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

Meeting Minutes

Date: August 13, 2015
Time: 10:00 AM – 12:02 PM
Chairperson: Joyce Dantzler MS, MCHES
Members Present: Joyce Dantzler, Lisae Jordan, Greta Cuccia, Christine Jackson, Gail Reid, Mark Arsenault, Verlin Meekins, Eunice Esposito, Brian McGarry, Susan Kraus, Tiwanica Moore, and Amy Robinson
Guests Present: Lisa Garceau (DHMH), Alexis Moss (DHMH), Jody Sheely (DHMH), Clifford Mitchell (DHMH)
Members Excused: Carole Mays, Mary Lou Watson

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 08/13/15
Welcome and Introductions	Roundtable introductions.	None	Membership	CLOSED
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	Joyce Dantzler	ONGOING
Review of Previous Minutes & Approval “Open” Issues Review	Reviewed July 9, 2015 meeting minutes. Minutes approved with no dissent.	Motion to approve July minutes made (Jackson) and seconded (Kraus).	Membership	CLOSED
Review of Draft Recommendations for the Committee Report to the Governor Hospital Policy	**Recommendation 2a. Comments:** At the July meeting, Office of Attorney General (OAG) oversight for SAFE programs was suggested. The committee continued to discuss this option. • The OAG could oversee the SART programs but should not be over the SAFE programs (Jackson). Dantzler agreed this may not be appropriate. • Currently no one has oversight over the SAFE programs in Maryland. In New Jersey (NJ), oversight is the responsibility of the Attorney General’s office.	Discussion	Membership	OPEN

	• There is a criminal justice component that cannot be managed through medical oversight. Perhaps we need to define "oversight", as the OAG would not be responsible for the actual quality of care (Reid). • In the NJ model, medical still owns the medical component (Espisito). • Perhaps MIEMSS should oversee/designate. SAFEs are a medical program. MIEMSS programmatic review is currently done for trauma, stroke, etc. (Arsenault). • MIEMSS designation may actually limit the availability of programs instead of improving access due to stricter guidelines and certification requirements. This process would also take a few years to get off the ground (Robinson). • Having the MBON oversee the SAFEs makes it a very medical-based oversight. The program, not the nurses, also includes ensuring connections with legal counsel, crisis centers, etc. The OAG ensures good evidence collection, and they can work with the MBON to ensure medical quality. The SAFE programs themselves need leadership so that they are not solely medically-focused (Jordan). • The MBON is responsible for nurse licensure. This is law that cannot be changed automatically. The MBON is currently looking at the recertification processes, which will have FNE recertification every two years. Elise Williams is the current acting FNE certification manager and is reviewing all credentials and requirements. Education also falls under the MBON. The MBON does not oversee the SAFE programs, but does oversee general practice and licensure. Online education could be done if it goes through the proper channels (Kraus). • MIEMSS is the best option to do the oversight (Arsenault, Dantzler, and Jackson).			

	• MIEMSS is not the best option. If oversight by the OAG, they have the political leadership to prioritize concerns. MIEMSS can still be assigned to create guidelines and operationalize reviews (Jordan). • Access to SAFE is access to the Criminal Justice System. With SAFE, there is a medical component but it is evidence collection, which should not be overlooked. To put oversight under a medical organization will not help the process overall (Reid). • The number of exams for FNE renewal has been stagnant since 2003. There is an issue of getting nurses but also of keeping nurses (Kraus). No consensus was reached about who should oversee SAFE programs. MBON does not oversee SAFE programs. Perhaps the committee should remove Recommendation A and focus on Recommendation B instead. The committee cannot specify the agency responsible for oversight, but can suggest the coordination among various entities to look at developing guidelines for this process (Dantzler). **Recommendation 2b. Comments:** • Change wording to read “statewide guidelines to increase access to sexual assault examinations” (Jackson). • The bullet points under 2b. should stay since they are all important points. Condensing any further may change the meaning. The introduction to these bullets should state that they are law and not just guidelines (Reid). • The last bullet point could be a stand-alone and the rest of them are the law. Recommendation 2E should be a stand-alone recommendation and not a subset (Jordan).			

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Add “all sexual assault victims” so that we are sure to include those that do not have an exam. Every patient should have that option regardless of whether or not there is evidence collection (Jackson).
Add the notation about SAFE programs as recognized by criminal procedure (per reference from Jordan).
Hospital Policy should also have a recommendation delineating hours for FNE as a full time staff member. This should include training, education, hospital hours, etc. (Jordan).
Number the bullet points for reference.
Revise the bullet about informing of options.
Include the fact that all hospitals should have a policy addressing sexual assault (Arsenault).

Recommendation 2e. Comments:
This statement should be reworded. For example, “sexual assault survivors who present at a Non-SAFE facility shall not be moved” (Jordan).
Recommendation 2e should be a standalone recommendation and not a subset (Jordan).
Recommendation 2g. Comments:
This needs to be reworded. Every sexual assault victim should have access to an advocate.
Using broad language is a concern because it could refer to anyone. It is helpful to say that “if you have a SAFE program”. This type of language includes advocates and not just nurses.
Recommendation 2f. Comments:
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<td>Verify language for Recommendation 2g.</td>
<td>Lisae Jordan
Amy Robinson</td>
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	• The information in 2f implies that victims would be moved if they are not stable, which contradicts what is stated in 2e (Reid). • Mercy has a mobile unit but other places don't, so the recommendation is not close to a reality (Jackson). This should be a long term goal. • The issue of moving patients is something that many people are concerned about. What the committee aspires to do should be stated as a goal, acknowledging there are challenges ranging from workman's comp. to MOUs (Jordan). • The AG's Office could be helpful in moving this forward and addressing some of the challenges to having mobile units (Reid). • Large system hospitals may be able to implement mobile units (Kraus). • For example, Dallas has established a medical program with 12 hospitals in the system. Nurses are employed by the system and can go into all these hospitals (Reid). • The long-term goal will be to have mobile SAFE units. In the short term, patients may have to travel (Dantzler). • The committee should not recommend that it's okay to move patients right now (Jordan). • The long-term goal should be that sexual assault patients not be moved (Jackson). • The long-term goal is to ensure the shortest time period from the victim asking for an exam to victim getting the exam (Arsenault). • AG oversight could facilitate addressing some of the issues (Esposito). • A timeline should be added if this is a long-term recommendation (Kraus). After the committee submits this report, the State legislature will review it and determine the next steps (i.e. introduce new legislation) if any (Dantzler).	Verify language for Recommendation	Lisae Jordan Amy Robinson	OPEN

	The committee report can be viewed as an advice letter from a bunch of experts (Jordan). The committee agreed that patients should not be moved. Regarding the physician reimbursement rate, Kraus recommends adding nurse practitioners. The issue of reimbursing nurse practitioners will be revisited during the reimbursement discussion. The legislature just passed a law allowing Nurse Practitioners to practice independently. Nurses are still unable to be reimbursed for SAFE exams on their license (Garceau, guest invited to speak). Appendix H. should be modified in reference to collecting information on children (Jackson). When reorganizing the hospital policy section, it should include additional information regarding SART teams (Reid).	about not moving the patient. Modify Appendix H. Incorporate language from Jordan under SART section.	Staff Staff	OPEN OPEN
Review of Draft Recommendations for the Committee Report to the Governor EMS/Law Enforcement	**Recommendation 1e. Comments:** Under the 4th bullet, change the word "coerce to force". The word coercion leaves a lot open to interpretation. 1e will be reworded to state that victims will be advised that going to the hospital is their choice. Consider specifically addressing Victim's Rights Law as an additional bullet point. Any urine or drug screening should be done at a medical facility.	Update LE/EMS Recommendations	Gail Reid Brian McGarry	OPEN

	According to the Victim's Rights Law in MD, police must transport the victim immediately to a medical facility. A lot of police may not be aware of this. The LE/EMS recommendations will be separated into individual sections. Anonymous reporting should be mentioned (Esposito). How to train law enforcement and EMS on managing information provided to the victim (protocol and training issues) remains to be addressed. Deliverable #10 is still empty in the draft report.	 Review appendices, EMS/LE recommendations and other information to include under deliverable #10.	Mark Arsenault Joyce Dantzler Staff	 OPEN
Review of Draft Recommendations for the Committee Report to the Governor Reimbursement	Jordan would like to adopt Kraus' suggestion regarding the physician reimbursement rate and adding nurse practitioners. **Recommendation 3 a. Comments:** The Medicare physician fee for the emergency room is in the document for reference. Changing the reimbursement rate would require a change in the regulations. Reimbursement issues need to be examined further. The Forensic Nurse is an agent of the physician; a physician would typically not be in the room for 120 min. (Arsenault). $80 is enough for the amount of time that the physician spends in the room. Nurses actually spend much more time (Esposito). It was agreed that the rates for physicians should be re-evaluated.	Research/update nursing reimbursement recommendations Make edits. Confirm with Jordan recommendations regarding Criminal Procedure Section 11-293.	Reimbursement Sub-committee Amy Robinson	OPEN OPEN

	Recommendation 3d. Comments: Considering billing victims' private insurance would cause significant privacy issues (Jordan). The private insurance portion of recommendation 3d will be removed. Additional recommendations, as submitted by the Reimbursement Subcommittee regarding nPEP, will be added. One of the most effective things that came out of the testimony that the committee heard was the recommendation for hospitals to place a forensic nurse on staff. This would be the same model as at Mercy and Frederick (Jordan). It is not clear if this type of recommendation would fall under the reimbursement section. **Recommendation 3b. Comments:** Change the word "consider" to "provide" reimbursement for mobile units utilizing VAWA funds (Jackson). VOCA funding is also a possibility. This should not just be limited to VAWA (Reid). Current document does not reflect the latest version of the recommendations that Dantzler read. The latest version will be incorporated into the next report draft.			
DHMH Report Approval Process	A handout was distributed about the DHMH clearance process. It's not an approval process but a clearance process. The report will be reviewed for consistency and grammatical corrections. The report reflects the committee's work and is not the Department's report. The process is not about			

	changing what's in the report. It's about creating the best final product (Dantzler). The wording of the final report should be approved by the committee (Arsenault, speaking as an MCASA Board Member). Tweaks will come back to the committee for review. This is a task force product and not a Departmental product. DHMH does not look at it for review for the purposes of content. In the past, there have been some legislative products that would have benefited from an editorial review. The Department is committed to providing a track changes version of the document back to the committee (Mitchell, guest invited to speak). Working inside a bureaucracy, requires a longer turnaround time. This is the origin of the deadline. (Sheely, guest invited to speak). The committee only has 1 more meeting to finalize the report and does not want to submit something they are not comfortable with (Reid).			
New Business Recap of Issues	September 10th meeting will be the extended meeting. There will be a morning and afternoon session with a break for lunch. The committee will convene on October 8th if necessary. Report revisions and information from tasks assigned at this meeting should be submitted to Amy by Tuesday, August 18, 2015. The committee has not reached consensus on the issue of SAFE program oversight. It was suggested that the key players be brought together to create guidelines for this.	Informational Send pieces to Gail with updated language. Send language regarding Hospital	Joyce Dantzler EMS/Law Enforcement Sub-committee Members Jordan	CLOSED OPEN OPEN

Identified for the Next Meetings	There was a consensus regarding mobile units. This should be a long-term recommendation. Deliverable #10 is blank and needs to be addressed by the Committee to which it was originally assigned. Therefore, LE/ EMS Subcommittee members Reid and Arsenault were asked by the Chair to take the lead on drafting content for this deliverable. The chart that was completed for the Hospital Policy Sub-Committee work could potentially fit under this deliverable. What was recommended for EMS to do could also fall under this one (Jackson). All materials will be distributed at least a week prior to the September meeting. The committee was encouraged to attend this key upcoming meeting in person if at all possible. End of meeting: 12:02 p.m.	Policy and mobile units. Revise reimbursement section related to expanding reimbursement. Informational Edit/Update Report and Recommendations	DHMH staff Joyce Dantzler Amy Robinson	OPEN OPEN ONGOING