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

Meeting Minutes

Date: October 8, 2015
Time: 10:00 AM – 12:19 PM
Chairperson: Joyce Dantzler MS, MCHES
Co – Chair: Carole Ann Mays RN, MS
Members Present: Carole Mays, Joyce Dantzler, Lisae Jordan, Christine Jackson, Casey Swope, Gail Reid, Susan Kraus, Mary Lou Watson, Brian McGarry, Tiwanica Moore, Amy Robinson
Members Excused: Greta Cuccia
Members Absent: Kathleen O'Brien, Verlin Meekins, Mark Arsenault
Conference Line: Eunice Esposito
Guests Present: Holly Vandegrift (Del. Kelly), Subha Chandar (DHMH), Katie Jones (DHMH)

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 10/08/15
Welcome and Introductions	Roundtable introductions.	None	Joyce Dantzler	CLOSED
Open Meeting Message	As a reminder, the public is invited to attend but cannot participate unless asked to do so by the Committee.	Introduction and Reference	Joyce Dantzler	ONGOING
Review of Previous Minutes & Approval "Open" Issues Review	Reviewed September 10, 2015 meeting minutes. Minutes were approved once a quorum was met.	Motion to approve (Kraus) and seconded (Reid).	Membership	CLOSED
Review of the Draft Report to the Governor, and the House Health & Government	**Executive Summary** In the original draft, an attempt was made to keep the executive summary under two pages.	Discussion	Membership	OPEN

Operations Committee Executive Summary	• For the MIEMSS clearance process, it is preferred that the deliverables and recommendations be included in executive summary. The 12 deliverables could be more defined (Mays). • A two page executive summary is preferred (Jackson). The first priority should be the shorter document (Watson). It was agreed that the deliverables in the executive summary remain in their current summarized version (Watson, Jackson). • Recommendations reflect the body of work, and if anything is cut, it should be background and history. Parts of the executive summary could be moved to the body (Jordan). • It was agreed that the recommendations be included in the executive summary in a concise, bulleted format. • The executive summary reflects a summary of the recommendations. The full recommendations follow in the report (Dantzler). • The title of the recommendations and not the content could be contained in the executive summary (Mays). • The process needs to be part of the general report not executive summary It could be organized as follows: bill was passed; statement of the problem (one or two sentences); the committee met; and here are the recommendations (Jordan). • The recommendations should be most prominent (Reid). • Background may come after the recommendations (Jackson). • Having a stand-alone document was the intent when the executive summary was put together (Dantzler). Committee voted to revise the executive summary to reflect Jordan's recommendations. The recommendations in the executive summary will be changed to match the actual finalized recommendations.	Remove background information to make room for recommendations in the executive summary (and keep the summary at two pages). Revise the executive summary.	Amy Robinson Lisae Jordan Amy Robinson Lisae Jordan	OPEN OPEN

Review of the Draft Report to the Governor, and the House Health & Government Operations Committee	**Recommendation #4** Reid was concerned about recommending something that will keep things the same. Jordan suggested putting (g) and (h) first. Every hospital must have a protocol but the committee is trying to say that it may not be the best way (Reid). The legislature was upset that survivors were being moved (Jordan). There was a lot of testimony that having every hospital do SAFE exams is not the way to go (Dantzler). The testimony was that every hospital should not have a SAFE program, not that they shouldn't provide an exam (Jordan). Through education, we will let people know which hospitals do (Mays). FNEs don't get credentialed and not all hospitals need an MOU. (4h) should be reworded to "or on-boarding" (Watson). The committee discussed process of approving nurses to work at certain hospitals. They do background checks, and nurses are essentially hired to be in per diem pool (Watson). There are too many background checks (Kraus). A physician may be needed at each place that would allow the nurses to go under their license (Jackson). Clarification was requested around whether the FNE is a certification or a license. MBON does not license a nurse as an FNE. It seems like a certification but it's not (Kraus). The wording is "certification" as an FNE (Watson). • "HIPPA" should be changed to "HIPAA" (Watson). **Discussion of Curriculum (4e):** In the past, MBON provided regular updates to SAFE training curriculum			

	(Jackson). The Board does not currently update curriculum. It is the clearinghouse. Updating curriculum is the responsibility of the group that's doing the training (Kraus). The Board sets up the requirements for FNEs to meet but does not dictate the content (Watson). What IAFN requires is different from what we require as a state (Jackson). IAFN covers nursing. MBON does typically maintains what IAFN puts forth (Esposito). The qualifier could be added as "curriculum approved by IAFN (Watson). Jackson was uncomfortable with adding IAFN because they make recommendations that may differ for Maryland. MCASA hears from nurses that they have to go somewhere for 40 hrs. for training, which doesn't work for them because they have to take time off. Increasing the number of nurses and supporting them would also increase access to SAFEs for survivors. The underlying policy purpose in statement (4e) is unclear (Jordan). Committee agreed to eliminate recommendation (4e). Right now there is alignment with IAFN. This adds some validity when you are on the stand if programs are modeled after IAFN (Esposito). For SARTS, (5a), "Locate" should be "local" (Watson). **<u>Reimbursement</u>** Jackson recommends putting back into consideration extending the 90-day regulation to 1 year. DHMH (SARU) proposes to keep the 90 days. Currently in regulations, if claims are submitted after 90 days with an explanation, up to 6 months out, they can be considered (Dantzler).			

	Federal law mandates that every state allow victims 1 year to get reimbursed. The hospital should be allowed the same privilege since they are the advocate for the victim (Jackson). Dantzler read the post 90-day denial summary, which provided other reasons why claims were rejected by SARU. DHMH feels that 90 days is reasonable and proposes to keep 90 days but allow up to 1 year with an explanation instead of 6 months (Dantzler). If medical providers say this is a barrier and an unreasonable bureaucratic burden, as advocates, the committee needs to be listening (Jordan). For (6d), this should include language to ensure access for all victims and victims eligible for nPEP (Jordan). This should be clarified under hospital policy (Reid). The billing person takes care of most of this (Esposito). The charge is a flat fee for an ER visit and covers ER supplies. Maryland is an all-payer State (Watson). All hospitals should screen and provide for nPEP (Jordan). A recommendation that all hospitals should be providing a starter kit to all victims that fall under the appropriate guidelines should be added (Jackson). There are two parts to this discussion; one is access and one is reimbursement. **<u>Public Education</u>** (7a) should be reworded to change "would" to "should continue" for MCASA (Jordan).	Rec 6d: Reword reimbursement section regarding accessibility and nPEP. Submit suggested wording regarding starter kit.	Amy Robinson Lisae Jordan Christine Jackson	OPEN OPEN

	Jurisdiction is used instead of county in the document to include Baltimore City. In police terms, jurisdiction is determined by police dept. "Jurisdiction" should be changed to read "each county and Baltimore City has access to" (McGarry, Dantzler). **<u>Use of Terms</u>** For the term Victim Advocate, a cross reference should be added (Jordan). If there are conflicting changes from members, the change will be based on the majority. Committee will be notified if this situation comes up. (Dantzler). There are currently 23 SAFE programs. The rest of document refers to 25 SAFE programs (Watson). The document will reflect MCASA's list of SAFE programs (Dantzler). MCASA called U of Md. and found that U of Md. felt like they didn't have a SAFE program. Therefore, they are not identified as such. To reconcile the discrepancy with actual number of SAFE programs, MCASA's listing will be used (Dantzler). It may be necessary to star or use an asterisk for pediatric programs (Reid). There is another table that conveys the pediatric information (Mays). One concern is that people may just copy the charts, which could create confusion. U of Md., Baltimore City does not have a SAFE program but they do handle pediatric cases. Residents do the exams (Jackson). There is a final chart that captures the pediatric and adult programs (Mays).	Update charts for clarity. Submit suggested wording regarding sexual assault	Carole Mays Mary Lou Watson	OPEN OPEN

	Deliverable #1 May need to include that hospitals are already required to have a protocol (Watson). It is unclear if some hospitals are non-compliant or just non-responsive. MHA would be the appropriate organization to send info. out about compliance (Mays, Dantzler). The date to be in compliance should be 6 months after the notice goes out (Jackson). **Deliverable #2** A barrier related to children was identified but not listed (Mays). In addressing the barriers for children, Maryland has a system to handle chronic cases. We should use the term "acute". (Jordan). Acute vs. chronic cases discussed somewhere in the document. Encouraging trauma centers to be able to provide a SAFE exams could be added as a place holder (Watson). Based on ACS guidelines, there is nothing in the regulations currently about sexual assault (Mays). As it pertains to Reid's earlier question, it was confirmed that 24/7 service availability is mentioned in the document. Having diversity in our state should not be viewed as a barrier. Rephrase "diverse populations" to "varying cultural competency" (Jordan). **Deliverable #3** Jordan prefers the wording "one advantage of". To show that there are other models and the committee is not necessarily advocating for a particular one, the word "advantage" was removed (Dantzler). **Deliverable #4**	protocol compliance for hospitals. Add language regarding children for Deliverable #2.	Carole Mays	OPEN

	In reference to trauma centers having a protocol for ensuring access, shock trauma is not considered an ED (Mays). A listing of all SAFE programs to go out to EMS was covered under Committee Recommendations. **Deliverable #5** To save space, list that victim has several options, which could just refer back to one place (Watson). The redundant statement should stay because many may not go back and look at a reference (Jordan and Dantzler). **Deliverable #6** The sentence about "No system in place to track renewals" is irrelevant and should be removed (Kraus). **Deliverable #7** For footnote 66, there is a more recent memo. The counties have been added to the list (Jordan). **Deliverable #8 –** No comments **Deliverable #9 –** No comments **Deliverable #10** In reference to the procedures for reporting to law enforcement this means that it only applies to 8 counties (Jordan). Mercy is not paperless but most hospitals are. SAFE records should not be available. There is a concern about linking the SAFE record to other medical records electronically. They should not be linked within the electronic medical record system (Jackson).	Provide recent memo for D7. Check the number of counties under D10. This number may have increased. Create language around developing protocols to	Lisae Jordan Amy Robinson Lisae Jordan Lisae Jordan	OPEN OPEN OPEN

	Add information about secure SAFE records under (a). As it pertains to the situation around minors when parents are abusive, it should address parent access (Watson). **<u>Deliverable #11</u> – No comments** **<u>Deliverable #12</u> – No comments** **Committee membership document corrections** Member Verlin Meekins was appointed while at McCready but she is now at Choptank Medical Center. It is not clear how to list her in the report. The consensus was to list Verlin as "formally at McCready". Abuse (#10) is not the definition of abuse relative to reporting. This abuse definition may be confusing since it does not distinguish between domestic violence and child abuse (Jordan). All agreed to remove it.	enhance protection. Submit committee membership listing corrections to reflect how members want to be listed in the document.	Membership	OPEN
Next Steps	Staff member, Amy, submitted her 2-weeks' notice to MIEMMS. She will continue to assist with the report under contract but may not be physically present at the meetings. Today is technically the last meeting. All the information discussed will be pulled together and sent through the agency clearance process. Any differences will be reconciled once the agency report comes in and is sent back to committee. Content changes will end. If there is something members can't live with, it will be addressed. The report needs to go to Governmental Affairs in the next two weeks. Something will be sent back to the committee in Nov. with about a week for review. The report will go to the General Assembly in December.			

	Meetings are on the calendar through next June (except for January). A conference call may be scheduled in place of an in-person meeting in November, if necessary. Jordan would like to bring Scott Beard in from Criminal Injuries Compensation Board (CICB). **Status of upcoming meetings:** • November date saved and cancelled. • December meeting has been cancelled. • No meeting scheduled for January. • February /March are scheduled as in-person meetings at alternate locations. • Meeting place holders have been established for April thru June 2016. End of Meeting: 12:19 p.m.	DHMH and anyone else that wants to join are welcome but this will not be a full committee meeting.	Lisae Jordan	OPEN