available?*

The University of Washington Harborview Center for Sexual Assault and Traumatic Stress, a member of the Washington State Hospital Association and the trainer for SANE providers in our state, maintains a publicly available list of facilities by county that provide sexual assault forensic evidence exams. The website is: http://depts.washington.edu/hcsats/ch/index.html and the search function is available here.

WSHA surveys members from time to time regarding sexual assault forensic exam availability but does not maintain an up-to-date database.

3. What *steps, if any, has Washington State Hospital Association taken to increase access or address the lack of access to SAFE kits in hospitals across Washington? Does WSHA partner with law enforcement agencies in any capacity to provide access to SAFE kits?*

Access concerns in Washington State focus on access to trained medical providers who are available to conduct sexual assault forensic evidence exams and collection. There is not a lack of availability of the

kits themselves. However, adequate law enforcement resources to track, analyze, and store the kits is a barrier.

Below is information on WSHA's work to increase access to trained providers who provide sexual assault forensic evidence exams and collection. Of note, most hospitals that provide sexual assault forensic evidence kit collection in Washington State use the TriTech Sexual Assault Evidence Kit Re-WA 3, which meets the requirements of the Washington State Patrol Crime Lab and the professional guidelines set forth by University of Washington Harborview Center for Sexual Assault and Traumatic Stress.

WSHA actively supports work that promotes access to sexual assault forensic exams, SANE services, and forensic evidence kits. Recent examples include:

- **Statewide sexual assault kit tracking system.** Washington State House Bill 2530 (passed in 2016) established a statewide tracking system for sexual assault forensic evidence kits. WSHA actively supported the establishment of the tracking system and is currently assisting the Washington State Patrol to train hospital staff to use the tracking system. The Washington State Patrol is bringing the tracking system online by region, with the goal of having the system operational by the end of the year. More information on the tracking system is available here.
- **Sexual assault kit testing and establishment of a statewide task force.** WSHA supported the passage of Washington State House Bill 1068 (passed in 2015), mandating the testing of reported, but untested sexual assault examination kits in Washington State. The bill also established a statewide task force on sexual assault forensic examination best practices. The resulting Sexual Assault Forensic Examination Best Practices Task Force is a statewide task force with representatives from hospitals, law enforcement agencies, survivor advocates, prosecuting and defense counsel, universities and colleges, and legislators. Zosia Stanley, Government Affairs Director at WSHA, has served on the Task Force since it was established in 2015. Information about the Task Force, including annual reports, is available here.
- **Studies on SANE availability.** Washington State House Bill 2711 (passed in 2016) directed the state Office of Crime Victims Advocacy (OCVA) to study the availability of SANEs in Washington State. WSHA assisted OCVA with this work and the final study is available here. According to the 2016 study, there are over 200 trained SANEs in Washington State. Washington State House Bill 2101 (passed in 2018) directed the Office of Crime Victims Advocacy (OCVA) to build on the 2015 report and identify best practices to increase patient access to SANEs and to increase statewide access to SANE training. WSHA is assisting OCVA on this study.
- **Funding for SANE training.** The University of Washington Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) provides SANE training in Washington State. WSHA works closely with HCSATS to support funding for SANE training and to publicize training opportunities to WSHA members. HCSATS also provides and publicizes professional guidelines to be used in sexual assault examinations and evidence collection. These guidelines are available here.
- **Coordination with law enforcement.** WSHA works with the Washington Association of Sheriffs and Police Chiefs, the Washington State Patrol, the Washington State Crime Laboratory, and the Washington State Office of the Attorney General to address access to forensic exams and kits and other areas including appropriate storage and retention of such kits.

- **Accurate count of untested sexual assault kits.** The Washington State Office of the Attorney General is working to inventory, test, and help investigate backlogged sexual assault forensic evidence kits as part of a grant from the U.S. Department of Justice. WSHA is assisting the Office of the Attorney General to count kits stored in hospitals.

4. *What challenges has Washington State Hospital Association identified that hospitals face in providing access to these services? How is Washington State Hospital Association working with your hospitals to address those challenges?*

As noted above, there can be significant barriers to providing sexual assault forensic evidence collection services and access to this service can be limited by provider availability.

- **Cost and time of training.** Specialty sexual assault forensic evidence collection training (such as SANE training) requires substantial time, the cost can be burdensome, and training often requires significant travel to a training site. For small, rural, and remote hospitals it can be challenging to cover patient care needs when a staff member is away for a multiple day training.
- **Provider interest and retention.** Staff may be uninterested or unwilling to take training or provide sexual assault forensic evidence exams. The service requires a specialized capacity. Some providers may be willing to collect exams but find the work difficult or burn out and leave a hospital's employment or seek other work within the hospital.
- **Maintaining skills and competency.** Hospitals with low or sporadic case volumes note that it can be difficult to provide staff with sufficient experience and practice to remain competent and confident. This is particularly important because the results of the exam often become evidence in a criminal matter and any mistake can taint the evidence and ruin the case.
- **Continuous availability.** In some hospitals there are a limited number of specially trained providers and they are not always available or on call. If a trained provider is not available, the patient may be transferred or referred to another hospital. In some hospitals the specially trained staff are also the most experienced. Especially in small hospitals, if these staff are needed to treat trauma or accident patients, the staff are not available in a timely manner to provide sexual assault examinations.
- **Court involvement.** Hospital providers do not have experience or expertise with court processes, particularly ones where a defense strategy is to question motives and competence. Many describe the experience as grueling, lengthy and demeaning. They often do not wish to repeat it.

5. *For hospitals in Washington that do not have a SANE program, does Washington State Hospital Association provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking a SAFE kit? If so, what procedures are recommended? If so, please provide copies of any such guidance, standards, or best practices. Do the procedures vary for hospitals in rural and urban areas, or based on the availability of local alternatives, such as a rape crisis center?*

In our role as an association, WSHA does not currently provide guidance, standards, or best practices on how to treat patients that come to the hospital seeking sexual assault forensic evidence kit collection because this expertise and training exists among our membership. WSHA does provide these

recommended resources for members, including the University of Washington Harborview Center for Sexual Assault and Traumatic Stress and the Washington Coalition of Sexual Assault Programs. We also work with Washington Coalition of Sexual Assault Programs to help hospitals coordinate with the local county sexual assault program in each county.

The availability of sexual assault forensic exams varies by region in Washington State. In rural areas of Washington State, including the far west, east, and north of the state, residents travel long distances to regional hubs for a variety of services, including health care. Some rural hospitals may not have the resources and capacity to provide sexual assault forensic exams, but all hospitals do provide medical care, stabilization, and referral to all patients. In addition, hospitals work with local county sexual assault programs to connect patients with local resources and supports

WSHA appreciates the Committee's interest in this important area. We look forward to hearing more about the work being done at a federal level. Please direct questions to me or to WSHA's policy lead on this subject, Zosia Stanley, Government Affairs Director, at zosias@wsha.org.

Sincerely,

Cassie Sauer
President and CEO
Washington State Hospital Association