STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

January 25, 2017

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

Re: 2016 Joint Chairmen's Report, Page 67, M00A01.01 – Report on Mobile Sexual Assault Forensic Exam Teams

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to page 67 of the Joint Chairmen's Report of 2016, the Department of Health and Mental Hygiene (DHMH) respectfully submits this report on Mobile Sexual Assault Forensic Exam (SAFE) Teams. Specifically, it was requested that the report (1) contain information on DHMH's efforts to establish mobile SAFE teams, or the establishment of protocols to ensure that all hospitals with emergency departments have a plan so that sexual assault victims have access to SAFEs at hospital facilities; and (2) detail any barriers to establishment and implementation of such plans and agreements.

I hope this information is useful. If you have any questions regarding this report, please contact Mr. Webster Ye, Director of the Office of Governmental Affairs, at (410) 767-6480.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Webster Ye, J.D., Director, Office of Governmental Affairs
Howard Haft, M.D., Deputy Secretary, Public Health Services
Donna Gugel, M.H.S., Director, Prevention and Health Promotion Administration
Clifford Mitchell, M.D., Director, Environmental Health Bureau, Prevention and Health Promotion Administration

Report to the Joint Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee

As required by the 2016 Joint Chairmen's Report, page 67, M00A01.01

Mobile Sexual Assault Forensic Exam Teams
December 2016

Larry Hogan
Governor

Boyd Rutherford
Lieutenant Governor

Dennis R. Schrader
Secretary

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Introduction

Sexual assault is a violent crime that affects thousands of Marylanders each year. In Maryland, an estimated one in five (466,000) adult women have been victims of rape and one in six (359,000) adult men have been victims of sexual violence in their lifetimes.[1]

Sexual assault is defined as any type of sexual contact or behavior that occurs by force or without consent of the recipient of the unwanted sexual activity, including forced intercourse, sodomy, child molestation, incest, fondling, and attempted rape. Sexual assault also includes sexual acts against people who are unable to consent either due to age or lack of capacity.

A sexual assault medical forensic exam (SAFE) is an examination of a victim of sexual assault by a health care provider. Examinations are ideally performed by a Forensic Nurse Examiner (FNE), a registered nurse with specialized education and clinical experience in the collection of forensic evidence and treatment of victims of sexual assault. The examination includes gathering of information from the victim for a forensic medical history, an examination, treatment of injuries, and documentation of biological and physical findings and collection of evidence from the victim. The SAFE also includes provision of information, treatment, and referrals for sexually transmitted infections, pregnancy, suicidal ideation, alcohol and substance abuse, and other non-acute medical concerns, as well as follow-up to provide additional healing, treatment, or collection of evidence as needed.

Of the 47 acute care hospitals in the state, 24 have the specialized equipment, personnel, and protocols and procedures in place to provide SAFEs. These 24 hospitals cover all five of the State's Emergency Medical Services (EMS) regions, which are designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS).[2] The remaining hospitals that do not operate a SAFE program have protocols to transfer sexual assault victims to one of the 24 hospitals that do operate a SAFE program. Therefore, all Maryland residents have access to a SAFE either in their county or an adjacent county. Appendix C is a list of hospitals that operate SAFE programs.

Background

Chapter 627 of the Acts of 2014 (HB 963) – Hospitals – Protocol for Sexual Assault Medical Forensic Examinations and Planning Committee was enacted during the 2014 Legislative Session to address concerns about access to SAFEs in Maryland. HB 963 established the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland (the Committee). The Committee met from November 2014 through June 2016, and submitted a report detailing its findings and recommendations to the Maryland

[1] Black, Michelle C., Basile, Kathleen C., Breiding, Matthew J., Smith, Sharon C., Walters, Mikel L., Merrick, Melissa T., Chen, Jieru, and Stevens, Mark R.,"The National Intimate Partner and Sexual Violence Survey – 2010 Summary Report," November 2011, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 15 December 2016 < https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf>.

[2] SAFE hospitals are located in the following counties: Region I: Allegheny and Garrett Counties; Region II: Frederick and Washington Counties; Region III: Anne Arundel, Baltimore County, Baltimore City, Carroll, Harford, and Howard Counties; Region IV: Cecil, Dorchester, Kent, Talbot, Wicomico, and Worcester Counties; Region V: Calvert, Charles, Montgomery, Prince George's and St. Mary's Counties.

General Assembly in December 2015.[3] A brief summary of the Committee's major findings and recommendations related to mobile SAFE teams is outlined below:

Findings

The Committee found that victims of sexual assault in Maryland may access SAFEs through various entry points. Victims may initially contact 911 or a sexual assault hotline, walk into an emergency department (ED), be brought to an ED by police, or be transported to an ED by EMS. When victims present for treatment at a hospital without a SAFE program (a "non-SAFE" hospital), accessing a SAFE can be burdensome. Victims who choose to have a SAFE performed must go to another hospital, which often results in hours of delay, possible loss of critical evidence, difficulty with transport to the SAFE hospital, and may even lead to a violation of the victim's privacy rights if appropriate policies and procedures are not in place. For example, there is no requirement for a police report to be filed in order for a victim to receive a SAFE, but, in some cases, police may be called regardless of the victim's wishes. In addition, transportation to a SAFE hospital may not be covered by insurance or other public or private sources of funding, which creates financial barriers to receiving a SAFE for individuals that initially present for treatment at a non-SAFE hospital.

Recommendations

Based on information from representatives from both SAFE and non-SAFE hospitals, the Committee did not consider it feasible or desirable for every hospital in Maryland to operate a SAFE program. Therefore, the Planning Committee recommended that:

- SAFE programs located in jurisdictions with more than one hospital should establish mobile SAFE teams and protocols to provide SAFEs off-site.
- Sexual assault victims should have access to SAFEs at all hospitals with an ED. If a victim presents at a hospital without a SAFE program, a local mobile SAFE team should go to the victim.

The Committee encouraged SAFE programs and non-SAFE hospitals to collaborate to implement the recommendation as soon as possible. However, creating mobile SAFE teams presents a number of logistical, legal, and institutional issues, including the credentialing of FNEs from other institutions and liability concerns, which may prevent immediate implementation. Recognizing that there may be issues with implementation, the Planning Committee recommended that all hospitals with an ED (including those with and without a SAFE program) should have a plan to implement this recommendation in place no later than October 1, 2016.[4] The plan should include identification of all obstacles and potential solutions, as well as any need for legislative or regulatory changes. SAFE programs should establish mobile SAFE teams and non-SAFE hospitals should develop Memorandums of Understanding with SAFE programs or conduct on-boarding and credentialing visits for FNEs who will provide

[3] Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland, "Report on Improved Access to Sexual Assault Medical Forensic Examinations in Maryland," December 2015, 30 November 2016 <http://phpa.dhmh.maryland.gov/Documents/Sexual-Assault-Forensic-Exam-Report-2015.pdf>.

[4] At the time of publication of this report, DHMH was not aware of any implementation plans established by hospitals per the Committee's recommendation.

SAFEs as part of the mobile SAFE team. These agreements should function promptly after the plan is created, and should be effective no later than October 1, 2017.[5]

Implementation Efforts to Date

On May 6, 2016, representatives from the Maryland Department of Health and Mental Hygiene (DHMH) and MIEMSS met with representatives from the Maryland Hospital Association (MHA) to review the Committee's findings and recommendations, clarify and discuss key issues, including establishing mobile SAFE teams, and plan for next steps.

DHMH, MIEMSS, and MHA determined that the next step for implementation was to solicit input from MHA clinical leaders on the Committee's recommendations. On July 8, 2016, representatives from DHMH and MIEMSS met with MHA to review feedback from MHA clinical leaders and determine what would be needed to better understand issues with regard to implementation of mobile SAFEs. DHMH and MIEMSS held a subsequent conference call with MHA on November 3, 2016.

In the above-mentioned meetings with DHMH and MIEMSS, MHA noted that it did not participate in the Committee's discussions. MHA expressed concerns that the Committee's recommendations were not based on enough data to determine where mobile SAFE teams are most needed. MHA intends to submit a separate letter providing feedback on this matter.

MIEMSS Data Collection

MIEMSS developed a "Sexual Assault Forensic Examination Hospital Survey Instrument" to collect data to understand differences in SAFE programs in hospitals across the State and to help determine where mobile SAFE teams are most needed. Some SAFE program coordinators reported that sexual assault victim data are not routinely collected or prepared by their hospitals. Depending on the practices of the regional or county Sexual Assault Response Team (teams include FNEs, victims' advocates, prosecutors, and law enforcement), some data may be shared at Sexual Assault Response Team meetings. There is currently no uniform collection of SAFE data in the State.

Identifying the appropriate individuals to complete the survey was difficult, as there is no list of Maryland SAFE program coordinators with contact information. Surveys were sent to all SAFE programs for which MIEMSS was able to obtain contact information. The survey was emailed to 14 of the 24 hospitals recognized by the Maryland Coalition Against Sexual Assault (the Statewide umbrella organization for the State's 17 rape crisis centers) that operate SAFE programs. MIEMSS received completed surveys from nine hospitals, a 38 percent response rate. Please see Appendix B for a copy of the survey instrument.

[5] Per Chapter 627 of the Acts of 2014 (HB 963), Health-General Article 19-310.2, Annotated Code of Maryland, all hospitals that provide emergency services are required to have a protocol to provide timely access to SAFEs performed by a FNE or a physician in place.

MIEMSS Survey Results

Unfortunately, the survey results were limited due to the small number of respondents, and subsequently are not included in this report. MIEMSS did learn, based on survey responses, that the average SAFE hospital stay for a victim of sexual assault is five hours. Some hospital stays were longer due to the sexual assault victim being intoxicated, which would require the individual to remain at the hospital until the blood alcohol level was reduced to a safe amount.[6]

MIEMSS also learned that the responding hospitals make and receive transfers of victims as indicated below:

- Anne Arundel Medical Center transfers to: Mercy Hospital, Prince George's Hospital Center, Howard County General Hospital, and Baltimore Washington Medical Center.
- Western Maryland Regional Medical Center receives transfers from West Virginia.
- Howard County General Hospital receives transfers from other jurisdictions and police officers often call Howard County General Hospital to see if there is a FNE on-call. Victims are generally transported to the hospital by family, friends, or police.
- Each EMS Region in Maryland has one to four hospitals that provide SAFEs to children under 12 years old. The Region II hospital, Meritus Medical Center, also receives pediatric victims from other states (West Virginia and Pennsylvania).

The information collected from the survey may be useful for assessing resource needs and geographic gaps in SAFE provision, and in pairing SAFE and non-SAFE hospitals to develop Memorandums of Understanding for provision of SAFEs. Overall, the SAFE data obtained via the survey did not give a thorough representation of the needs of Maryland's sexual assault victims.

Conclusion

Based on currently available data, it is not yet clear how or where to provide mobile SAFEs. There is insufficient data to determine where mobile SAFE teams are needed most, and where the experience of victims would be most improved by implementation of mobile SAFE teams. DHMH and MIEMSS believe that additional information would be helpful in clarifying the need for mobile SAFE teams in the State, including:

- A more comprehensive picture of the experience of victims in non-SAFE hospitals across the State with respect to wait times and treatment;
- What non-SAFE hospitals would require to accept mobile SAFE teams;
- Whether resources at SAFE hospitals would be diluted by sending mobile teams to non-SAFE hospitals;

[6] This requirement does not apply solely to sexual assault victims.

- What the specific legal barriers are to implementing mobile SAFE teams; and
- How the distribution of FNEs in Maryland will affect the establishment of mobile SAFE teams.

While some of this information may be available from hospital administrative data systems, some of it will require input from MHA, hospital administrations, and other organizations. In order to spur progress on the recommendations of this report, DHMH suggests the collection of additional data and close involvement from MHA.

Appendix A

Planning Committee to Implement
Improved Access to Sexual Assault Medical
Forensic Examinations in Maryland

Report to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee

Regarding

Improved Access to Sexual Assault Medical Forensic Examinations in Maryland

House Bill 963/Chapter 627, Section 2(g) of the Acts of 2014)

Executive Summary

December 2015

I. Executive Summary

House Bill (HB) 963 was enacted in the 2014 Legislative Session to address concerns about access to sexual assault forensic exams (SAFEs) in Maryland. The bill required that: 1) on or before July 1, 2014, each hospital that provides emergency medical services shall have a protocol to provide timely access to a sexual assault medical forensic examination by a forensic nurse examiner (FNE) or a physician to a victim of an alleged rape or sexual offense who arrives at the hospital for treatment; 2) a Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland be established; and 3) on or before December 1, 2015 the Planning Committee shall submit a report on its findings and recommendations, including any legislation required to implement the recommendations, to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee. The Planning Committee met monthly between November 2014 and October 2015 and solicited input from sexual assault victims and professionals working with victims. Below is a summary of the Planning Committee's findings and recommendations: the full report of the Planning Committee follows.

Findings

Victims of sexual assault in Maryland may access SAFEs through varied entry points. Victims may initially contact 911 or a sexual assault hotline, walk into an Emergency Department (ED), be brought to an ED by police, or be transported by Emergency Medical Services (EMS).

There is a burden on victims who present for treatment at a hospital without a Sexual Assault Medical Forensic Examination program (SAFE program) or a "non-SAFE" hospital. Victims who choose to have a SAFE must then go to another hospital, often resulting in hours of delay, possible loss of critical evidence, difficulty with transport to the SAFE facility, and may even lead to a violation of the victim's privacy rights. In addition, transportation may not be covered by insurance or other public or private sources, all of which create a major barrier to receiving a SAFE.

Across the State, there is a lack of standard response protocols for Law Enforcement, EMS and medical providers in facilitating access to medical/forensic services. In particular, there is no standard response protocol for "non-SAFE" hospital EDs regarding victims' rights and options. Enactment of HB 963 (Health-General Article §19-310.2, Annotated Code of Maryland); required all hospitals with an ED to have a protocol addressing appropriate responses to sexual assault victims. In Maryland, there are currently 47 acute care hospitals with EDs. Thirty eight submitted their policies to the Planning Committee. Twenty four of the hospitals submitting policies are recognized as SAFE programs.

Other barriers to timely access to SAFEs include lack of 24/7 access to a forensic examination at some SAFE programs due to FNE staffing shortages, low physician

reimbursement, lack of public education, limited reimbursement for mobile SAFEs, and language and cultural barriers.

Other states seeking to increase access to SAFEs have met with varying degrees of success. Their approaches include: 1) Comprehensive centers with nurses trained to assist multiple types of victims including domestic violence and the elderly; 2) Mobile SAFE units outfitted with the necessary equipment for a SAFE nurse to travel to victims and perform the exam; and 3) Telemedicine technology, which uses video conferencing to increase access to medical forensic expertise for victims in remote areas.

Planning Committee Recommendations

The Planning Committee to Implement Improved Access to Sexual Assault Forensic Medical Examinations in Maryland reached consensus on the following recommendations:

1. **Clarification of Statute and Regulation**
   Designation of Sexual Assault Forensic Exam Programs should be clarified to eliminate discrepancies between Criminal Procedure Article, §924 and Code of Maryland Regulations (COMAR) 10.27.21.02.

2. **Emergency Medical Services (EMS)**
   a. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) should list the SAFE programs in the Maryland Medical Protocols for EMS Providers;
   b. MIEMSS and Local EMS agencies should revise sexual assault treatment, transport, and training protocols for providers;
   c. Emergency Medical Dispatch Centers should review national guidelines and maintain a list of SAFE programs within their jurisdiction;
   d. EMS training should include transport decision-making, a Trauma-Informed Approach to care, Law Enforcement and mandated reporting requirements, victims' rights and options for reporting and evidence collection, evidence preservation, confidentiality/privacy considerations, and emergency medical record documentation requirements; and
   e. Treatment and transport protocols should, at a minimum, contain the following recommendations:
      i. Sexual assault victims should be transported to the nearest hospital ED that provides SAFE exams, unless the victim refuses, requires another type of specialty care, is medically unstable, or requests to be taken to an alternate facility;
      ii. Whenever possible, the receiving hospital should be notified in advance to have a place for the patient to be received in a private area;
      iii. Instructions on a Trauma–Informed Approach to care should be provided;
      iv. Instructions on evidence preservation should be included;
      v. HIPAA, confidentiality considerations, and Emergency Medical Record documentation should be included; and
      vi. Base stations protocols and procedures should indicate SAFE programs as specialty referral centers and should direct victims of sexual assault to a SAFE program when possible.

3. **Law Enforcement (LE)**
   a. Every LE agency should adopt a policy and establish a protocol for responding to individuals reporting a sexual assault. It should be noted that victims are not required to report to LE and federal law prevents conditioning SAFE services on cooperation with LE;
   b. LE officers should be informed of the options and rights of sexual assault victims and be able to inform victims of these rights and options;
   c. Initial LE response should address the safety of the victim and assure that the victim is transported immediately for medical care and evidence collection, unless the victim refuses, or the report is outside of the advised time frame for evidence collection;
   d. LE should not dismiss EMS or delay transporting the victim for medical care;
   e. LE officers should communicate to victims of sexual assault that a SAFE may be important to investigative and apprehension efforts, but should be aware that a victim has the right to choose whether or not they receive an exam;
   f. All biological evidence or specimens, including urine samples for drug screening, should be collected only at a medical facility;
   g. LE should work with the jurisdiction's local sexual assault crisis program, as established under Criminal Procedure Article, §11-923, and Sexual Assault Response Team to assure that victims have access to advocacy and other services; and
   h. LE training should include a Trauma-Informed response, which includes recognizing the range of responses to sexual assault, instructions regarding preservation of evidence, instructions regarding emergent medical needs of the victim, the rights and options of sexual assault victims, and the roles and responsibilities of other emergency responders.

4. **Hospital Policy**
   a. SAFE programs located in jurisdictions with more than one hospital should establish mobile SAFE teams and protocols to provide SAFEs off-site;
   b. Sexual assault victims should have access to SAFEs at all hospitals with an ED. If a victim presents at a hospital without a SAFE program, a local mobile SAFE program should go to the victim;
      i. Both SAFE programs and non-SAFE hospitals are encouraged to collaborate to implement this recommendation as soon as possible. However, creating mobile SAFE teams presents a number of logistical, legal, and institutional issues that may prevent providers from immediate implementation. Recognizing this, all hospitals with an ED (including those with and those without a SAFE program) should have a plan regarding implementation of this recommendation no later than October 1, 2016. This plan should include identification of all obstacles and potential resolutions, including the need for legislative and regulatory changes. Mobile teams should be established by SAFE programs and non-SAFE hospitals should formulate Memorandums of Understanding or on-boarding/credentialing visits of Forensic Nurses Examiners (FNEs). These agreements should function promptly after a plan is created, and no later than October 1, 2017.*
   c. The Maryland Hospital Association (MHA) and the Maryland Coalition Against Sexual Assault (MCASA) should provide input and collaborate with the Maryland Office of the

*As per Health-General Article 19-310.2, all hospitals are currently required to have a policy in place.

Attorney General (OAG) to develop statewide SAFE policies to increase access to SAFEs By law:

i. Health care providers and personnel should not contact LE without the consent of the sexual assault victim, with a few limited exceptions;
ii. Health care providers should be informed on mandated reporting laws including definitions of "child abuse" and "vulnerable adult";
iii. Materials on victims' rights should be made available to all sexual assault victims;

d. Health care providers should be informed of the options available to victims of sexual assault and should advise them of these options;
e. SAFE programs must include access to victim advocates and FNEs. SAFE programs should be connected and in close communication with local sexual assault crisis programs as established under Criminal Procedure Article, §11-923 to ensure that a victim advocate is always present when a victim undergoes a SAFE;
f. All hospitals should provide all sexual assault victims with information regarding local sexual assault crisis programs and access to victim advocates, whether a SAFE is performed or not. This recommendation applies to all hospitals, and includes those with or without SAFE programs.
g. SAFE programs should offer 24/7 access to a SAFE;
h. SAFE programs should establish at least one staff position for a FNE. The staff person's duties include performing SAFEs that are required during regular staffing hours, and coordination and mentoring of other FNEs in the SAFE program. SAFE programs may find that it is most effective to expand the SAFE program to also include other forms of personal violence, such as domestic violence, child abuse, and elder abuse;
i. MHA or other similar body should appoint a committee to review the needs of pediatric sexual assault victims and how they can be better addressed. This committee may also consider the possibility of Registered Nurse Forensic Examiner–Pediatric (FNE-Ps) and their availability to work with the Maryland Children's Alliance, Child Advocacy Centers, and the Maryland Child Abuse Medical Providers Initiative as defined by Health-General Article §13-2201;
j. SAFE programs should obtain written authorization from the patient to release any of their information to non-health entities, including: LE, Crime Lab, Toxicology Lab, Sexual Assault Crisis Center/Victim Advocacy, Prosecutor, and any non-health provider; and
k. All hospitals should provide an nPEP starter pack (HIV post-exposure prophylaxis) to all eligible patients.

5. <u>Sexual Assault Response Teams (SARTs)</u>

a. SAFE programs should participate in local SARTs. SAFE responses should maintain and strengthen community based connections, including working with local prosecutors, LE, and victim advocates; and
b. Statistics regarding SAFEs and related matters should be collected by SARTs using uniform data collection methods and should be submitted to the MCASA to be shared statewide.

6. <u>Reimbursement</u>

a. Increase the current physician reimbursement rate of $80 for a medical

b. forensic examination;
c. Provide reimbursement for mobile FNEs;
d. Provide payment for inter-hospital transportation costs;
e. Continue to work with the Criminal Injuries Compensation Board (CICB) to provide reimbursement for nPEP to victims eligible for CICB, and develop
f. alternative sources of funding for victims who are not CICB eligible;
g. Revise COMAR 10.12.02 to include reimbursement for nPEP screening in hospitals with approved nPEP protocol (including baseline testing, initial counseling, and starter pack);
h. Increase the current Sexual Assault Reimbursement Unit program budget;
i. Extend the timeframe for reimbursement to support better victim services; and
j. Ensure that victims are not responsible for the costs associated with SAFEs received outside of Maryland by working together with sexual assault response agencies in our neighboring jurisdictions.

7. <u>Public Education</u>

A statewide campaign should be undertaken to inform the community, including LE, EMS, and health care providers about options for victims of sexual assault. This should include the location and accessibility of SAFE programs, how to seek medical treatment, reporting options, and how to contact local sexual assault crisis programs.

Conclusion

The Planning Committee's full report, findings, and recommendations follow. The Planning Committee appreciates the opportunity to work with the Governor and the General Assembly to improve Maryland's response to sexual assault victims.

Appendix B

Sexual Assault Forensic Examination Hospital Survey Instrument

Sexual Assault Forensic Exam (SAFE) Hospital Statistics:	Fiscal Year (FY): 2016													
Indicator ↓/Number→	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**Total**	**Average/Mo**
Total Cases														
Encounters (Met with SAFE RN & either declined exam or outside timeframe)														
Jane Doe/Anonymous Reports														
Converted														
Transfers in from another hospital*														
Average LOS for SAFE Victim Please account to nearest hour														
Brought in By:														
Self/Family/Friend														
Advocate														
Law Enforcement/Police														
EMS														
Of SAFE Exams Completed:														
Female														
Male														
Ages:														
0-12-Children														
13-17-Adolescent														
18-24-Adult														
25-35														
36-45														
46-65														
66 +														

*** If Transferred in from another hospital, what hospital transferred the victim? Please list:**

Appendix C

Maryland Sexual Assault Forensic Exam (SAFE) Programs by County

FNE-A: Programs for individuals age 13 and older
FNE-P: Programs for individuals age 12 and under

Allegany County
Western Maryland Regional Medical Center
(FNE-P and FNE-A)
12500 Willow Brook Rd. Cumberland, MD 21502
(240) 964- 1333 x 41333

Anne Arundel County
Anne Arundel Medical Center
(FNE-A)
2001 Medical Pkwy. Annapolis, MD 21401-3280 (443) 481-1200

North Anne Arundel County
BWMC
(FNE-P and FNE-A)
301 Hospital Dr.
Glen Burnie, MD 21061-5803
(410) 553-2927

Baltimore City
Mercy Medical Center
(FNE-A)
345 St. Paul Pl.
Baltimore, MD 21202-2102
(410) 332-9494

University of Maryland Medical Center
(Emergency Room Physician- Pediatrics under 13)
22 S. Greene St, Baltimore, MD 21201-1595
(410) 328-6335

Baltimore County
GBMC
(FNE-A)
6701 Charles St.
Baltimore, MD 21204-6808
(443) 849-3323

Franklin Square Hospital Ctr.
(FNE-P)
9000 Franklin Square Dr.
Baltimore, MD 21237
(443) 777-7127

Calvert County
Calvert Memorial Hospital
(FNE-A)
100 Hospital Rd
Prince Frederick, MD 20678
(410) 535-8344

Caroline County
Memorial Hospital of Easton
(FNE-P and FNE-A)
219 S. Washington St.
Easton, MD 21601-2913
(410) 822-1000 x 7976

Carroll County
Carroll Hospital Center
(FNE-P and FNE-A)
200 Memorial Ave.
Westminster, MD 21157-5726
(410) 871-6655

Cecil County
Union Hospital
(FNE-A)
106 Bow St.
Elkton, MD 21921-5544
(410) 398-4000

Charles County
Charles Regional (Civista) Medical Center
(FNE-P and FNE-A)
701 E. Charles St.
LaPlata, MD 20646-5930
(301) 609-4144

Dorchester County
Dorchester General Hospital
(FNE-P and FNE-A)
300 Bryn Street
Cambridge, MD 21613
ER: (410) 822-1000 x 5557

Frederick County
Frederick Memorial Hospital
(FNE-P and FNE-A)
400 W. 7th St.
Frederick, MD 21701-4506
(240) 566-3416

Garrett County
Garrett County Memorial Hospital
(FNE-P and FNE-A)
251 N 4th St.
Oakland, MD 21550
(301) 533-4000

Harford County
Harford Memorial
(FNE-P and FNE-A)
501 S. Union Ave.
Havre de Grace, MD 21078
(443) 843-5000

Franklin Square Hospital Ctr.
(FNE-P)
9000 Franklin Square Dr.
Baltimore, MD 21237
(443) 777-7127

Howard County
Howard County General Hospital
(FNE-P and FNE-A)
5755 Cedar Ln.
Columbia, MD 21044-2912
(410) 740-7890

Kent County
UM Medical Center at Chestertown
(FNE-A)
100 Brown St. Chestertown, MD 21620
(410) 778-3300

Montgomery County
Shady Grove Adventist Hospital
(FNE-P and FNE-A)
9901 Medical Center Dr.
Rockville, MD 20850-3357
(240) 826-6000

Prince George's County
Prince George's Hospital Center
(FNE-P and FNE-A)
3001 Hospital Dr.
Cheverly, MD 20785-1189
(301) 618-3154

Queen Anne County
Chester River Health System
(FNE-P and FNE-A)
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

St. Mary's County
St. Mary's Hospital
(FNE-P and FNE-A)
25500 Point Lookout Rd.
Leonardtown, MD 20650
(301) 475-8981

Talbot County
Memorial Hospital of Easton
(FNE-P and FNE-A)
219 S. Washington St.
Easton, MD 21601-2913
(410) 822-1000 x 7976

Washington County
Meritus Medical Center
(FNE-P and FNE-A)
11116 Medical Campus Rd.
Hagerstown, MD 21742
(301) 790-8300

Wicomico/Somerset County
Peninsula Regional Medical Center
(FNE-P and FNE-A)
100 E. Carroll St.
Salisbury, MD 21801-5422
(410) 912-6382

Worcester/Somerset County
Atlantic General Hospital
(FNE-P and FNE-A)
9733 Healthway Dr.
Berlin, MD 21811-1155
(410) 641-11