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

Meeting Minutes

Date: July 9, 2015
Time: 10:00 AM – 12:09 PM
Chairperson: Carole Ann Mays RN, MS
Co – Chair: Joyce Dantzler MS, MCHES
Members Present: Joyce Dantzler, Carole Mays, Lisae Jordan, Greta Cuccia, Christine Jackson, Casey Swope, Gail Reid, Kathleen O'Brien, Tiwanica Moore, and Amy Robinson
Conference Line: Eunice Esposito, Susan Kraus, Mark Arsenault, Mary Lou Watson
Guests Present: Lisa Garceau (DHMH), Lynda King (MCASA), Alexis Moss (DHMH), Sarah Wilbanks (MCASA), Kim Sauer (BCAC), Muta Matambo (Del. Kelly), Holly Vandegrift (Del. Kelly), Jessica Roman (CICB)

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 07/09/15
Welcome and Introductions	Roundtable introductions.	None	Carole Mays	CLOSED
Public Testimony Criminal Injuries Compensation Board	Jessica Roman works with the Criminal Injuries Compensation Board (CICB) as a bilingual claims examiner. The Executive Director is Scott Beard. **CICB Services:** A language line is available for those who speak languages other than English or Spanish. The CICB pays out medical expenses up to $45,000 for sexual assaults. Medical bills may be submitted for: -Individuals who go to non-SAFE facilities and are transferred to other facilities -Victims who seek services out of state (VA, DC, DE) -Co-payments, deductibles, and out-of-pocket expenses -Bills from DHMH Sexual Assault Reimbursement Unit (SARU) for providers that did not provide bills to DHMH within the designated time period or that used the wrong diagnosis code	Presentation Handouts /applications were distributed containing presentation slides.	Jessica Roman, Claims Examiner, Criminal Injuries Compensation Board	CLOSED

	-Expenses for physical injuries that occurred at the time of the assault. As a payer of last resort, CICB refers clients to DHMH (SARU), private insurance, medical assistance, hospital charity care, tri care (military), MD Auto insurance, workman's comp. etc. as applicable because funding is limited. -Individuals are eligible for up to $5,000 for counseling services. Family members can receive up to $1,000 per member up to $5,000. -There is a maximum of $25,000 compensation for lost wages for individuals unable to work. Funding is also available when parents need to miss work to care for a child / dependent. For child abuse cases, the parent may be eligible for lost wages with certification from a doctor. -The dependency maximum benefit is $25,000. It is mainly used in cases involving death or incarceration. -Funeral/burial (up to $5,000) and crime scene clean up (up to $250) can also be covered. Clean up includes professional services or non-professional services if receipts are provided for cleaning products purchased. -The victim's contact information is needed for applications. -Victim paperwork can be overwhelming, and they often need assistance to complete it. -A police report or report number is necessary to show that the crime was reported within 48 hours of the incident. There may be leeway for specific cases when reporting was delayed (i.e. child abuse over a period of time since counseling expenses can be requested up to age 25). A statement explaining the situation (i.e. fear of abuser) may allow for later compensation if there is good cause. Applications must be in office within 3 years from the incident. Min. benefit is $100. Clients can apply for lost wages only if they meet the 2 week requirement.			

	The crime must have occurred in Maryland, with the exception of an overseas assault or terrorist attack. -The victim must have experienced physical or psychological injuries and must not have contributed to the victimization. -A social security number is requested to search for state indebtedness. A dummy number is used for those who do not have one. LaTisha Carter is the CICB Victim Services Coordinator. **Gaps in services identified by CICB:** CICB is payer of last resort. -Victims may be denied because there are other resources available. -Contributing to or failure to avoid injury -Failure to report in 48 hours -Lack of cooperation with law enforcement -Changes in the victim's story during the course of the investigation can delay or result in denied compensation. Victims may request a hearing in the CICB office if this occurs. -Repression of the assault delaying reporting (i.e. child abuse situations or if victim was drugged) -Providers may miss deadlines or provide the wrong diagnoses code for DHMH (SARU) claims. -Undocumented wages cannot be reimbursed. CICB is statutory based. -Relocation / lock changes are not covered. -Many situations are handled on a case-by-case basis (i.e. Jane Doe, pregnancy/abortion, and prophylaxis etc.). **Discussion:** -CICB can help with ambulance fees.			

	-Exams that are done on victims that go to a non-SAFE hospital can be covered if they are not eligible for the SAFE exam through said hospital. -In instances when doctors do not submit claims in a timely manner to DHMH (SARU), CICB may cover those expenses if reasoning is provided -Sexual assaults out of state are not covered. For assaults in Maryland where care is then provided out of state, CICB may cover expenses when DHMH (SARU) does not reimburse. DHMH (SARU) had a nice working relationship with CICB previously and would like to continue that. Victims should not be coming to CICB about hospital sexual assault exam billing since DHMH (SARU) reimburses the hospital directly. Thus, victims should not be billed at all (Dantzler). -CICB will follow up on these cases to confirm circumstances and why billing was not originally covered as it should have been. -CICB and DHMH will talk about re-establishing a working relationship moving forward. It is unclear who is providing follow up for the sexual assault victims. CICB is working on this. There are limited counseling services available in Baltimore City. **Discussion of HIV prophylaxis policies:** -Some hospitals in other states have prophylaxis available on site. -Prophylaxis is given when the suspected offender is known to be HIV positive. -Delays in administration interfere with effectiveness. Hospital protocols must be in place to address these issues ahead of time (Kraus). -The Board is not comfortable awarding on an emergency basis. There is no set protocol. This is one of the controversial topics but has been reimbursed in some cases. CICB is in communication with other agencies to see how this can be better addressed. One client paid for the drugs and was reimbursed (Roman). -Part of the reason it is not offered on an emergency basis is that the person may have acquired HIV previously and not as a result of the assault. If the victim is			

	not in a good frame of mind, it may be better to wait until the victim can process all of the information (Dantzler). - It took 4 years for Mercy Medical Center to put together a protocol that would meet the needs of its patient population. Mercy uses an algorithm to decide who is a candidate for HIV prophylaxis. Those patients that are considered to be a candidate for HIV prophylaxis (according to the protocol) are referred back to the ED physician who makes the final decision for HIV treatment. Those patients started on HIV prophylaxis are given seven days of medication from our pharmacy and referred to Jacques initiative at the University of Maryland. It usually takes a week to get them a follow up appointment. DHMH at this time does cover for 3 days of HIV medication treatment (Jackson). The times that the issue has come up has involved children (Roman). -It was previously communicated that CICB is not reimbursing because they were concerned that they were not the payer of last resort (Jordan). -They have learned that by treating the mother, you don't end up with an HIV positive baby (Jackson). -There are also coupons available, and clients may get a discount for the drug through insurance.			
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	Carole Mays	ONGOING
Review of Previous Minutes & Approval	Reviewed June 11, 2015 meeting minutes.	Minutes were unanimously approved.	Membership	CLOSED

"Open" Issues Review	Committee meetings scheduled from October 2015 through March 2016 are on hold until further notice. Arrangements have been made to convene meetings if necessary. Meetings will be held in Annapolis and will not have phone-in capability: February 3, 2016 - 8:30 AM – 10:30 AM The Women's Caucus, Lowe House of Delegates Building 6 Bladen Street Annapolis, MD 21401 March 10, 2016; 10:00 AM – 12:00 PM Anne Arundel Medical Center, Belcher Pavilion (Health Science Building) Doordan Institute (7th Floor), Room A 2000 Medical Parkway Annapolis, MD 21401 There is nothing in legislation that speaks to Department oversight. The process seems rushed. The committee needs to approve the final report (Jordan). The committee will work through the draft today, Aug., and Sept. If the committee feels that report content is not satisfactory in Sept., the chairs could potentially schedule another meeting. State agency protocol requires the report to go through the chain of command at both agencies to make sure that the report is formatted correctly and that the agencies are aware of the contents of the report prior to submission to the General Assembly (GA). The report must be in the hands of the specified agencies no later than early Oct. in order to secure all sign-offs in time to meet the GA deadline (Dantzler).	Information on additional meetings will be sent to the committee. For the September 10, 2015 meeting, the plan is to stay for an extended period of time to review the report before it is submitted to DHMH and MIEMSS. The committee will meet from 10AM-noon, break for lunch, and reconvene from 1PM-3PM to make sure that all changes and final edits have been made in order to meet the December deadline.	Carole Mays Joyce Dantzler	OPEN OPEN

	Jordan has never seen an agency ask for a report so early based on her participation on other committees. This committee will not be approving things in concept (Jordan). The committee will know the contents, although formatting or minor, non-substantive changes may occur (Dantzler). A word here or there really makes a difference (Jordan). The committee should see a final copy before submission (Reid). The process seems to be a DHMH process rather than an appointed committee process. There are procedural differences (O'Brien). The chairs will make sure the final "draft" document is given to the committee for a final review prior to sending to the Governor and Committees (Mays).			
Review of the Draft Report	Legislative reporting guidelines were received from DHMH. The sample report was distributed to SAFE Committee chairs and staff. **Comments:** -Formatting is up for discussion. It may be best to organize the report by deliverables. The report is currently organized keeping the charge in mind (i.e. gaps and recommendations etc.) (Dantzler). The organization as noted on pg. 49 of report is recommended since this is for the General Assembly (GA) (Jordan). It was agreed that the report be drafted based on the deliverable template format moving forward. -Pg. 50 requires the committee to discuss findings and recommendations. There are some larger concerns with recommendations. During the hearings, one of the major concerns was what happens when someone shows up at the "wrong" hospital. There needs to be a lot more public education around that. The committee should think about changing the policy of nurses going to the survivor only if the patient can't be moved. Differences in geography (rural vs. urban) are important. The most difficulty is occurring in Montgomery County. Maybe the committee should look at some of the bigger jurisdictions. There is concern	Discussion	Membership	OPEN

	about the big picture issues (Jordan). Committee has not come to an agreement on recommendations and may not be ready to review the report. The committee should start with recommendations (Reid). The committee should talk about the big picture things. Pam H. talked about the need for staff nurses. The committee should consider recommending support for full-time forensic nurses in this process since the whole idea is to increase access (Jordan). -There is some overlap on sub-committee issues (i.e. EMS and Victim Care). There are 3 counties (Montgomery, Prince George's, and Baltimore City) that have more than 1 hospital. The real issue is what to do with these 3 counties (Jackson). -There is also difficulty in the areas of Somerset, Queen Anne's and Caroline. There are distance issues and population issues (O'Brien). For the counties with 1 hospital, that hospital is the SAFE program. However, there are some counties with no hospital and no SAFE program, including Caroline and Queen Anne's. As it relates to the Eastern Shore (ES), Somerset comes to Peninsula. Atlantic General has their own program. Some of the SART training includes the entire ES group. They allow victims autonomy on where they want to go. Eunice's program works more closely with Worcester and Somerset. Karen Jackson works with the other group that's closer to the bridge. Services are provided wherever a patient presents, so they typically don't have territorial issues on the ES (Esposito). University of Maryland Shore Health consists of Queen Anne's (no hospital), Kent, Dorchester, and Talbot combined (Mays). -Baltimore City has a lot of hospitals, but people know that victims should be brought to Mercy. The real problems arise in areas with more than 1 hospital, such as Prince George's and Montgomery County (Jackson). Having multiple sexual assault centers would not be feasible for Prince George's based on volume and resources. There are 5 acute care hospitals (Laurel, Prince George's,			

	Southern Md., Doctor's Community, and Fort Washington (Arsenault). Mercy helped Baltimore County, which also has multiple hospitals, put into place the same concept, so that everyone knows where to take child and adult victims. Baltimore County does not have the same problems as the other jurisdictions with multiple hospitals (Jackson). Ninety-seven percent (97%) of victims make it to the right hospital in the beginning. The vast majority come by police, and there are very few transfers (Arsenault). You don't know who isn't making it to the right hospital because they don't get a SAFE exam (Reid). If the vast majority make it to the right hospital, than it would not be that difficult to send the examiner to the other hospitals (Jordan). Since it is such a small number of patients involved, that seems manageable to offer. Prince George's has received some grant money recently to evaluate that. Last year they evaluated the issue for Bowie and Laurel. The goal for 2016 is to have that program and establish MOUs with the other hospitals (Arsenault). -The recommendation should be that we never move the survivor unless the survivor wants to move, and the hospitals must have MOUs to send the program to the survivor (Jordan). The Victim Care sub-committee has recommended the mobile SAFE unit (Dantzler). Instead of reviewing the entire report, the committee agreed to focus on already proposed recommendations first.			
Review of the Draft Report - EMS/Law Enforcement	*Pg. 35 of the report* EMS protocol could be developed and needs to be more clear and comprehensive. SAFE programs are not currently apart of the EMS listing. Other protocols were researched, and they expanded on the victim-centered, sensitive response. It is in the victim's rights law that victims must be transported to a SAFE center immediately if the victim wants to go. There are instances where this is not happening. Although we have programs and procedures, they don't	Information	Gail Reid	OPEN

	always work well. Recommendations for law enforcement protocol should be made. Some jurisdictions/agencies have a protocol and others do not. Every agency should adopt a protocol, including 911 and uniformed response. Police are not trained to assess injuries, and there may be injuries that they cannot see. There may be a need to define the roles of each person on a SART team (O'Brien). This could lead to recommendations around SART. Everyone can advocate for a victim but the advocate role is very specific (Reid). There is a specific recommendation for strong SART Teams who meet regularly and work in cooperation with programs under the Victim Care subcommittee (Dantzler). It may be necessary to strengthen the recommendation around SARTs by saying there "should" or "shall" be rather than "it would be helpful". A long term recommendation is for education of EMS providers and formal education for law enforcement around the state. Recommendations will be pulled together into a list.			
Review of the Draft Report - Victim Care Sub-Committee	The recommendations listed in the draft report were read and discussed. *Recommendation #1 Comments:* MHA should work in collaboration with a law enforcement entity (Jordan). This one can be tweaked to include the phrase "working in concert with the AG's Office" (Dantzler). *Recommendation #2 Comments:* To address the last two lines, it should say that we do not move the patient. SARTS should be active with SAFE. The SART information could be a separate recommendation. Every SAFE should work with victim advocates from the local rape crisis center (Jordan). Every rape crisis center has an advocacy program but they don't always get called by the hospitals. There should be a clear separate recommendation for advocacy	Information	Joyce Dantzler	OPEN

	and one for SART. The survivor should not be moved (Jordan). Trauma-informed protocols may be needed. There are a lot of best practices around trauma-informed care. This should be a mandatory part of EMS and law enforcement training. Everyone interacting with the patient should have the training (O'Brien). Getting the patient to the right facility is the first priority. The idea of the mobile unit could be a backup for those few instances when the patient is not at the right place. *Recommendation #3 Comments:* In essence, there is already some form of regionalization. Counties that currently work together include: Allegany and Garrett; Washington and Frederick; Harford and Cecil; and the Eastern Shore. In reference to innovative practices, MD is not the only state struggling with this issue. One thread throughout the findings was being able to give each area some flexibility to develop what works best for them. The committee should think about crafting a recommendation that encourages a local SART to come up with something that would work for the area, involve not moving the patient, and create the best chance for the patient to get to the right place initially (Reid). Get the patient to the best place first. If you can't, the burden should fall on the program. There is no objection to regionalization as long as we also say something about having local advocates and connection to local services which is important to survivors (Jordan). The committee needs to plug gaps and eliminate barriers without changing the way the system is structured (Dantzler). It was agreed that recommendation #3 be taken out, and a separate recommendation on training be created. *Recommendation #4 Comments:*	Provide definition of "trauma-informed" and the language for the related recommendation	Kathleen O'Brien	OPEN

	In reference to addressing the needs of the pediatric population, CHAMPS is already in statute and Child Advocacy Centers (CACS) exist. If a pediatric trauma patient goes to Hopkins, no SAFE exam is done. Most cases are chronic, so there are not a huge number of cases. The majority of child victims end up going to their pediatrician. A recommendation could be that the SAFE exam be provided in pediatric trauma centers (Reid). If there is a trauma, the patient may not end up at a SAFE hospital because trauma trumps. Establishing MOUs with hospitals and mobile SAFE units for adults and children would provide adequate coverage (Cuccia). *Recommendation #5 Comments:* An increase for physician reimbursement (more than $80) is recommended. This would require a change to the DHMH regulations. This could be addressed under reimbursement and be removed from this section. Reimbursement for the exam and reimbursement for the physician are two separate issues, so there should be 2 recommendations. The physician component is more difficult to wade through and should be separate. If they go to Shock Trauma, Shock Trauma can get the ED fee from DHMH and reimburse Mercy. However, the chances of a secretary finding these cases are minimal (Jackson). The physician fee and labs are covered if performed at Mercy (Dantzler). A recommendation for consistent SAFE facility care (how they treat patients) protocols is needed (Cuccia). The MBON is supposed to be following this. There is a protocol in place (Jackson). The MBON does not train, it manages certifications. The trainings are approved but not created by the Board (Watson). *Recommendation #5 Comments:*			

	Hospital data collection is problematic because how patients present and the diagnosis code during discharge could be very different. This would not be clean data (Cuccia). The committee could possibly add to the SART recommendation. There is an absence of that type of data. SART should collect data, not the hospital, on the various components: the number of sexual assaults reported to police; how many had SAFE exams; how many Jane Doe exams done; how many victims saw advocates in the ER; how many had follow up from advocacy; and the number of cases charged and unfounded. SART should be given authority to ask for that data. There are program funding advantages to getting this data (Reid). Since no State SART exists, MCASA is willing to look into obtaining combined SART data. It is not a bad idea to say that local SARTs shall provide data to MCASA because it is difficult to get information from all SARTs to be representative of the entire state (Jordan). The sub-committee will clarify the recommendation that data collection occur in the SART.			
New Business Recap of Issues Identified for the Next Meetings	Report draft provides the background for the recommendations. It is still unclear who is regulating SAFE programs in Maryland. It appears that no one is doing it. Maybe the AG's office should be doing it (Jordan). Lisae Jordan to write the recommendation for this. Recommendations will be compiled and distributed to the committee for review. End of meeting: 12:09 p.m.	Compile recommendations into one sheet and send back out to committee.	Amy Robinson and Carole Mays	OPEN