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

Meeting Minutes

Date: Thursday, March 12, 2015
Time: 10:00am – 12:11pm
Chairperson: Carole Mays
Members Present: Christine Jackson, Mary Lou Watson, Gail Reed, Lisae Jordon, Susan Kraus, Greta Cuccia, Tiwanica Moore, Amy Robinson
Members Calling In: Eunice Esposito
Members Absent: Mark Arsenault, Verlin Meekins, Kathleen O'Brien, Brian McGarry
Members Excused: Joyce Dantzler, Casey Nogle
Guests Present: Subha Chandar (DHMH), Lynda King (MCASA), Kathryn McNally (MCASA), Jenna Williams (Del Kelly), Lisa Garceau (DHMH)
Guest Presenters: Debbie Holbrook (Mercy Medical Center), Carey Goryl (IAFN), Jana Parrish (IAFN)

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 2/12/2015
Welcome and Introductions	Roundtable Introductions	None	Carole Mays	CLOSED
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. 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.	Information and Reference	Carole Mays	ONGOING

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Review of Previous Minutes & Approval	February 12, 2015 draft minutes were discussed. Quorum was not met for approval. Corrections (presented by Jordan): Guest Laurie Chin is a representative of Delegate Kelly's office and not Montgomery County. The official committee name is as follows: Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland.	Corrections to the minutes will be made. Recommendation to approve corrected February meeting minutes at April meeting (Watson, Jackson).	Amy Robinson Membership	OPEN OPEN
Stakeholder Testimony	Highlights: Mercy Medical Center's (MMC) SAFE program was founded by Dr. Christine Jackson. There are 36 nurses working with the MMC program and have 1-2 people on call 24/7. Grant funds support this fully mobile 24 hour a day program; around 110/year mobile cases. The Sisters of Mercy absorb any extra costs as this work is part of the MMC Mission. They travel to all city hospitals and other facilities, such as nursing homes and prisons. They see victims of sexual assault 13 years of age and older. They provide other victim services such as a Strangulation Center for Baltimore City and Elder/Vulnerable Adult Abuse, Neglect and Maltreatment. The program does have MOUs (through Risk Management) with the hospitals where Forensic Nurse Examiners (FNE) are sent. The SAFE nurses use their MMC ID badges for identification at visiting facilities. Police transport the SAFE nurses due to safety, open evidence, and expensive equipment. Arrangements exist with Baltimore City police and the Police Chief's Association (for cases where victims are brought into Baltimore). The program does not provide advocates; most hospitals will have their own already available (and are often who request the FNE visit).	Information	Debbie Holbrook, Mercy Medical Center SAFE Program	CLOSED

	Up until a few weeks ago, no reimbursement was provided by DHMH for mobile cases. Mercy can now submit a claim for up to $80.00 under Dr. Jackson as a physician fee that goes into the Emergency Department(ED) cost center. Mercy still loses approximately $200 on each case. Lisa Garceau from DHMH (guest invited to speak by Carole) provided clarification. Reimbursement of claims is victim-focused. It takes care of patient expenses but does not necessarily cover overhead for hospital operating costs. The nursing cost is built into the ED fee and there is no other mechanism to pay the nurses. The DHMH Sexual Assault Reimbursement Unit (SARU) pays Dr. Jackson or any physician working collaboratively with FNEs. The Violence Against Women Act and Victims of Crime Act funding is limited to approximately $15,000 and $30,000 for direct salary reimbursement, respectively. There was a recommendation that updated MOUs could include a miniscule charge for FNE reimbursement (Watson). Fundraising is necessary to cover costs. Mercy also does community education work and works closely with stakeholders, which may help ensure victims know where to go for treatment. There are a relatively small number of people transferred. Mercy is the only SAFE program in the city and sees over 500 victims per year. The SAFE program is expensive to maintain and it does not generate money; it "breaks even." From Debbie's perspective, every hospital should not have a SAFE program, considering staff training. It's no different from transporting a patient where the specialty is addressed (i.e. trauma). There is a concern that some hospitals that say they have a SAFE program cannot provide			

	24-hr. care. MCASA's concern is that nurses are not getting paid and improved access for sexual assault victims is not the same as hand surgery (Jordan). Holbrook recommends 4-5 regional programs with mobile units. To address staffing concerns, it has to be a program that people want to work for, and nurses have to feel good about their skills. Debbie has run a successful program in rural and urban areas. The volume is different but the work is the same. State crime lab meeting revealed that semen can be obtained from high up in the cervix for up to 10 days (Jordan). Programs are held to the state standard of 120 hours. National policy is also 120 hrs. Mercy will still take cases over 120 hours though the claim may be denied if sent to DHMH/SARU. Pediatric FNEs handle ages 0-12 years. Mercy has pediatric FNEs, but University of Maryland has the "ownership" for pediatric victim care. All pediatric patients are transferred there. If a pediatric patient is admitted to Mercy, Sinai, Union, etc., they will NOT receive a forensic exam no matter the circumstances.	Any additional questions from the members should be e-mailed to Carole who will get them to Debbie. Consider inviting Dr. Closson from UMMC Children's Hospital to provide testimony on Pediatric SA examinations.	Membership Carole Mays	OPEN NOT STARTED
Victim Care Sub-committee Work-plan Review	The Sub-Committee has been looking at protocols across the state. One noticeable gap is the lack of handling pediatric cases and varied definitions of pediatric age. How/where you transport transferring patients is also an issue. Examples of Alaska (nine centers, but no clear direction) and Texas (no transportation plan or training of FNEs) were		Verlin Meekins Chris Jackson	OPEN

	mentioned. Maryland does not yet know how we get the forensic exam to the individual; Committee recommendations can become a model nationwide. There are also issues of reimbursement when discussing transferring versus personal transport (Jackson, Watson). Baltimore has a very strong Sexual Assault Response Team (SART), but a network response doesn't necessarily work when patients go to/come from another jurisdiction. There's a big funding push for a trauma-informed response so that everyone (Law enforcement, EMS, etc.) understand that victims have experienced trauma and need specialized attention. MCASA believes we're as far as we can go without a mandate for SART best practices. Now structured requirements may be necessary. In positive news, Montgomery County is now going to do a SART. SART structure varies by jurisdiction, with different levels of cooperation and resources. Mandate for inclusion is necessary (Jordan). The Committee is considering drafting a template policy for Hospital programs. MHA contact Katie Wunderlich is no longer there, so we do not have all hospital policies. The final committee report will note how many hospital policies we have received (currently about half, but still reaching out) (Mays).	Workplan document will be distributed with the minutes. Submit hospital policies to Carole for review.	Amy Robinson Membership	OPEN OPEN
EMS/Law Enforcement Sub-committee Work-plan Review	Presented by Gail Reid. Currently targeting 4 issues: 1. EMS Response – No clear procedure to take rape victims directly to a SAFE program. This is not part of the protocol. EMS may not be trained in knowing the victims' options.	Sample Law	Casey Nogle Gail Reid Sub-Committee	OPEN OPEN

	2. No clear standard for law enforcement response and no standard for getting a victim to an ED or SAFE program. A specific incident was discussed regarding a patient experiencing rectal bleeding that was left in a patrol car for three hours. Paramedics should not be dismissed when the victim is reporting an injury and requesting transport to a hospital. This is a life safety issue and a minimal standard for law enforcement response is necessary. Mercy meets with the police department every six months to train them on handling sexual assault victims. This may be a best practice to share (Jackson). 3. Victims who go to a hospital without a SAFE program for medical treatment may not know their options or do not wish to report the assault to a police. Reporting requirements need to be identified so that providers know how to respond and can inform victims of their options. 4. Time elapsed is a concern. This may be because of lack of protocols/specifications for action. Timely transport to proper care can be extended for multiple reasons. Access should be timely.	Enforcement Template Workplan document will be distributed with the minutes.	Members Amy Robinson	 OPEN
Reimbursement Sub-committee Work-plan Review	Sub-Committee is looking into getting some hard data. From a policy point of view, the big picture is needed. Questions have been generated about the 120 hour window of time and the science behind it. They are interested in learning more about the national perspective. Many states use criminal justice compensation funds that allow access to a federal level match of funding (Jordan). - Lisa Garceau from DHMH (guest invited to speak by Carole) provided clarification. The regulations show 120 hours. As a practical matter, the SARU receives claims over 120 hrs. Data would need to be published in order to consider changing these regulations. However,	 Workplan document will be distributed with the	Kathleen O'Brien Joyce Dantzler Amy Robinson	OPEN OPEN

	criminal injury compensation funds also often have a cap to them.	minutes.		
Public Testimony Sub-committee Work-plan Review	A second draft of the public testimony survey was distributed, reviewed, and discussed. The term "rape kits" was clarified and the SAFE Committee name was re-confirmed (review of minutes above). Concerns expressed included the list of hospitals in Q9, the wording of Q10, and the list of questions included in Q12. The sub-committee does not want it to feel like a survey, instead they would prefer the questions be listed individually to capture a narrative (Reed) and without the prosecution questions (Kraus). This is not a survey for MCASA, this is a survey MCASA has offered to present on behalf of the Committee (Kraus). The SAFE Committee has now heard from Mercy Medical center, GBMC, and IAFN (in the minutes below). Susan is working on having Pam Holtzinger from Frederick Memorial come to speak. Maryland Register will announce in the March and April publications that the May 14, 2015 meeting will accept public testimony from 12pm-1pm following the regular monthly meeting.	All comments should be sent to Lisae, Lynda and Kathryn and should copy Carole and Joyce. The survey draft must be finalized this month and then distributed to the Committee for approval. Workplan document will be distributed with the minutes.	Carole Mays Lisae Jordan Membership Carole Mays Lisae Jordan Amy Robinson	OPEN OPEN OPEN OPEN
Stakeholder Testimony	The International Association of Forensic Nurses (IAFN) Prepared comments were distributed. Highlights: • Forensic care needs to be consistent and timely. How jurisdictions/states decide to do that is variable, but consistency and reliability is most important. • IAFN has worked on projects with the National Sexual Violence Resource Center (NSVRC) around program sustainability. • They are looking into it how to minimize survivor travel. The assumption is that there is a nurse close by.	Information and Questions IAFN Prepared Comments will be	Carey Goryl and Jana Parrish, International Association of Forensic Nurses Amy Robinson	CLOSED OPEN

	• They do not think a traveling SAFE nurse is a good idea. • Training is moving online vs the 5-day traditional course. • West Virginia model (very rural) is based on a traveling program. • Access for pediatric victims is poor. There are so few trained medical professionals qualified to do pediatric exams. The national pediatric protocol is currently being written. • To integrate FN into healthcare, you need to look at health insurance. Healthcare codes and legislation allow nurses to practice to the full extent of their license – prescribe, diagnose, etc. The more we relegate SANEs to criminal justice programs, the more limited we will remain. Expanding the program to work with insurance reimbursement systems will involve transition outside of just sexual assault treatment and documentation. Specific solutions for victim privacy (i.e. a child under parent insurance) have not been identified. • IAFN does not foresee moving to a nurse practitioner model. The future of FN is in FN programs to provide holistic care to a wider population and not in SAFE programs.	distributed with the minutes.		
New Business Recap of Issues Identified for the Next Meetings	Subcommittee workplans should be ongoing. Please let us know if you need assistance. No other new business. Meeting adjourned at 12:11 p.m.	Report outline and requirements will be distributed to Subcommittee chairs. The hope is to have the report prepared for a June review.	Carole Mays	OPEN

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