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

***Meeting Minutes***

**Date:** June 11, 2015
**Time:** 10:00 AM – 11:23 AM
**Chairperson:** Carole Ann Mays RN, MS, CEN
**Co – Chair:** Joyce Dantzler MS, MCHES
**Members Present:** Joyce Dantzler, Carole Mays, Lisae Jordan, Mary Lou Watson, Mark Arsenault, Verlin Meekins, Greta Cuccia, Christine Jackson, Casey Swope, Brian McGarry, Susan Kraus, Tiwanica Moore, and Amy Robinson
**Conference Line:** Eunice Esposito, Gail Reed, Kathleen O'Brien
**Guests Present:** Subha Chandar (DHMH), Lisa Garceau (DHMH), Lynda King (DHMH), Alison Branitsky (MCASA), Alexis Moss (DHMH), Sarah Wilbanks (MCASA)
**Guest Presentation:** Pam Holtzinger, RN, Frederick Memorial Hospital and Frederick County Child Advocacy Center

| TOPIC | DISCUSSION | ACTION | PERSON/S RESPONSIBLE | STATUS |
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| Welcome and Introductions<br><br>Open Meeting Message | Roundtable introductions.<br><br>As a reminder, the public is invited to attend but cannot participate unless asked to do so by the Committee. | <br><br>Introduction and Reference | <br><br>Carole Mays | <br><br>ONGOING |
| Review of Previous Minutes & Approval<br><br>"Open" Issues Review<br><br>SAFE Committee Deliverables | April meeting minutes discussion:<br>Motion to correct the Committee title to match legislation for all minutes from April on. There is a concern that everyone should understand that improving access is the goal of the committee. The name given by the General Assembly is: Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland (Jordan).<br>Second (Arsenault).<br>Vote Count: Yeahs – 9; Nay – 3; (It is going to be confusing if the minutes will have a changed title halfway through; Watson) | Correct minutes to reflect proper Committee name. | Amy Robinson | OPEN |

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| | Motion carries.<br>April minutes are approved following this change.<br><br>May meeting minutes will also have the Committee title corrected. May minutes were approved with this change.<br><br>The co-chairs and their staff have started to draft a Committee report based on the Sub Committee reports. Some items will be added as a placeholder such as sample templates, to show the Committee the flow of the draft report, the gaps, barriers, etc. The July meeting will be focused on this draft and will allow for discussion of the deliverables, barriers, and especially the recommendations.<br><br>It was requested that the draft report include areas for discussion. The Committee may wish to consider having a third party person mediate the discussion to help the Committee sort out recommendations (Jordan).<br><br>Please have subcommittee narratives submitted by June 19 so that they can be included in the draft report (Mays).<br>Please include recommendations so that the committee can discuss them as a whole. The draft report will be sent out approximately a week prior to the July meeting (Dantzler).<br><br>The public testimony window for MCASA closes on June 30. A report will be forthcoming (Jordan). | Distribute draft to Committee members.<br><br>Submit updated Sub-Committee narratives by June 19. | Amy Robinson<br><br>Sub-Committee Members | OPEN<br><br>OPEN |
| Public Testimony – Frederick Memorial Hospital (FMH) and Child Advocacy Centers (CACs) | Pam Holtzinger , FNE-AP, has been with Frederick Memorial Hospital (FMH)for approximately 1 year and works in the Forensic Nursing program, which handles patients with any reports of sexual assault, domestic violence, elder abuse, etc. She was also on the original board for development of the Frederick County Childhood Advocacy Center (CAC) and has been a nurse examiner there since its opening. | Presentation | Pam Holtzinger, RN. | CLOSED |

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| | Staff development and call coverage has been a difficult process. It takes 6 months to a year to get a forensic nurse examiner (FNE) fully trained and working. The structure at the hospital is for the FNEs to be on-call, though it is a casual relationship that is not beneficial to current practice. This is causing a failure to provide 24-hour coverage. FMH has offered a full time position to begin addressing this issue. The hospital handles both adult and pediatric cases, and is collaborating with the Frederick County Child Advocacy Center (CAC) to develop and expand their pediatric capabilities. The majority of patients have a component or suspicion of sexual abuse/assault, but they are now also seeing child maltreatment and increased additional cases in response to violence. Many programs begin with sexual assault but increase capacity to be involved in domestic violence cases, child maltreatment, etc. This program is a healthcare response to violence.<br><br>Frederick County has a strong, well-engaged SART team.<br><br>Additional Barriers:<br>By not having dedicated individuals, there is limited education being shared. When an FNE is put in place, you can do more and be available for more than just exams. Recognition skills, resources, and testing should all be available. We need to legitimize that FNEs do more than just the actual exams. This would allow for larger scale collaboration and providing greater access to expertise. Putting a nurse in place with specialty skills with the ability to manage these types of populations can provide meaningful results and better care. Having this type of staff allows facilities to make connections early on to recognize violence and provide early intervention.<br><br>The current system to staff/train/recruit nurses is not sustainable. It takes hundreds of hours, additional costs for certification, and then requires the FNE to be on-call nights/weekends after already working a 40-hour work week. Pay will only be for when you come in; it's a lot of extra work with a limited money incentive. Taking less on-call hours limits the FNE's ability to stay current in practice, and getting called in is an individual responsibility where the FNE is the | | | |

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| | sole responder to handle the case. Preparation for the position takes months, and then calls must be covered; what happens when calls cannot be covered? The workforce does not exist because it is very difficult work and very emotionally challenging to maintain. There is about a 2 year turnaround; one year for adult training, then about 6 months for pediatric training, (sometimes more) and then soon after they are leaving due to the stress. Dedicating and legitimizing the position allows for continued skill proficiency and for the community to have a predictable workforce to respond to all types of violence cases, not just sexual assault (strangulation, domestic violence evaluation, elder abuse).<br><br>Regionalizing responses may move patients beyond where they are comfortable. Taking them somewhere for an exam and then referring them back elsewhere does not have as positive an impact as managing a patient within their own area (with local resources and team responses).<br><br>The CAC model is ideally a model to bring together specialty resources and multidisciplinary team members to deal with child abuse and sexual abuse. They do not often disclose unless there is severe trauma, and when they do it is usually outside of the evidence window. The CACs are to bring together law enforcement, medical (2 days a week in Frederick, very rare in other locations), counseling services, etc. It is a holistic response to healthcare and investigation. The CAC provides the opportunity for the child/family to address the situation and handle it appropriately. Acute care setting models typically will have a child go in during the evidentiary collection window. Outside of that, most children do not present during that window, but instead weeks (or even years) later. CACs do not usually do evidence collection, but instead provide counseling services and normalization of experiences. They can offer STD testing and minor treatment, but often it is the opportunity to have a healthcare screening and provide proper referrals for advocacy and counseling services.<br>Not all counties have a CAC. The Child Abuse Medical Professionals in Maryland group is concerned about access. They have been trying to train pediatricians and | | | |

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| | FNEs to support CACs. Not all CACs have a medical component, either. Those that do still have relationships that are somewhat casual – staff are usually on an on-call basis and are not working dedicated hours.<br><br>FMH offers a lethality assessment program to manage the patient beyond the exam itself. Patients need links to their local resources. The expertise is there and the focus is patient-centric. More can be offered than just the exam.<br><br>As a nurse, violence is a healthcare issue. If this means that 2.5 nurses are needed to cover 24/7, then perhaps that is what is necessary. FNEs with full time positions have longevity, support, and expertise, though budgetary concerns could be an issue in some facilities. Nurses are recognizing the need and are stepping up to respond to these cases, even though they are suffering for it financially and emotionally. Another limiting factor is that these FNEs working on-call become recognized as the local go-to people for the community, which stretches them even further.<br><br>The traditional FNE staffing model (recommended through IAFN) is time and a half, or stipend, for on-call responses. Having them work predictable patterns instead at a salaried or hourly rate (not time and a half) may normalize the FNE position. This allows the FNE to also teach, be available for follow up, participate in discussion with other providers, etc. It makes the FNE accessible.<br>With only two nurses full time, they would split the day; there would then be a smaller window where the hospital did not have coverage.<br>More dedicated staff would also reduce training costs because there would be fewer turnovers. FNE training costs thousands of dollars. There are also development costs, monitoring for independence, educational hours, equipment review, peer review, etc. Dedicated staff and resources would lend itself to longevity to the staff. | | | |

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| Victim Care Sub-Committee Work-plan Review | The Sub-Committee met this morning before the full Committee meeting to review the narrative document. The recommendations were not discussed due to time constraints. Another meeting is scheduled for next Monday to discuss the recommendations and finalize the report.<br><br>The gaps presented at the May meeting were re-introduced:<br>- Many SAFE programs do not mention pediatric patients or how they would be handled.<br>- Four hospitals do not offer a choice in exam type.<br>- Many hospitals do not discuss transfer options for patients. | Information<br><br>Information | Joyce Dantzler<br><br>Christine Jackson | OPEN<br><br>OPEN |
| EMS/Law Enforcement Sub-Committee Work-plan Review | The Sub-Committee found that many law enforcement agencies do not have protocols for sexual assault victim information; a template was drafted for initial police response regarding access to forensic exams, reference to victims' rights, etc.<br><br>The EMS protocol for sexual assault was found to be limited. The Sub-Committee looked at best practices and drafted a protocol for victim response and transportation to a SAFE hospital. SAFE facilities are not listed in the protocol; patients are taken to a trauma center or the closest facility instead. The process for submitting this information for EMS protocol inclusion has been discussed with Carole Mays.<br><br>When a patient comes to a hospital that does not offer SAFE, there should be a policy for appropriately providing information and transportation. This issue is still in discussion.<br><br>Emergency Medical Dispatch (911) protocols have been reviewed and will be included in the draft report for Committee review (Mays). | Information | Gail Reed | OPEN |
| Reimbursement Sub-Committee Work-plan Review | The report is being finalized and will be submitted by the June 19 deadline.<br>It was requested that the report include information on the staffing model discussed by Pam today (Jordan). | Information | Joyce Dantzler | OPEN |

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| Public Testimony Sub-committee Work-plan Review | Pam attended today to discuss FMH and the Frederick County CAC. We would still like someone from the Criminal Injuries Compensation Board (CICB) to present to the Committee. Casey and Lisae will speak with Carole to make contact.<br><br>A summary sheet of public testimony so far has been created to be added as an appendix to the draft report.<br><br>DHMH has received one public testimony from the Maryland Emergency Nurses Association (Moore).<br>MCASA has received approx. 30 testimonies. The testimonies show evidence of a disconnected system that may cause more harm than benefit to victims. Testimonies will only become public record if the victims allow it. Other testimony may be confidential and/or only for MCASA summary (Jordan).<br><br>Lynda King will be transcribing a testimony for someone who was unable to attend and/or write a testimony directly. | Information<br>Invite CICB to speak.<br><br>Include Pam testimony and redistribute.<br><br>Receive public testimony. | Carole Mays<br><br>Carole Mays<br><br>Carole Mays<br><br>Lisae Jordan<br><br>Lynda King (MCASA) | OPEN<br><br>OPEN<br><br>OPEN<br><br>OPEN<br><br>OPEN |
| New Business<br><br>Recap of Issues Identified for the Next Meetings | We would like to plan meetings for February and March 2016. Although the report will be submitted on or before December 1, 2015, there may be an opportunity to review comments and questions in the Spring.<br><br>We should consider having the meetings in Annapolis. This would support involvement from the legislature (Jordan). Carole and Lisae will work to schedule the meetings in Annapolis around the legislative schedule.<br><br>End of meeting: 11:23AM | Schedule February and March meetings in Annapolis | Lisae Jordan and Carole Mays | OPEN |

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

***Public Testimony***

**Date:** June 11, 2015
**Time:** 12:00 PM – 1:00 PM
**Guest Presentations:** Debi Wolford (WMRMC), Siobhan Copeland (CNMC), Joey Middleton (HCGH)
**Additional Guests Present:** Sarah Guerrieri (CNMC)

| PRESENTOR | PUBLIC TESTIMONY |
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| Debi Wolford, Washington Maryland Regional Medical Center | Debi works with the Allegheny County SAFE program at Western Maryland Regional Medical Center (WMRMC), which has two forensic nurses for 24/7 coverage.<br><br>Debi does not want ER physicians doing evidence exams, and they do not want to do them. We are in alliance with Meritus Medical Center and Frederick Memorial, so hopefully patients will be able to connect there if necessary. Garrett County and West Virginia patients also come to WMRMC. WMRMC does both adults and pediatrics. Debi has privileges at Garrett Memorial Hospital as well, but has only gone there once for a severely ill patient. Garrett and West Virginia hospitals both have FNEs, but they do not offer on-call pay or 24/7 coverage. Keeping nurses is difficult, but we do NOT want ER physicians giving exams. Victims that have been transferred have always been moved via law enforcement, never by family or EMS – the police have always volunteered. WMRMC is seeing patients from four counties, spanning an hour and a half away. The majority of patients are walk ins. Advocates are on- call and are always present during exams and/or transfers.<br>Mobile FNEs is an exciting prospect. Patients are able to stay in their own environment and care can come to them. The one time Debi traveled to Garrett County, it was on per diem. The arrangements WMRMC has with other hospitals are all informal.<br><br>Debi is a full time FNE. The domestic violence and sexual assault programs are combined for the FNE to have a full time position. They also now have a part time position so that Debi can also travel for meetings such as these. A call schedule is maintained by the hospital. Every SAFE program should have at least one full time person. |

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| Siobhan Copeland, Children's National Medical Center (CNMC) | A large portion of our patients come from Maryland. We see children throughout the DC, Maryland, and Virginia area. Comprehensive examinations are conducted by physicians and nurses with forensic specialties. Treatment for STDs and counseling for maltreatment (psychologists, clinical social workers) are offered. 2,033 encounters annually – 64% are victimized in DC, 17% in Prince George's County, and 18% come from other Maryland and Virginia locations.<br>60% of all in-patients in the hospital are Maryland residents.<br>Every county does not have a child abuse pediatrician, so CNMC serves as a backup for many localities when patients have acute needs. It is difficult to provide referrals for resources when you are not familiar with the area the patient comes from (i.e. St Mary's).<br><br>Pediatric care is considered care for anyone under the age of 22. Pediatric expertise is necessary – adult models for SAFE programs should not be applied to pediatric cases. Independent or systematic advocates for the child are not as welcomed as family advocates would be. In order for a child to deal with the trauma experienced, they need the support of the families. When the families aren't healthy, CNMC helps to get the family back on track. An adult model allows for strangers to be advocates, while children should really have the advocacy of a family member or guardian.<br><br>The Crime Victims Compensation Program (CVCP) is their main source for reimbursement. Medicaid doesn't pay for mental health services; if insurance doesn't cover, CNMC works with CVCP to help cover reimbursement. The DC CVCP helps with transportation, which is often a big cost, but Maryland program does not cover this. Maryland also does not assist with housing, which can be a problem for assault victims who are not safe at home and have nowhere to go. DC has safe housing.<br><br>Forensic exams for Maryland residents may be reimbursed through CVCP in DC (Maryland DHMH only covers reimbursement in Maryland facilities. DHMH has no mechanism to reimburse facilities not within the state; Joyce Dantzler). |

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| Joey Middleton, Howard County General Hospital | There are never enough nurses. There are no dedicated FNE positions and all FNES already have full time jobs. Howard County General Hospital requires the FNEs to be proficient in both adult and pediatrics. They receive patients from Baltimore County, Baltimore City, Anne Arundel, Prince George's, etc. There have been times when there was not a FNE available to see the patient and the patient had to be transferred elsewhere. The SAFE program is grant funded so they do not have the luxury of full time staff.<br><br>"Hope Works" is a local advocacy agency that provides an advocate for every patient. The hospital relies on them since one nurse does all the other work – photos, evidence collection, exam, information, etc. Law enforcement may also come in for an interview if it is not a Jane Doe case.<br><br>Howard County has an excellent SART team. Every two months "Hope Works," Child/Adult Protective Services, Law Enforcement, and the State Attorney's Office will meet with the SAFE program to discuss past and current cases.<br><br>Baltimore Washington Medical Center has been having an issue recently with a lack of pediatric certified FNEs (they currently have only 1). They are planning to train 7-9 pediatricians to do the exams if the FNE is not there. There is concern about doctors doing the training though, as FNEs are experienced at working with the patients under such difficult circumstances.<br><br>Oftentimes the exam process can be lengthy. FNEs are very skilled at talking down patients to make them feel at ease, be cooperative, and not feel as if they're being assaulted all over again.<br><br>Documentation needs to be standardized. Information on photo technique, written documentation, etc. would be very beneficial. Current processes do not allow for clear, full documentation (i.e., paperwork does not offer enough space).<br><br>An example: A young girl attacked by multiple assailants presented to Harbor Hospital with a friend. She was told they would have to call her parents, that they didn't do exams, and that they had no further information. Later that evening she told her mother, who took her to BWMC. They did not have a nurse on call, so she was later sent to Howard County General Hospital. All hospitals should know what resources are available elsewhere – what hospitals offer 24/7, pediatrics, etc. |

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