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

Meeting Minutes

Date: September 10, 2015
Time: 10:00 AM - 11:46 AM
12:50 PM - 3:00 PM
Chairperson: Carole Ann Mays RN, MS
Co – Chair: Joyce Dantzler MS, MCHES
Members Present: Carole Mays, Joyce Dantzler, Lisae Jordan, Greta Cuccia, Christine Jackson, Casey Swope, Gail Reid, Mark Arsenault, Mary Lou Watson, Tiwanica Moore, and Amy Robinson
Members Excused: Brian McGarry
Members Absent: Kathleen O'Brien, Susan Kraus, Verlin Meekins
Conference Line: Eunice Esposito
Guests Present: Holly Vandegrift (Del. Kelly), Del. A. Kelly, Cliff Mitchell (DHMH), Katie Jones (DHMH)

TOPIC	DISCUSSION	ACTION	PERSON/S RESPONSIBLE	STATUS 09/10/15
Welcome and Introductions	Roundtable introductions.	None	Carole Mays	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	Carole Mays	ONGOING
Review of Previous Minutes & Approval	Reviewed August 13, 2015 meeting minutes. Minutes were approved after a quorum was met.	Motion to approve minutes (Jackson) and seconded (Swope).	Membership	CLOSED

"Open" Issues Review	The committee revisited the discussion of designating SAFE programs. Current COMAR notes a reference to the Attorney General and DHMH. MIEMSS was also suggested. MIEMSS is willing to do it, but this is a time-sensitive and not a time-critical issue (Mays). Based on previous concerns, the handout explaining the DHMH clearance process that was disseminated at the last meeting was reviewed. Any changes that the Department makes to the report will be sent back to the committee with track changes.			
Review of the Draft Report to the Governor, and the House Health & Government Operations Committee	The committee reviewed and discussed the most recent draft of the report. Comments, recommended changes, and questions from the discussion are summarized as follows, referencing the page numbers and corresponding sections of the report: ***Executive Summary:*** The Executive Summary will be cut down to two pages if possible, and will be able to be used as a stand-alone document for legislators, etc. The information on hospital protocols should be summarized (Jordan). There are 3 categories of hospitals as it relates to protocols: 1. those that have a protocol, 2. those that don't have a protocol, and 3. those that did not respond or submit a protocol The concern that we should go to survivors needs to be a prominent feature. The burden should not be on the survivor (Jordan).	Discussion Submit wording of the sentence pertaining to reimbursement. Update the executive summary to discuss the breakdown of DHMH reimbursement funding and discuss the issue of burdening the victim to find care.	Membership Chris Jackson Joyce Dantzler	OPEN OPEN OPEN

	Pg. 3 - Jackson would like to add that the claims are submitted to DHMH for review and reimbursement, and this should be reworded to state what is actually covered. DHMH reimburses at HSCRC rates. • It would be helpful to clarify state vs. federal funding for the General Assembly (Jordan). DHMH SARU funding is largely State funding (about 95%).			
Review of the Draft Report to the Governor, and the House Health & Government Operations Committee	Attachments that were disseminated to the committee will be put into appendices rather than links. **Introduction – pg.5** • Add advocate as a term (Reid). The VAWA definition of advocate was read. • In the victims section, make reference to the fact that some people who experience sexual violence prefer the term "survivor" (Jordan). This could be added under "survivor" or also known as "survivor". • The definition of rape is incorrect (Jordan). The definition of rape in the report is based on the data, and this distinction is addressed in the report (Dantzler). The current definition should be used (Jordan). The current definition is already in the document and will be pulled forward. For the purposes of this document, SAFE refers to the exam. **Background & History – pg. 9** MBON does not designate SAFE hospitals. The report will reference COMAR and clarify that neither MBON nor anyone else is currently designating SAFE hospitals. The committee will recommend that MCASA, MHA, and OAG come together to look at how SAFE programs should be designated. The committee still has not reached consensus on this issue. If the regulations need to be revised, that would have to be addressed by the appropriate process.	Submit VAWA definition of advocate. Submit additional changes on the sheet passed around at the meeting or in writing by tomorrow.	Gail Reid Committee	OPEN OPEN

	The statute says MedChi, and statute "trumps" regulation. From a historical perspective, COMAR may reference MBON based on the past work. This is trauma sensitive and assault sensitive which distinguishes it from a high quality medical exam. Sensitivity should be included (Watson). • Recommended wording is to "Address the sexual assault victims concerns with sensitivity…" **Pg. 10** The time frame was 1993 not mid90s. • Use of the word citizens is not accurate. We provide services to non-citizens also (Jordan). **Pg. 11** • For pg. 11a, first sentence, revise repetitive phrases such as "during their lifetime" (Watson). There was concern that the male stat is relatively low (Jordan, Reid). The most impactful data should be used (Arsenault). • Talk about rape vs. sexual assault. We are not just looking at rape. Anal rape could also require an exam. Make it clear that rape is looked at in different ways. We are trying to convey to this group, more than just rape (Jordan, Jackson). **Pg.12** • The report should clarify that while law enforcement agencies had been operating under the new definition of rape prior to January 1, 2015, this was the date the UCR began using the definition for purposes of data collection. (Swope). Based on the data presented, the UCR still reflects the old definition.	Review and research other data. Add rape statement and talk about sexual assault more broadly.	Joyce Dantzler/ Tiwanica Moore Joyce Dantzler/ Tiwanica Moore	OPEN OPEN

	• Make people realize that these are only vaginal rapes (Jackson, Jordan). **Pg. 13** • There is a typo in the first line (b.). There needs to be agreement in the sentence (Reid). • Under current Maryland law, add a statement that speaks to existing protocols and those received. • Add a statement that some hospitals don't have a protocol (Mays). This should go under deliverable #1 (Dantzler). Only one hospital stated that they didn't have a protocol. Although, several did not submit. Not every SAFE program uses the uniform rape kit. Mercy uses the kit but adds to it and has its own paperwork. • Add a statement that indicates that some programs supplement the uniform kit (Mays). Two other hospitals have also used different kits at some point (Jackson). In testimony, we heard that some are not using the state kit (Mays). • Qualify the statement since we point out that MD has a uniformed kit (Dantzler). • Say "standardized" instead of "uniform" (Watson). The kits appear to be less effective or substandard if there is a need to add something (Arsenault). If you are not using the standardized kit, you could be subjecting yourself to questions about whether or not proper protocol was followed (Watson). Also, different labs are used (Swope). Once you start adding things, then you have to do it every time (Arsenault). The kit gets revised periodically (Jackson).			

	The recommended wording is as follows: "Maryland is 1 of 18 states that has developed a standardized kit." **Pg. 14 – Deliverable 1 -** A list of all hospitals that provided protocols is available. **Deliverable 2 -** The reference for the information about the 150 nurses came from MBON. Information provided by Shirley Devaris. • Insure should start with "e". **Diverse populations** Other barriers discussed are not included in the report (Reid). For instance, you can show up at the wrong hospital (Jordan). Reid likes the term "no wrong door" for victim access. Suggested statement: In addition to the barriers unique to the individual survivor, systemic barriers are addressed. Page 27 includes other barriers. • Include the need to go to specific hospitals, which addresses the General Assembly's original concern (Jordan). • Point out lack of community education (Dantzler). **Deliverable 3** • Before the 2nd sentence, add "previously". **Pg. 16** • Add a statement about the block grant funding, and clarify that it is not all state funds (Jordan). Funding information is already included. • List the source of the federal funding (Jordan). The source is the Preventive Health and Health Services Block Grant (Dantzler). In reference to other states, it may be helpful to add that one advantage to	Submit suggested wording to clarify section in Deliverable 2 under diverse population.	Committee	OPEN

	this funding is that the federal govt. provides a partial match for crime victims compensation funds (Jordan). **Barriers to Reimbursement - Pg. 18** Regarding the number of claims rejected due to the 90 day filing period by DHMH's Sexual Assault Reimbursement Unit (SARU), there is a process in place so that hospitals can re-submit with an explanation about why the claim was not submitted by the deadline. DHMH reports that the bulk of vendors submit on time. Jordan requested a summary of the number of claims rejected for other reasons. A recommendation was made to extend the filing period (Jackson, Jordan). There are problems that exist that may hinder Mercy from getting claims in on time. It is a reasonable request to look at the cases to see if there is a pattern (Mitchell, guest invited to speak). This does not need to be included in the document. DHMH can do the review and consider changing the regulations (Dantzler). • In the 2nd full paragraph, it would be helpful to have it broken out and the number provided (Jordan). It was agreed that a statement will be added that the DHMH will examine the issue of submission of the claims beyond the 90 day filing period. There is no law stating that an FNE has to travel. • Say "FNEs may need to travel" (Jackson). A more appropriate wording is as follows: "may be requested to travel" (Watson). The redundant statement under the chart will be removed.			

	Pg. 19 Some hospitals pay for transportation. The Criminal Injuries Compensation Board (CICB) has compensated for transportation in some instances when the individual makes a police report. There is still a concern about whether the police report is necessary. Jordan reported that Scott Beard from CICB is interested in meeting with this group, and he has not yet met with DHMH. *The committee took a recess for lunch at 11:46 a.m. and reconvened at 12:50 p.m.* **Pg. 20 Deliverable 4** The law talks about EMS (hospital services). When we say EMS we are referring to pre-hospital care. EMS has a minimal protocol that is the same for EMS across the State. **Pg. 21** • Reword "suffered injury". • Say trauma instead of severe injury. • For EMS protocols, say "guidelines" instead of "direction." • The issue about who designates SAFE programs need to be cited where it says "should be listed in the Specialty Referral Centers" (Mays). There are 19 counties where it doesn't make any difference (Jackson). Most victims come in by EMS. • Clarify trauma centers. **Pg. 23 Table 4** In 1999, there were no protocols at that time. For region 1, no responses were received.			

	Pg. 24 Deliverable 5 A definition for ACFNE-A is needed. A compact definition can be found on the MBON's website or by contacting the committee member representing the MBON. **Pg. 26/27 - Deliverable 7** In the background, centers are listed by regions. **Pg. 27 - Deliverable 8** Mays requested clarification regarding instances when EMS/LE are dispatched and appear on the scene for a traumatic event even if the victim never asks for them. Most counties automatic dispatch. In this case, LE reports that they arrived on scene but does not do formal report. The victim may be transported by police but still may choose not to file a report. EMS transports very few victims of sexual assault. The word "charts" was changed to "medical record". A lot Deliverable 8 info. on privacy laws (first paragraph) is addressed in Deliverable 10. **Chart pg. 23 revisited** There is concern about conflation of acute and chronic cases. CACs may be upset that it's not clear (Jordan). This is what we received and reflects what's in policy (Mays). • Note the lack of clarity in these policies between the response to children in chronic vs acute cases, and many CACs provide care for chronic cases. The table does not clarify between chronic and acute child sexual assault cases. There should be a prominent distinction between acute and chronic cases. This should be noted as a deficiency in the LE policies (Jordan).			

	Pg. 28 Deliverable 9 • In the 1st paragraph, fund raisers should be noted as a source of funding (Mays). • It should be referred to as private fund raising (Jordan). **Pg. 27** • This should say local sexual assault crisis centers (Jordan). **Pg. 28 - Deliverable 9** It is unclear who pays for Uber in Washington, D.C. There is a concern that they are not professionally licensed, considering that hacks are a major source of sexual assault. **Pg. 29** • Mention the new Texas law that requires all hospitals with an ER to provide SAFEs. They have a lower level of training for people. Other states are doing exams without trained FNEs. Also, some of the tribal communities are doing exams by lay people. Halle B. White is an additional resource for this. This is not suggested as a model but more of an interesting innovative approach. Texas law can be found on the coalition website (Jordan). There are still legal issues surrounding telemedicine. It's like Skyping. The patient is given the option of being a part of it beforehand. Once they agree, the person is watching the exam being performed. The examiner can take pictures but not on the Skype component. Consultant will not have pics to refer to. Training requirements are in place. The biggest problem is going to a place out of state. The nurse who is consulting has to get credentials in that state and in that hospital (Jackson).			

	• In the Colorado section, SARTs should have another heading (Reid). Some places refer to their team as a SART response. They say SART exam instead of SAFE exam. **Pg. 27 - Deliverable 7** • From a legal perspective, add a note that the "telemedicine program may be helpful to address the geographic concerns in Maryland (Del. Kelly). **Pg. 31 - Deliverable 10** Information submitted by Gail Reid on behalf of her sub-committee for Deliverable 10 will be incorporated. This information included current regulations and not recommendations. This deliverable will have different content in the next version of the report. **Pg. 33** • Add supporting documentation for two issues included in recommendations: (1) FNE on staff and (2) Advocates on SARTS (Jordan). In reference to FNE recruitment, two centers said that having people on staff and not just on call works best for them. • This could be added under #6 on pg. 33 (b). • This should be worded as "permanent" FNEs (vs full time). The committee majority did not recall lack of advocacy coming up in testimony as an issue. All agreed that it is important to have advocates. This is a recommendation but not a gap. • There should be an underlying fact for each recommendation (Jordan).	Submit additional information on victim rights.	Lisae Jordan	OPEN

	Victims having access to an advocate as part of the initial response is a recommendation from testimony not from the committee. There is inconsistent participation in SARTs across the state. **Pg. 34 Deliverable 12** • Add recommendation about paying for SAFE nurse's time (Jackson). This recommendation is included in another section. **Pg. 36** The guidelines included here are currently the law, and laws should not be referred to as guidelines (Jordan). Clarify what is current law in the bullet point (Del. Kelly). **Pg. 36 3b** Many advocates are provided by community-based programs. **Pg. 35** MIEMSS includes local agencies and already has protocols. Training is more jurisdictional. MIEMSS protocols are lacking. Some local agencies don't have treatment, transport and training protocols. Local jurisdictions have had to add things that MIEMSS have been silent about (Arsenault). Del. Kelly and Amy do not recommend using acronyms in the recommendations since many will skip to recommendations. **Pg. 36** • Require that a law enforcement response include information on common responses of survivors after a sexual assault (Jordan). This	Confirm consistency of the term "crisis center" to match with the defining Criminal Procedure.	Chairs/Staff	OPEN

	should entail how to respond in a trauma-informed way to a victim vs just having a level of understanding (Reid). Trauma informed care may refer for example, to victims "changing their story" as a result of trauma, so we are talking more about the victim's response to trauma (Dantzler). The term is defined in the report. The majority of readers may not go back to the definitions, so case studies are recommended as a training technique (Jordan). • Under (h) ii. , change "instructing" to "advising" (Jordan). **Pg. 36g.** There should be consistency on how we are referring to rape crisis programs (Jordan). **Pg. 37** • Under (g), add a legal cross reference for the requirement for hospitals to currently have protocols (Jordan). • CHAMPs should be mentioned under (i). Pediatric committee shall work with the Maryland Children Alliance and MD CHAMP (Jordan). • For (h), if there's no option for the patient to come back for a repeat exam, remove the info. about follow up (Jackson). A report was submitted on behalf of the LE/EMS Subcommittee to discuss Deliverable 10. The 8 new recommendations from the report (submitted by Reid) were read aloud, and 1-4 were determined to be already included and/or reflected in current law.			

	Hospitals need to understand that they need consent to release info. to LE in telemedicine or etc. (Reid). For (g) i., this is really talking about SAFE hospitals having mobile units and having MOUs with a non-SAFE hospital. Non-SAFE hospitals cannot create mobile units (Cuccia). It is necessary to clarify the steps. A tight timeline may not be realistic, but it may not look good to indicate long period of time. The committee gives thoughts based on expertise. It is the legislature's place to make a determination, so it is not a bad thing to say what the committee's goal is (Jordan). It was agreed to change the wording for clarification. **Pg. 37 -4.** • Under section 4a, include victim advocates as another grouping (Reid). SART is defined in the report in the use of terms. There is a need to look for additional funding to support mobile FNEs. Some states are using VAWA. • Recommended wording: Provide reimbursement for mobile FNEs. Leave out the specific funding sources since there is competition for funding. • (c.) Leave it open (Jordan). • (d.) Leave it open. Keep as is (Jordan). • (g.) Take out (Dantzler). • (h.) Take out since the charge is about increasing access in MD (Dantzler). This should not be removed since there are a number of cases of victims raped in MD who receive an exam in D.C., and we don't want to punish the victim (Jordan). In some respects we already have some reciprocity. For example, If a			

	DC victim goes to a MD hospital, we will pay for that (Dantzler). It is most important to ensure that the victim is not responsible for their exam (Arsenault). **Pg. 36 Public Education** Someone would need to be responsible for maintaining the contact information. MCASA already has a list of sexual assault centers on the website with hotline numbers and could do this. MIEMSS cannot put the list of SAFE programs in specialty referrals until there is a designation. MIEMSS handles time critical issues, and sexual assault is time sensitive. The desired end result is that those centers should be designated to be included in EMS protocols (Arsenault). If MIEMSS designated, quality improvement, data, and coverage could limit the number of programs because some hospitals may not be able to meet all requirements (Mays). There is no current protocol that tells EMS providers about the centers (Arsenault). • Clarify that HIPPA/privacy laws are specific to sexual assault (Jordan). The discussion of designation still appears in COMAR in two places. MIEMSS is an excellent place to develop standards but not designate because of potential to lose programs. The process may put SAFE programs out of business (Reid). We don't want to sacrifice quality for concern of losing programs (Arsenault). If it becomes solely a medical orientation, programs would end up being cut. There is a need for someone more politically sensitive (Jordan). Jackson would like to see OAG more active around the State to improve SAFE programs. COMAR needs to be flushed out for clarity. • Make a new recommendation to clarify both for currency and consistency, and add references to existing COMAR (Mays).			

	It should be listed in the protocols vs. under Specialty Referral Centers. The list went out to jurisdictions but was not incorporated into protocol (Arsenault). MIEMSS and local EMS will revise protocols (Arsenault). EMDs will review National Guidelines (Mays).			
New Business	The remaining 2015 meetings are scheduled and will be posted for the following dates: October 8, November 12, and December 10. January is tentative and may be held via conference call if needed. 2016 meetings are scheduled as follows: February 3 in Annapolis 8:30-10:30 AM; March 10 at Anne Arundel Medical Center from 10:00AM-12:00PM; April 14, May 12, and on June 9. Jordan would like have Scott Beard invited for one of the extra meetings. Changes to the report submitted will be made, and the document will be sent back to the committee for review. It will be vetted through the Departments. The process is about having a high quality product in the end, not about changing the committee's recommendations. The October meeting will be the last opportunity to make changes to the document before the sign off process. Jordan is concerned about members being given respect in terms of time to turn around a report like this. The Chairs confirmed that the committee will be given as much time as possible.	Information Send google invites for meetings. Submit additional edits via track changes.	Carole Mays Tiwanica Moore Membership	CLOSED OPEN OPEN
Recap of Issues Identified for the Next Meetings	Delegate Kelly will provide a general update at the upcoming Women's Caucus meeting. End of Meeting: 3:00 p.m.			