Hospitals-Protocol for Sexual Assault Medical Forensic Examinations and Planning Committee (SAFE Committee)

Meeting Minutes

Date: Thursday, February 12, 2015
Time: 10:00 AM – 12:10 PM
Chairperson: Carole Ann Mays RN, MS, CEN
Co – Chair: Joyce Dantzler MS, MCHES
Members Present: Joyce Dantzler, Carole Mays, Lisae Jordan, Kathleen O'Brien, Gail Reid, Mary Lou Watson, Mark Arsenault, Verlin Meekins, Greta Cuccia, Eunice Esposito, Christine Jackson, Casey Nogle, Brian McGarry, Susan Kraus, and Tiwanica Moore
Guests Present: Subha Chandar (DHMH), Laurie Chin (Montgomery County), Lynda King (MCASA), Kathryn McNally (MCASA), and Laura Clary (GBMC)
Members Excused: Amy Robinson
Members Absent: N/A

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 2/12/2015
Welcome and Introductions	Roundtable Introductions	None	Carole Mays	CLOSED
Open Meeting Message	Excerpts from the "Maryland Open Meetings Act" were relayed. No member of the public attending the open session may participate unless specifically requested by a committee member for subject matter expertise.	Information and Reference	Carole Mays Joyce Dantzler	ONGOING
SAFE Committee Deliverables	Deliverables for this committee were summarized: 1. Review hospital protocols. 2. Examine barriers for providing care to sexual assault patients. 3. Study any reimbursement issues. 4. Examine EMS and Law Enforcement protocols.	Information	Carole Mays	CLOSED

	5. Determine best practices for public education. 6. Make recommendations for SAFE practitioner caseloads. 7. Consider geographic differences as it relates to the provision of SAFE services. 8. Consider hospital reporting requirements. 9. Review other State practices of SAFE services. 10. Develop and recommend protocols for victims' rights and privacy. 11. Receive public testimony from stakeholders. 12. Adopt recommendations consistent with State Medicare and Medicaid contracts.			
Review of Previous Minutes & Approval	January 8, 2015 draft minutes were distributed.	Motion to approve the January minutes made and seconded (Watson, Arsenault).	Members	CLOSED
"Open" Issue Review	Response from the AG's office regarding voting by phone was relayed. Voting by phone does not violate the Open Meetings Act, and is therefore allowed. A work plan was previously requested from each Sub-Committee. Two work plans have been submitted by: (1) Verlin for Victim Care and (2) Carole for Public Input Sub-Committees. Hearing testimony was previously distributed.	Information and Reference Remaining Sub-Committee work plans are due to the Committee. Testimony received and reviewed by members.	Joyce Dantzler Sub Committee Chairs Committee Members; Robinson and Mays	CLOSED OPEN OPEN

	The SAFE Committee Report has been started and we need summaries, tables, gaps, best practices with references to add to the draft. We will share the document at a future meeting.	Sub-Committees are to provide whatever information they have a present for a place-holder in the document; updates can be made later		
SAFE Sub-Committee Work Plan Review: Victim Care & Hospital Protocols	**Sub-Committee Report (Jackson):** Protocols received (about 11) were reviewed and outlined for the sub-committee. The sub-committee found that state protocols don't address transportation. Mercy Medical Center SAFE program may be a best practice model. They have a team go to unstable patients, which sounds like the best approach. Stable patients are transported to a facility;, it's not always clear how. Police transport or hospitals provide transportation, and sometimes by cab. Concerns were expressed about having a team go to un-stable patients. The optimal answer is to have the nurse travel to the patient. Concerns about this approach center on liability issues. However, the sub- committee intends to propose this moving forward (Dantzler). Gaps were identified in policies received from non-SAFE hospitals in the event that victims happen to walk into a non-SAFE center(Mays). U of Md. addresses it best. They have a protocol which outlines what to do in that case. For other protocols, most of them refer the patient to a SAFE facility (Jackson). Of the protocols reviewed so far, one of the gaps has been transporting the patient (Dantzler). The gap	Submit Work Plan Summarize similarities. Continue to collect Non-SAFE hospital SA Policies Begin to formulate a summary of recommendations with Best Practice references Document Identified Gaps	Jackson and Meekins MHA	OPEN

	is lack of education on the part of the non-SAFE hospital to address the needs of the victim (Arsenault). Committee discussed setting up a template/sample policy for Non-Safe hospitals. The protocol from Virginia for Non-Safe hospitals was shared by Reid. Every hospital should know their designated sexual assault center (Reid). There are existing vehicles for education that can be used to talk about sexual assault (Mays). Committee discussed the potential to develop additional SAFE programs. Staffing those programs may be an issue (Watson). It is necessary to look at entry points when victims seek help (Kraus). Liability concerns with proposed "traveling nurse" approach can be worked out (Jordan). Victim care sub-committee agreed that this is a viable option (Dantzler). The question following question was raised: "Is it possible that Non-SAFE hospitals have a SAFE nurse working on every shift?" The majority of SAFE nurses are ED nurses (Watson). The problem with that is that nurses need enough volume to maintain certification. An increase in programs may dilute number of exams that each nurse does (Arsenault). There's a need to look at saturation points. Areas struggling with numbers don't need any more SAFE programs (Watson). Once we set an expectation that SANE nurses will travel, it will become an encumbrance for some. This will challenge the existing pool (Watson).	Education Needs Develop a Sample Template for Non-SAFE hospitals; Capture "the things they need to have" Identification of possible Educational venues for getting information out re: education, access, exams, and transportation.		

	It may help to look at geographic issues. UCR numbers are available but don't include Jane Doe cases.	Many nurses across the state have no idea that being a SAFE nurse is an option. Critical to get the word out. (Watson, Kraus). Stats on distribution of cases were requested. Check Sexual Assault Reimbursement Unit stats at DHMH to see breakdown.	Joyce Dantzler	OPEN
SAFE Sub-Committee Work Plan Review: Law Enforcement & EMS	**Sub-Committee Report (Reid):** Sub-committee is in the process of collecting protocols from Maryland SOPs regarding police and EMS response. They have also looked at model policies and 911 protocol. The protocol or lack thereof varies widely among police depts. Sub-committee is exploring the recommendation that every police dept. has one and what elements should be included. It varies by jurisdiction. Maryland EMS protocol has limited information on sexual assault. Sub- committee is looking at what recommendations to make regarding EMS protocol.	Submit Work Plan. Summarize similarities. Document Identified Gaps Begin to formulate a summary of recommendations with Best Practice references Education Needs	Reid and Nogle	OPEN

	Sub-committee will identify the target issues and start working on a report. Input from victims would be helpful.			
SAFE Sub-Committee Work Plan Review: Reimbursements	**Sub-Committee Report (O'Brien):** International Association of Forensic Nurses offers an online training for SAFE nurses. However, Maryland regulations do not allow online training. Sub-committee plans to look at how other states use Criminal Injury Compensation to support SAFE exams. Victims use funds for underlying costs that are not covered by DHMH, such as getting to and from court cases and childcare. Some states used Services-Training-Officers-Prosecutors money (STOP Violence Against Women Act funding) for that purpose. The Governor's Office of Crime Control and Prevention manages those funds. Those funds can also be used for training SAFE nurses. SAFE vs SANE clarification: Maryland started using the term SAFE because Nurse Practitioners and Physician Assistants wanted to be part of the program. Most programs are now doing more than just the SAFE exams so that also helped the new term evolve.	Submit Work Plan. Identify reimbursement issues and Gaps Begin to formulate a summary of recommendations with Best Practice references	O'Brien and Dantzler	OPEN
SAFE Sub-Committee Work Plan Review: Public Testimony	**Sub-Committee Report (Mays):** Sub-committee will be using regular committee meetings to receive some public testimony from stakeholders.		Kraus and Mays	

	MCASA is in the process of gathering survey questions. Survey link will be placed on MCASA's website. Invitations to take the survey will be sent to various groups, including SAFE committee members, rape crisis centers, and SAFE/non-SAFE hospitals etc. A draft of the survey questions was distributed, reviewed, and discussed. Members discussed the pros and cons of the survey including the formatting to use open-ended questions, checklists, or a combination of both.	Send electronic version of the survey questions with initial feedback from the SAFE committee members incorporated for additional feedback to both Chairs. Review introductory section.	MCASA Carole Mays Joyce Dantzler	OPEN OPEN
Stakeholder Testimony	Speakers are lined up for this, next, and future meetings. At the May meeting, a suggestion was to invite public testimony at the end of the meeting. Committee will have the regular meeting extended to allow time for any speakers who attend. Committee preferred the testimony time be 12-1 p.m.	Contact Debbie Holbrook again. Post in Maryland Register	Susan Kraus Carole Mays	OPEN OPEN
New Business	MHA has been sending protocols to Joyce and Joyce has been sharing them. Co-chairs have a list of ED protocols received to date.			
Recap of Issues Identified for Next Meetings	For next meeting: -Hone in on the sub committees.	Members should share information to be	Committee Members	ONGOING

	-Identify gaps and best practices. -Start with some recommendations. Regular Meeting adjourned at 11:25 a.m. to allow time for speakers.	referenced in the final report.		
Presentations	**Speaker 1 - Eunice Esposito RN, SAFE Program Manager, Peninsula Regional Medical Center(PRMC)** The Eastern shore is unique. Facility has 24/7 coverage for adults and pediatrics. Program is growing to encompass DV, elder abuse, gunshot wounds, and not just sexual assault. Staffing issues exist. They started doing a lot of trainings on Shore to keep people there and save money. Barriers include how many times training can be offered due to the associated cost. The Pediatric piece is a separate teaching piece. The location is unique. They get some patients from Delaware and Virginia. They are working with sexual assault response team in VA. Eunice is working with Verlin on possibly establishing a SAFE program for McCready Hospital. Nurses are paid hourly rates when they come and when they go to court. They did a makeshift contract (16 hrs. per week). The original hospital contract was removed. There is an expectation list for the nurses and checks are done to determine if they have completed their expectations for the program. **Speaker 2 – Laura Clary RN, Clinical Program Manager of SA and DV Programs from Greater Baltimore Medical Center (GBMC) was invited by Susan Kraus to speak.**			

	GBMC has They have a good interdisciplinary team and a lot of nurses to provide coverage. Shifts are divided into 12 hrs. The SAFE program has a DV component. Advocates are cross trained to respond to SA and DV. Patients walk in through the ED. Triage nurses know they can activate SAFE team. Patients also come in with law enforcement. Patients presenting at another ED are transferred to GBMC. Patients may drive in or be transported by EMS or law enforcement. Most of the time they come in with someone and drive personal vehicles. If a patient is unable to be transferred due to medical reasons, they can respond to them. When nurses travel to another hospital, they need their IDs;many times police are involved and do transport the FNE. Barriers: Nurse retention (staffing 24/7) is a barrier. There is high turnover in forensic nursing due to some of the following reasons: Most of the nurses have other jobs besides being a SAFE nurse; personal issues; inability to commit to amount of call time that the program required etc. Having a minimal set call time would not work for GMBC. There is a SART meeting every other month. Towson and all other local colleges send representatives. They also do community outreach. Laura does presentations in schools and on campuses.	Members expressed concerns with traveling nurses, which will be further explored with regular committee business. .		

	They pay their nurses hourly for prep and time they are in court. They submit invoices for reimbursement, and can be paid even if they are no longer with the program Pediatric Cases: Acute exams are done in the hospital. One barrier for children is the need for more hospitals to offer exams because there is a much smaller window with how fast exams have to get done. Laura is currently the only nurse FNE for pediatric cases. Most of the time pediatricians do the exam. 12 & under go to Franklin Square. There is a care and custody issue. Interdisciplinary team comes in. A sub-committee should be looking at Peds if that's a part of the charge of this committee. There could be an entire sub-committee devoted to this because there are a lot of barriers and an intersection of services (i.e. protective services, rape crisis etc.) (O'Brien). Laura takes calls at Franklin outside of her regular FT job. Kids never come to GMBC unless they are 13 and over. Hospitals have procedures to make sure that persons practicing in their facilities are legit, which is one concern with have a traveling practitioner (Watson). The committee is looking at hospitals and not Child Advocacy Centers, which is the bulk of the child cases	The committee is charged with looking at what goes on in the hospitals in regards to acute cases.		