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

Meeting Minutes

Date: May 14, 2015
Time: 10:00 AM – 12:10 PM
Chairperson: Joyce Dantzler MS, MCHES
Co – Chair: Carole Ann Mays RN, MS, CEN
Members Present: Joyce Dantzler, Carole Mays, Christine Jackson, Gail Reid, Mark Arsenault, Mary Lou Watson, Tiwanica Moore, and Amy Robinson
Conference Call: Eunice Esposito (disconnected), Lisae Jordan, Kathleen O'Brien
Guests Present: Clifford Mitchell (DHMH), Lisa Garceau (DHMH), Jody Sheely (DHMH),
Guest Present: Dr. Forrest Closson, University of Maryland Children's Hospital
Members Excused: Casey Nogle, Margaret Cuccia, Susan Krauss, Verlin Meekins

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 5/14/2014
Welcome and Introductions	Roundtable Introductions	None	Joyce Dantzler	CLOSED
Open Meetings Message	As a reminder, the public is invited to attend but cannot participate unless asked to do so by the committee.	Information and Reference	Joyce Dantzler	ONGOING
Review of Previous Minutes & Approval	No discussion on April 9, 2015 minutes, as quorum is not present for approval.	Approval of minutes will be tabled until June meeting.	Membership	OPEN
Public Testimony	The University of Maryland Children's Hospital (UMCH) sees children under the age of 14: approximately 225 cases each year (15-20/ mo.). Most are between 2 & 8 years old, while only 1 – 3 adolescent aged children are seen each month. Most cases (90%) have "normal" findings of sexual abuse and not penetrative sexual assault. Children who have been sexually assaulted tend to have more findings that those who have been abused.	Information	Presented by Dr. Forrest Closson, University of Maryland Children's Hospital	CLOSED

	Barriers to Care: 1. Financial – The perception victims have is that they have to pay for their own evaluations. Sexual abuse/assault evaluations do not have to go through their own health insurance. 2. Potential notification of parents - When adolescents request any sexual health, abuse or assault services, they can receive care without parental notification/consent. Whether to notify police or engage parents is often unclear. Providers prefer to follow guidelines exactly so that there can be no questions. The current lack of specific age guidelines leads to ambiguity re: evaluation and reporting. 3. Transportation – Many children/adolescents do not have transportation and cannot get to care in a timely fashion. 4. Training – There are a fewer pediatric cases across the State which makes it difficult for providers to maintain FNE-P credentialing. For pediatricians that do the exams, most are child abuse specialists with special training that differs from FNE programs. At both UMCH and MedStar Franklin Square Medical Center the providers feel comfortable doing evaluations. However, many referring physicians and primary pediatricians do not feel comfortable with the protocols, triage, exams, etc. a. Some pediatric nurses with FNE training only work part time and maintain their licenses at other full time facilities (Jackson). b. Financial reimbursement and administrative barriers limit the availability of mobile SAFE nurses for pediatric evaluations, though this may be an area of opportunity to reach patients that should be considered (Jackson, Reid, Mays). <u>Recommendations</u>: 1. Adequate funding to properly train FNEs in MD. Lack of adequate coverage for pediatric cases is a concern. 2. Better redefining of the options that are available to some of these			

	children is recommended. Mandated reporting only applies to sexual abuse and not sexual assault. Many pediatricians also do not feel comfortable with a child/adolescent providing consent. Child Advocacy Centers (CAC) are able to handle non-acute pediatric cases, however most facilities are not open 24/7. Approximately 16 of every 20 cases each month go to the hospital when the CAC is closed (Reid, Closson). CACs handle mostly chronic cases, so there is not usually a pediatric sexual assault exam done (rape kit). Typically a general physical exam and history is completed. (Dantzler). Gail Reid has requested that the Committee contact CAC representatives to present. Lisae Jordan supports the request for a CAC representative to attend the Committee. Most physicians are not comfortable working on safety plans for sexual assault patients within their ED (Closson). Physicians are mandated reporters. Many do not like calling Child Protective Services however, since its very time consuming and a risk of being called to court. In assault cases, physician discretion is a less clear situation when there may be a consulting physician involved (i.e. tending to fractures that may be abuse) (Mitchell, Closson). There are also issues that Friday evening calls to Child Protective Services will not result in visits until Monday morning, keeping the adolescents in the hospital all weekend (Jackson).	Invite CAC representatives to present to Committee Membership.	Carole Mays Gail Reid	OPEN
Victim Care Sub-committee Work-plan Review	The State of Maryland has 57 hospitals: 46 have EDs and 26 have submitted protocols to the sub-committee. 21 have SAFE programs, and 9 with programs did not send in a protocol. Of the SAFE protocols received, 6 see only adults, 1 sees only children, and 14 see both.	Presented by Chris Jackson.	Verlin Meekins Chris Jackson	ONGOING

	Of 188 nurses with FNE certifications, 121 see only adults. 67 are available to see children, 9 see only children, 58 see both adults and children. This data comes from the Maryland Board of Nursing (MBON). They do not have the information regarding where they practice, as nurses are tracked through home addresses (Watson). Originally, the MBON was supposed to be monitoring SAFE programs across the state to ensure that each program is run by a trained SAFE Nurse, complying with additional requirements, etc. Due to the transition in leadership at MBON, some of the procedures and information may have been lost. Some hospital protocols do not address pediatric patients and/or have definitions for pediatrics/adults that are not correct. Some protocols do not state where/how you would refer/send a patient. Some programs do not offer the Jane Doe option to their patients (these must be outdated, as this is not in compliance with the Violence Against Women Act). For the most part, nurses have to pay for their own training. Prince George's will support maintenance of certification (Arsenault). Mercy Hospital tries to get grant funding to pay for nurse training (Jackson). <u>Barriers to Care:</u> It is very difficult to confirm what facilities actually have SAFE programs. Calling some programs did not lend itself to helpful information – operator would not be clear or know details of SAFE program. Some programs only offered a voicemail option and even some did not return calls until multiple messages were left. It is unknown if the MBON requires that SAFE programs have 24/7 coverage. It is unclear who is monitoring SAFE programs. The MBON monitors nursing practice, but there is no outside entity monitoring the programs.	This data will be submitted in template form for Report submission.	Sub-Committee Membership	OPEN

	The Prince George's SAFE program reports to the internal hospital board, but there is no outside regulation (Arsenault). It has also been difficult to clearly identify a designating agency. COMAR notes that the DHMH MBON authorizes SAFE facilities. It is also mentioned in Maryland Criminal Procedure §11-924: The nearest facility to which a victim of sexual assault may be taken shall be designated by the DHMH, etc. In 1998, it was requested that MBON oversee SAFE programs. Oversight of the programs has gone by the wayside since overseeing the FNEs has become so complicated. Originally, the person in charge of the program was expected to be a SAFE nurse with two years of experience. MBON should not be evaluating programs. The system should aspire to have specialty referral centers for domestic violence and/or sexual assault (Arsenault). The Board of Nursing exists to license nurses and keep the public safe; they are not focused on running programs (Watson). The Governor's Office of Crime Control and Prevention (GOCCP) would like to have a SART in every jurisdiction (Reid). New York has criteria for SAFE program certification that is required to maintain designation (Reid). There is no designation of SA centers across the country. To be designated as a trauma or specialty referral center in Maryland, there are written state regulations that may take 1-1.5 years to be promulgated and brought forth. Designated specialty referral centers are re-verified every 5 years, and have the organizational commitment for the program, nurses, physicians, education requirements, etc. Those that do not meet the standard may be put on provision, probation or may have their designation revoked. MIEMSS does not have responsibility for	Confirm if MBON has a 24/7 requirement for SAFE Programs. Provide MBON with related COMAR for discussion.	Mary Lou Watson Carole Mays Mary Lou Watson	OPEN OPEN

	overseeing SAFE programs. MIEMSS designation of SAFE centers may lead to a more limited number of and more regionalized, centers (Mays). The next step is to look at the SAFE programs since the focus has been on just the SAFE nurses in the past (Jackson). It is agreed that there should be a distinction between what the MBON is regulating and who is regulating programs. Cost should not become the driving factor for a forensic issue. Forensic exams to collect evidence are costly but we still expect governmental evidence collection for prosecution – we should be finding a balance between services offered and costs, as we do not want cost to be a limiting factor in forensic issues. The Office of the Attorney General may be the appropriate authority since this is a forensic and not a health issue. A multidisciplinary approach is recommended (Jordan). This would be a difficult shift as the DHMH currently handles all financial reimbursement (Dantzler). Rural programs need to remain in the conversation. Some of the smaller areas are trying to figure out on their own how to make this work (O'Brien). On the Eastern shore, they are attempting to combine SAFE programs to provide better services locally. Smaller areas cannot be compared to the more urban areas (Jackson). The Sub-Committee should consider how low volume facilities can maintain competency. How can we ensure victims still get appropriately timed exams with a shrinking of program availability? (Arsenault) Definite program oversight and criteria definition is needed and should be a recommendation from the Committee (Jackson, Mays).			

EMS/Law Enforcement Sub-committee Work-plan Review	Drafted report addresses four areas: 1. EMS protocol – sexual assault falls under the trauma protocol, but there is nothing that directs EMS to a designated SAFE hospital. The sub-committee would like to see in protocol that patient should be taken to a SAFE hospital. Pediatric specific-issues must also be addressed. a. Carole confirmed with Dr. Alcorta that SAFE hospitals can be listed in the protocol, as long as there is a caveat saying who is regulating/authorizing these SAFE hospitals. Also, EMRC <u>does</u> have a list of SAFE hospitals for reference for EMS providers. 2. Many police department protocols do not address sexual assault victims. It may be beneficial to write a template with recommendations for protocol use. The group may also recommend that police training academies and roll call trainings include sexual assault victim options. For example, some victims are being taken to the station first where police are collecting urine. Victims feel differently about police asking for a urine sample than when asked by a hospital. There is a Maryland State Law for Victims Rights – police have to transport to nearest facility, but many police are unaware. Designated SAFE programs are where victims should be taken. a. How does this affect hospital specimen chain of custody? (Watson) 3. This crosses over to the Victim Care Sub-committee – many people will just go to their local hospital where they feel comfortable. There is a lot of confusion about whether or not the police should be called (even among hospital staff who think they are mandated to notify the police when they are not). This is a HIPAA violation. Hospital protocols must be in place. 4. Many victims do not learn about services until they become victims and go through a roundabout process, often disclosing first to friend/family (Dantzler). The Sub-Committee may recommend efforts to raise public awareness for those who may become victims of sexual assault. One example of a campaign that addresses this is called “You Have Options.”	Presented by Gail Reid. The sub-committee is working on template for law enforcement for those agencies that don’t have a protocol. Regionalization is being considered.	Sub-Committee Membership	ONGOING OPEN

	a. Colleges also have issues with mandated reporting and may often discourage students reporting assaults (Jackson). There is currently a big push in process for campuses to connect with SART teams to bring resources together (Reid).			
Reimbursement Sub-committee Work-plan Review	The reimbursement sub-committee has drafted a report. Currently, Maryland pays for all services in connection with a sexual assault and for diagnostic testing up to 90 days after an assault. Coverage in neighboring states is not as extensive. A chart is included in the report to detail state regulations, services covered, and source of funding for services. The report has not yet been signed off by the subcommittee, but will soon be finalized and submitted to the Committee for review. Gaps in reimbursement processes have also been examined. Major barriers include: - Low reimbursement rate for the professional component. Maryland is the only state that has a Health Services Cost Review Commission (HSCRC). The Sexual Assault Reimbursement Unit (DHMH) will pay what's required by HSCRC for the hospital ED charges. For the professional component, the rate is capped at $80, which is believed was established in the 1970s. The sub-committee will more than likely recommend to increase the rate. - There is currently no mechanism to reimburse FNEs. Right now they cannot be reimbursed and there are no means to do so. The Sub-Committee would like to further investigate options for reimbursement as well as for inter-hospital travel. - Victim transportation is not currently reimbursed. Criminal injuries compensation sometimes works to help cover costs, but recommendations should be made to consider other means of compensation for victim transportation. - The minimal estimated costs based on 2014 Medicare conversion factors are as follows:	Presented by Joyce Dantzler. Finalize report for submission.	Kathleen O'Brien Joyce Dantzler Sub-Committee Membership	ONGOING OPEN

	1. $218.35 for inter-facility specialty care and $3445.07 for trauma. A BLS ambulance is $250, ALS $350, and helicopter $4,000 per Medicare coverage. Many jurisdictions are now charge $200-$600 for initial transports, but charge insurance directly and often do not request additional copays (Mays). 2. Private commercial BLS facility transfers are usually $400, which will be charged directly to the patients if they are not insured (Arsenault). - In Prince George's County, private commercial transportation is typically used for inter-facility transports. The vast majority of victims are transported to the appropriate facility by the police. Victims normally call the police and very few get transported by EMS (Arsenault). In the City, police will transport Jane Doe cases without any involvement. This does not occur in the County (Jackson, Mays). The Sub-Committee should consider a recommendation for more engaged SART teams. An additional concern is the lack of coverage for HIV prophylaxis, since medication is so expensive. The Sub-Committee should also look at staff models, such as at Mercy where FNE is included in staff responsibilities and is not a separate part time position (Jordan).	A best-practice template should be drafted for the report.	Sub-Committee Membership	OPEN

Public Testimony Sub-committee Work-plan Review	For the June meeting, Pam Holzinger from Frederick Memorial will be coming at 11:30 AM. Following the regular Committee meeting at 12 PM, public testimony will be received. The announcement for Public Testimony on June 11, 2015 at 12Noon was posted by DHMH. There are concerns about the public testimony occurring at the next meeting. Is the room and location welcoming for survivors? Are plans being made for publicizing the public testimony session? (Jordan)	Carole will work with Gail Reed to work on a Child Advocacy and Criminal Injuries Compensation contacts to provide testimonies. Inform patients, providers, and the public of the opportunity to submit public testimony.	Carole Mays Susan Krauss Membership, MCASA, DHMH, MIEMSS, MHA	OPEN OPEN
	Please be sure to submit completed sub-committee work plans and reports prior to the June meeting. Due to time restrictions, verbal reports may be shortened (Dantzler). DHMH has not yet received any public testimony (Dantzler). MCASA has received 20 stories so far. Lynda King went to the DC/MD chapter of the FNEs and they will try to work with their members/schools to provide input. Requests also sent to crisis centers. Nature of stories vary – difficulty of long wait, exam, English not primary language, moving nurses to survivors, some victims have strong feelings about hospital and healthcare choices, facility processes for receiving survivors from another county, transportation from schools, issues with programs not having available nurses, difficulty receiving HIV prophylaxis, challenges with cognitive/language difficulties, etc. MCASA will be submitting testimony report with stories included (Jordan).	Submit sub-committee reports prior to June meeting. Continue to collect public testimony	Sub-Committees MCASA and DHMH	

New Business Recap of Issues Identified for the Next Meetings	The revised report outline will be distributed. Content is needed to follow original deliverables within report. Summaries and recommendations are needed as soon as possible (Mays). The draft will not be completed by the June meeting date, but a finalized report from each Sub-Committee is needed as soon as possible so that a draft report can be provided to the Committee in July. A finalized report should be given to DHMH and MIEMSS for approval by September (prior to the final December 1 submission to the General Assembly). If the Committee requires additional time to make edits, it will be necessary to do so (Jordan). The next meeting will be held on Thursday, June 11, 2015. Meeting adjourned: 12:04 PM	Send out revised report outline. Review outline and provide feedback to Chairs. Submit a draft of sub-committee reports and updated work plans by the next meeting in June.	Chairs / Staff Membership Sub-Committee Chairs	OPEN OPEN OPEN