SANE Program Development and Operation Guide

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Acknowledgements

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Note: The revisions made to the original content in this version was completed by OVC TTAC and did not involve the original SANE Committee. Please note this document may contain outdated information and links may no longer function as originally intended.

Introduction: How to Use This Guide

An informed, effective response to sexual violence in America transcends the criminal justice system and needs to incorporate many disciplines, including the health care sector. Victims of sexual assault suffer psychological trauma and, frequently, short- and long-term health consequences as a result of victimization. Providing sensitive and evidenced-informed health care to victims is critically important in the aftermath of a sexual assault, and the Office for Victims of Crime (OVC) is committed to promoting the development and sustainability of Sexual Assault Nurse Examiner (SANE) programs throughout the United States, which represent a best practice in providing this care.

To assist nurses and other community leaders in developing, strengthening, and sustaining SANE programs, OVC, in collaboration with other federal partners, the International Association of Forensic Nurses (IAFN), and a group of multidisciplinary subject matter experts in the field, revised and enhanced the original SANE Development and Operation Guide (Guide). The new version includes many advances in forensic nursing practice, forensic science, and criminal justice since its first publication in 1999.

The original Guide served as a blueprint for hundreds of communities to develop local SANE programs. OVC expects that this updated Guide will continue to serve as a practical, research-based, trauma-informed tool for nurses, physicians, medical directors, victim advocates, prosecutors, and other community leaders who are responsible for developing new SANE programs and enhancing and sustaining existing programs across the country.

This Guide provides a step-by-step outline, beginning with the basics of SANE program development and then examining critical aspects of SANE programming including the legal and ethical foundations of SANE practice, SANE program management and operation, and guidance on how to develop a multidisciplinary team approach and expand your program to provide care to other patients who are victims of violence or other forms of trauma.

Throughout the Guide, you will find resource links, call out boxes, short videos, and the following icons which represent the five key principles of SANE care.

Patient-centered Care

Trauma-Informed Care

Evidence-Based Practice

Recognition of Community Uniqueness

Multidisciplinary Approach

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Chapter 1: Introduction to the SANE Program Development and Operation Guide

The purpose of the SANE Program Development and Operation Guide (Guide) is to provide a blueprint for nurses and communities that would like to start a Sexual Assault Nurse Examiner (SANE) program. For communities with existing SANE programs, the Guide serves as a resource to help expand or enhance services provided to the community. This Guide is designed to both complement and integrate resources that already exist, such as the 2024 National Protocol for Sexual Assault Medical Forensic Examinations, the International Association of Forensic Nurses SANE Education Guidelines, the National Sexual Violence Resource Center SANE Sustainability Project, the American College of Emergency Room Physicians Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, and the National Sexual Violence Resource Center's Sexual Assault Response Team (SART) Toolkit.

In the original SANE Development and Operation Guide, much of the research looked at whether registered nurses **could** perform sexual assault medical forensic examinations. Twenty years later, using nursing theory and SANE practice research, this revision and enhancement of the Guide demonstrates that nurses **should** be the ones to provide this care.

NOTE: References in this Guide to recommendations in the *National Protocol for Sexual Assault Medical Forensic Examinations* reflect the recommendations published in 2013 and may not reflect the recommendations in the National Protocol published in 2024.

VIDEO: The Role of SANE Programs

Chapter 1 Subsections:

Go to Chapter 2: Building a Patient-Centered, Trauma-Informed SANE Program

1.1 What Is a SANE?

A SANE is a registered nurse who completed additional education and training to provide comprehensive health care to survivors of sexual assault. In some communities, SANEs are called Forensic Nurse Examiners. Other categories of providers, such as physicians or physician assistants, may use the title Sexual Assault Forensic Examiner, Sexual Assault Examiner (Indian Health Services), or Sexual Assault Medical Forensic Examiner (military). For this Guide, the term SANE will encompass all similar providers.

In order to offer comprehensive care, the role of the SANE includes evaluating and treating the patient in a holistic way, being mindful of both the acute and long-term consequences of sexual violence victimization. The SANE can gather a comprehensive medical history and a history of the assault, with an essential understanding of the medical and legal implications of both. Gathering this history lays a foundation to offer the patient suitable options in care, which may include forensic evidence collection, testing and treatment or prevention of sexually transmitted diseases and the human immunodeficiency virus (HIV), pregnancy prevention, and immediate and followup services with community-based sexual assault advocacy, and medical and law enforcement partners. The SANE ultimately provides developmentally appropriate, trauma-informed, and patient-specific evaluation and treatment. SANEs are also prepared to testify in a criminal or civil trial as a fact or expert witness when necessary, and understands the ethical obligations of their testimony and the limitations as well.

1.2 Understanding the Problem of Sexual Assault

Rape and other forms of sexual violence are linked to long-term consequences for both the individual and the community as a whole. When looking at epidemiological studies, it is important to understand how rape and sexual violence are defined and how data are collected. For example, if statistics are obtained from law enforcement sources, they may only represent victims who chose to report their victimization. Phone surveys may miss portions of the population who are transient or do not have access to a telephone. Definitions of rape and sexual violence have changed over time. In 2012, the Federal Bureau of Investigation broadened the definition of rape for the Uniform Crime Reporting Program to include "penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim." This expanded definition allowed male victims to be counted in the rape category.

The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence, published in June 2022, showed that 1 in 4 women and 1 in 26 men will experience rape, which they defined as "forced attempted or completed rape."[1] The rates of sexual violence other than rape that include being forced to penetrate another person was experienced by 1 in 9 men, sexual coercion was experienced by 1 in 4 women and 1 in 9 men, unwanted sexual contact was experienced by 1 in 2 women and 1 in 4 men, and sexual harassment in a public place was experienced by 1 in 3 women and 1 in 9 men during their life.[2] These national statistics do not adequately reflect the experience of populations where rape and sexual violence occur in much higher numbers. The Amnesty International

Report, The Never-ending Maze (a followup from the 2007 report, Maze of Injustice) states that "56.1 percent of American Indian and Alaska Native (AI/AN) women have experienced sexual violence in their lifetime" and 29.5 percent, or approximately 1 in 3 women, have experienced rape in their lifetime.[3] The population of people with disabilities also has a higher risk of sexual assault. A study done in North Carolina found that women with a disability were four times more likely to be sexually assaulted than women without a disability.[4] SANE programs should note which populations are at greater risk and which situations increase the risk of experiencing sexual violence for the patients they will see.

1.3 History and Development of SANE Programs

SANE programs (SANE Program Development, Office for Victims of Crime Archives) developed slowly beginning in the early 1970s. Nurses saw that services to victims of sexual assault were inadequate and were not equal to the high standards of care provided to other emergency department patients.[5, 6] These patients had specific concerns about contracting a sexually transmitted disease or becoming pregnant. Nurses led the effort to provide better, tailored services to victims seeking care after a sexual assault.

The first SANE programs were established in Memphis, Tennessee, in 1976; in Minneapolis, Minnesota, in 1977; and in Amarillo, Texas, in 1979.[7, 8, 9] These nurses worked in isolation until the early 1990s. In 1991, there were 20 known SANE programs in the United States. The initial slow growth of SANE programs was influenced by two factors. First, the role of the SANE was an expansion of the "regular" registered nurse's practice and required additional education beyond the standard nursing education. Second, many professionals who were used to working with physicians in the past, such as prosecutors, were reluctant to support nurses serving in this expanded role.

Two significant events occurred that accelerated SANE program development. First, in 1992, the International Association of Forensic Nurses was formed at a meeting of SANEs at the University of Minnesota in Minneapolis. The formal organization of these nurses led to significantly better communication and collaboration among these concerned professionals. As a result of their efforts, forensic nursing was recognized as a nursing subspecialty by the American Nurses Association in 1995. In 1997, the Office for Victims of Crime (OVC), a component of the Office of Justice Programs at the U.S. Department of Justice, took an important step toward facilitating SANE program development by recognizing that initial research showed SANE programs provided better victim care and facilitated better forensic evidence collection.[10, 11] These findings resulted in OVC supporting the first SANE Development and Operation Guide.[12] In 2016, there were more than 800 SANE programs.

Progress continues toward ensuring that a trained forensic examiner is available to provide care to every sexual assault patient who presents to a hospital. It is now considered the standard of care for medical facilities to identify and provide appropriate and complete services to victims of rape and abuse. The role of the SANE continues to develop as an important component of the emergency medical response to

patients reporting sexual assault. Furthermore, the SANE is instrumental in assisting with a coordinated response from law enforcement and prosecution.

Pediatric SANEs

Approximately half of the SANE programs provide services for children in addition to caring for adolescents and adults. With the recognized efficacy of this model, many child advocacy centers now employ SANEs with specialized education and experience working with pediatric populations to conduct the medical forensic examinations once reserved for physicians. These programs are often only open Monday through Friday for scheduled evaluations, so many emergency pediatric cases are still seen in the emergency department, much like the adult and adolescent patients.

1.4 Are SANE Programs Effective?

SANEs directly address or provide support in addressing psychological, medical, forensic, legal, and community concerns. While the current literature on the impact of SANE programs is somewhat limited, there is evidence of SANE program effectiveness across several domains.

With regard to…	SANEs/SANE Programs…
Psychological Effectiveness	Are perceived as helpful, caring, compassionate, and supportive by rape survivors.[13, 14] Leave patients feeling supported, believed, heard, respected, safe, reassured, in control, informed, and well cared for post-assault.[15,16,17]
Medical Effectiveness	Routinely offer pregnancy testing (97%), provide emergency contraception (97%), provide sexually transmitted infection prophylaxis (90%), and do so at higher delivery rates when compared to the traditional emergency department response.[18, 19, 20] Provide more comprehensive medical care than traditional emergency department care.[21, 22, 23]
Forensic Effectiveness	Complete more thorough and accurate evidence collection (e.g., use of the correct number of swabs) as compared to non-SANEs.[24, 25] Properly seal and label specimen envelopes, complete accompanying forms, and maintain the chain of custody at a higher rate than non-SANEs.[26]
Criminal Justice System Effectiveness	Increase the sexual assault reporting rates, the number of patients who complete evidence collection, the law enforcement investigational efforts, the number of sexual assault charges filed, the sexual assault conviction rates, and the average sentence for a sexual assault conviction.[27, 28, 29]
Multidisciplinary Response Effectiveness	Centralize care for survivors by acting as a point for multiple service providers to come together to help victims.[30]

With regard to…	SANEs/SANE Programs…
	Reduce the amount of time police spend waiting at the medical facility, thereby making them available for other community needs.[31] Improve working relationships and communication between medical and legal professionals (e.g., developed standardized response protocols, hosted meetings).[32]

1.5 Building a Theoretical Framework for SANE Practice

For a SANE program to survive and be sustainable, it must begin with a strong foundation. When starting this process, many groups begin with a business plan or budget. This section proposes that programs start the SANE development process by acknowledging the importance of incorporating a nursing practice theory into every aspect of the program. Providing care as a SANE is one of the most challenging areas of nursing practice. It requires a nurse to be an expert in psychosocial skills, physical assessment, critical thinking, collaboration, and coordination. The Quality-Caring Model© developed by Joanne Duffy[33] provides a nursing theoretical framework that supports all aspects of the SANE role. This nursing theory recognizes what research about SANE practice already finds: that having a caring relationship with the sexual assault patient achieves the best outcomes for both the patient and the community.[34] In her Quality-Caring Model, Duffy describes four caring relationships and eight factors of caring.[35] The four caring relationships are (1) caring for the patient and family; (2) caring for self; (3) caring for others, which views collaboration as a form of caring; and (4) caring for the community. Examples of the four caring relationships within a SANE program are given below. The eight factors of caring provide specific categories of caring behaviors. Table B provides examples of what that caring looks like when provided by a SANE.

Video: Four Caring Relationships

Table A. Four Caring Relationships

Caring for Patient and Family	Caring for Self
One survivor described the importance of the care given by the SANE, *"It just seemed like their arms were open, were wide open, and if you needed a hug, they'd give you a hug. If you needed somebody to hold your hand, they'd hold your hand. If you had any questions, they'd answer your questions, and they would be honest and try not to hide behind euphemisms or just patronize you or pat you on the back and say, 'You're fine now. Go away.'"*[36]	*"Compassion fatigue has been described among cancer care providers, emergency room personnel, chaplains, and first responders, among others. This fatigue may impact nurses in any specialty when, in the process of providing empathic support, they personally experience the pain of their patients and families.* *It is important for nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies and to*

– Giannina Fehler-Cabral	*develop a personal plan of care so as to achieve a healthy work-life balance."*[37] – Compassion Fatigue: A Nurse's Primer
Caring for Others (including collaboration as caring) *"The best approach to sexual assault investigation, prosecution, and recovery of the victim is the collaboration within multidisciplinary teams. This really addresses the victim throughout the whole process."*[38] – Police Officer	**Caring for Community** *"[If we want a world without violence,] we must tip the balance in communities and replace current norms with norms that promote respect, safety, equality, and healthy relationships and sexuality. This beckons for a primary prevention approach and a community-wide solution."*[39] – Spectrum of Prevention

Table B. Eight Factors of Caring[40]

Concepts	Examples in SANE Practice
Mutual problem solving describes nursing behaviors that help patients and caregivers understand how to confront, learn, and think about their health and illness. This gives patients the information they need in order to be better partners in decision-making regarding their care and treatment.	1. Providing options about evidence collection. 2. Discussing how to inform family and friends about the assault. 3. Performing a dangerousness assessment as part of safety and discharge planning. 4. Counseling about options for emergency contraception.
Attentive reassurance refers to availability and a hopeful outlook. Patients learn that they can rely on the nurse, and they feel a sense of security. This requires a conscious effort on the part of the nurse to concentrate fully on the patient at that moment.	1. A nurse stopping the exam after realizing the patient cannot stop shaking. 2. Ensuring limited interruptions during the exam so the patient understands they are the priority.
Human respect refers to honoring the worth of humans through unconditional acceptance, kind and careful handling of the human body, and recognition of rights and responsibilities.	1. Providing the same respectful care and response to the homeless teenager, the commercial sex worker, and the undocumented immigrant. 2. Asking a patient's permission before examining any part of their body or collecting any forensic samples.
Encouraging manner refers to displaying caring through the demeanor or attitude of the nurse. Messages of support, positive thoughts and feelings, and openness to the	1. Supporting patients appropriately when they self-blame after an assault.

feelings of others are what make patients feel cared for with regard to this factor.	2. Reassuring patients about the extent and implications of their injuries. 3. Providing comforting measures throughout the exam process.
Appreciation of unique meanings refers to knowing what is important to patients, including distinctive sociocultural connections associated with their experiences. Nurses use those features that are important to them in the provision of care.	1. Having an examination room blessed by a native healer. 2. Approaching Tribal elders before starting a SANE program in a Tribal community. 3. Allowing adolescents to text on their cell phones during an examination.
Healing environment refers to the setting where care is taking place. This environment is focused on holistic care and strives to maintain patient privacy, safety, and control.	1. Providing care in a room with a door and walls instead of a curtained cubicle. 2. Creating a point of entry for care that avoids having patients wait in a public waiting room. 3. Allowing the patient to have a support person with them at all times.
Basic human needs refer to those needs identified by Abraham Maslow: physical needs, safety and security, social and relational needs, self-esteem, and self-actualization.	1. Getting an oral swab first so a patient can eat or drink before starting an examination. 2. Ensuring that the sexual violence victim's children are safe before focusing on the examination.
Affiliation needs refer to the need for belonging and membership in families or other social contexts. This factor focuses on the importance of families and other caregivers with regard to the health and well-being of patients in the hospital.	1. Providing education to family members, friends, accompanying clergy, and others about the normal response to sexual assault and trauma and ways to be supportive. 2. Allowing family members to be present during an examination if requested by the patient.

In addition to Duffy's eight factors of caring, this Guide covers five key principles of SANE care that should be emphasized as a program is developed. The key principles are patient-centered care, trauma-informed care, evidence-based practice, recognition of community uniqueness, and a multidisciplinary approach. Without recognition and application of these key principles, it is impossible to provide comprehensive care to the sexual assault patient. In Table C, the Guide defines the principles and gives examples to help the SANE incorporate the principles into practice.

Table C. Five Key Principles of SANE Care

Key Principles	Examples
Patient-Centered Care The Institute of Medicine defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[41] Respecting patient preferences regardless of outcomes is described as the right thing to do.[42] This requires more than providing the sexual assault patient with information and options about what will happen during the examination; it requires taking a step back before starting the exam and finding out what the patient needs to happen first.	1. Helping the patient arrange for someone to pick up their child from school before starting the examination. 2. Finding a place where the patient can smoke a cigarette before starting the examination. 3. Allowing the teen to use their cell phone during the exam. 4. Allowing a urine pregnancy test to a patient who declines a blood draw. **Video: Patient-Centered Care**
Trauma-Informed Care Trauma-informed care is defined as care that "involves seeking to understand the connection between presenting symptoms and behaviors and the individual's past trauma history. As a practice and set of interventions, trauma-informed care involves the professional relationships and interventions that take into account the individual's trauma history as part of efforts to promote healing and growth." [43] – Gordon Hodas, M.D. It is important for the nurse to understand that trauma history can include the present traumatic event, previous traumatic experiences, and, for some populations, it will also include historical trauma.	1. Recognizing that while taking a history of the assault, the patient may have disassociated during the traumatic event. Discuss strategies to prevent disassociation during the examination with the patient, and reassure them that the exam will stop if that happens. 2. Understanding that some individuals distrust the health care system and health care providers as a result of previous trauma or even historical trauma. **Video: Trauma-Informed Care**
Evidence-Based Practice The Agency for Healthcare Research and Quality defines Evidence-Based Practice as "applying the best available research results (evidence) when making decisions about health care. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences."[44]	1. Understanding and being able to explain why genital injury can be present or absent after sexual assault. 2. Understanding that while valuable evidence may be lost if anal swabs are not collected, the patient has the right to *not* have it collected. **Video: Evidence-Based Practice**

Key Principles	Examples
– AHRQ, 2015	
Recognition of Community Uniqueness When creating a SANE program, it is important to recognize that communities have unique assets and problems that impact program development. The first SANE programs in the United States evolved in mostly urban hospital settings. One of the early frustrations for SANE program development was recognizing that the original models of care did not work well in rural or tribal communities. Since the first guide was published, nurses and other professionals have come to recognize that there is no "one size fits all" SANE program model. By incorporating various options and models of SANE care, each community should be able to develop a program that meets the needs of the people they serve.	1. Adapting existing program models to meet the needs of a community. 2. Allowing SANE programs to determine when a nurse is competent to provide an examination independently instead of having a required number of preceptored examinations. 3. Recognizing that some communities cannot provide 24/7 SANE coverage, and creating protocols that provide the best access to care. 4. Recognizing that some communities may need to use community health workers to perform evidence collection immediately after the assault. **Video: Community Uniqueness**
Multidisciplinary Approach Getting the best results for both the patient and the community requires a team approach. Every team member has an important role to play and a contribution to make. The multidisciplinary team approach is essential if sexual assault survivors are going to experience healing and perpetrators of violence are going to be held accountable. Because the SANE's primary duty is to provide health care to the patient, SANEs must be willing to work closely and collaboratively with advocates, law enforcement, prosecutors, forensic scientists, and other professionals in the community. Other professionals may include child and adult protective services, school counselors, and mental health care providers.	1. Creating protocols for team member response when one agency receives a report of a sexual assault. 2. Valuing each team member's contributions improves the patient's care and outcomes by providing all team members with an opportunity to introduce themselves to the patient and offer services if the patient consents. **Video: Multidisciplinary Approach**

The Impact of Trauma on Health - The ACE Study

In the 1990s, Dr. Vincent Felitti supervised a weight loss program for Kaiser Permanente in San Diego, California. He realized that many women who were able to lose a substantial amount of weight often

regained the weight after a short period of time. After interviewing the women, he identified that they had a common history of childhood sexual abuse. With this information, Dr. Felitti and Dr. Robert Anda developed the Adverse Childhood Experiences (ACE) Study.[45] The study examined the impact of childhood trauma on health behaviors and long-term chronic illness. The study looked at more than 17,000 patients and found that exposure to childhood trauma was linked to an increased risk of unhealthy behaviors, such as smoking and substance abuse, which resulted in higher rates of chronic diseases, such as heart disease, depression, and chronic obstructive pulmonary disease. Since the initial publication of the ACE study, many researchers have looked at the impact of trauma on various aspects of physical and mental health.

SANEs need to recognize that many of their patients will have a history of previous trauma. The ACE study helps explain why many patients with a history of trauma demonstrate unhealthy behaviors that place them at risk for sexual assault, such as excessive alcohol use and substance abuse. The risk of being sexually assaulted as an adult is 2.5 times greater for women who have a history of childhood sexual abuse.[46] It is important to see these behaviors as symptoms of a problem that may not be solved until the underlying trauma is acknowledged. As Dr. Felitti states, "We need to change the question from what is wrong with you? to What has happened to you?" Being familiar with the ACE study and other research about the short- and long-term health impacts of trauma is an important first step.

ACE Resources:

Adverse Childhood Experiences: Informing Best Practices

ACEs Too High News, ACEs publications

Conclusion

As you start the process of creating or enhancing a SANE program, it is important to understand the evolution of this essential nursing role, but it is most important to recognize that the success of SANE programs comes from having a strong nursing practice foundation. This is not a job for nurses who are tired of being nurses and want something different; the work of a SANE requires the nurse to use all of their nursing skills to provide compassionate and evidence-based care to this extremely vulnerable population of patients.

Chapter 2: Building a Patient-Centered, Trauma-Informed SANE Program

To establish a SANE program that provides patient-centered and trauma-informed care, the program should be developed with core values that recognize every patient brings a unique set of needs that must be acknowledged throughout the episode of care. There is no universal approach to services. It is impossible to identify in this Guide every patient population that may have unique needs. It takes both time and effort to seek out the people who need SANE services and may not be accessing them because of perceived or real barriers. This section provides a framework for looking at issues that impact access to care for different communities and ensuring services are victim-centered and trauma-informed.

Video: **Video: Patient-Centered Care**

Video: **Video: Trauma-Informed Care**

Video: **Video: Community Uniqueness**

Chapter 2 Subsections:

Skip to Chapter 3: Building a Sustainable SANE Program

2.1 Creating Trust

Creating a relationship based on trust with both individual patients and communities is a critical part of SANE program development. Before a program can begin to develop trust, there must be recognition that health care systems in the United States have not always provided equal access or care to some specific individuals or specific communities. Nurses need to understand why patients or communities may not have automatic trust in a health care program. For example, when nurses label patients as "drug seekers" because they have a history of using narcotic pain medication, patients may feel that they cannot seek care for problems unrelated to their chronic pain for fear of having their problems ignored

or dismissed. Native American women may have a historical distrust of health care systems because sterilizations were performed on some native women without their consent as late as 1976. Trust begins by listening to members of your community. There are several ways to begin the conversations by involving specific communities.

One approach is to identify and reach out to the leaders of a specific community, recognizing that there may be several leaders and several different perspectives coming from one group. Trust is not automatic and will only develop with time.

A common saying in the disability community is "nothing about us without us." This is a good saying to remember across the spectrum of community members who your SANE program will serve, and it is a reminder to acknowledge the expertise those in the community can provide. SANE programs need that expertise to provide appropriate care to all individuals who may have unique needs for sexual assault care.

2.2 Patient-Centered Care

Every sexual assault medical forensic examination should begin with identifying what the patient needs. This helps the patient to feel safe, supported, and in control of all aspects of their care. As a program develops policies and procedures for providing patient-centered care, incorporating Duffy's Eight Caring Factors[47] throughout the examination process allows for a routine that meets the needs of all patients. Each section of the Guide highlights strategies for making care patient-centered.

2.3 Trauma-Informed Care

Trauma-informed care starts with understanding the sources of trauma that survivors of sexual assault experience. These sources include the trauma from the recent assault, trauma from previous experiences of abuse or violence, and historical trauma. This understanding can help programs support healing, acknowledge patients as whole people, and reduce retraumatization. Providing trauma-informed care means evaluating all components of the program from the perspective of trauma survivors. It also requires recognizing that family and friends of survivors may be dealing with their previous experiences of trauma, which may impact their ability to provide support to the patient who is seeking care. For example, the mother of an adolescent victim may not have disclosed that she was a victim of sexual assault as a teenager. It may be hard for the mother to provide support for her daughter if she is re-experiencing her own assault. It is important to understand that trauma is common, and programs need to be prepared to recognize symptoms related to trauma and to provide care and support.

2.4 Recognizing and Removing Barriers to Care

When developing a SANE program, it is important to identify barriers that may prevent survivors of sexual assault from seeking care.

Are Services Available?

Depending on the setting of your program, some services for survivors may be limited or may not exist at all. Some SANE programs are not able to staff their facility 24/7. There are many communities that do not have community-based advocacy programs. Interpretation for non-English language speakers may be limited to a single language. As you assess what is available in your community, it is important to look at creative solutions for providing services that may not be readily available. For example, a statewide hotline could provide victim advocate services, and a language line could be used for interpretation services. A program might be able to coordinate with another program in order to make sure 24/7 services are available nearby. The goal is to have a protocol in place to ensure that all of the patient's needs are met.

Are Services Acceptable?

The SANE program needs to work closely with different groups in the community to identify what will make community members feel safe and welcomed and to ensure that services are acceptable to all patients. For example, there is a hospital where members of the security staff wear uniforms that resemble the uniforms of immigration enforcement officers. This setting may not be acceptable for survivors who are undocumented immigrants. Rural hospitals that do not provide a private waiting area for survivors may not be acceptable because of privacy and confidentiality issues. The language used by program staff is important, too. Programs with staff who use language such as “hearing impaired,” “disabled person,” or “mental retardation,” for example, may not be acceptable to people with disabilities because this outdated language signals a lack of awareness and understanding of disability and Deaf culture.

Are Services Affordable?

Under the Violence Against Women Act (VAWA), states must certify, as a condition for certain grant funds, that the state or another governmental entity bears the “full out-of-pocket costs” for medical forensic examinations. This might include costs for medication and other aspects of medical care provided during the collection of forensic evidence, but every state is different in its approach. Some states require other sources to pay for medications and other medical expenses. SANE programs must look at the actual costs for survivors to access care, such as transportation, parking, and medications, and create strategies to make sure cost is not a barrier. For example, in Westchester County, New York, patients are transported via ambulance to SANE providers and are given taxi fare to return home. Recognizing community uniqueness requires that each community create solutions that work in their setting. Additionally, programs should be knowledgeable about victim compensation programs in their region and connect patients to advocacy services for assistance with financial needs.

2.5 Preparing Your Program To Meet the Unique Needs of Survivors

As stated earlier, it is impossible to anticipate every situation that might arise due to the unique needs of each patient. Unique needs can arise based on age, disability, language, religion, social status, occupation, and many other factors that ultimately define who we are as humans. Using a patient-centered approach, patients should be given the opportunity to determine which factors are important to their care. By using the Duffy Caring Factors[48] of human respect and mutual problem solving, the medical forensic examination and other aspects of care can be adapted to meet the specific needs of each patient. Many sources for information and advocacy address the unique needs that specific populations may have during a medical forensic examination. A list of patient populations, and some of the specific resources for providing patient-centered and trauma-informed care to them, follows.

Table A: Populations With Unique Needs

Populations With Unique Needs	Resources
Adolescents	• Adolescent Sexual Assault Victims' Experiences with SANE-SARTs and the Criminal Justice System • Lifespan: Sexual Violence Against Youth and Young People - NSVRC • *Linking the Roads: Working with Youth Who Experience Homelessness & Sexual Violence* - NSVRC
Adults Molested as Children	• Rape, Abuse & Incest National Network (RAINN)
American Indian/ Alaska Native	• *The Never-ending Maze* from Amnesty International • *Maze of Injustice* from Amnesty International • Southwest Center for Law and Policy • Mending the Sacred Hoop • National Sexual Violence Resource Center: Sexual Assault in Indian Country: Confronting Sexual Violence • Tribal Law and Policy Institute: Sexual Assault Response Teams: A Resource Guide for the Development of a SART in Tribal Communities
Americans Overseas	• Help for U.S. Citizen Victims of Crime Overseas • Addressing Sexual Assault While Abroad
College Students	• Addressing Sexual Assault While Abroad • Culture of Respect • Alcohol-Related Sexual Assault: A Common Problem among College Students • *Overview: Campus Sexual Violence Prevention* - NSVRC

Populations With Unique Needs	Resources
	• Help for U.S. Citizen Victims of Crime Overseas
Deaf and Hard-of-Hearing	• Special Collection: Violence in the Lives of the Deaf or Hard-of-Hearing • Culture, Language, and Access: Key Considerations for Serving Deaf Survivors of Domestic and Sexual Violence • Understanding the Needs of the Victims of Sexual Assault in the Deaf Community • Eight Step Advocacy Plan for Deaf and Hard-of-Hearing Survivors of Sexual Assault
Homeless Persons	• Housing and Sexual Violence • Housing and Sexual Violence Collection NSVRC
Human Trafficking	• Assisting Trafficking Victims Information Packet - NSVRC • Toolkit to Combat Trafficking in Persons - United Nations • Human Trafficking Task Force Guide • National Human Trafficking Hotline • Services Available to Victims of Human Trafficking: A Resource Guide for Social Service Providers • Screening for Human Trafficking: Guidelines for Administering the Trafficking Victim Identification Tool (TVIT) • Services Available to Victims of Human Trafficking: A Resource Guide for Social Service Providers
Immigrants	• *Dynamics of Sexual Assault and the Implications for Immigrant Women* • Immigration Options for Victims of Crimes
Incarcerated Survivors	• National PREA Resource Center • PREA Data Collection Activities, 2023 • Understanding Rape in Prison - PCAR • Mental Illness and Sexual Abuse Behind Bars
Male Survivors	• Male Survivor • Female Perpetrators and Male Victims of Sexual Assault: Why They are so Invisible
Mental Illness	• *40% of women with severe mental illness are victims of rape or attempted rape* • Mental Illness and Sexual Abuse Behind Bars

Populations With Unique Needs	Resources
Military	• Department of Defense Sexual Assault Prevention and Response Office (SAPRO) The Sexual Assault Prevention and Response Office (SAPRO) works with each of the Services and local communities to develop and implement sexual assault prevention and response programs. • Department of Defense Safe Helpline: Sexual Assault Support for the DoD Community The Department of Defense contracted with RAINN to provide independent and anonymous services for this hotline. • Strengthening Military Civilian Partnerships to Respond to Sexual Assault Training Strengthening Military-Civilian Community Partnerships To Respond to Sexual Assault is an interactive 2-day training that will help participants establish partnerships with local military installations in order to respond effectively to the needs of sexual assault victims in the military.
Older Adults	• Sexual Violence in Later Life Research Brief • NSVRC Sexual Violence in Later Life Resources
Patients With Physical and Cognitive Disabilities	• A Law Enforcement Guide for Working with Children with Autism, Intellectual and Communication Disabilities • Considerations for Victims with Cognitive and Communication Disabilities - NSVRC This presentation will help advocates and allied victim service professionals identify some of the ways in which people with communication disabilities may relay messages, both verbally and nonverbally, and highlight some techniques and technologies that can help bridge the language gap in order to provide quality sexual violence services. (27 minutes)
Pediatrics	• Through Our Eyes: Children, Violence, and Trauma • Lifespan: Sexual Violence Against Children - NSVRC • From Approach to Practice: Improving outcomes for children after sexual abuse - NSVRC
Refugees	• The Advocates for Human Rights – Sexual Assault Against Refugees
Religious Resources	• *Violence Against Women and the Role of Religion* • *Sexuality and Sexual Violence in Religious Texts*: An Annotated Bibliography

Populations With Unique Needs	Resources
Runaway Youth	• National Center for Missing and Exploited Children • *Unaccompanied Youth Fast Facts* • Homeless Youth and Sexual Violence • Homeless Youth National Conference of State Legislatures • *Homeless, Runaway & Throwaway Youth: Sexual Victimization and the Consequences of Life on the Streets* • *Linking the Roads: Working with Youth Who Experience Homelessness & Sexual Violence* by the NSVRC (2014)
Rural Communities	• *Stopping the Stigma: Public Perceptions of Sexual Assault in Rural Communities* • Unspoken Crimes: Sexual Assault in Rural America • *Sexual Assault in Rural Communities* • Rural Domestic and Sexual Abuse Program Advocates: Making a Difference in the Lives of Older Survivors of Abuse • *Sexual Violence in Rural Communities* NSVRC • *Implementing SANE Programs in Rural Communities: The West Virginia Regional Mobile SANE Project*
Survivors of Stalking	• Stalking Prevention, Awareness, and Resource Center | SPARC
Survivors of Torture	• Heal Torture.org – Provider Resources
Veterans	• U.S. Department of Veterans Affairs Military Sexual Trauma

Chapter 3: Building a Sustainable SANE Program

This chapter will guide the individual or group that would like to develop a SANE program through the process of identifying members of the community who need to be part of the initial development process. It also examines critical issues that need to be addressed before starting a SANE program. Resources and examples of tools for program development are provided in the resource section.

Video: Philadelphia Sexual Assault Response Center

Chapter 3 Subsections:

Go to Chapter 4: Legal and Ethical Foundations for SANE Practice

3.1 Partners and Stakeholders

Support for developing a SANE program can come from many sources within a community. Stakeholders may be identified geographically, organizationally, or by their service to sexual assault victims/patients in your community. Stakeholders may be involved at various phases of the program development process. Partners are those who are directly involved in the decisionmaking process for program development and may be called a Task Force, Development Team, or SANE Development Partners. The partners are usually medical, law enforcement, prosecution, and advocacy, and they may eventually become part of the multidisciplinary team response. Each of these partners will be involved in program planning, startup, and subsequent protocol development. There are steps you can take to identify those who will champion the program throughout the development process.

Stakeholders

One of the first steps in program development planning is identifying stakeholders. There are two groups of stakeholders to consider involving. The first group includes organizations that will have direct contact with sexual assault survivors. A second group of stakeholders are community members who may be in a position to help SANE program development by providing financial resources, political support, or other types of goods and services used by the program. A third group of stakeholders are partners who will be working alongside the primary agency that is spearheading the SANE program development process. Stakeholders may be impacted directly or indirectly by the implementation of a SANE program and may participate in the needs assessment process that follows.

Direct Service Providers	Key Community Members	Partners
Emergency department nursing staff Hospital medical staff Law enforcement Community-based service providers Sexual assault victim service providers Hospitals Health care providers in the community Prosecution Criminal laboratories Tribal elders Tribal council members Faith-based community groups Advocacy groups Community-based advocates System-based advocates	Government officials, policymakers, tribal councilmembers Media professionals Business leaders Community-based organization leaders Researchers Funders	Victim advocates Health care professionals Prosecutors Law enforcement officials Crime Lab Forensic Scientists

3.2 Readiness Assessment

Readiness is the degree to which a community is prepared to take on a SANE program. As you begin the process of program development, there are steps you can take to assure that your institution and community are prepared for SANE services. Several considerations may contribute to successful program development. Determine if there is an existing trauma-informed approach within the health care system (for hospital-based program development) or community (for community-based programs). If not, do some preparatory work with the health care team to educate them on the impact of trauma on the lives of the patients they are serving.

Readiness for SANE programs: Before you proceed with SANE program development, you may find it helpful to network with nurses working in the field. Find other programs in your state/territory or nationally. The International Association of Forensic Nurses is a membership organization of working forensic nurses. You can find a listing of SANE programs on their website.

Find out what is currently happening in your community. Some things to investigate include—

- Determine who provides sexual assault services in your community

1. Local rape crisis advocacy centers
2. Law enforcement agencies
3. Prosecution agencies
4. Health services for sexual assault (clinics, universities, etc.)

- Network with these providers to determine support for developing a SANE program
- Take time to understand the local statistics on sexual assault
- Determine where victims of sexual assault are currently going for medical forensic exam services (Is it far away? Are they not being referred for exams?)
- Educate yourself on the local incidents of sexual violence
- Begin the process of garnering support **within your institution** about the need for services (including administrative and clinical staff)
- Use the local service providers to assist you in your efforts
- Educate yourself on the funding resources that may be available for SANE program development in your state/territory/tribe
- Networking and working with those who are currently providing services, near and far, will help you throughout the process
- Reach out and use the available resources, including www.safeta.org and www.forensicnurses.org

The algorithm below can help individuals or groups that are interested in developing a SANE program within their community. In conjunction with the SANE Program Readiness Assessment tool, the algorithm will help to determine your readiness to proceed and provide guidance on the initial steps. While the algorithm is organized in steps, determining your level of readiness and what steps you need to take to start a SANE program is a fluid process. For example, you may not need to complete each step before starting on the next step. The short-term goal is to make forward progress while improving the current level of care being provided in your community. The long-term goal is the development of a sustainable SANE program that provides quality medical and forensic services to victims of sexual assault and collaborates effectively with community partners.

Step 1 – Is there a need for a SANE program?

- **How is this determined?**
  - Determine if there is an existing SANE program in your community.
  - Utilize the SANE Program Readiness Assessment tool.

- Are there victims of sexual assault who currently lack access to care or who are dissatisfied with the quality of the care available? Are there gaps in services for victims of sexual assault?

Step 2 – Is there community support for a SANE program?

❖ **How is this determined?**

- Meet with community stakeholders and key partners as described in Section 3.1.
- Utilize the SANE Program Readiness Assessment tool.
- Determine the resources that currently exist for victims of sexual assault and determine gaps in coverage and areas for improvement.

Yes	No
Ask community stakeholders and key partners if they are willing to draft letters of support for a SANE program. Begin scheduling regular meetings to discuss the current response to sexual assault with the short-term goal of improving the current response and the long-term goal of developing a SANE program. Proceed to Step 3.	Work toward increasing community among community stakeholders and key partners. Once there is community buy-in

Step 3 – Is there administrative support for a SANE program at a local health care facility?

❖ **How is this determined?**

- Use the information from Steps 1 and 2, as well as the SANE Program Readiness Assessment tool, to develop a brief presentation that highlights the need for a SANE program and the community's support for it. Include information regarding the health care costs of sexual violence as well as the positive impact of SANE programs.

- Ask to meet with a representative(s) from the hospital (i.e., hospital administration, medical director, emergency department director, chief nurse executive, emergency department nursing supervisor, social services department).
- If the administration offers support for a SANE program at their facility, what kind of support can be determined by asking more specific questions, such as:
    - Is the administration willing to dedicate time and resources to the development and implementation of a SANE program? A SANE program based solely on volunteered time will not be sustainable, and this needs to be addressed before moving forward.
    - Would the administration support the role of a full-time or part-time SANE program coordinator?
    - Is there a physician who would be interested in fulfilling the role of a medical director for the SANE program?
    - How would the administration support nurses who are interested in becoming SANEs (e.g., initial and ongoing training needs, compensation for on-call hours and completed exams)?

Yes	No
Work with administration to learn what the next steps would be for their facility. Simultaneously, proceed with Step 4.	Is there another health care facility in the area that might support SANE program development? Is there any indication that continued education and advocacy would lead to administrative support at the current facility? If not, consider developing a community-based clinic or other program model. (Please refer to Section 3.6.) Once support is obtained, proceed to Step 4.

** This step is often the most challenging and may require many discussions, spanning several weeks, months, or years. While this may seem daunting, this step is essential to the future success and sustainability of a SANE program. It is important to remain motivated and determined, and keep in mind the tremendous need for services as well as the support from the community. Seek guidance from other SANE programs as well as local and national forensic nursing groups. **

Step 4 – Are there nurses who are interested in being trained as SANEs?

❖ **How is this determined?**

- Reach out to nurses and other health care providers who might be interested in providing care to victims of sexual assault. Some good places to start are emergency departments and OB/gyn departments.

- Develop a one-page flier to distribute via email, post in break rooms, etc., to generate interest.
- Meet with interested nurses, provide additional information, and work with an established SANE program to schedule share time.

Yes	No
Work toward developing a comprehensive training plan and competency assessment tool. Proceed to Step 5.	Provide education to generate and increase interest. You will eventually find the right group of interested professionals. Once you have, proceed to Step 5.

Step 5 – Is there funding available?

❖ **How is this determined?**

- Refer to Chapter 5.

Yes	No
Develop a strategic plan to achieve your goal of establishing a successful SANE program that will increase access to quality care for victims of sexual assault.	Pursue alternate sources of funding as outlined in Chapter 5.

3.3 Assessing the Community Need for a SANE Program

There are two main purposes for a community needs assessment, the first is to determine what services are being provided to survivors of sexual assault currently. Is anyone providing medical forensic examinations or are patients transferred to another community for care? Are services provided to patients of all ages, or is there a need for a program with pediatric examiners? What other services are available, such as rape crisis or agency victim advocates?

The second purpose is to estimate the number of patients who would be seen by a new program. When looking at potential numbers, it is important to gather information from all groups that provide services to survivors. This would include surveying law enforcement and advocacy, realizing that those two groups may have very different numbers.

Who is Your Community?

The next part of a community assessment is listening to members of the community in order to identify who lives there. Do members of your community report sexual assault? If they do, are they able to receive services? Start looking for information about who lives in your community by looking at reports from the U.S. Census Bureau. Census reports can also provide the proportion of community members in different age categories. It is important to look for groups that may not be adequately represented in a Census report. To look for these "hidden" community members, contact community-based service providers. For example, how large is the homeless population in your community? Does your community have a college or university whose students are not counted as residents of the community? To find out who lives in your community, connect with faith-based and community organizations. Once you have a picture of who lives in your community, it is important to compare that picture with the number of victims that are being identified by victim service providers. Do the two groups match?

Some Examples of Hidden Communities

1. Homeless adults and youth
2. Sex workers
3. Incarcerated individuals
4. Communities practicing plural marriage
5. Native Americans who live in urban communities not connected to tribal lands

Knowing who lives in your community enables your program to provide better, more appropriate care and to make sure that connections are made to encourage victims of sexual assault to seek services.

3.4 Developing an Organization That Represents Your Community and is Welcoming to all Survivors

In Chapter 5, this Guide discusses the importance of hiring a diverse staff for your SANE program, one that represents the diversity of your community. Since the profession of nursing does not represent the population overall, this may be a difficult goal to achieve. There are real advantages to having a staff who have lived an experience similar to that of the patients they serve.

In addition to hiring a qualified staff of nurses and other providers, your program can take other steps to make sure the services are welcoming to all patients. Physical environment can determine whether a program feels safe or comfortable for patients. One program in Arizona conducted a blessing ceremony for its examination room to make it more welcoming for native survivors. Many programs place artwork or decorations in examination rooms to make the space feel more comfortable and less institutional for patients. One Children's Advocacy Center has elaborate murals on the examination room wall that can be used to distract a child during the examination.

In addition to the physical environment, programs should examine their forms and procedures to make sure they are appropriate for all patients. All staff should receive education to better serve all patients based on age, religion, or other experiences.

3.5 Marketing Your Program

The American Marketing Association defines marketing as the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives. This definition remains true even when you are marketing services for sexual assault victims. Like all services, if people are not aware they exist, they will not use them. Marketing can break down this barrier and improve access to services.

With this definition in mind, how does the work of your SANE program meet the overall mission of the organization? What are the community benefits? What kind of marketing efforts already occur within your larger organization? Is there a marketing department that can be a resource in assisting you? These are just some of the kinds of questions you and your team will want to address. The seven steps to creating the best marketing plan document are a great place to start, but other useful resources are listed as well.

The following is a list of marketing techniques that have been used by successful SANE programs:

- Create a commercial that airs on the local cable TV network
- Advertise on public transportation and billboards
- Create a brochure (in a variety of languages) describing services and distribute it widely in the community
- Present to or meet with local groups, including schools, clubs, health care providers and facilities, community partners, and business owners about your program
- Place informational articles in free local papers that advertise programs and services
- Buy advertising space
- Develop and implement annual fundraisers such as foot races, silent auctions, and wine or beer tasting events
- Create opportunities to set up an information booth at high school career days, health fairs, college nights
- Create a logo to place on promotional items such as water bottles, sunglasses, lip balm, flashlights, etc., to disseminate widely

3.6 Program Models

Once you complete your community assessment, it is time to discuss what type of program model might work best in your community. You need to decide if your program will be hospital- or community-based, or you could create a model that combines more than one type of care setting. If you have an

existing hospital-based program, you may want to expand to a mobile program or provide care at a community site. Some communities will not be able to provide 24/7 coverage. This lack of coverage should not prevent the development of a SANE program that can offer many improvements to the care received by sexual assault patients.[49] The table below describes the different types of program models. It is important to realize that models can be blended or combined, and what is most important is to create a program that best meets the needs of your community.

SANE Program Models

Type Description	Advantages	Challenges
Mobile Program - Nurses are employed by a single agency or hospital. They travel to some or all of the hospitals in a community to provide medical forensic examinations.	1. Nurses go to the patient to provide care. 2. Increased volume of patients can help nurses maintain competency. 3. Law enforcement and prosecution only deal with one SANE provider. 4. Does not impact staffing of each emergency department. 5. Patients who are seen in an emergency department can immediately access a higher level of medical care if needed based on their condition. 6. Can allow for creative employment models, including employee, independent contractor, or contracted employee.	1. Depending on the area of the community, care may be delayed. 2. Nurses need to be careful about leaving confidential patient information unsecured, unless charts are immediately returned to a central location. 3. The program will need a memorandum of understanding with each hospital where care is given, particularly when hospitals are from multiple health systems. 4. The program is responsible for ensuring the nurse is properly licensed, has malpractice insurance, and meets all required standards for providing care at the individual hospitals. The nurses should not have to satisfy several sets of requirements/trainings at each site. 5. Must have a plan for when two different locations require an examiner at the same time. 6. There should be thorough and complete instructions for nurses about processes at each site (directions, parking location, hospital staff contact, etc.). 7. Other logistical considerations include transportation to and from locations, insurance for use of a private vehicle, and handling/storage of evidence. 8. Hybrid programs (fixed setting and mobile team) need to have clear guidelines for which cases require mobile team activation versus transfer to a fixed location.

Type Description	Advantages	Challenges
Hospital-Based Program - Provides medical forensic examinations in a hospital setting. This can be in the emergency department or another area of the hospital, such as labor and delivery.	1. Facility has medical staff onsite 24/7. 2. Facility has the ability to provide higher levels of care for patients with other trauma or medical needs. 3. Hospital provides infrastructure and ancillary services such as legal counsel, medical records.	1. Using an emergency department is a costly way to access care that might not require the equipment and personnel. 2. Patient care may be delayed if other emergency department patients with more urgent medical needs are seen first. 3. Will need an agreement about how the program will be staffed. There must be either a separate schedule for SANE shifts or a backup person who will be called in if the SANE nurse is working a regular shift in the emergency department and needs to do a case.
A hospital-based child abuse team is embedded in the SANE program.		1. Nurses will need pediatric-specific training.
Community-Based Program - Examinations are provided at the community-based location.	1. Patients can be seen in a setting that is less medical and more private. 2. Lower costs for medical care by avoiding emergency department charges.	1. Need to provide all infrastructure for the program, including medical records storage, examination room, and examination equipment. 2. Need to have facility liability in addition to malpractice insurance. 3. Need to provide security if examinations will be provided 24/7. 4. Need to have protocols with hospitals about how to have higher levels of care for patients. 5. Need to have protocols with hospitals and law enforcement about how patients will be transferred to the program and how evidence will be picked up or stored.
Family Justice **SANE programs are incorporated with other programs or agencies that provide**	1. Patients can be seen in a setting that 2. Patients can receive other types of the services that might be housed in the same setting, such as legal,	1. Need to provide all infrastructure for the program, including medical records storage, 2. Need to have facility liability in addition 3. Need to provide security if examinations

Type Description	Advantages	Challenges
	3. Eliminates the need for patients to go to multiple locations to receive services.	4. Need to have protocols with hospitals and law enforcement about how patients will be transferred to the program and how evidence will be picked up or stored.
Children's Advocacy Center Model - SANE may provide both acute and chronic examinations in this setting.	1. Minor patients are more likely to receive the comprehensive medical care and mental health referrals needed to address their sexual victimization to address their sexual victimization and other unmet medical needs.[5051] 2. Patients may present with law enforcement or child welfare, with a parent or caregiver, with a friend, or alone. 3. Provides a multidisciplinary approach to the investigation of child abuse.	1. May be difficult to staff 24/7. 2. Will need a referral source for children with injuries requiring a higher level of medical care (e.g., x-ray).
Regional/Shared Program	1. Cost effectiveness – shared costs since many hospitals cannot afford 24/7 coverage. 2. Patients get appropriate care with more positive outcomes. 3. Nurses who work in hospitals without many cases have more opportunities to provide care and maintain their skill level. 4. 24/7 coverage is provided for several hospitals. 5. Standardized policies/protocols/ documentation, paperwork, and job descriptions. 6. Nurses maintain their skills in the care of this patient population. 7. Nurses' documentation skills improve through increased experience and consistent peer review. 8. A call system can be put in place that increases coverage but decreases	1. Hospitals must get buy-in from hospital managers, administrators, human resource directors, and attorneys in signing an MOU/contract/agreement spelling out details. 2. Several issues must be agreed upon, including the reimbursement process; acceptance of the orientation of each respective hospital; and the willingness of forensic nurses at each hospital to participate, travel to the various hospitals, and take minimum call. 3. Emergency department staff must be accepting and helpful to forensic nurses who may not be familiar with the care/equipment/exam room layout, and these nurses will not provide care to other emergency department patients. 4. This model requires a paid coordinator who can oversee that competency standards are maintained, case/peer review, a call schedule, etc. 5. Will forensic nurses be willing to take calls?

Type Description	Advantages	Challenges
	overall call responsibility since more nurses are available.	6. Set minimum call standard.
Independent Contractors - SANEs who provide care at a hospital or facility based on a written contract.	1. May be able to provide economical care to hospitals that have only a small number of sexual assault patients.	1. Storage and maintenance of medical records and evidence. 2. Billing and payment of services. 3. Will need to be credentialed at every facility where the SANE provides care. 4. Will need to arrange with another program or provider to obtain peer review.
Facility-Specific Setting - Corrections	1. Able to provide SANE care in a secure environment that reduces risk of injury to staff and others when transporting inmates outside of the correctional facility.	1. Will need to provide special training to nurses about safety issues when providing care in a correctional facility.
Military/Deployed	1. Military personnel have access to forensic examinations, health care (medical and mental), and victim advocacy from a certified victim advocate. 2. Sexual assault victims are given priority and treated as emergency cases. Emergency care consists of emergency medical care and the offer of a Sexual Assault Forensic Exam (SAFE). 3. The victim is advised that even if a SAFE is declined, the victim is encouraged (but not mandated) to receive medical care, psychological care, and victim advocacy. 4. The Sexual Assault Prevention and Response Program provides care that is gender-responsive, culturally competent, and recovery-oriented.	1. Ensuring access to trained advocates and Sexual Assault Medical Forensic Examiners in remote locations without a U.S. military medical facility. 2. Maintaining evidence integrity and chain-of-custody when collected and when transported stateside. 3. Maintaining patient confidentiality in a remote setting. 4. Jurisdictional issues when in a foreign country.

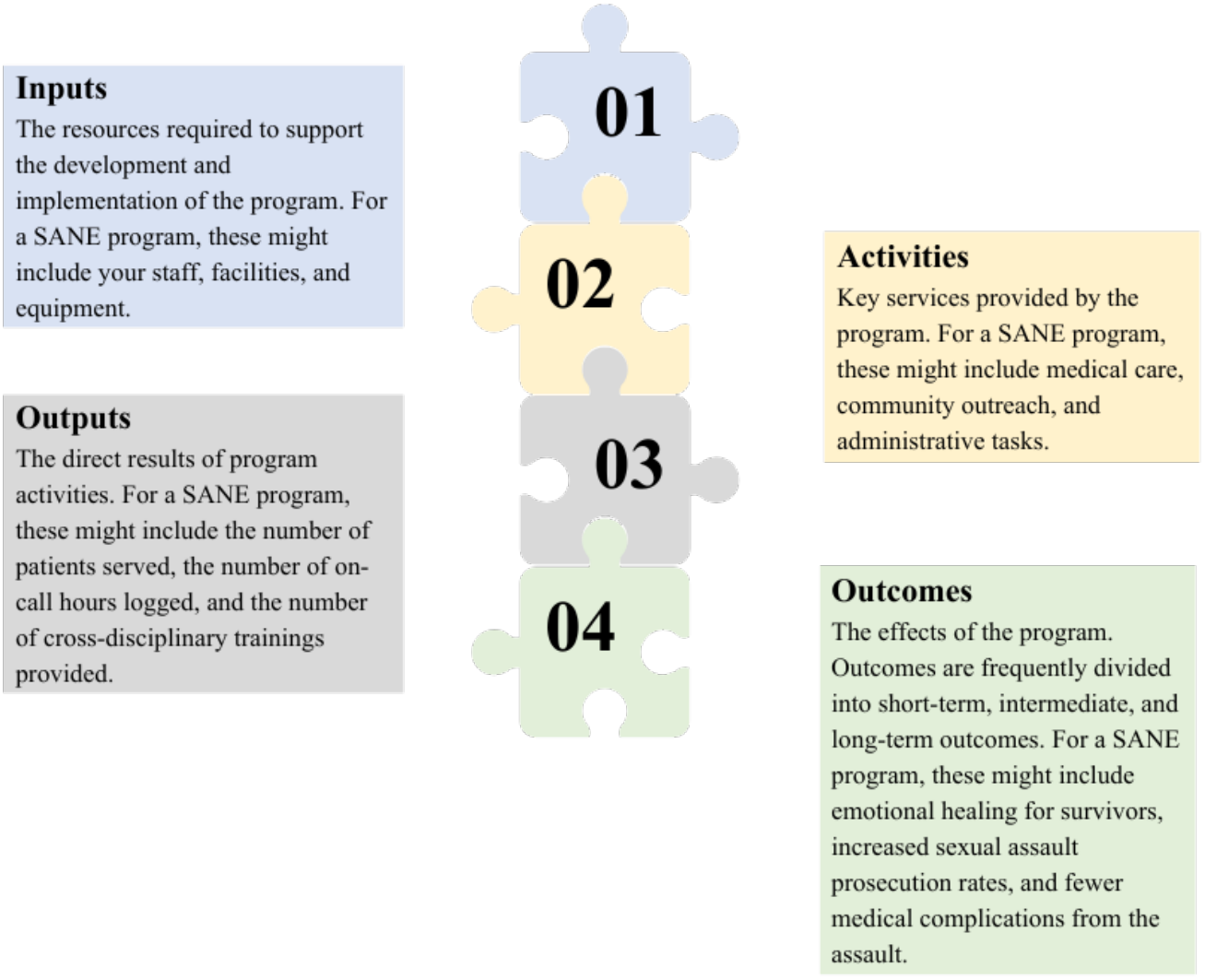
3.7 Program Goals and Objectives

A mission statement that represents the goals and objectives of your program can be helpful in developing and maintaining your program. Consider that the mission statement will help you to solidify

the rationale behind your program (the "why" of your program). Gathering input from your community team, partner agencies, and other providers within the institution may help to formulate/write your plan.

After developing your mission statement, it can be helpful to also develop a logic model for your SANE program. A logic model is a visual display of how your program is supposed to work. Logic models map out a program's goals, along with the different activities and resources necessary to meet those goals. A logic model can be used for program planning and development, ongoing management, and evaluation. Additionally, many funders require that programs provide a logic model to support requests for funding, making it a useful tool for many aspects of program development.

Logic models typically include four main parts:



Developing a logic model from scratch can take time, and a blossoming SANE program may not have the resources to invest in its creation. Several sample logic models can be found in the SANE Evaluation Toolkit[52] and they are included here as a starting point. Each logic model is presented as a chart and as a

diagram so each SANE program can choose the form they (or their funder) prefer. These logic models are not copyrighted and can be used or modified to best meet the needs of your SANE program. The first logic model emphasizes how SANE programs can have a beneficial impact on patient care and emotional well-being, while the second logic model emphasizes SANE program impact on legal prosecution. It is probable that your SANE program will have desired outcomes related to both of these domains—patient care and emotional well-being as well as legal prosecution. Feel free to select items from each of these logic models, as well as adding items specific to your SANE program's goals, to present how your SANE program works.

3.8 Business Plan

One foundational step for beginning the process of SANE program development is to create a business plan for your venture. According to research from the SANE Sustainability Project of the National Sexual Violence Resource Center (NSVRC), financial issues are one of the contributing factors to a program's closing.[53] A business plan provides the SANE program with a realistic overview that includes costs and a timeframe for program operations.

A business plan is a critical tool for making the argument to hospital- and/or community-based program administrators. It can demonstrate there was thoughtful consideration to financial responsibilities, opportunities for growth in services, and potential challenges to program sustainability.

A business plan can help an organization describe how it intends to implement its mission and achieve its goals and objectives. The business planning process involves researching the market for the service the organization plans to offer, investigating the resources needed to provide the service, devising implementation and marketing strategies, assessing risk, and determining ways to evaluate success.

Business plans may appear in different formats, but most address the following areas:

1. The organizational/program summary describes the product or service, its purpose, management, operations, marketing, and finances.
2. The organizational/program opportunity describes what unmet need the project will fill, including outlining the need and how services will be paid for. This can include community or program benefits and competitors. The plan describes who will be responsible for developing, marketing, and operating the project, and why their backgrounds and skills make them the right people to make the project successful. Implementation of the plan is outlined in detailed descriptions of startup costs, marketing, financials, and operations.
3. The financial plan should include the costs to launch, operate, market, and finance the business, along with conservative estimates of revenue, typically for 3 to 5 years. In most instances, an outline of how the program will respond if there are problems with implementation is included.

Steps to creating a SANE program-specific business plan include the following (from the NSVRC SANE Sustainability Bulletin Series, Sustainability 101: Creating a business plan for sexual assault nurse examiners by Elise Turner):

Evaluation of care needed

1. Current costs of providing care
    - # of cases per year
    - Costs for space used
    - Average time the cases take from sign-in to discharge
    - # of workers that interact with the patient
    - Categories of workers that interact with the patient
    - Supplies, equipment used
2. Current billing practices
    - Reimbursement sources for medical forensic exams
    - Reimbursement sources for other services (outside of medical forensic examinations)
    - Current nonreimbursed costs and/or write-off costs
3. Current standards of sexual assault care in facility (is the care meeting national standards) for:
    - STD prophylaxis
    - HIV nPEP
    - Pregnancy prevention
    - Evidence collection
    - Options for patients for examination
    - Are there any other current staff concerns related to care of this particular patient population?

Cost projection

1. Personnel-related costs
    - Salary
    - Benefits
    - On-call pay
    - Overtime

- Administration

2. Nonpersonnel costs
    - Space rental (based on current community rental costs)
    - Office supplies and equipment
    - Clinic/forensic supplies and equipment and replacement costs
    - Insurance
    - Medications
    - Laboratory costs
    - Internet access, phone/fax, postage
    - Travel costs (for training, education, meetings)
    - Professional membership dues
    - Recruitment, training, licensure, and certification fees
3. Costs that could be donated or part "matching" funding
    - Exam room space (use current rental cost estimate from above)
    - Copy costs
    - Staff and volunteer time donated
4. Patient care costs
    - Determine per patient cost based on estimated # of clients to be served (based on current numbers)
5. Other costs to consider in planning
    - Initial education and training for staff
    - Ongoing training for staff
    - Security if needed for space (particularly important for community-based programs)

Income projection using actual income from billing and payment records. Include the following—

1. Income from billing sources for payment for the exams
2. Donated costs from the institution
3. Donated or existing supplies
4. Use of ancillary support service staff if donated
5. Medicare/Medicaid

6. Crime victims' compensation
7. Grants
8. Other income sources

Once the listed items are compiled, include a one-page summary for the proposal. Update this resource annually based on current information from the program. The business plan can be helpful to use for grant applications and other financial assistance for the program.

3.9 Creating Programs in Unique Community Settings

All communities face challenges when trying to develop a SANE program. The next section looks at specific types of communities and explores strategies for providing care.

Tribal Communities

There are approximately 550 federally recognized American Indian and Alaska Native (AI/AN) groups representing an estimated 1.5 to 2 million individuals living in the United States. Historically, violence within native communities was rare because it was believed to be unnatural and a threat to harmony (NSVRC 2000[54]).

Individuals within AI/AN communities experience sexual assault and violent victimization at a higher rate than most populations. More than 1 in 3 AI/AN women, and nearly 1 in 5 AI/AN men, will be sexually assaulted in their lifetimes. This is more than 2.5 times higher than for the general United States population.[55] In some communities, the rate is up to 20 times the national average (Amnesty International 2022).[56] The rate of unreported sexual assaults, as well as polyvictimization, is also predicted to be higher in AI/AN communities.

These alarming statistics clearly demonstrate the need for comprehensive medical and forensic services within AI/AN communities. Despite this fact, less than one-third of tribal land is within a 60-minute drive of a facility offering sexual assault services.[57]

Challenges to Program Development
a. Health care facilities in tribal communities are often required to provide for all health care needs of the population. Hospital administration may be hesitant to budget time and resources toward creating a program for a small number of patients who a program might serve.
b. There is often a high vacancy rate of health care workers at tribal facilities as well as a high level of staff turnover.
c. There may be a lack of community resources, such as advocacy programs and shelters, which would provide additional services for victims.

d. When community resources are available, jurisdiction can be confusing as there are often multiple jurisdictions that must be considered (e.g., multiple tribal jurisdictions, state, federal).

Challenges To Providing SANE Care

a. Within tribal communities, there is often a lack of trust in the health care system, as well as other entities such as law enforcement, due to a history of oppression and exploitation.

b. Similar to rural communities, confidentiality is an issue because quite often everyone knows everyone else. Victims may be reluctant to report a sexual assault or seek care. They may be concerned about social stigma and that they will be blamed for the assault. They may also be concerned about the impact that reporting may have on their families and on the community.

c. Achieving and maintaining clinical competency is difficult for nurses who may perform only one or two examinations a year. Due to the high turnover of nurses, recruitment of new SANEs will likely be a consistent concern.

Creating Solutions to the Challenges

a. Tribal communities are eligible for funding to provide sexual assault services from many federal sources, including the Indian Health Service Domestic Violence Prevention Initiative, the Office on Violence Against Women, and the Office for Victims of Crime, including victim assistance formula funding directed to the states.

b. Advocate for dedicated time and resources toward SANE program development. A program will not be sustainable if dependent solely on volunteered time. Provide information to hospital administration regarding the health care costs of sexual violence. Provide assurance that, once a program is established and community awareness is increased, the number of patients seen will also increase.

c. Health care facilities should work in collaboration with community resources with the goal of forming a Sexual Assault Response Team (SART).

d. Health care facilities and the community response should incorporate traditional values to emphasize the strengths of native cultures.

e. Community education is essential to increasing awareness of available resources as well as increasing the trust of the health care system. The health care system must possess native cultural awareness and offer services such as medical interpreters and traditional healing options.

f. To address confidentiality concerns, a health care facility should consider strategies that allow a patient to bypass the emergency department waiting area when arriving for a medical forensic exam.

g. It is imperative to develop a comprehensive training plan and thorough competency assessment for SANEs. Nurses should attend a SANE course that includes a clinical component.

h. Tribal SANE programs with a low annual volume should partner with higher volume SANE programs that can provide precepting and mentoring experiences for nurses.

i. Scheduled mock examinations and skills sessions can be used for practicing skills and maintaining competency. Nurses may also be able to assist in a women's health clinic to maintain competency with speculum examinations.

Rural Communities

According to the U.S. Department of Agriculture in 2014, 46.2 million people, nearly 15 percent of U.S. residents, lived in nonmetropolitan communities. The U.S. rural population occupies 72 percent of the country's land mass.[58] Rural communities experience many challenges when it comes to providing any type of health care services. The challenges faced by rural communities include geographic isolation, lower percentages of health care providers compared to urban communities, and populations that have higher rates of poverty and lower rates of having health insurance.[59] According to the Bureau of Justice Statistics, from 2005–2010, the rate of sexual violence for females in rural areas (3.0 per 1,000) was higher than the rate of sexual violence for females in urban (2.2 per 1,000) and suburban (1.8 per 1,000) areas.[60]

Challenges to Program Development

a. Similar to tribal health care facilities, rural hospitals are required to provide for all of the health care needs of a community. In an urban setting, those may be shared by several hospitals and other types of health care facilities. It may be difficult to justify the costs involved in creating a program for the small number of patients the program might serve.

b. Rural communities may have limited resources for funding a SANE program.

Challenges To Providing SANE Care

a. Confidentiality is an issue in small, rural communities where everyone knows everyone else. Victims may be reluctant to report a sexual assault or seek care.

b. Initial training and maintaining clinical competency is difficult for nurses who may perform only one or two examinations a year.

c. Seeking care in a rural community does not eliminate the need for programs to be prepared to deal with problems more common in an urban environment. For example, while HIV prevalence may be extremely low in many rural communities, patient may be sexually assaulted in a higher prevalence urban area, but then return home to seek care.

Creating Solutions to the Challenges

a. When considering the cost to start a SANE program, rural communities need to look at the economic impact of sexual violence on the community, and the substantial burden of direct medical, mental health, lost productivity, disruption to families, and decreased safety in the community.

b. Rural communities are eligible for funding from the Office on Violence Against Women (OVW) to provide sexual assault services. In addition to the formula grants available to all communities, rural communities can also apply for a rural discretionary grant from OVW. The Rural Sexual Assault, Domestic Violence, Dating Violence, and Stalking Assistance Program enhances the safety of rural victims of sexual assault, domestic violence, dating violence, and stalking, and supports projects uniquely designed to address and prevent these crimes in rural areas. Eligible applicants are states, territories, Indian tribes, local governments, and nonprofit entities, including tribal nonprofit organizations.

c. OVC's annual crime victim assistance grants to states under the Victims of Crime Act (VOCA) may allow the funds to be used for forensic interviews for children and individuals with disabilities, to support forensic medical examinations for victims of sexual assault, and to pay a portion of the salaries for protective service workers who provide direct services to child victims and for SANEs who provide direct services to victims. As with all VOCA funds, eligibility requirements are determined by the state.

d. Consider the ways a hospital can improve the options for confidential care of patients. This might mean bypassing the emergency department waiting room when a patient comes to the hospital for a medical forensic exam.

e. Make sure nurses attend a SANE class with a clinical component.

f. Create a collaborative examination model where the emergency department physician works with the nurse to provide care to the patient.

g. Have mock examinations to practice and maintain skills. Some communities use model patients, similar to practicing mock codes, to maintain skills.

h. You may need to work collaboratively with a SANE program in an urban community for peer review and mentoring staff and leadership.

i. Consider other possible community resources to use, such as the public health department for HIV prophylaxis and Planned Parenthood for clinical training and skills maintenance.

Military/Deployed Settings

The U.S. Department of Defense (DoD) recognized the need to provide services to all military sexual assault victims and has been actively seeking to do so since the Task Force Report for Care of Victims of Sexual Assault was convened in 2004. In response to the Task Force's recommendations and a National Defense Authorization Act for Fiscal Year 2005 directive, DoD developed an overarching sexual assault prevention and response policy and a permanent Sexual Assault Prevention and Response Office (SAPRO) in 2005. SAPRO serves as DoD's single point of authority for sexual assault policy and provides oversight to ensure that each of the Services' programs comply with DoD's Sexual Assault Prevention and Response Program Procedures (DoD Instruction 6495.02). Under this program, every sexual assault victim will have access to a military victim advocate, legal support, medical and mental health services, and a sexual assault forensic examination (SAFE).

Challenges to Program Development

In civilian communities, staff turnover often makes it difficult to maintain a core of trained SANEs. In the military setting, this is an even more critical issue with the constant relocation of personnel to a new installation. This regular turnover in personnel also makes it more difficult to establish a working collaborative SART, which is important to coordinated patient care. On many stateside military installations, this was initially resolved by developing Memorandums of Understanding (MOU) with community facilities for advocacy and medical care. The more recent move, however, is to ensure trained Sexual Assault Medical Forensic Examiners (SAMFE) are available at military treatment facilities. If a military treatment facility does not have the capability to offer the SAFE onsite, the military continues to use partnerships through established MOUs in the community to provide the SAFE, while ensuring that patients receive the appropriate case management for any follow-on medical and behavioral health treatment. For additional information about the Sexual Assault Prevention and Response Program Procedures, visit the SAPRO website for details.

While military commanders initially insisted they be notified automatically when a member assigned to their command is sexually assaulted, since March 2005, the military has provided the option for members to make a Restricted report, where commanders and law enforcement are not notified of the identity of the victim. The only official notification, for documentation and data collection purposes, is that within 24 hours of a report of sexual assault, the sexual assault response coordinator must notify the senior commander of the assault without providing the person's name or personally identifiable information. When a member of the military selects the restricted reporting option, they can choose to have a forensic medical exam, talk with the military victim advocate or a civilian victim advocate if available in their area, but not have the assault reported to the military police. Much like in the civilian community, they can change their mind and go Unrestricted at a later time, involving military police at that point. For additional information, visit the visit the SAPRO website for details.

Challenges To Providing SANE Care

a. Frequent reassignment of medical personnel.

b. Inability to maintain competency once trained because of small caseload in remote locations.

c. Providing for patient confidentiality and followup in remote settings.

Creating Solutions to the Challenges

Per Directive-type Memorandum 14-003, DoD, working with the military services, established the Special Victim Capability Prosecution and Legal Support Program, a legal support function for victims of sexual assault, that provides legal advice and guidance and maintains a victim's confidentiality. A victim can access this support whether they file a Restricted or Unrestricted report.

Under this program, the Army, Air Force, National Guard, and Coast Guard refer to these professionals as Special Victims' Counsel (SVC), while the Navy and Marine Corps refer to them as Victims' Legal Counsel (VLC). SVC/VLCs receive specialized training to address the legal concerns of sexual assault victims. They understand the legal process and are able to advise victims of their rights and address other legal issues that arise, as not all cases result in a trial. For additional information about the SVC and VLC programs, visit the SAPRO website for details.

To address the challenge of maintaining competency, the Services developed a tri-service program for training SAMFEs. This training includes all of the requirements mandated by Congress, is mapped accordingly to the Department of Justice National Protocol for Sexual Assault Medical Forensic Examinations 2nd Ed, and provides a period of time for the individual SAMFE to develop competency in performing the SAFE, taking into consideration locations that are remote, low volume, or in a deployed position.

NOTE: References in this Guide to recommendations in the *National Protocol for Sexual Assault Medical Forensic Examinations* reflect the recommendations published in 2013 and may not reflect the recommendations in the National Protocol published in 2024.

In addition, the United States Department of the Navy engaged in a partnership with the National Sexual Assault TeleNursing Center (NTC), which provides the opportunity to enhance the quality of care delivered to victims of sexual assault in remote military locations. The NTC was developed by the Massachusetts Department of Public Health SANE Program, through a cooperative grant from OVC and the National Institute of Justice (NIJ), to provide a community of support for sexual assault clinicians to increase their confidence, competence, and retention, and to develop quality care for sexual assault patients.

This partnership with the NTC affords the Navy the opportunity to enhance the quality of care delivered to victims of sexual assault in remote military locations. Naval Hospital Twentynine Palms (NHTP) became the first remote site to receive 24/7 real-time support and guidance from the NTC on November 1, 2014. As pioneers of this project, the NHTP SAMFE team and the NTC have developed protocols and best practice guidelines to deliver quality forensic examinations. This innovative application of telemedicine involves more than turning on a camera and consulting with an expert. The integration of technology during forensic evidence collection is thoughtful, with consideration of each patient's unique needs, privacy, and security. The successful partnership with NHTP led to the addition of a second naval hospital. On February 1, 2016, Naval Hospital Camp Pendleton became the second naval hospital, and the third hospital in the Nation, to receive 24/7 support from the NTC. The University of Illinois at Urbana-Champaign is conducting a process evaluation to document and assess the NTC's activities. For additional information on the NTC project, please visit the National TeleNursing Center.

Telemedicine Programs

Telemedicine is the practice of using technology to provide care or consultation to a remote site. Health care providers use telemedicine to provide health care to communities with limited access to resources or without access to specialty services available in larger medical facilities. Telemedicine can be used either for providing direct care or for providing expert consultation to local health care providers. Telemedicine is used most often for radiology, cardiac monitoring, neurology, dermatology, psychiatry and, for the past several years, to provide expert evaluation of child abuse findings.[61]

For more information regarding telemedicine:

- National TeleNursing Center
- TeleSAFE Webinars - International Association of Forensic Nurses
- TeleSAFE Toolkit - International Association of Forensic Nurses
- Emergency Nurses' Experience Providing Care and Perceptions About Using Telemedicine for Sexual Assault Patients | Office for Victims of Crime
- National TeleNursing Center (NTC) Sustainability | Office for Victims of Crime

Telemedicine has been proposed for multiple types of SANE settings. Isolated rural and tribal communities may benefit from the ability to access expertise from SANEs who, by virtue of dealing with a higher volume of patients, can maintain and share their clinical expertise. Military installations and deployed personnel may be able to use telemedicine to provide or enhance care. For patients who are incarcerated, using telemedicine allows the patient to remain in their secure facility while receiving expert care.

In 2012, the Office for Victims of Crime (OVC), in collaboration with the National Institute of Justice (NIJ) and the Office on Violence Against Women (OVW), provided a grant to the Massachusetts Department of Public Health SANE Program to create the National TeleNursing Center. This Center, located at Newton Wellesley Hospital in Newton, Massachusetts, is just beginning to deliver care to several pilot sites throughout the United States. See the text box for more information regarding telemedicine.

Challenges to Program Development
a. Isolated communities may not have sufficient infrastructure to provide digital access 24/7.
b. In addition to the privacy concerns faced with traditional SANE exams, factors related to the security of transmission of video streaming during exams, consultations, and electronic data sharing needs to be addressed collaboratively by the telemedicine hub and remote sites.
c. Equipment used for telemedicine needs to be incorporated into the exam to be as nondisruptive to the exam and the patient experience as possible.
d. All costs for care need to be considered, including equipment and software, expert consultation and travel, and other expenses if consultants are subpoenaed for testimony.
Challenges To Providing SANE Care
a. Nurses must be licensed in the state where the telemedicine hub is located and the state(s) where they are providing consultation. Nurses providing telemedicine consultation may also be

required to provide additional documentation or credentialing information at each hospital where services are provided.

b. Nurses need to be familiar with the operation of the telemedicine equipment used in their facility. (*Staff turnover could be a challenge or a benefit to the use of telemedicine technology for sexual assault patients. This use of technology may help providers in settings with high turnover maintain a state of readiness.)*

c. Some patients may not find telemedicine equipment acceptable.

d. Nurses must be available at both locations when care is provided.

e. Formal agreements may be required between client organizations.

f. Since the use of technology for real time adult medical forensic examinations is relatively new, there may be issues raised about the role of the nurse in providing testimony. Until cases are completed and charges filed, these issues may not be completely resolved.

Creating Solutions to the Challenges

a. SANEs can start by using existing telemedicine resources to enhance their programs. For example, many community education institutions have remote video access that allows SANE programs to receive education at a distance.

b. Hospital SANE programs must work closely with HIPAA compliance/privacy officers to ensure any transfer of information is secure.

c. There are varied levels of complexity in available telemedicine equipment, considerations need to be made to purchase equipment that is user friendly and does not require a high level of technical expertise. Nurses participating in these efforts should be involved in helping to select appropriate equipment.

d. As is the case with all patients, informed consent should be obtained prior to the use of telemedicine, and patients must get the opportunity to decline its use.

e. SANE programs should work closely with local prosecutors to determine if expert consultants need to provide direct testimony in trials and hearings.

f. SANE programs should routinely collaborate with a rape crisis counselor who can provide the victim additional support, information, and case management.

Chapter 4: Legal and Ethical Foundations for SANE Practice

This section provides an overview of state, tribal, and federal laws and other sources that provide the legal and ethical foundations for SANE practice. The issue of informed consent is discussed in greater detail in section 7.4. It is essential for nurses to understand how state, tribal, and federal laws intersect and how they impact nursing practice in the jurisdictions where SANEs provide care.

Chapter 4 Subsections:

Go to Chapter 5: Management of SANE Programs

4.1 State Laws and the Nurse Practice Act

SANEs are nurses first, and they must be familiar with their Nurse Practice Act. Nurse Practice Acts are laws in each state that determine the legal duties and responsibilities of a nurse to patients, other nurses, and the community. There are 15 states where the state codes or regulations have language specifically referring to SANE practice. If your state does not mention SANE practice in any statute or regulation, look for language that describes how a nurse can expand their scope of practice beyond what is typically considered the role of the registered nurse. If you have any questions or concerns about SANE practice, there should be a mechanism for contacting your state's board of nursing. It is the responsibility of the state board of nursing to provide an interpretation of the Nurse Practice Act. Other state

Text Box A: Legal Questions To Answer Before Starting a SANE Team Outside of a Hospital

1. What is the best business structure allowed by my state, territory, or tribe to protect individuals from personal liability?
2. If I am opening a freestanding site for SANE examinations, does the facility need to be licensed or meet any specific qualifications in order to provide health care?
3. Will the nurses be employees or qualify as independent contractors? How will this impact whether employment taxes need to be paid to the state?

laws impact many aspects of SANE practice. State laws provide guidance for creating a business when developing a community-based program. (See Text Box A: Legal Questions To Answer Before Starting a SANE Team Outside of a Hospital.)

State laws also specify the rights and responsibilities related to health care; determine how, and under what conditions, someone can consent to health care; and specify what is required for informed consent. States laws also indicate when a nurse has a mandatory duty to report abuse and neglect. Public health laws determine when communicable diseases need to be reported to the state. Table A presents the various types of state laws, and how they may impact SANE practice.

It is not enough to be aware of state laws. It is essential to know how state laws interact with each other and with tribal and federal laws. For example, in Utah, a minor of reproductive age has a right to confidential reproductive health care. At the same time, the sexual assault of a minor is required to be reported to law enforcement under mandatory child abuse reporting laws. This means that a nurse cannot notify a parent that their adolescent has been assaulted without the child's consent, but the nurse must report the assault to law enforcement. In most cases, law enforcement will then contact the parents and notify them of the assault. This is an example of a situation where multidisciplinary team members need to work together to ensure that the adolescent survivor receives patient-centered and trauma-informed care. There may be situations where notifying the parents may create greater harm for the child. It is essential for team members to have open communication in order to make decisions with input from everyone involved in the case.

It is important to consult with an attorney who is knowledgeable in both business and health care law when starting a community-based program. Most states have websites that provide basic information about incorporation. You can also start with the U.S. Small Business Administration for information on starting a business.

Getting Legal Advice

It is important to seek legal advice early in the process of developing a SANE program. If you are developing a program in a hospital, it is important to request that the in-house legal counsel and risk management director review the program's policies and procedures. If you are developing a program outside of a hospital, it is important to seek legal services to assist in the development of the business structure, facility licensing, and employer policies. While prosecutors are experts in criminal law, they may not be experts in nursing practice regulation and health law. Prosecutors can review evidence collection policies and procedures, but should not be responsible for policies related to patient health care.

Table A: State Health Laws Impacting SANE Practice

Types of Laws	What SANEs Need to Know
Health consent laws specify who can consent to health care and under what conditions.	1. Can a minor patient consent to reproductive health care? This would include contraception, sexually transmitted disease testing, and treatment. 2. When can a minor consent to a sexual assault medical forensic examination? 3. Who can give consent for health care for a patient who is incapacitated?
Confidential care laws specify when a patient is entitled to confidential care or when communication with a health care provider is privileged or protected from disclosure.	1. When can a minor receive confidential care? 2. Are there areas of health care that have increased protection from disclosure, such as mental health and human immunodeficiency virus (HIV) treatment? 3. Are there exceptions to confidentiality laws, such as reporting a patient who is threatening harm to self or others?
Mandatory reporting laws determine when and how health care providers report the abuse or neglect of a patient.	1. What are the mandatory reporting laws for abuse of a child, elder, and vulnerable adult (adult with a disability)? 2. Does your state have laws that require the reporting of sexual assault, domestic violence, or any injuries that are the result of a crime? 3. Does your tribe have laws that require the reporting of sexual assault, domestic violence, or any injuries that are the result of a crime? 4. Do all multidisciplinary team members have the same mandatory reporting requirements?
Public health laws indicate when infectious diseases should be reported to local health authorities.	1. What infectious diseases are reportable in your state?
Medical record and privacy laws describe the requirements for the release of medical records and any other protected health information.	1. Does your state or tribe have medical record and privacy laws that are more restrictive than the Health Insurance Portability and Accountability Act (HIPAA) requirements? 2. Are there types of medical records that have heightened confidentiality protections? These protections typically apply to mental health, substance abuse treatment, and HIV records.
Emergency contraception laws require hospitals and other providers to provide	1. Does my state or tribe have an emergency contraception law? 2. Who is required to provide emergency contraception under the law?

Types of Laws	What SANEs Need to Know
emergency contraception to sexual assault survivors.	
State victims' rights laws provide protections and rights to victims of crime.	1. Do the relevant state or tribal victims' rights laws require access to medical forensic examinations? 2. Do the relevant state or tribal laws require that the patient have the option to have an advocate present during an examination? 3. Does the state or tribe have an OVC-funded or OVW-funded victims' rights legal clinic where patients can get legal help?
State laws that address payment for medical forensic examinations and treatment.	1. Under state laws and regulations, which entity is designated as the payment source for medical forensic examinations? 2. What is covered by the designated payment source? For example, does it only cover items that are considered purely medical, such as sexually transmitted disease prophylaxis? 3. How are invoices submitted to the payment source? 4. What types of providers can be reimbursed (e.g., nurses, physicians, other health care providers)? 5. Do the laws and regulations include a cap on charges for services? 6. Can the victim's insurance be billed?

4.2 Federal Laws

There are many federal laws and regulations that impact SANE programs. It is beyond the scope of this Guide to provide a detailed analysis of how each law may impact a SANE program. If your program receives federal financial assistance, the applicable federal civil rights laws will apply to all of the operations of your organization. If you are developing a program in a hospital, it is important to request that the in-house legal counsel and risk management director review the program's policies and procedures. If you are developing a program outside of a hospital, it is important to seek legal services to assist in the development of the business structure, facility licensing, hiring practices, and employer policies. It is essential to seek legal advice early in the process of developing a SANE program to ensure that the program is in compliance with all federal laws and regulations.

Table B: Federal Laws Impacting SANE Practice

Federal Statute	How It Impacts SANE Practice
Emergency Medical Treatment and Active Labor Act 42 United States Code (U.S.C.) § 1395dd	Provides emergency treatment and stabilization to anyone presenting to an emergency room with either an emergency medical condition or in active labor.

Federal Statute	How It Impacts SANE Practice
Heath Insurance Portability and Accountability Act (HIPAA) 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164	Describes how health care providers and other covered entities will maintain the privacy of patients' protected health information. It also provides patients access to their protected health information.
Health Information Technology for Economic and Clinical Health (HITECH) Act 42 U.S.C. § 300jj et seq., § 17901	Addresses the privacy and security concerns of electronic medical records.
Federal Child Abuse Reporting Laws 42 U.S.C. § 13031	Describes laws for reporting child abuse on federal lands or in federal facilities.
Americans with Disabilities Act 42 U.S.C. § 12101	Protects the rights of persons with disabilities. This law protects all persons, including both patients and health care providers with disabilities. Prohibits discrimination in both employment and in the delivery of services or benefits against persons with disabilities in state and local government services, public accommodations, or commercial facilities.
Civil Rights Act, Title IX 20 U.S.C. § 1681 et seq.	Prohibits discrimination on the basis of sex by any federally funded education program. The Amendments include rules and regulations related to the reporting and handling of sexual assault.
Section 504 Rehabilitation Act 29 U.S.C. § 701	Prohibits discrimination based on disability by organizations receiving federal funding.
Prison Rape Elimination Act 42 U.S.C. § 15601 Final Rule, 28 CFR Part 115	Provides direction to correctional facilities for the provision of care for inmates that report sexual assault.
Civil Rights Act, Title VI 42 U.S.C. § 2000d	Prevents discrimination based on race, color, or nationality. Requires health care organizations receiving federal funds directly or indirectly from the U.S. Department of Health and Human Services (HHS) to take reasonable steps to ensure that persons with limited English proficiency have meaningful access to programs and activities.
Section 1557 of the Patient Protection and Affordable Care Act 42 U.S.C. 18116	Prevents discrimination based on race, color, national origin, sex, age, or disability, under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency

Federal Statute	How It Impacts SANE Practice
	or any entity established under Title I of the Affordable Care Act or its amendments.
Age Discrimination Act 1975 29 USC §6101	Prevents discrimination based on age by programs receiving federal financial assistance.

The Violence Against Women Act (VAWA)

The Violence Against Women Act was originally enacted in 1994 and has been reauthorized by Congress three times, in 2000, 2005, and 2013. VAWA provides communities with tools to improve responses to victims of domestic violence, dating violence, sexual assault, and stalking, and enhances services available for victims.

Violence Against Women Acts of 1994, 2000, 2005, and 2013
Public Laws 103-322, 106-386, 109-162, and 113-4

Forensic Examination Payment

a. As a condition for certain grant funds, the state or another governmental entity must "bear the full out-of-pocket costs" for medical forensic examinations.

b. Victims must have access to examinations free of charge, regardless of their cooperation with law enforcement or the criminal justice system.

c. States can use formula grant funds to pay for forensic examinations, but only if victims are not required to submit the costs to their personal insurance carriers and the exam is conducted by a trained examiner. It does not need to be a SANE or SAFE, but does need to be someone with sexual assault training.

d. States can use a victim's insurance to pay for the cost of the examination, but a victim cannot receive a bill for any out-of-pocket costs, such as a copay or a deductible.

e. States must coordinate with health care providers in the region to notify victims of sexual assault about the availability of rape exams at no cost to the victim.

f. For members of federally recognized tribes, the Indian Health Service is the payer of last resort.

Immigration

a. VAWA and subsequent legislation provide immigration relief to victims of domestic violence and sexual assault. U visas are specifically designated for victims of certain crimes, including sexual assault, who are cooperating with law enforcement.

b. All sexual assault victims should be provided with information regarding U visa relief in the event that the information would be helpful.

c. A T visa provides temporary nonimmigrant status to victims of "severe forms of human trafficking" who are cooperating with law enforcement.

d. SANE programs should develop partnerships with organizations serving immigrants in order to make the appropriate referrals.

Violence Against Women Acts of 1994, 2000, 2005, and 2013 Public Laws 103-322, 106-386, 109-162, and 113-4
The Sexual Assault Forensic Evidence Reporting (SAFER) Act of 2013 a. VAWA of 2013 includes the SAFER Act. b. The SAFER Act encourages jurisdictions to conduct audits of backlogged and untested sexual assault evidence. c. The SAFER Act also requires the National Institute of Justice to develop recommendations regarding the processing of DNA evidence in sexual assault cases.

4.3 Tribal Law

As of 2016, there are 567 federally recognized tribes. Federally recognized tribes are considered to possess certain inherent rights of self-government. Many tribes have enacted their own legal codes. A SANE program that provides care to a tribal entity should be aware of any tribal laws impacting that specific program. The following information will be helpful to programs that work with tribal victims.

Determining Who is American Indian/Alaska Native or a Member of a Federally Recognized Tribe

The recognition of an individual's legal status as American Indian/Alaska Native can vary depending on a variety of factors, including whether the determination is being made pursuant to tribal law or federal law, whether the individual is a member of a federally recognized tribe, whether any legal action is a criminal or civil case. Legal recognition of Indian status may also differ based on rules and regulations created by federal agencies to determine who qualifies for services. For example, the Indian Health Service uses the following criteria to determine eligibility:

A person may be regarded as within the scope of the Indian Health program if he is not otherwise excluded from by provision of law, and:

a. Is of Indian and/or Alaska Native descent as evidenced by one or more of the following factors:
    1. Is regarded by the community in which he lives as an Indian or Alaska Native;
    2. Is a member, enrolled or otherwise, of an Indian or Alaska Native Tribe or group under federal supervision;
    3. Resides on tax-exempt land or owns restricted property;
    4. Actively participates in tribal affairs; or
    5. Any other reasonable factor indicative of Indian descent.

b. Is an Indian of Canadian or Mexican origin, recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program; or

c. Is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post-partum (usually 6 weeks); or is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease that constitutes a public health hazard.

SANE programs need to consult appropriate legal counsel in situations where determination of legal status impacts jurisdiction of sexual assault cases or services available to patients.

Federal Definition of Indian Country

The term *Indian Country* is defined in 18 U.S.C. § 1151 as including (a) all land within the boundaries of the reservations of federally recognized Indian tribes, including patented land and any rights-of-way running through the reservation; (b) dependent Indian communities; and (c) Indian allotments to which title has not been extinguished, including any rights-of-way running through the allotment.

The General Crimes Act

The General Crimes Act, 18 U.S.C. § 1152, was passed by Congress in 1817. It extended federal criminal jurisdiction over interracial crimes committed in Indian Country. It applies to cases where the offender is non-Indian but the victim is Indian. The General Crimes Act can also apply where the offender is Indian and the victim is non-Indian, the crime falls outside of the Major Crimes Act, and the offender has not already been punished by the tribe for the offense.

The Assimilative Crimes Act

The Assimilative Crimes Act, 18 U.S.C. § 13, provides that where this is not an applicable substantive federal crime, the law of the state in which the crime occurred may be incorporated into the federal criminal code in 18 U.S.C. § 1152 prosecutions. State misdemeanor offenses can also be assimilated.

Non-Indian versus Non-Indian Crimes in Indian Country

The U.S. Supreme Court in *United States v. McBratney,* 104 U.S. 621 (1881), held that states have exclusive jurisdiction over crimes in Indian Country involving only non-Indians.

The Major Crimes Act

The Major Crimes Act, 18 U.S.C. § 1153, was enacted in 1885. It provides federal criminal jurisdiction over certain enumerated crimes if the defendant is Indian. The covered offenses are ones frequently seen in cases of severe intimate partner violence: murder, sexual assault, felony physical assault, and felony child abuse and neglect, among others. The Major Crimes Act is the source of federal jurisdiction for

crimes in which both the offender and the victim are Indians and the crime occurred in Indian Country. Tribes retain jurisdiction to prosecute Indians for conduct that might constitute a § 1153 felony. Accordingly, an Indian defendant may be prosecuted concurrently in two jurisdictions for the same offense. The Constitutional prohibition against double jeopardy does not apply because the United States and Indian tribes are separate sovereigns.

General Federal Crimes of Nationwide Applicability

These crimes constitute a federal offense regardless of where the crime occurs and who commits the crime (Indian or non-Indian). These federal statutes apply to Indian Country independent of the Major, General, or Assimilative Crimes Acts. Examples of relevant crimes include those involving firearms, controlled substances, and VAWA crimes, such as Interstate Domestic Violence or Interstate Violation of a Protection Order.

Public Law 280

Public Law 280 was enacted in 1953. It provides that criminal jurisdiction and limited civil jurisdiction over Indian Country was delegated from the Federal Government to six states: Alaska, California, Minnesota, Nebraska, Oregon, and Wisconsin. These states are frequently referred to as "mandatory PL 280" states. There were some tribes within these six states that were specifically exempted from the law. The law also permitted nonmandatory states to opt in; these states are referred to as "optional PL 280" states. Later amendments allowed states to retrocede jurisdiction back to the Federal Government, and section 221 of the Tribal Law and Order Act of 2010 provides that tribes can ask the Attorney General to reassume concurrent jurisdiction.

Tribal Court Sentencing Authority

The Indian Civil Rights Act (ICRA), 25 U.S.C. § 1302, was originally enacted in 1968. ICRA extended certain federal rights found in the Constitution's Bill of Rights to Indians in Indian Country. When originally passed, ICRA limited the tribal court's sentencing authority to 6 months in jail and a $5,000 fine. The maximum possible tribal court sentence was increased to 1 year in jail and a $5,000 fine via an amendment to ICRA in 1986. In 2010, passage of the Tribal Law and Order Act restored limited felony sentencing authority to tribes and allows for sentencing of up to 3 years, and $15,000 per offense, for a combined maximum sentence of 9 years per criminal proceeding. Tribes choosing to use this felony sentencing authority must guarantee certain rights, including the right to law-trained, licensed defense counsel for indigent defendants.

Tribal Court Criminal Jurisdiction Over Non-Indians

In 1978, the U.S. Supreme Court ruled in *Oliphant v. Suquamish Indian Tribe*[62] that tribal courts do not have criminal jurisdiction over non-Indian offenders; however, VAWA recognized tribes' inherent power to exercise "special domestic violence criminal jurisdiction" (SDVCJ) over certain defendants, regardless of their Indian or non-Indian status, who commit acts of domestic violence or dating violence,

or violate certain protection orders in Indian Country. In order to exercise this authority, tribes must guarantee that defendants are afforded the rights described in the Tribal Law and Order Act of 2010 by providing:

- effective assistance of counsel for defendants;
- free, appointed, licensed attorneys for indigent defendants;
- law-trained tribal judges who are also licensed to practice law;
- publicly available tribal criminal laws and rules; and
- recorded criminal proceedings.

In addition, tribes must provide defendants charged under SDVCJ a jury trial where the jury pool includes a fair cross-section of the community and does not systematically exclude non-Indians. This law became effective for all tribes on March 7, 2015. (Note: Both TLOA and VAWA 2013 are completely discretionary for tribes. They may make the changes they need to exercise either of them, but absolutely do not have to.)

4.4 The Impact of Jurisdiction on SANE Practice

The term *jurisdiction* refers to the power, right, or authority to interpret and apply the law; the authority of a sovereign power to govern or legislate; the power or right to exercise authority; or the limits or territory within which authority may be exercised. SANEs must understand that jurisdiction determines who will investigate and prosecute the crime. Jurisdictional issues can occur in every community. A sexual assault in a tribal community may have state, federal, or tribal jurisdiction. An assault involving military personnel or dependents may come under military jurisdiction. Every multidisciplinary team should have a plan in place that allows the SANE to proceed with providing health care and the collection of medical forensic evidence until jurisdiction for the case can be determined. If you live in a community where boundaries for jurisdictions are not always clear, identify one agency that can be contacted when there is a problem concerning determining jurisdiction. It is their responsibility to determine who will ultimately be responsible for the case. For example, a county sheriff's department may be willing to act in that role where there are several municipal law enforcement agencies. Programs should be aware of the following laws and how they may impact jurisdiction.

- Tribal communities: Public Law 280 and VAWA of 2013, Title IX: Safety for Indian Women
- All communities: State and federal human trafficking laws
- Military installations: Military law and jurisdiction over service members and dependents
- Providing services to American victims assaulted overseas

4.5 Hospital and Agency Policies and Procedures

Hospital and agency policies and procedures (Link to section 5.3c) provide written guidance for how care is provided by the SANE. Protocols are frequently used to describe how SANEs will comply with laws and regulations. For example, a policy on consent for minors with regard to contraception should cite, and be consistent with, any applicable state or federal laws. Policies should be reviewed, updated, and approved by the administration regularly. Nurses need to be familiar with any policies that apply to their jobs, and reviewing policies should be a regular part of a performance review. While policies are not actual laws or regulations, they can be used as evidence that a SANE is aware of any legal obligations described in the policy. Old polices should not be destroyed, keep them for legal purposes in case of a lawsuit or other legal conflict to demonstrate what the standard of care was at the time the incident occurred.

4.6 Forensic Nursing Scope and Standards of Practice

First published in 1997, and then revised and updated in 2009 and 2015, the Forensic Nursing Scope and Standards "identifies expectations for the role and practice of the forensic nurse." This document, created by the International Association of Forensic Nurses (IAFN) and approved by the American Nurses Association, specifically recognizes the role of the SANE as a forensic nurse. In 1996, IAFN published the *Sexual Assault Nurse Examiner Standards of Practice*.[63] Since recognition of the Forensic Nursing Scope and Standards of Practice by the American Nurses Association, IAFN has not created a separate standard for SANEs. IAFN believes that the standards for forensic nurses should apply to all roles, including the role of the SANE; therefore, this document serves as a guide for identifying appropriate roles and responsibilities. The Forensic Nursing Scope and Standards are currently being revised and updated and should be available in 2016.

4.7 Ethical Decisionmaking

Because the role of the SANE intersects both the health care system and the criminal justice system, conflicts do arise between the needs of the patient and the needs of the criminal justice system. When faced with an ethical conflict, nurses should start with the Nurse Practice Act. Does the Nurse Practice Act speak to the nurse's duty to give care in a specific situation? SANEs can also use the American Nurses Association Code of Ethics as a framework for ethical decisionmaking. In 2008, IAFN published Vision of Ethical Practice. The Vision of Ethical Practice provides a guide for looking at ethical issues within forensic nursing. It is designed to be a document used for encouraging, instead of enforcing, a standard of practice.

Having clear policies and procedures about informed consent, providing examinations for unconscious patients, and collecting evidence from nonconsenting suspects allows nurses to provide ethical care in many situations. It is impossible to predict all of the possible scenarios that a SANE nurse might face in advance. Programs should have protocols in place for seeking legal and ethical advice. Most hospitals

have risk managers and ethics committees, and SANEs should be aware of how they function and when to contact them with a concern. It is not sufficient for nurses to make a decision based on what they think is right. Ethical decisionmaking requires a broader look at what is legal under the circumstances, and what patients would decide for themselves if they were able. Hospital ethics committees provide valuable assistance in ethical decisionmaking because they are composed of members who represent both the hospital and the community. Chapter 7 provides more guidance on creating specific policies for ethical issues such as collecting evidence from an unconscious patient.

For SANEs involved in either clinical or practice research, Institutional Review Boards (IRB) provide a required evaluation of the ethical implications of the research. Seeking IRB approval helps to ensure that the safety, privacy, and confidentiality of a patient or other subjects, such as nurses, are considered before any research is conducted. HIPAA also requires IRB approval for any research involving patients, including chart reviews.[64] Hospital-based SANE programs may have access to an IRB through their facility. Other programs may wish to partner with a local college or university. Some tribes may also have their own IRB. It is important for SANEs to realize that any data collection from patients regarding their experiences with interpersonal violence can potentially trigger a trauma response from the patient, and nurses need to be prepared to provide support to patients dealing with a trauma response if it occurs.

Conclusion

It is critical to understand the legal and ethical aspects of SANE practice. SANE programs must be aware of any state, tribal, or federal laws that impact the nurses in their practice. SANEs must also create policies and procedures that comply with the laws of the state and, if practicing in Indian Country, the laws of the tribe and the Federal Government. Appropriate legal counsel should be consulted throughout the process of SANE program development.

Chapter 5: Management of SANE Programs

This chapter offers assistance to programs as they develop their management and staffing structures. It will also help existing programs look at strategies for retaining nurses in a job setting that can be very demanding, both physically and emotionally. A good resource to review for this section is the National Sexual Violence Resource Center's SANE Sustainability Project. Materials from the Sustainability Project will be referenced throughout this chapter.

It is important to understand how the unique characteristics of your community will impact this part of the process. For programs that are part of a hospital organization, many of the management tools are already in place to develop different aspects of the program, such as job descriptions and hiring procedures that can be adapted to meet your staffing needs. If you are

starting a program outside of a hospital, you may want to create a plan that outlines how you will approach each step of the process. For a community that has no SANE services currently, starting a small, part-time program will improve access to care and create a foundation for future program expansion.

Chapter 5 Subsections:

Go to Chapter 6: Program Operational Costs and Funding

5.1 Importance of Leadership and Management

As stated in the SANE Sustainability Project, "Leadership is different than management… Leadership in nursing is about people—engaging with, inspiring, and building confidence in the team." As a SANE program is developed, acknowledging the importance of leadership, and providing opportunities and resources for developing leadership skills, will increase the success and sustainability of the program. As critical as leadership is, no program can function without effective management, and the people filling these roles need to work together to develop a cohesive team with a clear mission and vision for the future. Appropriate staffing for the critical management and leadership positions listed will give a new SANE program the best chance for success.

Program Manager/Coordinator

The SANE program manager/coordinator is not required to be a practicing SANE, or even a nurse, but if the program manager/coordinator is not a SANE, their role is limited to program administration. Program administration activities include budget development and implementation, scheduling of staff, and program logistics, which include patient populations served, hours in-house, or call time distribution. All of these functions need the input of the clinical nurses who provide the SANE care. Many SANE programs choose to combine the roles of program manager and clinical manager to address their needs.

When the program manager/coordinator is a nurse, compliance with nursing practice and supervision under the Nurse Practice Act can be handled by the role. When the program manager/coordinator is *not* a nurse, there must be allowances for supervision of the nursing staff in order to comply with the state Nurse Practice Act, so it is critical that systems are put in place for a nurse to evaluate and supervise staff competency.

Does My Program Need a Program Manager, Clinical Manager, and a Medical Director?

If you are starting a small program, it is possible for one person to fulfill the functions of both the program manager and clinical manager. This role would need to be held by a nurse because someone who is not a nurse cannot supervise nursing practice. If the nurse is licensed as a nurse practitioner or nurse-midwife, and has the legal ability to prescribe, the nurse may also fulfill the role of the medical director. If a program does not have a medical director, the legal responsibility of providing STD and pregnancy prophylaxis will need to be delegated to the medical providers of the emergency department where the SANEs are providing care. There will also need to be clear guidelines on when emergency department staff will become involved in patient care.

Clinical Manager/Coordinator

The SANE program clinical manager/coordinator should be a practicing SANE, as this role is responsible for supervising both SANE policy and the practice of individual SANEs. This position usually reports to a program manager who may be an administrator of other areas in the institution, and who relies on the clinical manager's knowledge and expertise to ensure clinical competency within the program.

Medical Director

Because the licensure and scope of practice of physicians and nurses differ significantly, and because SANE programs are housed in a variety of settings, from hospitals to nonmedical facilities, the requirements for the medical director can vary dramatically. The role of the medical director, whether a licensed advanced practice nurse (APRN) or a physician, is to provide direction, feedback, and consultation to the SANE program. Regardless of licensure or structure, having an active and engaged medical director is a key component of SANE program success.

Choosing a Medical Director or Consultant

The medical director or consultant (this may also be an APRN with prescriptive authority) should be chosen by the program director and be someone who has a complementary vision and passion for the job. When selecting a medical director, it is important to choose someone whose work is familiar and who has a common vision/mission, shared values, and mutual respect. It is crucial to find a medical director who can act as a champion for the program. Hospital policy may dictate what specialty the medical director should come from, but there is no steadfast rule. In general, emergency physicians, pediatricians, public health officers, family medicine physicians, women's health practitioners, and medical examiners are logical choices. A nurse practitioner with prescriptive authority can also serve as a medical director or consultant. The medical director should be a respected member of the medical community who has a good working relationship with nurses. There should be mutual respect among the members of the medical director's team and other medical staff.

Once there is agreement on a common vision for the medical director, other important issues to discuss include: controversies about SANE/forensic nursing practice, practice strengths and limitations, anticipated time commitments for the SANE coordinator and medical director, salary structure (if any), and medical director liability. There should be a job description for the medical director that outlines the requirements and expectations for the role. Open and frequent communication between the SANE program coordinator and the medical director is crucial to a positive working relationship and healthy conflict resolution interactions.

Text Box B: Role of the Medical Director

Depending on the program, some of the identified tasks may also be the responsibility of other key personnel.

- Approve protocols
- Administer medication
- Orders for diagnostic testing
- Standing orders
- HIV nPEP protocols
- Participate in clinical issues working to assure that appropriate consultative services are available for SANE patients by collaborating with other physician specialties
- Participate in quality assurance/quality improvement processes
- Assist with clinical education
- Participate in some administrative aspects of the program
- Participate in strategic planning and benchmarking process
- Assist with clinical expansion and new program implementation
- Oversee research protocols and adherence to state and federal regulations

Medical Director Role (See Text Box B)

Being a champion for the SANE program means supporting the role the SANE plays in provision of comprehensive care to sexual assault survivors of all ages. To that end, the medical director plays an important role clinically, administratively, educationally, fiscally, and strategically. Probably one of the most important aspects of the role is participation in the quality review/assurance process related to direct patient care. All team members need to be vigilant about not calling on the medical director to serve as a referee for team issues.

Succession Planning

Many SANE programs begin and run successfully as a result of a "champion," someone who is committed to making these services available for victims. This situation is ideal, until the champion steps down or other staff changes leave the program in jeopardy. For these reasons, succession planning within a SANE program can be critical to a program's sustainability. Succession planning should occur at two levels. First, there should be an emergency plan in place in the event key program members become unable to perform their jobs. Training staff to serve as backup for critical positions, including scheduling, payroll, and ordering supplies, will allow a program to continue functioning until the person can return to work or be replaced. Second, there should be succession planning for a change in program leadership. These plans should be discussed with staff and, when appropriate, members of the multidisciplinary team.

Staff do not stay with any organization indefinitely, and developing a succession plan that addresses what will happen when staff changes do occur can aid in that transition. Typically, this type of planning occurs for personnel who are crucial for operations or who, based on knowledge, skills, and expertise, will be difficult to replace. Program managers should consider whether internal staff could advance based on their qualities that prove successful in the current organizational structure.

5.2 Sexual Assault Nurse Examiners

Finding, training, and retaining the nurses who will provide patient care to survivors of sexual assault is a critical component of SANE program development. Because the role of the SANE in many communities is a secondary nursing position, and due to the nature of working with trauma victims, SANE recruitment and retention tend to be ongoing issues within programs.

Hiring Nurses for a SANE Program

Since the SANE must be able to function both within the health care system and the criminal justice system, criteria for selection may be more rigorous than for other nursing positions. For example, a nurse can successfully complete a diversion program for substance abuse and be hired in many hospital settings. As a SANE, a substance abuse history might be used to challenge a nurse's integrity when it comes time for him or her to testify in a sexual assault trial. The SANE program staff should have a

clear idea of the role and function of the SANE before starting the hiring process. It is important to consider several issues that may impact who should be hired as a SANE.

SANE Compensation

How SANEs are paid for both their on-call time and their time spent seeing patients will depend on the type of setting and the budget of the organization. Types of compensation may include:

1. On-call pay plus case pay – Nurses receive an hourly wage (typically in line with other on-call staff at the facility) for hours of call they are available to respond when there is a patient. If called in to see a patient, they may receive time and a half for providing patient care.
2. Case pay – Nurses receive a flat rate for completing an examination.
3. Shift pay – Nurses receive an hourly wage, with shift and/or weekend differential, like other departments.
4. Court pay – Nurses receive an hourly wage from their employer for court preparation time and testimony time.

In addition to paying nurses for their time, some programs provide compensation for—

1. Cell phones
2. Certification examination costs
3. Continuing education
4. Health benefits
5. Contribution to retirement plans, etc.
6. Mileage

Compensation may be dependent on the status of the program. For instance, some programs have in-house examiners whose only responsibility is providing forensic evaluations and care. They work regularly scheduled shifts instead of on-call and are paid as part- and full-time employees.

Some facilities avoid paying call time by circumventing a set call schedule and providing emergency department staff with a list of SANEs to call who come in only if they are available. The downside of this is there may be inconsistent coverage, which reflects poorly on the SANE program and the community partners. Other programs may have a system where they call in a backup nurse when a sexual assault patient comes to the emergency department if the SANE is working a regularly scheduled shift. If a hospital uses this system, it must ensure that the SANE is not placed in the position of trying to give care to emergency department patients and the sexual assault patient at the same time.

If facilities choose not to utilize a SANE call schedule, there must be a plan in place for other available staff to address the needs of the sexual assault patient quickly and competently. It would be

inappropriate for emergency department staff to keep a patient waiting for hours or send them away without proper care because the hospital could not reach a SANE.

SANE Education

Functioning in the role of a SANE means functioning in a recognized nursing specialty, much like being an ICU, emergency department, or neonatal intensive care nurse. As such, it requires additional education to meet the minimum required expectations for practice. This minimal level of knowledge is outlined in the IAFN SANE Education Guidelines. The guidelines highlight both the required didactic as well as clinical expectations. SANE programs need to ensure that the nurses they hire meet these guidelines in order to practice in the role. Many programs hire trained SANEs to fill their staffing needs. In this instance, management must confirm the SANE training meets the expected standard. Programs may also choose to hire nurses who are not yet trained as SANEs. In this case, supporting the potential SANEs while they attend and fulfill the requirements of a course that meets the guidelines is equally important.

Many nurses will have attended the didactic portion of SANE training, but will require additional training as it relates to meeting the clinical requirements. Because most SANEs are registered nurses versus advanced practice nurses, one of the first clinical training expectations will be achieving competency in conducting speculum or pelvic exams. It is important for the manager to understand that competency is achieved at the local level. Even hiring a veteran SANE with 15 years of clinical experience requires the program to evaluate/validate that clinician's skills in order to confirm that their education is up to date and they may function independently in the role. Managers should be familiar with the specific components of the Education Guidelines.

In addition to the base education required to become a SANE, nurses and programs should be prepared to address the ongoing continuing education needs of the SANE as it relates to sexual assault care. Remaining current in the science behind the practice is an essential aspect of ongoing competency.

Preparing the SANE for Clinical Practice

Licensure: The SANE program, whether community- or hospital-based, should have a method in place to verify that newly hired staff, and those who work in the program, have unrestricted licensure to practice as a registered nurse (or the other provider levels such as P.A., M.D., or APRN). This should be completed on the date of the initial hire and be monitored annually as a component of the SANE performance appraisal process.

Preceptorship: The preceptorship afforded the newly trained or newly hired experienced SANE is a critical aspect of assessing the competency of the practitioner. Because SANE programs vary dramatically from one area to another, this can be achieved in a variety of ways. Some programs utilize clinical simulation laboratories to teach and allow SANEs to practice or demonstrate specific skills as they relate to speculum exams, history-taking, genital exams, and other methods of assessment if used in the program, such as urinary catheter insertion for hymen visualization, use of colposcopes for

magnification, photography techniques, and evidence collection. Others require a precise number of precepted sexual assault exams prior to independent practice. The key to success is outlining an orientation and preceptorship program that will work in your program while allowing for individualized competency to be determined by someone experienced in the activity being evaluated.

Privileging: This is the process used by hospitals to make sure health care providers meet acceptable standards for licensure, education, and clinical competency. If a nurse is employed by a hospital, this process is included as part of the typical employment process. If the SANE program is independent of the hospital, but provides SANE services to the hospital, the SANE may be required to go through typical employment processes, or the SANE program may contract with the hospital to make sure all employment requirements are met. The SANE program becomes responsible for making sure each nurse is licensed, carries malpractice insurance, has required immunizations, complies with HIPAA, has the proper level of education, and maintains their clinical competency. If an APRN, physician's assistant, or physician is part of the independent team that will provide patient care at the hospital, they must go through the medical staff credentialing process. When a SANE team contracts to provide care for a hospital, they usually have the hospital agree to waive any fees related to the medical staff application.

Medical Malpractice Insurance: Every nurse should be covered under a malpractice policy when providing care as a SANE. Nurses can be covered under the following types of policies:

1. **Personal policy** – This is a policy that is purchased by the nurse to cover any liability that occurs as a result of nursing practice. This policy covers the nurse no matter when or where he or she is practicing.
2. **Group policy** – Some SANE programs purchase a group policy that is prorated based on how many nurses are on the team and how many take calls at the same time. This policy only covers the nurse while working for the SANE program.
3. **Hospital policy** – Most hospitals either carry or provide malpractice insurance for their nurses. They typically cover the nurses who work for the hospital, and they may extend coverage if a nurse is doing community service work without pay.

It is important to realize that a nurse must always have insurance that covers the highest level of their licensure. For example, if a SANE program hires a nurse practitioner who is performing the same job as a registered nurse, the nurse practitioner must have insurance covering his or her licensure as an APRN. Unfortunately, this might make it cost prohibitive to provide insurance for nurses who have the highest rates of malpractice insurance, such as certified nurse midwives, unless the nurse provides their own policies.

SANE Certification: There are three types of certifications that are available to SANEs. They are—

a. Board certification through IAFN as a SANE-A®
b. Board certification through IAFN as a SANE-P®
c. State-specific certifications or credentialing (See Text Box F)

IAFN SANE-A® certification is focused on the adolescent and adult population of sexual assault patients, and SANE-P® is focused on the pediatric and adolescent populations. The Forensic Nursing Certification Commission outlines the eligibility requirements needed to sit for the exam. These requirements are reflective of other national nursing certifications in their rigor and expectations of a specialty practice. No state currently requires IAFN certification in order to practice as a SANE.

The certification examinations were designed to be taken and passed by experienced SANE nurses. They are not designed to be a test of entry-level knowledge, but instead as a professional recognition of nurses who have achieved high levels of specialized knowledge in the area of sexual assault care. While many programs encourage their nurses to become certified, it is important to understand that certification is not necessary for a nurse to give competent care or to be able to provide expert testimony in a sexual assault case.

Text Box F: State SANE Certification

As of 2017, there are eight states that require SANEs to meet a state standard of certification in order to practice in this capacity. These states are:

- Kentucky
- Maryland
- Massachusetts
- New Jersey
- New York
- North Carolina
- Oregon
- Texas

Performance Appraisal/Individual Staff Evaluation: It is very important to have an organized and ongoing evaluation process in order to have an efficient and successful program. "Performance appraisal is a process and a means of setting goals, measuring and enhancing individual and organizational performance. It also fosters professional and career development on behalf of ordinary staff members."[65]

The evaluation process should have clearly defined expectations of performance as well as timelines. The goals of the evaluation process are to provide a culture of continued development and professionalism, and should coincide with your program's goals. Each goal should meet the following criteria: S-specific, M-measurable, A-attainable, R-realistic, and T-time bound (think SMART).

The approach of the program coordinator needs to be positive and constructive.

1. **Performance appraisal** should address professional expectations, including dress, attendance, punctuality, dependability, interpersonal relationships, and the practice appraisal. Examples of performance measures include determining if protocols were followed and amended to meet a specific patient's needs, and if evidence collection was appropriate for the history obtained. Depending on the number of cases your program has, each nurse should have a minimum number of exams per year to maintain their skills. If there are few cases, simulated skills testing should be available. Set a timeline for meeting any certification requirements.

2. **Practice appraisal** should include a well-defined position description, including performance expectations and standards. When developing a practice appraisal form, take the following into consideration: psychomotor skills, interpersonal skills needed to interact with the victims, law enforcement, families, and other medical providers; and critical thinking skills needed to provide forensically sound and safe care. The coordinator/manager should meet with each nurse regularly

to discuss performance and the goals of the practice appraisal. Increase the frequency if issues arise throughout the year. Update goals if needed. There should be no unexpected conversations during the annual appraisal. If you need to remove a nurse from the program, the nurse should not be surprised.

3. **Peer Review:** SANE peer review is a process by which the chart/report, including photos, is evaluated by a group of other nurses with experience in the SANE field. Every SANE chart should go through some type of Quality Assurance/Quality Improvement/peer review process that results in feedback to the examiner. In the beginning, the medical director or the coordinator may need to provide the peer review; however, every SANE nurse in the program should participate in the peer review process. This will increase competency, knowledge, continuity in care, and improve collaboration among team members.

4. **Maintaining a Healthy Nursing Staff:** As stated in the introduction in Chapter 1, one of the important components of Duffy's **The Quality Care Model©** is the recognition of the importance of self-care for nurses. When creating or enhancing a SANE program, it is important to ensure there are resources available to the nurses who are dealing with the trauma of their patients. There are several strategies to ensure that the nurse's emotional health is maintained while working as a SANE.

   Some recommendations for addressing these issues in programs include:

   1. Provide formalized debriefing after difficult cases.
   2. Partner with employee assistance programs (EAP) to provide support during staff meetings or to provide formalized EAP counseling for staff.
   3. Partner with a community therapist to provide counseling to nurses.

5.3 Essential Documents for SANE Programs

The type of program you create will determine what types of documents you will need as a SANE program. Hospital-based programs will not need to create a separate legal entity and will not require some of the document listed below. The SAFETA website provides examples of many of the required documents.

Articles of Incorporation – These are created when a SANE program is developed as an independent legal entity. Incorporation under the laws of a state, when done properly, protects the management of the program from personal liability for lawsuits that arise from the actions of nurses or other employees. Many states have websites that will walk a business through the process of incorporation. It is recommended that you consult an attorney to make sure the program is created under the correct type of business configuration.

Contracts and Agreements – SANE programs need to create other types of contracts and agreements. These include—

1. Employment contracts for nurses, other employees, and possibly for physician consultation.
2. Scope of Services: Some programs may contract with law enforcement, prosecutors, or other agencies to provide forensic nursing services.
3. Memorandums of Understanding (MOU) With Hospitals and Agencies: An MOU is typically an agreement between a hospital and a SANE program that allows the program to provide SANE care. It spells out the responsibilities of both the hospital and the SANE program. It may or may not have the same level of legal protection and obligation as a contract. Consult legal counsel when drafting an MOU.

Policies and Procedures – These documents describe specific aspects of program administration and the care given by the SANE.

1. Personnel policies should provide guidance about the employment expectations of the SANE, including scheduling, performance evaluations, salary, benefits, and grievances. Policies should also be in place that discuss sexual harassment, workplace violence, and discrimination.
2. Patient care policies should create a minimum standard of care for the sexual assault patient. Patient care policies should be drafted in a way that allows for flexibility in order for a nurse to be able to adapt a procedure to meet the needs of the individual patient. For example, a policy may specify which forensic samples are to be collected, but the order may change depending on the situation. Strict policies and procedures that do not allow for change or adaptation may be used in a trial to question a nurse's credibility or competency.

5.4 Models of Collaborative Practice

All hospital staff who interact with patients who are victims of sexual assault should practice trauma-informed principles of care. This means being able to provide nonjudgmental and compassionate care immediately while providing options to the patient about what services are available. Staff who are in position to receive a disclosure from a victim of sexual violence (emergency department triage personnel and nurses, labor and delivery nurses, and other nursing staff) should be aware of local reporting policies and the procedures for activation of the SANE, advocacy, and other team members as directed by local protocols. This process may be more complex for minors who have experienced sexual victimization by not only peers or strangers, but also, more commonly, by relatives or caregivers. As a result, the response may not only include the SANE or forensic medical providers and law enforcement, but also child welfare. Because of this additional complexity, establishing intra-organizational collaboration within a hospital system is imperative. The collaboration may include clinical pathways that provide direction to the frontline emergency department staff, with specific instructions for who to contact under what circumstances, and clinical care sets that delineate routine labs and medications needed for victims

of sexual violence. Patients should be able to wait in a safe, comfortable space. Patients should not be denied the opportunity to void or eat pending the forensic kit. Instead, the appropriate staff should assist the victim with urine collection and store it in a forensically sound manner.

Screening for Interpersonal Violence: Requirements of the Joint Commission

The Joint Commission, an accrediting organization that oversees health care organizations and programs in the United States, includes a standard (Standard PC.3.10) for the identification of victims of abuse who may present to any area of the facility. There should already be a facility-wide policy or criteria developed/in use for identifying these victims. SANE program managers may be instrumental in developing, instituting, and educating staff on the policy and the implications of trauma on patients who are treated in the facility.

There are seven elements identified in Standard PC.3.10:

1. Each hospital must develop or adopt criteria for identifying victims of:
    - Physical assault
    - Rape
    - Sexual molestation
    - Domestic abuse
    - Elder neglect or abuse
    - Child neglect or abuse
2. Hospital staff must be educated about abuse and neglect. All staff should be able to screen for abuse and neglect.
3. Each hospital must maintain a current list of service agencies and organizations.
4. Screening for abuse and neglect must occur on an ongoing basis.
5. Suspected victims of abuse or neglect must be assessed.
6. All cases of abuse, neglect, or exploitation must be reported to outside agencies as mandated by hospital policy and applicable law.

All cases of abuse or neglect must be reported immediately within the hospital.

Rationale—

- Victims of abuse may not voluntarily disclose abuse.
- Abuse may not be obvious.
- Assessment of victims must preserve evidence and support future legal action.

5.5 Collaboration in the Facility Where Care is Provided

There may be opportunities for the SANE program management and staff to work with other departments within the facility to assure that these standards are being met and that patients have the response necessary to ensure that they are treated compassionately and in a trauma-informed manner.

1. Triage/intake staff should all be aware of the steps necessary for activation of the SANE (if there is an on-call or call-in system involved). Triage staff should ensure that the patient has a private, safe place to wait, if necessary. Patients with a complaint of sexual assault should be treated as emergency patients and triaged accordingly. Triage staff should be aware that their role is not to investigate the sexual assault (questions should be limited in this area), per jurisdictional protocol. Triage staff should be aware that police are not to be notified as a matter of course, unless the patient is requesting that notification be made from triage.

2. Emergency department staff nurses should also be aware of the medical screening procedure for sexual assault patients and any duties that the emergency department staff is responsible for in providing for emergency treatment needs of the patient while addressing the need to preserve forensic evidence.

3. Emergency department physician staff should also be aware of their role in the care of the patient who reports sexual assault for medical screening, acute injury assessment, intervention, as needed, and the exam protocol. Emergency department physician staff may also be available to consult when the patient's needs exceed the level of care the SANE is able to provide.

4. Child abuse pediatricians, when available, may be able to care for the pediatric/adolescent populations. There should be protocols in place to assess the need for an acute or chronic child sexual abuse examination, per jurisdiction protocol; however, it should be clear that there may be a need for direct intervention by the SANE, in concert with advocacy, when an acute suspicion of child sexual abuse arises, no matter when it occurred.

5. Mental health crisis workers can offer valuable services to the patient in the aftermath of the acute assault. Those services include working with SANE staff to assure that an adequate safety plan is in place for discharge and assisting with the crisis needs of family members, as well as addressing the mental health needs of the patient. Sexual assault impacts the body, mind, and spirit of the patient, which is important to remember when providing trauma-informed, patient-centered care. SANE programs may involve mental health crisis workers at any point in the examination process, and mental health staff should be familiar with the program protocol and team members. Involving this group can also be an effective way to see if your team members are meeting their own mental health needs after a particularly difficult case. They may be willing to interact with the team on a broader basis for staff meetings and personal needs.

6. Social workers may serve dual roles to arrange for housing or transportation and fill the mental health crisis worker role in some settings.

7. Child life specialists can be employed to prepare children for examination procedures and to provide distraction during the examination. They are also useful to occupy the patient while the SANE is talking to caregivers or other team members.

8. The SANE program should work with the billing office to make sure patients are not billed for their medical forensic examination in violation of VAWA. The billing office also needs to be sensitive about sending any statements to patients who may not want to disclose their assault to a spouse or a parent.

9. The medical records department is involved in maintaining and storing records or photographs. The medical records department should also be involved during the creation of policies regarding the release of records.

10. The department responsible for assessing risk management should review all policies and procedures that involve patient consent and release of information.

5.6 Interdisciplinary Collaboration Outside of the Facility

Collaborations with other professionals and with community organizations are an essential part of SANE program development. This topic is covered in Chapter 8.

Factors that Impact Initial SANE Selection	Specific Concerns
A psych nurse has applied for a SANE position. Should this nurse be hired?	Many programs require emergency or trauma experience before hiring someone to work as a SANE. This may be important in a setting where patients frequently need additional types of trauma care. At the same time, a nurse with a psychiatric or maternal child health background may be able to provide specialized knowledge to the SANE program that can improve care to all patients. If you are in a community setting, the nurse needs to be able to identify which patients might require a higher level of care. Triage and transfer need to occur before there is a critical need. Nurses in these settings need good assessment skills and enough experience to know when a patient might need to be transferred to a hospital setting. It is equally important to have policies that outline when physician intervention or transfer are necessary. In addition, the job description should identify what skill sets are essential (e.g., phlebotomy or microscopic examination).
Will nurses be allowed to work another job while working as a SANE?	Like all other nursing jobs, the SANE needs clear guidelines about call and shift expectations, preferably prior to hiring. Many programs expect a nurse to be able to work 3–4 hours after their shift ends in order to finish a case they started during their scheduled shift. This means a nurse cannot plan to cover a shift from midnight to 6:00 a.m. and then plan to go to another job at 7:00 a.m. Some teams have the nurse from the next shift start answering calls that come in during the last half hour of the previous shift. Shift change should be determined by safety and quality issues relating to patient care, the ability to maintain proper chain of custody of the evidence, and the individual patient's needs.

Factors that Impact Initial SANE Selection	Specific Concerns
What if the victim has a preference for an examiner of a specific gender?	It is important to recognize that the sex of the SANE is not as important as their ability to provide compassionate care to promote the healing and resilience of the patient; however, programs should accommodate patients' requests for responders of a specific sex throughout the exam whenever possible, and as consistent with applicable laws. For a variety of reasons, some patients may prefer to work with a male or female law enforcement official, advocate, and/or examiner.
What should happen if a nurse applying for a job as a SANE discloses a history of sexual assault or sexual abuse?	With 1 in 3 women and 1 in 5 men having a history of sexual victimization, many SANEs will be survivors of some type of sexual assault or abuse. There are two issues that need to be discussed with the nurse. First, the nurse must understand that self-disclosure to a patient is never appropriate because this changes the episode of care from patient-focused to nurse-focused. The nurse should fundamentally understand that her/his victimization cannot be generalized to the patient's experience. Second, the nurse needs to consider whether they will be able to perform their job safely and accurately if they experience a trauma response. Being a previous survivor should not prevent a nurse from working as a SANE.
I have a nurse applying for a job whose spouse is a sex crimes detective for the community. Is that a conflict of interest?	If your program is in a small, rural community, potential conflicts of interest are inevitable. Nurses in **all settings** must maintain patient confidentiality. If you have concerns about a conflict of interest, consult with the prosecutor and the human resources or legal departments of the facility.

Chapter 6: Program Operational Costs and Funding

The purpose of this chapter is to identify the financial requirements for starting and sustaining a SANE program. This section will guide the SANE program through creating a budget and learning how to identify sources that may provide funding.

Chapter 6 Subsections:

Go to Chapter 7: Identifying Essential Components of a SANE Program

6.1 Determining Funding Needs and Creating a Budget

One of the most important steps in starting a SANE program is creating an operating budget. The budget

provides the overview, encourages finding effective ways to address money issues, fills the need for required information (funding proposal, rationale, and reports), and facilitates discussion of the financial realities of the program or organization.

If the program is hospital-based, the office of the chief financial officer may create the budget, but the program manager should have input on what is included. The budget should be defined as either a stand-alone cost center or part of a larger department's budget (e.g., the emergency department). If starting a community-based, free standing, or entrepreneurial SANE program, budget creation is a critical step in the feasibility evaluation of the project.

The budget should include both startup and annual costs and revenue. Many startup expenses, such as capital equipment, occur initially and then not again for several years. One option is to include the startup expenses in the first year's budget. In this instance, note which expenses fall into the one-time-only versus annual category.

Budget creation is typically based on "conservative estimation." [66] When creating the startup budget, establish your available capital. Available capital may be in the form of grants, donations, and upfront money promised by the institution. In many instances, reimbursement may already be established and ongoing, but if the program is truly just beginning, it may take some time before it begins to receive reimbursement for services.

Identify all of the anticipated startup costs, as well as ongoing expenses. These figures may be estimates or based on actual numbers from previous years.

Conservative Estimation

When preparing a budget, try to be as accurate as possible. Always use actual figures if you have them, and when you don't, estimate conservatively for both expenses and income.

When you estimate expenses, guess high. For instance, take your highest monthly phone bill and multiply it by 12 rather than taking an average. By the same token, when you estimate income, guess low, using the smallest number realistically possible. Estimating conservatively when you plan your budget will make it more likely that you stay within it over the course of the year.

Startup Expenses

Initial purchase of durable equipment is reflected in the initial startup costs. All equipment over capital budget in cost will require replacement planning in future year budgets based on the anticipated lifespan of the equipment. Additionally, maintenance costs for capital equipment should be reflected in subsequent budgets. The following is a list of possible equipment to anticipate:

- Exam table/stretcher that is accessible for all patients
- Colposcope
- Digital camera
- Alternate light source
- Computer with a secured server

- Copy machine
- Swab box/dryer
- Refrigerator for temporary storage of evidence

Not all of the equipment listed is required in a program. Some programs may choose to begin on a smaller scale with regard to equipment, setting specific annual equipment goals.

Ongoing Annual Expenses

Personnel

Salaries for part- or full-time, on-call, and per diem staff, including benefits at the appropriately designated rate for the institution, should be identified. Salaries should be based on formulas utilized institution-wide for other specialty nursing services (e.g., call rate). Benefits for full- and part-time employees range from 25–40 percent of the annual salary and should be figured in to overall expenses for personnel. Malpractice insurance would typically be provided by institutions hiring full-time, part-time, or per diem SANEs, whereas institutions contracting out for SANE services would typically expect the SANE contractor to carry her/his own insurance. Court preparation and testimony time would generally be considered paid time by the institution.

Disposable Equipment

Equipment that is considered disposable, but is required on a routine basis in order to provide services effectively, should be calculated into the budget expenses. This would include supplies such as disposable speculums, lubricant, toluidine blue dye, urinary catheters, bags for evidence, labels, swabs, evidence collection kits, urine collection kits, blood drawing equipment, rulers or measuring tapes, CDs for giving photographs to law enforcement, medications, sheets, blankets, and patient clothing.

Facility Expenses

Facility expenses include rent/mortgage for office space and examination space, utilities (electricity, phone, Internet, TV), office supplies, cleaning services and supplies, security services, general facility insurance, and maintenance.

Expenses Related to Providing Accessibility to Patients With Disabilities

In hospital programs, equipment related to items such as adaptive aids or American Sign Language (ASL) interpreters may be part of the overall hospital budget. For community-based programs, budgets should consider interpreter costs and possibly structural changes to a facility to make it accessible for all patients. The average cost for an ASL interpreter is $55 to $65 per hour, with a minimum of two interpreters required in a team-interpreting format.

Expenses Related to Providing Interpreters to Patients With Low English Proficiency

All programs should include the costs of providing interpretation services for patients with low English proficiency (LEP). It is important to always use certified interpreters and to never rely on family members to interpret. Language lines and video conferencing services can provide interpretation when in-person interpretation is not possible.

Educational Expenses

If the program covers educational expenses, they may include training for SANEs, ongoing continuing education, and certification costs, plus travel, lodging, and per diem.

Determining Program Revenue

The revenue should be based on realistic projections of patient volume and expected reimbursement rates. This is often estimated from historical data on the number of cases and number of patients served. This is where to include startup money, annual stipends/donations, revenue from benefits/donors, and grant awards. Revenue should be estimated using insurance or crime victims' compensation reimbursement based on expected census and other sources of potential revenue/income.

It is important to understand that there may be a delay from the time a program starts seeing patients until it begins receiving revenue. Having adequate funds to operate for 3 to 6 months until revenue is available is an essential part of program development. Once a program is established, it is advisable to create a reserve account containing 3 to 12 months of funds to pay operating expenses to keep a program from closing in case of an emergency. For example, cuts or freezes in the budget may stop or limit sources of payment for a period of time.

Reducing Need for Revenue With In-Kind Donations

For community-based programs, in-kind donations may be an alternative for funding program expenses other than salaries. For example, community businesses may be willing to donate office supplies, clothing for victims, or food for patients or staff meetings. Programs may be able to receive donated office or examination space from another organization. Hospitals may be willing for community-based SANE programs to obtain equipment, such as examination beds, from a surplus facility.

Conclusion

When creating projected subsequent year budgets, try to include a 2–4 percent cost of living increase for all expenses. The key to any budget is that it is realistic and appropriately represents all potential expenses and income for the program.

6.2 Financing Your Program

All programs should have income that results from the services they provide. In addition to revenue generated from services provided, SANE programs may need to look to other sources for funding.

Billing for Care of Sexual Assault Patients

SANE programs typically have three options for billing directly for services, but different options for reimbursement may exist in your state. SANE programs can bill a patient's health insurance company. All billing of insurance companies must be in compliance with VAWA regulations. As discussed in Chapter 4.2, under the Violence Against Women Act (VAWA), states must certify, as a condition for certain grant funds, that the state or another governmental entity bear the "full out-of-pocket costs" for medical forensic examinations. Although it is allowable for states to help fund the examinations through billing of a victim's personal insurance, OVW strongly discourages states from requiring victims to use their insurance. In some cases, insurance billing can present a hardship for victims. For example, a victim of spousal rape may not want her husband to find out that she got a forensic exam. If the victim is forced to submit the claim to her insurance company, and she is on her husband's insurance policy, he may receive a statement from the insurance indicating that she got the exam. In addition, billing departments need to ensure that victims do not receive bills for any out-of-pocket costs, such as copayments or deductibles.

In some states, programs may be able to bill the state Crime Victims Compensation program directly. State and federal monies derived from fines paid by convicted criminals fund these programs. The funds are used for victim services and to compensate victims for some losses that occur as a result of a crime.

In some jurisdictions, law enforcement or prosecution may pay for the evidence collection because they view it as a law enforcement function.

Billing and Coding Practices

In order to bill both insurance companies and victim compensation funds, the SANE program may need to provide itemized bills using standard health care billing practices. This means proper International Statistical Classification of Diseases and Related Health Problems (ICD-10), coding of charges. A list of ICD-10 Codes can be found at the end of this chapter.

Other Sources of Earned Income

SANE programs may provide other services that can be billed. Two common services are suspect examinations and expert witness fees.

1. **Suspect Examinations**

   These types of examinations fall outside the SANE's scope of victim sexual assault examinations. Existing laws and statutes may not cover suspect examinations in the same manner

as examinations for victims. If the SANE program is involved in suspect collections, a fee schedule and a payment process should be discussed with the law enforcement or prosecuting agency requesting the examinations.

2. **Expert Witness Fees**

   Because of their unique skills in administering forensic exams, SANEs are sometimes asked to provide court expert witness testimony and case consultation. This assistance may be requested by either a prosecuting agency or defense counsel, and could be outside the scope of their existing employer. When considering this type of potential work, it is important to remain within the individual's field of expertise. If employed by a medical facility, the SANE should take steps to advise their present employer of any involvement in court testimony or consultation. Depending on how this service is provided, the team may be paid for the nurse's services or the nurse may be reimbursed directly. It is important to make sure that providing testimony is not a conflict of interest for a nurse who is a member of a SANE team.

   Providing this testimony and consultation usually entails a fee schedule. There is a minimal amount of information in the public forum pertaining to fee schedule. These fees may vary from within jurisdictions as well as by the scope of the testimony and consultation requested. Any compensation should ultimately be determined by the nurse's work, education, certification, and experience.

Fundraising

If you are part of a hospital-funded program, then fundraising may not be a significant part of your program development. For community-based programs, fundraising is a critical component as the program identifies how to purchase equipment, provide nursing education, and fund basic administrative costs. Once a program is established, fundraising fills the gap between what the program earns by billing for the examination and the actual program costs. It is important to know if there are people who need to grant you permission if you want to do fundraising. For example, in a tribal community, tribal leaders may need to grant permission to raise money. SANE programs need to understand that they are part of a larger community, and should be aware when there are limited dollars for social programs, so their fundraising may impact the ability of other organizations to provide services. For example, a community fund might be willing to contribute to the SANE program, but only if they cut existing funding to rape crisis services and the Children's Advocacy Center. It is important to work with community partners to avoid creating an atmosphere of competition for limited funds.

Getting Started – How Will You Ask for Money?

Before you can ask for money, you need to have some sort of corporate entity established that can accept the money. Most corporations or foundations will not give to an organization unless they are recognized as a not-for-profit, tax-exempt organization by the Internal Revenue Service (IRS). It can

take 3 to 6 months or longer to receive approval from the IRS after an application is submitted. If you are part of an existing nonprofit, such as a rape crisis center, you will need to work closely with them to see if they will allow donations for your program to be designated for your use.

It is possible to use another organization's tax-exempt status to raise funds for your SANE program initially. This concept is called a fiscal sponsorship. It is both helpful and recommended to have legal counsel during the process of creating your nonprofit and if you decide to create a formal relationship with an existing nonprofit. There are also many web-based organizations with free information about starting nonprofits and fundraising in your community.

In addition to obtaining tax-exempt status, 40 states require charitable organizations to register with the state before they can solicit individuals for funds. A SANE program that serves more than one state will need to register in all states where they plan to solicit donations. If a program solicits donations on a website, they may be required to register in all 40 states.

Sources of Fundraising Money

1. **Events**

   Depending on how much money you need to raise, fundraising events can serve a dual purpose. They can bring in donations while raising awareness about the issues surrounding sexual assault and the need for a SANE program at the same time. Events typically do not raise a lot of money for the amount of time and expense required to organize and hold the event.

2. **Community Clubs and Organizations**

   Sponsorship from a community organization can raise money without a lot of time or expense on the part of the SANE program. Many community organizations, including fraternal, service, and religious groups, may provide funds for a specific piece of equipment or other needed items, such as teddy bears to give to children during an examination or clothing for a patient to wear home after evidence collection. Service clubs will often hold events in the community and donate the proceeds to other organizations. Volunteering to talk to a monthly meeting of a club or organization is a good way to develop a relationship that can be a source of funding and increase community awareness.

3. **Private Grants**

   Grant writing to private foundations is another source of funding. It is important to make sure the foundation provides funds for your type of program. For example, there are some foundations that only provide money to the performing arts or scholarships for college students. Make sure you complete any requested forms and meet all application deadlines. All foundations are required to file IRS 990 forms, which can be searched online. Looking at a foundation's 990 forms will let you know what types of causes they give money to and what is a typical amount donated to any one cause.

4. Federal Grants

In addition to private grants, there are federal sources of money for SANE program development. As of 2017, the Office on Violence Against Women (OVW) administers 24 grant programs authorized by the Violence Against Women Act (VAWA) of 1994 and subsequent legislation. Four programs are "formula," meaning the enacting legislation specifies how the funds are to be distributed. The remaining 20 programs, including 6 formerly authorized programs that still have open and/or active grants, are "discretionary," meaning OVW is responsible for creating program parameters, qualifications, eligibility, and deliverables in accordance with authorizing legislation.

Please see the OVW website for more details on each program. You can also review past years' solicitations for an idea of what you will need to prepare in order to apply. For formula grants, you can apply for subgrant funding through the state administering agency.

The Office for Victims of Crime also provides federal funding to the states in the form of Victim Assistance Formula Grants. Check with your state VOCA funds administrator to learn how to apply.

5. Nonprofit Hospital Community Benefit

If your program is either nonprofit hospital-based or in a community with a nonprofit hospital, funds may be available as part of the hospital's community benefit program. Under the Affordable Care Act, nonprofit hospitals are required to perform a community needs assessment every 3 years. Find out how this is done in your community and if sexual violence programs and services are part of the assessment. Once an assessment is completed, the nonprofit hospital must use a certain percentage of its funds to meet these community needs. Many nonprofit hospitals also have a foundation where SANE programs may be able to apply for money.

6. In-Kind Donations

Many community businesses may not be in a position to donate money, but may be willing to donate their products or services. Everything from carpet cleaning to office supplies are one less expense for a SANE program budget if donated. It is also a way to educate and engage the community about your program and other sexual violence issues.

7. Funding Programs in Tribal Communities

The United States Government has a legally defined responsibility to provide health care to American Indians and Alaska Natives. Health care services are provided through facilities managed by the federal Indian Health Service (IHS), through facilities managed by tribes under contract with IHS and urban Indian health programs.

The IHS Domestic Violence Prevention Initiative (DVPI) has funding available to develop and implement a SANE program and a Sexual Assault Response Team. Receiving funding through a

DVPI grant involves a competitive application process. Federal IHS facilities, tribes, tribal organizations, and urban Indian health programs are eligible to apply.

Additional funding opportunities may also be available, and creative funding options such as fundraising should be considered. Federal IHS programs must have all sources of funding approved through the regional IHS area office, as well as IHS headquarters. Federal IHS programs should also ensure that sources of funding are acceptable and approved by tribal leadership. Tribal organizations may have more flexibility with funding sources but, similar to federal IHS programs, all sources of funding would need approval by tribal leadership.

ICD-10 Codes:

- Confirmed abuse, neglect and other maltreatment, confirmed (adult and child)
- Confirmed abuse, neglect and other maltreatment, suspected (adult and child)

Chapter 7: Identifying Essential Components of a SANE Program

This chapter looks at the patient care aspects of a SANE program. There are many existing resources to help with this part of the process. Start with a review of the National Protocol for Sexual Assault Medical Forensic Examinations, which will provide a good foundation for this stage of SANE program development.

NOTE: References in this Guide to recommendations in the *National Protocol for Sexual Assault Medical Forensic Examinations* reflect the recommendations published in 2013 and may not reflect the recommendations in the National Protocol published in 2024.

Chapter 7 Subsections:

Go to Chapter 8: Multidisciplinary Response and the Community

7.1 Identifying and Defining Populations Served by the SANE Program

While every program cannot serve every patient population, every door should be open. No patient should hear "It's not my job" from a provider. Patients may need to be provided referrals if they are not served by the program (e.g., pediatric patients), but all members of the team and the emergency department staff should know the protocols of who can be served and where to refer someone if needed.

Patients may require triage and treatment of certain medical concerns beyond the capacity of the SANE program. This may be more applicable to community-based programs. In hospital-based programs, most of these services should be readily available. Medical evaluation and treatment of strangulation, provision of HIV prophylaxis, and ability to treat vaginal trauma, while not needed for every patient,[67] are services that should be readily available to all sexual assault patients. For cases when those services are not available, or for community-based programs, establish memorandums of understanding (MOU) with specific agencies and develop mechanisms for a timely transfer of patients to those locations.

Triage and treatment of medical concerns beyond sexual assault—

Pregnancy. Patients may find out they are pregnant during the medical forensic examination, or may already have a viable pregnancy at the time of their assault. For the most part, pregnant patients do not need any different treatment. The program should have predetermined medication and HIV prophylaxis protocols that are safe for the pregnant patient and fetus. Genital examinations can proceed as usual; however, use caution in the second/third trimester patient with vaginal bleeding. An examination in conjunction with an obstetrical provider is warranted. Also, a patient past 20 weeks gestational age with trauma, abdominal pain, or contractions should be sent for an emergent obstetrical evaluation. Sometimes, the patient may report to Labor and Delivery for evaluation and disclose the sexual assault. The SANE may be called to the unit to perform the medical forensic exam.

Mental health/suicidal patient. People with underlying mental illness can be victims, and actually may be victimized at a higher rate than others. Rape and sexual assault may induce suicidal ideations in any patient. Patients should be evaluated for suicidality and referred to appropriate services (emergency department, crisis response center, etc.). A difficult situation is the patient with mental illness who repeatedly makes unsupported claims of sexual assault. These patients require a multidisciplinary team approach to their problem.[68]

ICU/Trauma. Patients may suffer serious medical illness and/or traumatic injuries that require ICU admission or trauma center evaluation. In programs where the medical screening exam is performed by the SANE, the presence of certain complaints or mechanisms of injury may require medical evaluation by emergency department or a trauma surgeon. For these patients, their medical/traumatic needs take

priority over their forensic needs. The medical forensic examination should be deferred until the patient is stabilized. Some programs may elect to do a simple, modified exam prior to procedures/surgical interventions and then do a more thorough examination after stabilization. A coordinated team approach is required and a written protocol should be in place to explain this process. The SANE nurse may be called to the ICU, OR, or inpatient unit to perform an evaluation.

Unconscious. Unconscious patients provide a difficult challenge to the SANE program.[69, 70] An unconscious patient is unable to give informed consent for the exam, provide an assault history, or actively participate in the exam process. Because valuable evidence may not be properly identified or collected and may be inadvertently destroyed by therapeutic intervention, time, and bodily functions, an examination should be performed as soon as possible. Some would argue that no exam (particularly pelvic/genital) should be performed on the unconscious patient, as doing so would violate their autonomy and right to self-determination, but also that it is a second assault on the patient and their body. Others argue that the examination is no more invasive than other procedures that can be emergently performed on a seriously injured patient, and there is often no consent process for those procedures (central line, laparotomy, craniotomy), and that most victims would want the opportunity to have the evidence collected.

Some states have specific statutes that address the issue of performing a sexual assault medical forensic examination on an unconscious patient, but the majority of states do not. A program should have a specific policy and protocol for SANE examination of an unconscious patient in order to protect the institution, program, SANE, and most importantly, the patient. Options include: (1) deferring an exam for a period of time, waiting to see if patient regains consciousness; (2) deferring an examination until a surrogate decisionmaker/legally authorized representative (LAR) is identified (spouse, parent, sibling); (3) not performing an examination at all if consciousness is not regained; and (4) proceeding with the medical forensic exam and holding the evidence until the patient or designated LAR provides consent for police involvement and release of information.

As stated in the National Protocol for Sexual Assault Medical Forensic Examination, "Examiners should develop policies and procedures for providing sexual assault care to the unconscious patient. Such care should respect the autonomy of the individual and be consistent with jurisdictional interpretations of emergency exceptions to informed consent."[71] When developing a protocol, input from the district attorney, hospital counsel/risk management, and/or an ethicist may be sought. If a patient is incapable of providing consent for a period longer than 5 days, thereby creating a real time conflict about examining an unconscious patient, risk management or the hospital ethics committee should be consulted.

Incapacitation. Patients may be incapacitated for a number of reasons, and the incapacitation may be permanent, long-term, or short-term. Patients with permanent or long-term incapacitation often have a designated power of attorney, LAR, guardian, or family member to give consent for the examination. More frequently, incapacitation is short-term, from alcohol, drugs, or mild injury. In these cases, it is appropriate to wait until the patient regains the capacity to consent to and participate in the process.

Pediatric Non-Accidental Trauma and **Elder and Vulnerable Adult Abuse**. Some patients may present with findings indicative of physical abuse or neglect, at which time a history or physical exam

may suggest sexual victimization. Conversely, patients may present with concerns for sexual victimization and findings of physical abuse or neglect may be discovered during the evaluation. Therefore, it is important that medical professionals coordinate the evaluation and care of these patients, regardless of the setting (inpatient versus outpatient). Child abuse pediatricians, emergency medicine, or other medical providers and SANEs may have shared responsibilities for these patients. Institutional policies and procedures and/or MOUs should be implemented to make such cases as seamless as possible. If physical abuse or neglect is suspected, the SANE should report the findings to child welfare in accordance with the local mandated reporting laws. Of course, the medical needs should always be prioritized over the forensic medical exam and collection of evidence.

Consultation with other providers. A consultation with other providers may be required at some time during the evaluation of the patient. Examples of specialty care that may be consulted include gynecology if there is vaginal or cervical trauma, infectious disease if there are problems prescribing HIV prophylaxis, or psychiatry if there are significant mental health concerns. In hospital-based programs, this is often accomplished by calling for a consult with the specific specialty provider. Other programs may find the easiest solution for urgent referrals is to send the patient to an emergency department for evaluation by a specialist. These programs should have specifically designated referral hospitals. Which hospital to use depends on the patient's needs. Outpatient referral may be appropriate, and all efforts should be made to assist the patient in getting a followup appointment.

There are some common referrals that patients need following a SANE evaluation. For these services, the program should have specific referral patterns, and those providers should know that they will be receiving referrals from the SANE program. An MOU may be required. These referrals usually include, but are not limited to—

- Rape crisis center
- Social services agency
- HIV N-pep follow up. All programs should be able to provide immediate access to HIV medications, but may refer patients for the ongoing care required during the 28-day treatment period (public health, infectious disease, immunology)
- Medical follow up
- Victim service providers

7.2 Options for Reporting

As part of the informed consent process program, a nurse should be able to explain to the patient his or her options for reporting. Options may vary depending on the age of the patient, jurisdiction of where the assault occurred, and whether or not there are mandatory laws for reporting sexual assault.

Violence Against Women Act (VAWA) reporting requirements

Victims must have access to the medical forensic examination without having to cooperate with law enforcement. Whether or not a victim cooperates with law enforcement, no out-of-pocket expenses that result from the forensic examination can be billed to the patient.

Under VAWA and subsequent legislation, states must ensure, as a condition of certain grant funding, that victims have access to medical forensic exams and that those exams are paid for without regard to cooperation with law enforcement or the criminal justice system.

Some states meet this requirement through a system of "blind or anonymous reporting," where the case is assigned a number rather than the victim's name, and the victim is given the number to use if he or she wants to report the case to law enforcement at a later time. Reporting the crime is not required so long as the victim has access to the exam.

Mandatory Medical Reporting Requirements

Some states have mandatory medical reporting requirements for sexual assault cases that go beyond the mandatory reporting laws for vulnerable populations such as children, elder adults, and persons with disabilities. These laws are compliant with the VAWA provision because the medical provider making the report is not requiring victim cooperation with law enforcement. The victim/patient should still be informed that the medical provider is mandated to report by state law.

1. While military commanders initially insisted they be notified automatically when a member assigned to their command is sexually assaulted, since March 2005, the military has provided the option for members to make a Restricted report, where commanders and law enforcement are not notified of the identity of the victim. The only official notification, for documentation and data collection purposes, is that within 24 hours of a report of sexual assault, the Sexual Assault Response Coordinator must notify the Senior Commander of the assault without providing the person's name or personally identifiable information. A sexual assault victim in the military can convert their reporting option from Restricted to Unrestricted at any time. The only consideration is that the SAFE kit is only retained for 5 years.

2. Campuses may have mandatory reporting for campus employees under the campus definition of Title IX requirements.

7.3 Before the Examination Begins – Providing Patient-Centered Care

Sexual assault patients should be treated as emergency cases.[72] Acute injuries, trauma care, and safety needs of the patient should take priority before or in concert with the medical forensic examination. Several steps should be taken to reinforce to the patient that their needs come first. The patient should be

asked who they want to remain in the room during both the history-taking and the examination. It is preferable, however, to have only the advocate in the room during the history so the patient is able to speak freely and honestly. Where available, patients should always have the option to have a victim advocate present. It is important to identify any needs that the patient might have prior to starting an examination. This may include everything from arranging child care to taking a few minutes to smoke a cigarette. Examination protocols need to be flexible enough to protect important evidence while meeting the immediate needs of the patient. For example, the nurse can collect oral swabs and then let the patient eat before starting the examination or obtain a urine sample first if drug-facilitated sexual assault is suspected.

7.4 Informed Consent and Patient Confidentiality

Informed consent and patient confidentiality are legal concepts that are usually defined by state laws. For legal purposes, it is important to obtain consent for health care. The health care provider should be the one who obtains informed consent. The victim advocate can play an important role in assisting the patient during the consent process, but should not be delegated the role of obtaining informed consent. In order to provide patient-centered care to the sexual assault patient, each patient should have all steps explained in a developmentally appropriate manner and have an opportunity to cooperate or decline any or all parts of the examination. Even patients who do not have the legal ability to consent should give their assent to a medical forensic examination. It is also important to recognize that informed consent is a process—it is not just completed when the patient signs a formal consent form. Informed consent should be an ongoing process throughout the examination. The patient should be aware that they are able to decline any procedure or any part of the examination at any time during the examination.

While informed consent and patient confidentiality are essential parts of the provision of all health care, in the sexual assault setting there are three special considerations:

a. Is the patient able to give informed consent, and is the patient entitled to confidential care?
b. Does the patient understand the role of each member of the team and whether or not the information disclosed to a specific team member is protected from further disclosure?
c. How does trauma impact the ability of the patient to understand the long-term implications of consent given at the time of the examination?

Under what circumstances does a patient have a legal right, under state, federal, or tribal law, to provide consent for health care?

- Typically, patients who are 18 years or older and can legally consent for all aspects of care.
- Adolescent patients may be able to consent to specific types of health care:
    1. Reproductive health care
    2. Sexually transmitted disease treatment

3. Mental health treatment
4. Alcohol or substance abuse treatment

- Children usually require the consent of their parents in order to obtain a medical forensic examination. In some states, the consent of the parent may not be required if the parent is suspected of being the perpetrator of the assault. In that situation, the state may take custody of the child and give consent for the examination. In any case, a patient should not be restrained for the examination. With an uncooperative pediatric patient, performing an exam under sedation should be considered if significant acute injuries are suspected. For patients too frightened to proceed with the examination, consider postponing the exam.

- Patients with cognitive impairment related to age or disability are legally able to consent unless they have been assigned a legal guardian. Some elderly patients may have a person who is designated to make health care decisions for them. This usually is documented with a Medical Power of Attorney. For most patients, the Medical Power of Attorney does not become effective unless the patient is incapacitated and unable to consent.

- Patients who are impaired with drugs and alcohol may be able to consent if they are able to respond appropriately to questions and physically cooperate throughout the examination.

Text Box A: Guardianship

Being granted legal guardianship is the legal process by which a person assumes the position of decisionmaker for someone who is deemed by the state to be unable to make some decisions. Understanding guardianship is essential to any program committed to serving people with disabilities. Terminology for guardians differs from state to state and may include conservators and curators. In general, guardianship can be imposed over a person, their estate or finances, or both. Each level of guardianship has unique implications for a person's ability to consent to and receive services from a SANE program independently, from a limited decisionmaking ability to a broader authority.

It is common for staff in human and medical services to assume that people with disabilities who have guardians cannot make any decisions on their own behalf. This creates barriers for several reasons. The patient may not feel comfortable disclosing sexual violence to his or her guardian, the guardian may be the offender, or the staff may wait for the guardian's consent for delivering crisis intervention, which delays services. Moreover, when people with disabilities have a guardian who has full authority, there are often legal exceptions to requiring a guardian's consent in matters involving crisis intervention and health and safety. Having a guardianship policy allows programs to delineate their states' guardianship laws and the different levels of guardianship that staff should explore while also providing expectations about service provision when a guardian is present.

What types of informed consent are required for a medical forensic examination?

1. Consent to perform an examination and collect forensic evidence.
2. Consent to provide treatment for STI and pregnancy prophylaxis.
3. Consent to take photographs.
4. Written authorization to release information and other items, such as a sexual assault evidence kit and clothing, to other members of the Sexual Assault Response Team (SART).

- An unconscious patient cannot consent, but a SANE program should have in place a protocol to obtain consent from another person (family member or court order from a judge), a protocol to obtain evidence to be held by the program until consent can be legally obtained.

- It is important to understand the difference between mental capacity and mental competency. Whether or not a person is competent is usually a legal determination made by a judge. Capacity is the ability for the patient to understand what is happening in order to provide consent or assent to the examination process. There is no objective test for determining whether a patient is capable of providing consent or not. In most situations, capacity is assumed if a patient can respond appropriately to questions and follow directions.

Under what circumstances is information shared by a patient with a health care provider required to be kept confidential?

- Typically, information shared by an adult to a health care provider is considered to be confidential unless the health care provider receives permission to share that information. If the person receiving the information is not another health care provider, permission or authorization to share information should be in writing and signed by the patient.

- State, tribal, and federal mandatory reporting laws create exceptions to the requirement to maintain patient confidentiality. These mandatory reporting laws include:
    1. Child abuse reporting
    2. Elder/vulnerable adult abuse reporting
    3. Infectious disease reporting
    4. Injury reporting
    5. Duty to warn if a patient is threatening themselves or others

- Adolescents may be able to obtain confidential care under specific circumstances:
    1. Reproductive health care, contraception
    2. Sexually transmitted disease treatments
    3. Mental health treatment
    4. Alcohol or substance abuse treatment

- Disclosures to parents or a guardian may be limited if they are the suspected perpetrator of the assault or abuse, or if disclosure would endanger the child.

- Certain types of care can have higher levels of privacy protection:
    1. Mental health treatment

2. HIV/AIDS treatment

When are disclosures or statements made by a patient confidential?

Part of obtaining informed consent is notifying the patient what information will be shared with other members of the team and what information will be kept confidential. SANEs should inform their patients who the information collected as part of the SANE examination will be shared with law enforcement. The nurse should obtain written authorization to make those disclosures. If a patient does not authorize release, the nurse should maintain patient confidentiality unless a mandatory reporting law requires the release of information. If a mandatory reporting law applies, only the information specified in the law can be released without the consent of the patient.

In many states, community-based rape crisis advocates can have a confidential relationship with the patient. This means that if a patient speaks privately with a rape crisis advocate and does not want the information disclosed to anyone else, the advocate cannot disclose that information. Frequently, there is information that a patient may be fearful about disclosing. For example, it is not unusual for a patient to be afraid to disclose information about consensual illegal substance use that occurred prior to an assault. When given an opportunity to talk about this with a rape crisis advocate who can have a confidential conversation with the patient, the victim can then be reassured that they will not be charged for using an illegal substance, if that is the policy of the law enforcement agency. When providing care to elderly patients or patients with cognitive disabilities, confidentiality with a rape crisis advocate may be limited if mandatory reporting laws require disclosure of abuse or neglect. It is important for SANE programs to know in advance what laws apply to different circumstances in order to be able to explain to the patient what information can be kept confidential.

Privileged communication is defined as a special relationship between two people that allows for confidentiality. The law recognizes that there are certain relationships where communication should be considered private or privileged. These typically are those between husband and wife, clergy and communicant, doctor and patient, and attorney and client. Again, mandatory reporting laws may supersede these relationships.

Military

Confidential communications are oral, written, or electronic communications of personally identifiable information concerning a sexual assault victim and the sexual assault incident provided by the victim to the sexual assault response coordinator, victim advocate, or health care (medical and mental health) personnel in a Restricted report. This confidential communication includes the victim's Sexual Assault Forensic Exam kit and its information.[73]

How does trauma impact a patient's ability to give consent?

This section contains a list of the types of consent that are needed before performing a medical forensic examination. It is important to realize that because of the changes that occur in the brain as a result of

experiencing trauma, patients are not always capable of making decisions that require complex judgment. It is common for patients not to remember the specific details of what took place during the examination. When creating a consent process, it is important to balance the need to provide care to the patient with the need to provide information to the criminal justice system. The reality is that consent for some things can take place at a later time.

Patients should never be asked if they want to "press charges" prior to evidence collection, this is typically not a decision the patient will ultimately make. As part of the reporting options discussed in Section 7.2, the patient should consent to whether or not they want to report the crime; be interviewed by law enforcement; and have a medical forensic exam with evidence collection. Only after an investigation has been completed, and the prosecutor decides there is enough evidence to file charges, should a victim be asked if they will cooperate with the prosecution of the suspect. The nurse examiner would not ask that question.

While it is important to get photographs of genital and non-genital injury at the time of the examination, the patient should not have to make a decision about releasing the photographs to law enforcement or prosecutors until they are needed to prepare a case for trial. Genital photographs usually require a medical expert for proper interpretation, and law enforcement and prosecutors can use body diagrams to understand the extent of injuries seen during an examination. Limiting consent to what is needed to obtain and preserve evidence allows the patient to have some control over a process that can seem extremely overwhelming immediately after an assault.

7.5 Medical Forensic History-Taking and Documentation of the Medical Forensic Examination

As stated in the **2013 National Protocol for Sexual Assault Medical Forensic Examinations**, "(T)his history, obtained by asking patients detailed forensic and medial questions related to the assault, is intended to guide the exam, evidence collection, and laboratory analysis."[74]

Many states have standardized sexual assault examination forms. It is important to understand that the location of a SANE program may influence the content of a standardized examination report form. For a patient evaluated in an emergency department, the provider who performs the initial medical screening examination may obtain information such as chronic medical problems and medications from the patient. While the nurse providing the sexual assault examination should review this information prior to commencing care, it may not be necessary to repeat those questions as part of the SANE's evaluation. For a SANE providing care in a community setting, obtaining a history of current medical conditions is necessary in order to give safe care. For example, if a patient has a history of a seizure disorder, the nurse will need to assess the patient for anti-epileptic medication use and the risk for a seizure being triggered before, during, or after the examination.

When creating or revising a form, it is important to decide how the information will assist in the care of the patient. Recognizing community uniqueness means realizing that different states and different

communities may create forms with different content. Members of the multidisciplinary team should be consulted during the development of a form. For example, the crime lab may use the descriptions of the type of evidence collected to determine what type of analysis will be employed. Prosecutors may use the descriptions of the type of contact described by the patient to determine what criminal charges will be filed against the suspect. While input of team members is important, the goal of a form is ultimately to assist the nurse in providing comprehensive and safe health care to the patient, which includes identifying any sites of injury or locations where medical forensic evidence can be collected.

Below is a list of suggested content for a sexual assault examination form.

1. Chief complaint – including acute complaints of pain or bleeding.
2. Allergies to medications, food, and latex.
3. Current medications.
4. Pertinent medical history, recent anal-genital injuries, surgeries, or diagnostic procedures, blood-clotting history, and other pertinent medical conditions or treatment. [75]
5. Reproductive history – LMP, vaginal deliveries, age of first menses.
6. History of assault – time, date, location, and what occurred.
7. Acts that demonstrate threats or lack of consent – use of weapon, restraints, strangulation, or verbal threats.
8. History of drug or alcohol use prior to or during the assault.
9. History of loss of consciousness or awareness.
10. Details of all physical contact, including genital or oral contact.
11. Post-assault hygiene.
12. Recent consensual sexual activity (important for issues on DNA recovery, as well as pregnancy implications for the victim).

This is not an exhaustive list, but it includes many of the topics that are typically covered by state or jurisdictional sexual assault examination forms. It is important to get enough medical history to make sure the SANE can provide safe care and treatment. For example, some nurses feel documenting the use of an antidepressant may later be used to imply the patient is mentally ill or making up the assault. As a health care provider, the SANE must put the health care needs of the patient first, and make sure the patient is not at risk for suicide or other self-harm. Knowing about antidepressant or other medication use informs the nurse with regard to risk of subsequent problems or potential interactions with medications that may be offered at the time of the exam.

Children and Patients With Cognitive Disabilities

The medical forensic history-taking of a child or an adult with a cognitive disability, like all other patients, is a critical component of the examination. In some cases, the patient may use nonverbal communication, in other cases, the child or adult may be at a developmental level incapable of obtaining a successful or accurate history of event (e.g., a child under 4 years of age), requiring the history be obtained from other parties, such as the nonoffending parent, caregiver, or other witness. While SANEs should not be held to the standard of forensic interviewers, experience and training in developmentally appropriate history-taking and familiarity with strategies to enhance understanding and engagement of people with cognitive disabilities is important.

Accompaniment During an Examination

It is appropriate to allow the patient to have a support person with them throughout the examination. Who that support person is will help determine their role in the examination.

Victim advocates. A victim advocate can provide support, and in many cases, can provide the added benefit of offering comprehensive, longer term services to aid the victim. In many communities, they are an essential component of the SART. Typically, community-based advocates are able to speak with the patient with a greater degree of confidentiality (which can be jurisdictionally dependent).

Family members. Although family members may be supportive of the victim, they should not be relied on to provide emotional accompaniment during the examination. It should be recognized that family members might also be experiencing emotional trauma and distress related to the assault. Recognize that if the patient does prefer a family member to be with them during the exam, both should be aware of the implications of that. It will be necessary to inform them that they may potentially be required to testify in criminal justice proceedings as a witness. The patient may also be reluctant to disclose the details of the assault in the presence of family members, and the patient should be informed that some of the questions asked during the exam will be intimate in nature. In some cases, the family member may be the offender. When the patient is a minor, the child should still be asked if they would like a support person in the exam room with them. As another option, the patient may want the supportive individual in the room for the exam, but not while the history is being obtained.

Personal care attendants. A personal care attendant may accompany some patients with disabilities. It should be the patient's choice whether or not the attendant is present during the examination, unless there is a concern the personal attendant is the suspected offender.

7.6 Suicide Assessment

It should be recognized that there is an increased risk of suicidal ideation[76, 77, 78] and suicide attempts[79, 80, 81, 82, 83, 84, 85] in patients with a history of childhood sexual abuse. In a study of the impact of adult sexual abuse, 12.84 percent of survivors experienced suicidal ideation.[86] One of the essential elements

of medical forensic care of the patient should include safety planning regarding suicide risk as a component of discharge planning.

7.7 Evidence Collection

The collection of forensic samples from the patient during the medical forensic examination should proceed from the medical forensic history provided by the patient and the physical examination. In some cases, the patient may be unable to provide the history (in the case of lapse of consciousness due to alcohol or drug intoxication [voluntary or involuntary]) or may be developmentally unable to relate the details.

In these cases, the collection of samples may include, as appropriate, the collection of—

- Oral swabs
- Peri oral swabs
- Swabs of the neck area
- Swabs of the breast area in the female
- Swabs of the patient's hands
- Swabs of the patient's fingernails
- Swabs of any areas of injury or that fluoresce with ALS
- Genital swabs – external genitalia in the female and male
- Internal vaginal swabs in the patient (exception for pre-pubertal children)
- Collection of any debris or foreign materials identified
- Buccal swabs or blood for the patient's DNA

Examination adjuncts may be used to assist the physical assessment of the patient. Programs may have policies to address the training needed and the use of these examination tools. They include the use of toluidine blue dye to highlight injuries in the ano-genital area, tracing the hymen, or floating the hymen.

For more information, please refer to the National Protocol - Examination Process: Exam and Evidence Collection Procedures.

7.8 Photo Documentation

The National Protocol Adult/Adolescent states that photography is an integral component of the medical forensic examination. Photographs are taken to document injury and other physical findings from the examination. These photographs should meet the facility standards of medical photography. The legal uses of medical photography may include—

- Preservation of the appearance of injury
- Documentation of evidence found on the patient's body before it is moved or collected
- Future reference or memory aid
- Documentation of the details of injury
- Permit jurors to see things as they were
- Education for nurses and other providers
- Case review/peer revie

The following considerations need to be central when developing program policies for medical legal photography.

1. **Consent** – The patient should always consent to the taking and any release of photographs. It should be clear on the consent form what the photographs can be used for, including teaching and/or peer review.

2. **Storage** – Photographic images must be securely stored and backed up. Access must be limited and trackable. Photographs should not be stored on a single computer as there must be concern over possible equipment failure, including the loss of a hard drive.

3. **Release and Transfer of Photographs –** SANE programs need to have protocols and procedures in place for the release of photographs. Because of the intimate nature of genital photographs, and the need for medical expertise to interpret the findings present in these photographs, routine release to law enforcement is not a standard practice in many communities. SANE programs need to work with prosecutors to provide protection for these images. Several options can be used to protect genital images from disclosure. First, the program can have a policy that requires the opposing medical expert to meet with the SANE to view and review photographs. Second, a judge can create a protective order that limits how opposing counsel can use the photographs. In all situations, a patient should provide consent prior to release of the photographs. While a program may be required to release photographs when ordered by a judge, the patient should still be notified in order to have an opportunity to challenge the court order if the patient is unwilling to give consent for the release.[87]

   Non-genital photographs also require patient consent for release to law enforcement. Since photo documentation of a physical injury may facilitate immediate arrest of a suspect, some programs routinely release copies of non-genital photographs to law enforcement at the time of the examination. Photographs are part of the medical record and original copies need to be maintained by the SANE program.

While photo documentation is not a *required* part of the medical forensic examination (and can be declined by the patient), it creates a mechanism for peer review of exam findings. It is the only way that

a nurse's evaluation of an injury can be peer reviewed, an essential part of SANE practice. In cases where child pornography is part of the history or disclosure, the taking of photographs may be traumatic, in which case, apply clinical judgment. Also, consult risk management about possession and sharing of pediatric images to make sure federal and state pornography laws are not violated.

7.9 Prevention of Sexually Transmitted Infections

All programs should have the ability to provide prophylaxis for STIs. The patient should not be referred to another treatment facility for prophylaxis. This is particularly true for HIV prophylaxis—in which it is critical that medications be given within 72 hours of exposure. The Centers for Disease Control and Prevention (CDC) provides guidance for post-exposure prophylaxis after sexual assault. A program may determine that alternative therapies are needed in their community based on STI surveillance data. It is not recommended that routine testing for STIs be performed for adult/adolescent patients. In children, where any sexual contact may be considered evidence of assault, the presence of an STI may be important evidence, therefore, testing policies may differ by age group; however, when findings require a differential diagnosis, testing may be indicated.

For more information, please refer to the National Protocol-Examination Process: STI Evaluation and Care.

Hospital-based programs should be able to provide these medications readily, but community-based programs will need to procure medications in advance to have them available for administration and to follow the pharmacy laws of the state.

All programs should have a policy in place for HIV risk screening and prophylaxis. They should work closely with infectious disease physicians who treat HIV patients in the community to create the policy. Unlike prophylaxis for gonorrhea, syphilis, and chlamydia, HIV prophylaxis medications require oversight by a licensed provider. If a patient has a significant risk of HIV infection, the SANE should consult with a licensed prescriber. In some communities, the SANEs may be in the best position to start HIV prophylaxis and may not have a licensed prescriber onsite for consultation. In those situations, there should be an arrangement for the option of a telephone consult if the patient is pregnant or has a chronic medical condition that may create a need to alter treatment protocols. A protocol should include how patients will be screened, how to obtain baseline lab tests, and what mechanism to use for immediate provision of the medication since HIV prophylaxis is extremely time sensitive. It is essential to identify sources of payment for medication since they can cost in excess of $2,000 for the required 28-day supply. This may include providing access to patient assistance programs provided by the drug manufacturers.

7.10 Prevention of Pregnancy

All programs should have the ability to provide pregnancy prophylaxis medications after a sexual assault. This medication should be considered time sensitive and should be administered at the exam site rather than referring the patient elsewhere for the medication. Many states have laws that require the provision of emergency contraception.

Hospital-based programs should be able to provide this medication easily, but community-based programs will need to procure medications to have onsite for administration and follow the pharmacy and emergency contraception laws of the state.

All patients should be tested for an existing pregnancy before emergency contraception is provided. It is important for the patient to know definitively if a pregnancy is preexisting or the result of the rape.

For more information, please refer to the National Protocol - Examination Process: Pregnancy Risk Evaluation and Care.

7.11 Discharge and Followup Care

All programs should provide the patient with options for followup care after discharge. This may be done with the program itself or with community partner organizations, such as health departments, community health clinics, university health services, or Planned Parenthood. These community services should have been identified during the assessment phases of program implementation.

Options for Follow Up

The SANE program may provide the follow up, but if the program is not able to provide that care, there are other options. Keep in mind that some options may not be comfortable for male patients.

- Primary care providers
- Local public health department
- Local women's clinic
- Planned Parenthood
- Community clinics
- Other community health or STI clinics
- Child abuse pediatric programs
- Children's Advocacy Centers

Danger/Lethality Assessment

For patients who are being seen after an assault by an intimate partner, it is important to discuss with the patient signs of increased danger or risk for death. Many programs may use formalized lethality or danger assessment tools.

Safety Planning

All patients should be assessed for safety at discharge. This should include a determination of whether they have a safe place to go. Depending on where they were assaulted, and who the assailant was, the patient may need help in determining where they can go at discharge. This may necessitate the involvement of other community agencies to assist the patient with transportation, housing, and other needs.

Patient Resources and Discharge Instructions

Written discharge instructions should be a component of any discharge from the facility. Recognize that patients in the aftermath of trauma will not be able to recall all the information provided during the visit. It is essential that written discharge instructions include—

- Treatment delivered
- Medications administered at the time of the examination
- Any necessary followup appointments and medications for patient initiating HIV prophylaxis
- Phone numbers for the program
- Names and numbers for other recommended followup services (counseling, housing, legal)
- Law enforcement case number and investigating agency, if appropriate
- How to report if a patient has originally chosen not to cooperate with a law enforcement investigation

Other Considerations at Discharge

Patients may choose to return to an abusive partner or living situation. It is essential that programs consider the ways that patients are contacted by the facility. Some patients may need specialized referrals to mental health services or additional health care providers. For example, a patient found to be HIV+ at the time of the exam should be referred to an HIV provider.

For more information, please refer to the National Protocol- Examination Process: Discharge and Followup.

7.12 Medical Records Maintenance

All programs should have a protocol for medical record storage and maintenance. It is important to remember that the medical record belongs to the agency or health care provider who created the record. The program should always maintain the original copy of any written documentation. Independent contractors may arrange with the hospitals where they provide care to store and maintain the records. Some programs are starting to use electronic health records (EHR) for their sexual assault medical forensic records. It is important to limit who has access to the electronic record to preserve patient privacy. EHRs should be HIPAA and HITECH compliant.

While most medical records are required to be kept for only 5 years, a SANE program should not destroy any medical records because the statute of limitations for prosecution can be indefinite depending on the laws of your state or tribal jurisdiction.

7.13 SANE Testimony

In the courtroom, medical witnesses are held in high esteem by judges and juries. Medical providers are generally considered to be neutral, professional, and highly skilled; therefore, their testimony is given significant weight by the finders of fact in the legal system. One of the advantages of SANE programs is the willingness of nurses to testify in cases of sexual assault, and it should be an expectation of the role for all SANE nurses.

Types of Court Testimony

SANEs may be asked to testify in many different settings. It is important to know what is expected from each setting. This requires working closely with the attorney who has asked the SANE to testify.

Types of settings include—

- Criminal court
- Juvenile court
- Civil court
- Military court
- Grand jury proceedings

A SANE may be called to testify as either an expert or a fact witness. In either case, the SANE should testify clearly that a SANE's duty is to provide comprehensive health care to patients, and that evidence collection is done as a service to the patient.

SANEs as Fact Witnesses

A "fact witness" is a witness who testifies only about what they did and what they observed, and expresses no opinions in the case. A fact witness may also be asked questions about typical protocols used for the sexual assault exam, so the SANE should be very familiar with not only the exam done in the case, but also have a good understanding of the protocols that apply and the reasons for those protocols.

SANEs as Expert Witnesses

The definition of an "expert witness" in federal court, and in the vast majority of state courts, is a person with more knowledge and experience than an average juror on the subject matter. Education, training, and experience—or any combination of these three things—may be used to establish a witness as an expert for the case. This means that every SANE can be qualified as an expert witness on the subject of sexual assault exams and patient behavior. The primary difference between fact witnesses, who only testify about what they have seen, heard, or experienced, and expert witnesses is that in addition to this, expert witnesses educate and give their opinions to the judge or jury.

The SANE who is testifying as an expert witness should be prepared to testify about these different areas of specialized knowledge:

- The SANE's qualifications as an expert witnesses, including education, training, any prior clinical experience, and whether it is general nursing or SANE experience.
- Best practices for performing medical forensic examinations.
- What happened during the sexual assault examination, explaining the presence or absence of findings.
- Victim behavior and common victim presentation at the exam.
- Mechanisms of injury and wounds.
- Opinions based on the findings of the examination.

In addition to providing testimony, SANEs may be asked by attorneys to provide expertise by reviewing medical records and giving opinions.

Working With Prosecutors and Defense Attorneys

It is important for SANEs to understand that their role as a patient advocate does not conflict with their role as an impartial witness at a trial. The nurse who performs a medical forensic exam should be willing to talk to both prosecutors and defense attorneys about their examination. One good approach for a SANE program is to have a policy that encourages SANEs to meet with the attorneys on both sides of the case at the same time. When the attorney who is calling the SANE as a witness requests a meeting, include the attorney on the other side of the case. This way, both sides learn what they need to know

about the upcoming SANE testimony, and there is full transparency for both attorneys. Nurses should consult with hospital or agency legal counsel before talking to outside attorneys to make sure they have proper consent for release of information from the patient. Usually, attorneys on both sides of a case receive a copy of the examination report. If that is true, any information in the report can be discussed. If the nurse has additional information about the patient, that is not included in the report, consent from the patient to disclose that information may be required.

SANE programs should make sure that nurses who are called to testify meet with the attorney who has requested their testimony before the trial or court hearing.

Prior to the trial or court hearing, the SANE should know—

1. Is the SANE testifying as a fact witness or expert witness?
2. What are potential subjects and questions that will be asked during the testimony on direct examination?
3. Does the SANE need to provide any records or photographs?
4. When will the SANE be expected to testify?
5. Will the SANE be expected to listen to other testimony?
6. What is likely to be asked on cross-examination by the opposing attorney?

Preserving Confidentiality of Patient Information

SANEs should respect the privacy and confidentiality of all patients. SANEs must strictly follow all HIPAA rules and any of the SANE's employer's protocols regulating the disclosure of patient information.

SANEs must not discuss a patient's case with colleagues, other attorneys, or any other third party unless given permission to do so by the patient and by the attorney calling the SANE as a witness (if the SANE is under subpoena).

When a SANE receives a subpoena for patient records, the SANE should immediately contact the attorney for the SANE's employer and seek guidance as to how to respond. Even if a valid subpoena for medical records is provided, there may be a duty to contact the patient to allow them an opportunity to challenge the subpoena before the records are released.[88]

Many courts have procedural rules that impact how and under what circumstances SANE's records must be provided. Some courts may require an *in camera* review by the court, which means that a judge must review the records to rule on what must be disclosed and to whom the disclosure must be made. The SANE may also be required, in some jurisdictions, to notify the patient that their medical records have been subpoenaed.

Working as an Expert Witness for Defense Attorneys

There is no prohibition against SANEs acting as expert witnesses for the defense. SANEs who are part of a team may have policies about testifying against other team members. Peer and case review are essential parts of a SANE program. Nurses need to be able to discuss and critique each other's work, with an expectation that the information will be kept confidential. (See section 9.2 Peer Review.) Working as an expert for both prosecution and defense demonstrates that the nurse is not inherently biased toward any specific side.

The Importance of Ethical Testimony

The SANE should keep in mind at all times that their testimony is public record and may be used by others on the issue of the credibility and competency of the SANE. As a citizen and as a professional with special training and experience, the SANE has an obligation to assist with the administration of justice when called upon to do so.

- A SANE must not become an advocate or a partisan in the legal proceeding, and should work to maintain neutrality and objectivity.
- A SANE should be adequately prepared and should testify honestly and truthfully.
- The attorney for the party who calls the SANE as a witness should be informed of all favorable and unfavorable information developed by the SANE's evaluation of the case.
- It is unethical for a SANE to accept compensation that is contingent on the outcome of the litigation.
- A SANE testifying as an expert witness should review relevant medical and scientific data carefully and thoroughly before offering an opinion. If a SANE believes that the information provided is incomplete or inaccurate, the SANE should request additional information or clarification from attorneys or other relevant parties before agreeing to render an opinion. A SANE should never give an opinion that is outside the SANE’s area of expertise or is without an adequate medical basis.

For more information on SANE Testimony, please refer to the National Protocol - Examination Process: Examiner Court Appearances.

Chapter 8: Multidisciplinary Response and the Community

The purpose of this section is to explain the importance of a multidisciplinary approach to sexual assault care that engages key stakeholders from across your community. Whereas nurses embedded in the medical system treat sexual assault *patients*, these patients may seek services from the criminal justice system as *crime victims* or from advocacy organizations as *survivors*. The needs of sexual assault patients/victims/clients/survivors are multifaceted; therefore, a comprehensive response requires the involvement of multiple disciplines. In this chapter, we discuss—

- The purpose of implementing a multidisciplinary response to sexual assault in your community and the diverse activities of multidisciplinary teams. (See section 8.1 Multidisciplinary Team Models)
- The wide range of community partners you may choose to involve in a multidisciplinary response and the benefits of their involvement for SANE program development, implementation, and ongoing operation. (See section 8.2 Collaboration With Community Partners)
- The value of ongoing multidisciplinary team quality assurance. (See section 8.3 Assuring Quality of the MDT)

In a multidisciplinary response, different disciplines use different words to refer to the same individual—patient, victim, client, survivor. The varied terminology exhibits the varied services provided by each discipline and its essential role in helping to provide a comprehensive response to sexual assault.

SART Toolkit

- The need for ongoing training and education for all multidisciplinary team members. (See section 8.4 Community and Partner Education).

Video: Multidisciplinary Approach

Video: Safestar

Video: Partnerships

Chapter 8 Subsections:

Go to Chapter 9: Maintaining a Quality Program

8.1 Multidisciplinary Team Models

Similar to the traditional emergency department response to sexual assault that inspired the creation and implementation of SANE programs, the uncoordinated and inadequate community response to sexual assault catalyzed the creation of multidisciplinary teams (MDT), sexual assault response teams (SART), and sexual assault response and resource teams (SARRT). [89,90] Respecting community uniqueness means accepting that the development and function of the MDT may vary significantly from one community to another. While different communities use different names to refer to their multidisciplinary coordinated community efforts, and we will alternate between these different terms in this Guide (i.e., MDT; SART; SARRT), they serve the same purpose—to improve the community response to sexual assault by bringing together multidisciplinary sexual assault stakeholders.[91] Through cross-system coordination, these teams frequently aim to improve victims' experiences when seeking help, engage in prevention education, and achieve more desired legal outcomes.[92] MDTs have been widely adopted across the United States, and MDT implementation is considered a best practice in the response to sexual assault.[93] (See text box regarding the effectiveness of SARTs. [94])

Are SARTs Effective?

The current empirical literature on the effectiveness of SARTs is limited and has not assessed impact from the patient's perspective; however, the research suggests that SARTs can lead to:

- **Improved multidisciplinary relationships** in terms of increased cross-system contact and information exchange, understanding of one another's roles, and collective decisionmaking;
- **Improved legal factors and outcomes**, such as victim participation, delays in reporting, amount of forensic evidence collected, and arrest and charging rates; and
- **Increased rates of victim referrals to services**, such as transportation to the hospital, and rape crisis counseling.

While SARTs frequently operate in communities with established SANE programs,[95] it does not mean that the MDT must be initiated and lead by the SANE program. While medical/forensic examiners sometimes assume the role of MDT leader, it is more common for rape crisis center advocates or staff to act as the formal leader of the SART.[96] Just as a SANE program can be initiated by different community members (see section 3.6 that discusses how to start a SANE program depending on your role in the community), the SART can too, and may come before, after, or in absence of SANE program implementation. Community needs assessments (see section 3.3) can help in determining how to best meet the needs of your community.

As of 2016, there are hundreds of SARTs in operation. While there are numerous resources on SART development (e.g., see NSVRC resources), there is not a single standardized SART model. As such, SART operations, and the degree to which these operations are institutionalized, vary across

communities. Table 1 lists some of the common MDT activities and the frequency with which they are implemented and institutionalized. The key goal of the MDT is to coordinate patient/victim/client/survivor services across systems; therefore, in addition to the activities listed in Table 1, MDTs will, for example, ensure that victims who report to the police are informed about medical/forensic services and are given the opportunity to have an advocate accompany them to court hearings.

What kinds of communities do SARTs serve?

Note: these data do not include SARTs/MDTs that serve child victims exclusively.

Number of Counties Served		Region Served		Community Size Served	
One Country	75%	South	31%	Rural (< 500 people/sq. mi.)	66%
Partial County	19%	Midwest	29%	Non-Rural	34%
2+ Counties	6%	West	25%		
		Northeast	15%		

Table 1. SART Activities*[97] (Greeson & Campbell, 2015)

Collaborative Activities	% of SARTs engaging in this activity at all	% of SARTs engaging in this activity on a regular basis
Policy/protocol development and review	82.5%	31.2%
Multidisciplinary cross-trainings	76.0%	38.0%
Trainings conducted by non-SART members	74.3%	22.8%
Development or adoption of memorandums of understanding between different stakeholder groups	69.6%	23.2%

**These data do not include MDTs that served child victims exclusively.*

8.2 Collaboration With Community Partners

MDTs improve the response to sexual assault by creating positive relationships and collaborations among sexual assault responders.[98,99] Police, rape crisis center advocates and staff, SANEs, and prosecutors are the most common active members of MDTs;[100] however, many other disciplines are involved in the response to sexual assault, thus MDT membership is frequently composed of representatives from 5 to 15 different organizations.[101] The typical representation in SART membership is illustrated in Table 2.

Table 2. Active Membership in SARTs*[102] (Greeson & Campbell, 2015)

Sexual Assault Stakeholder Group	% of SARTs With Active Membership From This Group
Police	97.7%
Rape crisis center staff	94.8%
Sexual assault nurse examiner or sexual assault forensic examiner	90.1%
Prosecutor	84.9%
Domestic violence agency	73.3%
Advocate from the victim witness unit in the prosecutor's office	64.0%
Other medical personnel	61.0%
Other social services (e.g., drug abuse or welfare)	60.8%
Children's advocacy center	50.0%
Higher education (i.e., a college or university)	40.1%
Corrections (including probation and parole)	28.7%
Crime lab	19.8%
Sex offender treatment	17.0%
Judicial system	14.0%
Clergy/faith community	10.5%
Schools (grades K through 12)	8.1%
Victims/survivors (representing the perspective of victims/survivors only and not an organization on the SART)	4.7%
Other**	30.4%

**These data do not include MDTs that served child victims exclusively.*

***This included related task forces or coalitions; the attorney general's office; dispatch; and the FBI.*

It is valuable for MDT membership to include representation from all stakeholder groups that play a role in the response to sexual assault. This will help ensure a comprehensive and coordinated cross-system response in your community. Below is a list of different stakeholder groups to consider for MDT membership. These cross-discipline relationships can bring a variety of skills to support SANE program development, implementation, and ongoing operation, and Table 3 provides specific benefits of their inclusion.

Adult Protective Services/Long-Term Care Resident Protection: Many programs are mandated to report abuse of people with disabilities to the authorities as specified by state law. In many cases, reports involving adults are made to adult protective services (APS). Staff from your local APS can assist you in understanding your program's responsibilities under mandatory reporting laws, including who within the program is a mandated reporter; under what circumstances reports must be filed; and the appropriate

process to follow when making a report. Moreover, having local a relationship with APS staff helps ensure survivors' needs are met when reports are made. In some states, if the sexual assault or abuse occurs while an individual is living in a long-term care facility, the abuse needs to be reported to a long-term care ombudsman.

Deaf victim service organizations: There is a small, but growing number of agencies that provide Deaf-centered services to Deaf survivors in the United States. These organizations are run by and for Deaf people and provide victim services that are rooted in the culture and language of the Deaf community. The majority of these agencies are stand-alone, Deaf-specific victim services organizations. To a lesser extent, some programs are run out of general Deaf social service organizations or community victim service organizations. These programs provide the Deaf community with emergency hotlines, crisis intervention, medical and legal advocacy, counseling and other supportive services, peer support opportunities, and community outreach and education. These organizations can provide training on Deaf culture; assess your program's ability to serve Deaf individuals who experienced sexual violence; provide suggestions for trauma-informed American Sign Language interpreters in your area; and help you develop relationships with the Deaf community in your area.

Disability Abuse Response Team (DART): These specialized teams respond to abuse or neglect of persons with disabilities, and it is important that they coordinate the response with the SART when there are allegations of sexual abuse and assault. APS should know if a team exists in your community.

Child Advocacy Centers (CAC): These centers, developed in the early 1980s, are based on the multidisciplinary team concept. Some CACs are hospital-based, some are community-based. CACs are composed of members from criminal justice, law enforcement, child protective services, mental health services, child abuse-trained medical personnel, advocacy services, and specially trained forensic interviewers. The goal of the CACs is to minimize the interviewing of children while providing the team with all the information needed to adequately investigate abuse allegations and protect the child.

Child Protection: Inclusion of child protection/welfare benefits the victim, the agency, and the MDT partners. Since a family member or acquaintance commits most sexual victimization of minors, child welfare/protection is often an integral part of the investigation with law enforcement. Collaborative investigations by child protection/welfare and law enforcement, in partnership with the other MDT partners, maximizes the sharing of critical information through a trauma-informed and developmentally appropriate process. Having child protection/welfare on the MDT promotes not only the criminal justice outcomes, but also the safety and well-being of minors and their families.

Child Protective Services (CPS) is often the entry point for abuse cases involving children, as mandated reporting usually initiates the investigation by the team. The CPS worker coordinates the investigation into the allegations of abuse and neglect that are received by the mandated reporting hotline. In some communities, CPS workers have additional specialized training in child growth and development as well as physical and sexual abuse.

Indian Child Welfare: Indian Child Welfare is an agency created to assure that the interest of the tribe and the rights of the Indian child who has to interact with the system are protected. The Indian Child Welfare workers oversee the day-to-day implementation of tribal child welfare laws and the Indian Child Welfare Act. They attempt to ensure that if an Indian child needs to be placed in the foster care system, that placement is with an Indian family. Basically, they assure that the Indian child's and the tribe's rights are protected throughout the response system. Many of the Indian Child Welfare workers are Indian and have devoted their careers to serving tribal communities. As such, these workers are familiar with the languages, customs, traditions, familial structures, and child-rearing practices of the tribal communities they serve. A representative from the Indian Child Welfare Department should be a mandatory member of any MDT that serves tribal communities.

Clergy/faith community: The community team may want to consider involving local faith-based organizations in the MDT. These organizations can assist with outreach and addressing issues that impact the communities they serve. Often, parishioners may not be reporting to conventional agencies or systems. (See section 8.1) Clergy and faith-based organizations can also assist with disseminating the message about SANE services.[103]

Sexual Assault Advocacy Centers: Sexual Assault Advocacy Centers provide counseling, crisis intervention, support, advocacy, referrals, hospital and court accompaniment, hotline management, and many other services to support survivors of sexual violence and their significant others. Centers can be community-based, hospital-based, or located on college and university campuses. Some states have organized training and certification requirements for advocates who work in these centers. Advocates provide confidential services, and in many communities, adult victims have legally protected privileged communication with advocates. As a part of the MDT, rape crisis advocates help maintain the victim-centered approach for the team and represent the interests of the victim throughout the process. They also provide ongoing support across the lifespan to survivors and their friends and family.

Systems-based advocacy: Victim advocates can also be employed as part of law enforcement agencies, prosecutors' offices, and military installations. These advocates play various roles in making sure survivors receive services and support. It is important for survivors to be informed about the function of the advocates and whether their communication is confidential in the same manner it is with a sexual assault center advocate. In addition to providing support to the victim, these advocates also represent the interests of law enforcement and prosecution.

Corrections: Participation in the development and implementation of a SART in a correctional setting can assist in providing a coordinated response within these facilities. The facility-based SART will help identify the core responders when a sexual assault occurs, create a standardized protocol for activating team members, and educate those unfamiliar with the special circumstances faced within a correctional institution. Many times the response to a sexual assault may require assistance from resources outside the jail or prison. Coordinating and meeting with external partners can assist the facility internally as they develop their response.

Crime lab: Collaboration between an established or emerging SANE program, the crime laboratory and other members of the MDT are an essential component of the successful delivery of sexual assault forensic services. Only through a regular dialogue between a SANE program the crime laboratory and members of the MDT can provide important information regarding the collection and testing of physical evidence be exchanged in the thorough and timely manner necessary to ensure maximum forensic use of these items for the generation of critical investigative leads in systems such as the Combined DNA Index System (CODIS). SANEs collect the evidence that the crime laboratory analyzes, so both should work to optimize the procedures for collecting, preserving, transporting, and testing items. Because SANEs and crime labs must often negotiate the gap between the medical and law enforcement elements of sexual assault responses, and because they operate independently within different agencies, collaboration is essential if both parties are to operate in concert to maximum effect in support of a victim of sexual assault. Within this partnership, the SANE program has a platform in which to communicate the unique requirements, demands, and restrictions of the medical/hospital setting while the crime laboratory can offer feedback to the SANE program regarding various aspects of evidence documentation, collection, and preservation and chain-of-custody requirements.

Civil attorneys: Teams should include a civil attorney who can advocate for the legal rights of the victim throughout the response. This may be a local attorney or some communities have agencies that fund a victims' rights attorney who can participate on the team.

Domestic violence or other crime-specific victim services: Some communities have programs that provide care to specific victim populations, such as domestic violence or human trafficking survivors. Many of these victims will also be sexual assault survivors. Their involvement in an MDT helps provide comprehensive services to all survivors.

Disabilities services agencies: Organizations that serve people with disabilities exist in virtually every community. They range from county-run boards for people with developmental disabilities to independent living centers that promote the independence of people with any disability to community mental health centers. Partnering with disability organizations can increase your program’s capacity to serve survivors with disabilities. Staff from these organizations can provide training on disability; help assess and build the physical and programmatic accessibility of your program; and assist in the development of protocols for asking about any accommodations survivors need to fully participate and resources for providing those accommodations.

Education system representatives: The MDT can benefit from including representatives from both public schools and from colleges and universities in the community. School-age victims may need the support of educators to make sure they feel supported enough to stay in school. Colleges and universities also represent a high risk population for sexual assault. Members of the MDT can be teachers, school counselors, or psychologists. For colleges and universities, representatives of their Title IX office may want to be involved.

Judicial system: The team may have a representative from the judicial system. In some communities, this may not be possible if the members of the judiciary feel their participation would create a conflict of interest.

Law enforcement: In a vast majority of reported sexual assaults, law enforcement is the gateway into the criminal justice system. This critical position can be an influence on whether victims of sexual assault remain engaged in the process or decide to drop out. As part of an MDT, law enforcement can ensure they are continually coordinating and communicating with other disciplines to ensure victims receive a coordinated and supportive response—no matter how the victim wishes to proceed. Law enforcement's position in the MDT can provide training to other members; create trust and dispel myths by explaining the investigative process and legal restrictions they face; identify and fill gaps in the services to victims; and work as a team member to identify and secure additional resources. At the same time, law enforcement can receive critical training and understanding on the forensic exam, victim trauma, and prosecutorial standards, and membership can help with the development of departmental policies that are victim-centered.

Medical system: Hospitals and medical service providers are an important to include in the MDT, because they are a major access point for victims who disclose rape and sexual assault. Their input is essential in order to make sure that when a victim does disclose protocols are in place to activate the MDT response. Medical providers also need to know when and under what circumstances they will be required to provide a higher level of care for sexual assault patients.

Military: The military has specific requirements related to reporting and additional resources available to its members. It is important that local SARTs partner with local military installations and National Guard Bureaus so the special resources are used and military members' special needs are addressed.

Social services/tribal social services: Social service providers should be involved in the MDT to make sure services and resources are available for survivors who qualify. These services may include housing, food, child care, and even education for victims.

Prosecution: The prosecution can assist MDT members in understanding the basics of the criminal justice system, both in criminal law and procedure. Because the law is constantly in flux, prosecutors can also update MDT members on changes as they occur. Issues including how to handle and package sexual assault kit items so they will be admissible in court should be discussed at MDT meetings. (MDT members should use caution when asking prosecutors to comment on civil issues, such as civil liability, how to respond to subpoenas, and disclosure of medical records, because prosecutors are practitioners of criminal and not civil law and do not represent individual members or agencies on the MDT. Questions about matters other than criminal law or procedure should always be referred to the individual or agency attorneys.) Prosecutors should contribute to discussions of inter-agency system issues and provide the prosecution perspective on cases and protocols. In turn, prosecutors benefit from MDT participation in learning how cases flow through the system, the basics of sexual assault exams and protocols, and the related scientific research, which will make a more effective presentation in court.

Researcher/evaluator: Researchers/evaluators can oversee ongoing evaluation of the MDT. They can also design and execute research to answer important questions for the MDT (e.g., if a new response protocol improves victims' help-seeking experiences). Local universities may have researchers/evaluators open to collaboration.

Senior services programs: Communities may have special programs for seniors that provide various services, including transportation, help with medication, housing, and disability accommodation support.

Sex offender treatment: The purpose of sex offender management is to detect and deter offenders who fail to comply with the conditions of community supervision. Sex offender treatment programs support SARTs in multiple ways. Details can be found in the SART Toolkit.

Victims/survivors: Many teams will have a representative who is a survivor of sexual assault. Their role is to provide a unique perspective and keep the team focused on the needs of the victim. It is important to work closely with victim service providers to make sure the team is supportive of the survivor and that the survivor's participation does not create harm.

8.3 Assuring Quality of the MDT

Only 15 percent of MDTs assess their collaborative efforts through program evaluation.[104] As described in the SART Toolkit, assuring quality should include both monitoring the function of the team and assessing victim satisfaction. Teams should create a process for ongoing evaluation.

8.4 Community and Partner Education

Ongoing training and education is an essential part of a successful MDT. The vast majority of MDTs engage in multidisciplinary cross-training (76%) and training conducted by non-SART members (74.3%), though fewer than half engage in these trainings on a regular basis (38% and 22.8% respectively).[105] There are many advantages to training together as team. First, it helps clarify each team member's role and responsibilities. Second, it helps to build better working relationships, making it easier to find solutions when problems arise. Education should occur if a change in one member's protocol would affect other team members. For example, if a crime lab decides that samples for DNA can be collected more than 5 days after the assault, everyone will need to be involved to make sure patients are offered the opportunity for evidence collection within the appropriate time period. Team training should be an expectation of all MDTs.

Table 3: SANE Program Benefits of MDT Membership Variety

Stakeholder Group	During Program Planning	During Implementation	During Ongoing Operation
Adult Protective Services	Determine a program's mandatory reporting requirements	Assist in developing mandatory reporting policies and procedures	
Children's Advocacy Centers	Assist with needs assessment Provide demographic and statistical information Preceptorship/clinical training for SANE-P	Assist in developing team protocols, confidentiality issues Assist in ongoing training SANE-P	Provide process for case reviews Neutral locations for team to meet
Child Protection/ Indian Child Welfare Services	Provide expertise on child maltreatment with emphasis on sexual victimization of minors Educate MDT partners on mandated reporting and maltreatment types that require a report	Assist in protocol development in cases that require or may benefit from child protection/ welfare involvement Promote cooperative co-investigations of child welfare/ protection and law enforcement	Refer victims to MDT partners and receive referrals from MDT partners Participate in the case review process to promote the safety and well-being of victims Participate in cross-training of MDT partners
Clergy/Faith Community	Assist with needs assessment of invisible communities	Education for faith community members Input on issues important to their members	Referral source for clients Possible supportive role for provision of items for victims (clothing, personal items)
Community-Based Rape Crisis Advocacy	Assist with needs assessment Provide demographic and statistical information Site visit for SANE training	Train on the advocacy needs of victims Develop a victim-centered approach and protocols	Referral sources for patients and families Represent and advocate for the needs of victims during the team process
Corrections	Assist with needs assessment regarding correctional victims	Train on special needs and circumstances of victims in corrections	Responsible under the Prison Rape Elimination Act (PREA) for providing response to rape victims, including access to forensic

Stakeholder Group	During Program Planning	During Implementation	During Ongoing Operation
			examinations and victim advocacy
Crime Lab	Provide the service laboratory(ies) with the necessary information to forecast expected collection/submission metrics for the identification of testing resources Design/procure/distribute appropriate sexual assault kits for evidence collection	Train SANEs on the collection and preservation of evidence Clarify the potential and limitations of forensic testing services Brief MDT partners on the submission and searching of forensic DNA profiles to CODIS	Develop best practices for the collection and testing of evidence Provide data on the success of forensic testing Provide training to SANEs to remain proficient
Civil Attorneys	Assuring that a patient's civil legal rights are protected through the response process	Forms and protocols meet privacy needs	Provide consultation about victims' rights issues
Deaf Victim Services Agencies	Assist with needs assessment Provide expertise on sexual violence against Deaf people	Train on Deaf culture and language access Provide guidance for how to make services accessible Assist in developing language access policy, including how to secure qualified interpreters	Referral source for patients
Disabilities Services Agencies	Assist with needs assessment Understand the specific needs of the populations they serve, including the need for adaptive equipment or modification of processes and protocols	Train on disabilities and accessibility Provide information on how to make services accessible and applicable to the populations they serve Assist in developing accommodation	Referral source for patients and families. Provide expertise for specific patient populations Assess accessibility of the program on an ongoing basis

Stakeholder Group	During Program Planning	During Implementation	During Ongoing Operation
		policies and procedures.	
Domestic Violence Crime-Specific Agencies	Identify existing resources	Assist in protocol development	Provide expertise for their specific patient populations
Education System	Identify existing resources for survivors within education systems in the community	Make sure protocols do not conflict with Title IX	Provide ongoing consultation
Judicial System		Provide input on protocols	
Law Enforcement	Work to create a standardized communication network, identify response partners, and determine a logistical response to sexual assaults Assist in developing regional or statewide response practices.	Assist in defining roles and creating MOUs Educate the team on law enforcement response to sexual assault Provide information from the SART to other law enforcement agencies	Continue to identify gaps and needs Facilitate case review and analysis Update policy to reflect best response practices Assist in delivering and receiving training in SANE, forensic evidence, victim response
Medical System	Assist in determining patient treatment sites and protocols for care Assist in training SANEs (anogenital examination, which includes pelvic exam training and experience; identification of non-anogenital injuries) Help develop treatment protocols Sign off of standing orders Medication/prophylaxis protocols	Finalize treatment and prophylaxis protocols Determine emergency department protocols around MD involvement in care and medical screening exam requirements Educate medical staff and non-SANE nursing staff Assist SANE team as requested by team leadership	Protocol and operations review Update medication/prophylaxis protocols Review referral practices and protocols Mitigate issues with referral physicians/practices Perform QA review Assist in program expansion and development SANE education

Stakeholder Group	During Program Planning	During Implementation	During Ongoing Operation
	Assist in establishing followup care and HIV N-PEP followup care	Assist in developing QA review process	
Military	Provide information specific to DoD policies, programs, and services available to military victims of sexual assault and points of contact at local installations Develop protocol or memorandums of understanding with community-based victim service organizations to establish effective partnerships with local military installations to effectively respond to the needs of victims of sexual assault in the military Develop memorandums of understanding between local installations and community hospitals if the local military treatment facility does not have a SANE program	Discuss recommended protocol for military victim advocates to work in partnership with local community-based victim advocates	Assist with specific needs of sexual assault victims in the military, coordinate a collaborative response, and navigate potential jurisdictional issues
Social Services/Tribal Social Services	Help with protocol development to ensure that required notifications are included in protocols and procedures		Provide consultation for patients who are eligible for their services
Prosecution	Contribute to a discussion of which agencies should be members of the MDT and extend invitations to all identified prosecution and law enforcement agencies to join the MDT Help write general goals for MDT meetings	Discuss recommended guidelines for review of system issues and individual case studies at MDT meetings Discuss the screening process generally at prosecution offices and how MDT members can work	Have a prosecution representative at every MDT meeting Contribute to case studies scheduled by MDTs Provide basic training and ongoing updates on criminal

Stakeholder Group	During Program Planning	During Implementation	During Ongoing Operation
	Discuss and determine confidentiality issues applicable at MDT meetings	effectively with prosecutors	law and procedure for the legal collection of evidence Provide training and specific consultation for MDT members on being a witness in a criminal case
Research/ Evaluator	Conduct community needs assessment; make empirical argument for SANE and SART programs	Provide ongoing feedback on what works and what needs to be revised	Design and execute ongoing evaluation of the SANE and SART programs
Senior Services Program	Provide information about senior communities and facilities	Make sure services are accessible for senior patients	Provide feedback about the accessibility of services to seniors and resources and support for service providers
Sex Offender Treatment	Allow for communication to be established between Sex Offender Treatment and the MDT.	Assist with protocol development that are consistent with Victims' Rights laws.	
Victims/Survivors	Should provide an opportunity to share how their experience was impacted by the system response	Assist in protocol development to make sure the victim's viewpoint is represented	Provide ongoing consultation

Chapter 9: Maintaining a Quality Program

Evaluations of both the SANEs and the SANE program are critical components of all SANE programs. It is important to remember that the goal of every community should be to increase access and improve the quality of care provided to sexual assault patients. This section gives guidance to programs on how to start the process of improving and maintaining quality by using tools such as peer review, competency evaluation, and program evaluation. How this is done may look different depending on the resources and expertise available in each community. While some skills may be difficult to practice and perfect in communities

with lower volumes of patients, every program should be able to provide patient-centered and trauma-informed care.

Chapter 9 Subsections:

Go to Chapter 10: Expanding Forensic Nursing Practice

9.1 Quality Assurance and Quality Improvement

According to the Health Resources and Services Administration (HRSA), quality assurance (QA) measures compliance against certain necessary standards, typically focusing on individuals, whereas quality improvement (QI) is a continuous improvement process focused on processes and systems. QA tends to be defensive with a focus on providers. QI is proactive and preventive in nature, focusing on patient care.

The World Health Organization (WHO) notes that evaluation and monitoring are important aspects of all forms of health care provision,[106] and the care of patients who have been victims of sexual violence is included.

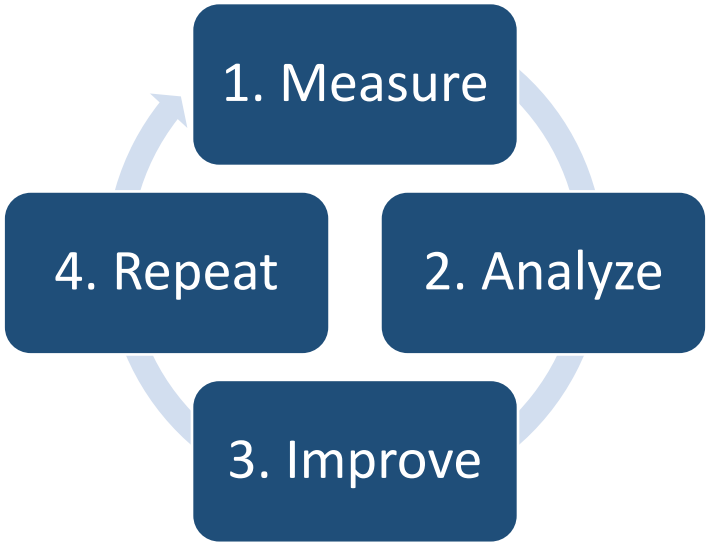
Quality assurance and quality improvement can take place at many levels and, depending on what is being evaluated, should involve the SANEs and may involve other members of the multidisciplinary team or community. It is important to be clear about what type of information will be evaluated and who will have access to the results. Information that could identify a specific patient should not be shared unless proper consent from the patient has been obtained.

SANE programs should outline their definition of quality, as quality can differ from organization to organization, and they should involve stakeholders as well as staff. SANE program stakeholders include the patient, provider, employer, members of the multidisciplinary team, and even payers. Some hospitals and clinics may have programs in place to evaluate patient satisfaction.[107] One example of this type of quality measure is the Press-Ganey customer satisfaction survey. For this survey, patients receive a questionnaire following their hospital, outpatient, or emergency care visit that evaluates their perception of that care. While these surveys are helpful for looking at patient satisfaction for routine hospital or clinic care, it is important for SANE programs to ensure contact by surveyors does not disclose to someone other than the sexual assault patient the fact that the patient sought care for a medical forensic examination. Sexual assault patients should be given the option to decline participation in the survey. If

they agree to participate, they should be offered a method of contact, such as a personal cell phone, that guarantees their confidentiality. Many SANE programs opt out of automated surveys such as the Press-Ganey entirely, and give other types of evaluation tools to the patient at discharge and provide a pre-addressed and stamped envelope for the patient to return the evaluation and avoid any privacy violations.

Most health care systems moved away from the traditional QA approach to one of QI in an effort to avoid assigning blame and focus on ways to prevent the error or variation from standard from occurring in the first place.

The National Committee on Quality Assurance recommends the following simplified formula:



If QI is performed internally, and meets both state and federal requirements, the results may be kept confidential and cannot be discovered in most legal situations. If a QA process includes team members who are not part of the health care team, results may not be protected from legal discovery. It is essential to have input from the hospital's legal counsel and risk management to make sure you know whether your process is protected.

While internal evaluation of nursing practice provides one type of information, it may also be beneficial to have a process where other team members have input about the performance of a nurse. In many settings, the only person who directly observes how the nurse interacts with the patient may be the rape crisis or victim advocate. They may be able to provide valuable feedback about whether a nurse is patient-centered when providing care.

9.2 Peer Review

According to the American Nurses Association, peer review is the process by which professionals from common practice areas systematically assess, monitor, make judgments, and provide feedback to peers by comparing actual practice to established standards.[108] Many health care organizations, such as The

Joint Commission's hospital accreditation process and the American Nurses Credentialing Center's Magnet Recognition Program®, have peer review components in their standards. Peer review is often used for individual performance improvement and improving patient outcomes, but also as a mechanism for identifying areas of weakness or strength, recognizing trends, and strengthening accountability and performance. Some are formal, others informal. One of the keys to the success of this is that it is truly peer review, not manager to staff, but rather staff members responsible for the same clinical care reviewing one another. This is a nursing responsibility, and if a program manager is not a nurse, they should not be part of the peer review process, with the exception of maintaining records. While peer review may be protected under state and federal laws that encourage health care providers to have quality improvement, many programs destroy any documents used during peer review that itemize problems identified in a specific case and only keep a summary of how well the nurse performed.

When peer review is instituted in a SANE program, the manager will want to consider the rationale behind the peer review. Is the peer review being instituted to achieve Magnet® status? If so, are there regulatory requirements? Has the process been defined, outlined, and described? Who will be responsible? One of the keys to success is ensuring the review occurs in a timely manner, soon after the episode of care. Another critical key is that peer review should not be construed as punitive, but more as a means of delivering mentoring.

In order to build an organizational culture that supports peer review, the process should be ongoing, like QI, and built into the expectations outlined in job descriptions, policies and procedures, education, and quality improvement processes.

For additional resources, please refer to SAFEta.org.

9.3 Competency Evaluation

In every area of nursing practice, the clinical skills of the nurse are evaluated to establish competency in performance of those skills. Competency evaluates the nurse's ability to apply knowledge and skills effectively to a specific practice setting. The skills can be generalized or specific to a specialty, they can be basic or advanced.[109]

SANE practice is no different. Nurses functioning in this role are expected to achieve a variety of competencies in their practice, and program managers must ensure that competency is evaluated and documented. Clinical competencies in SANE practice, whether adult or pediatric, are outlined in the IAFN SANE Education Guidelines and can be used as a guide for all program managers for formal evaluation.

9.4 Maintaining Currency of Practice

Nursing practice and forensic science are continually evolving and refining. To stay current with the science of forensic nursing, SANEs should participate in ongoing continuing educational activities. Education specific to forensic nurses is available through specialty nursing associations such as the International Association of Forensic Nurses (IAFN) and the Emergency Nurses Association. Education should include updates on issues and trends in sexual assault care and patient care for this population. SANE programs and facilities should support the ongoing educational needs of SANEs, both financially and by providing education.

9.5 Evaluating the Effectiveness of the SANE Program

Quality assurance and quality improvement measures frequently focus on maintaining a set standard of patient care and assessing patient satisfaction with care provision. While QA and QI are essential to the successful operation of a SANE program, there are additional ways to evaluate SANE program effectiveness.

Why Should SANEs Invest in Program Evaluation?

Program evaluation can be used by SANEs to—

- **Better understand the impact** of their work on the people and communities they serve.
- **Discover ways to improve** services and programs.
- **Provide information to funders** about how the program is working, successes, and opportunities for improvement.
- **Provide information to community partners** about how the program is or could benefit from intra- and inter-organizational collaborations.
- **Improve community support** for the program by documenting what the program is doing well and ways in which it could be improved.

The Two Main Types of Program Evaluation

There are many reasons for SANE programs to invest in evaluation beyond QA and QI (see Text Box A), and many ways in which a SANE program can be evaluated (see section below, **Choosing What to Evaluate**).

There are two main types of program evaluation:

- **Process Evaluation:** Focuses on and evaluates the program's processes or activities. Process evaluation examines what the program is doing, how it is doing it, and the degree to which the program is operating as intended. This could include documenting the services provided, how they are provided, and patient satisfaction. QA and QI can be considered process evaluation.
- **Outcome Evaluation:** Focuses on and evaluates the program's outcomes. Outcome evaluation examines to what extent the program is having its intended impact. This could include assessment of patient health outcomes, the accuracy of forensic evidence collection, and final case dispositions in criminal case proceedings. Input and feedback from crime labs, law

enforcement, and prosecutors can provide information about adequacy of forensic evidence collection and criminal case outcomes.

Both process and outcome evaluations can provide useful information for SANE program development and operation. SANE programs should identify what they want to learn from evaluation, and then determine which type of evaluation (process or outcome) will provide the most comprehensive answer. It is often useful for a SANE program to first conduct a process evaluation to understand what they are doing and how they are doing, then examine if that process is effective. For example, if a SANE program wants to know if their services have a positive effect on patients' psychological well-being (i.e., an impact evaluation), it may be important to understand first exactly what and how services are being provided to patients (i.e., a process evaluation).

Choosing What to Evaluate

SANE programs address patients' psychological and physical health, conduct forensic evidence collection, participate in legal proceedings, and strive for community change, thus SANE program evaluation could focus on any of these domains. For a discussion on what is already known regarding SANE effectiveness in these domains, see Chapter 1.4: **Are SANE Programs Effective?** It is not possible to evaluate it all in one effort.

For any evaluation, it is necessary to identify one or two key evaluation questions. Evaluation questions define the scope of the evaluation by making explicit what is to be learned. A SANE program's logic model can be particularly useful in selecting evaluation questions as it maps out program resources, activities, and goals (see Program Goals and Objectives section 3.7*).* SANE programs can use their logic model to ask pointed evaluation questions about how select activities are operating (i.e., process evaluation) and if they are leading to their intended impacts (i.e., outcome evaluation). When developing evaluation questions, it is essential that they are specific enough to be measured. For example, it is not possible to measure "coordination," but it is possible to measure how often prosecutors consult with a SANE. The Table below, **Sample Evaluation Questions**, provides example process and outcome evaluation questions for the many domains in which SANE programs operate.

Sample Evaluation Questions

Domain	Process Evaluation Questions	Outcome Evaluation Questions
Psychological Health	What percentage of patients believed the nurse was supportive? What percentage of patients trusted the nurse?	Do patients seen by the SANE program report fewer posttraumatic stress symptoms than those in the emergency department? Do patients seen by the SANE program report fewer depressive symptoms than those in the emergency department?

Domain	Process Evaluation Questions	Outcome Evaluation Questions
Medical/ Physical Health	How many patients received STI prophylaxis? How many patients received emergency contraception?	Are patients seen by the SANE program more likely to receive followup treatment for STIs compared to those in the emergency department? Do patients seen by the SANE program report fewer gastrointestinal problems compared to those in the emergency department?
Forensic Evidence Collection	How many wet swabs, dry swabs, and smears are used for each sample collected? What paperwork is included in the kit when turned over to police?	Are SANEs completing evidence collection more completely and correctly than non-SANEs? Are SANEs more likely to maintain the chain of custody than non-SANEs?
Legal Proceedings	What percentage of patients received information about the criminal justice process? How many times did SANEs provide witness or expert testimony in criminal case proceedings?	Are SANE cases more likely to be prosecuted or result in conviction than non-SANE cases? Are cases in which SANEs testify more likely to result in a conviction than cases in which SANEs do not testify?
Community Change	How many trainings were provided to other organizations engaged in the coordinated community response to sexual assault? How many trainings/informational sessions were provided to the general public/potential jurors?	Are prosecutors more likely to consult a medical expert after training on the value of such consultation? Are police more likely to refer victims to the SANE program after formalization of the police-SANE relationship (e.g., via a memorandum of understanding)?

Overcoming Obstacles in Evaluation

Many SANE programs are hesitant to conduct evaluation due to a lack of expertise in evaluation, prior bad experiences with researchers or evaluators, a lack of resources, or a fear of negative evaluation results; however, each of these obstacles can be overcome.

Lack of expertise in evaluation: There are resources available that breakdown the evaluation process in a way that SANE program staff can implement the evaluation without prior experience or expertise (for example, see textbox The SANE Evaluation Toolkit). Alternatively, SANE programs can partner with an outside evaluator or researcher. Local colleges or universities may be a place to start looking for these partners.

The SANE Evaluation Toolkit

The SANE Evaluation Toolkit is a step-by-step guide for SANE programs to examine their impact on prosecution outcomes. It has already been used successfully in several jurisdictions across the country, allowing each community to know how many sexual assault cases treated by the SANE program reach prosecution and result in a conviction. The Toolkit is built for SANE programs that do not have any prior experience or expertise in evaluation. You can find it here.

Prior bad experience with researchers or evaluators: A prior bad experience with an evaluator or researcher will likely discourage a SANE program from engaging in these partnerships in the future. Not all researchers or evaluators are the same. A good research or evaluation partner will ask for and value the SANE program's input, understand the dynamics of sexual assault, protect confidentiality, and plan for utilization of the evaluation findings.

Lack of resources: Evaluations do not have to cost a lot of money or take up a lot of time. Build resources for evaluation into the SANE program budget and remind funders that evaluation can actually bring in more money as it can provide hard evidence that the program is working, prompting additional financial support for its operation. An external researcher or evaluator may be able to help the SANE program identify how to implement an evaluation without compromising the program's number one priority—patient care.

Fear of negative evaluation results: Not knowing what will be discovered in the course of an evaluation can be concerning; however, it is important to remember that unexpected results are not a bad thing—they are a first step in identifying opportunities for program improvement.

Conclusion

Evaluation should be incorporated into SANE program development from the beginning. Effective evaluation becomes a useful tool for improving care to sexual assault patients and for improving all aspects of SANE services.

Chapter 10: Expanding Forensic Nursing Practice

The need to provide health care solutions to victims of interpersonal violence goes beyond care for the sexual assault survivor. Many SANE programs are recognizing the need to use their unique abilities to evaluate and treat trauma by providing care for other populations. This chapter will explore how to expand your SANE program to provide care to other patients who are victims of violence or other forms of trauma.

SANEs typically have skills that would be useful when working with other populations and in other health care settings. These skills include the ability to document injury, including photo documentation, collecting and preserving forensic evidence, testifying with regard to the injury and evidence collected, providing trauma-informed care, and working collaboratively with community partners such as advocacy and criminal justice practitioners. Having these skills make SANEs the ideal providers to deal with many types of patients beyond sexual assault patients.

Before looking at expansion, there are several factors to consider:

1. Is someone else already providing the service successfully? Duplication of services may not be necessary. It is important to collaborate with community partners and others who may offer similar services.
2. Does adequate staffing exist to expand the program? If your program cannot provide SANE coverage 24/7 now, expansion may harm your existing services or may not be possible.
3. Do the nurses and other program staff support expansion? If the nurses are not prepared to take on other patient populations, staff turmoil may result. In addition, input from the nurses may identify potential benefits or obstacles to expansion.
4. Is there a source of reimbursement for the expanded services?
5. Are medical staff with the appropriate skills readily available to provide consultation for more medically challenging or complicated patients? For instance, if the program is planning to see victims of strangulation, there must be appropriate diagnostic testing and interpretation services available.
6. Do the resources exist to provide the necessary additional nursing education, supplies, and other expenses that will be needed to expand the practice? Providing additional education may have significant costs both in providing didactic as well as clinical training for onboarding of staff. Prior to expansion, consider the following for each type of forensic patient: development of an educational curriculum, clinical practice guidelines, review of legal issues related to that specific population, and preparing for potentially new forms of testimony.
7. If expansion results in increased court time, will the expenses and time away from patient care be covered?

8. Will there be additional equipment needs based on an increase in patient volume or individual need?
9. How will you prioritize forensic patients when you have two or more at the same time?

Chapter 10 Subsections:

Go to Conclusion: The Successful SANE Program

10.1 Expanding Your Program To Include Intimate Partner Violence

Since hospitals are required to screen patients for intimate partner violence (IPV), facilities with SANE programs may choose to use their forensically trained nurses to evaluate patients once they are identified by other nursing or medical staff. When considering adding IPV, it is important to be familiar with all local resources. Programs expanding to serve this population will want to ensure collaborative working relationships with local IPV crisis centers and shelters in an effort to meet all of the patient's needs.

Challenges to this type of expansion—

1. Protocols will need to be in place to determine when program staff will be called to evaluate a patient. Will all assaults be evaluated? For example, a bar fight between two strangers, or only assaults where there is ongoing contact between a victim and a suspect, such as with an adult child and elder parent?
2. Nurses will need to understand that many patients who identify as victims of IPV may chose not to accept services that would allow them to leave an abusive situation.
3. Program staff will require education in history-taking surrounding the patient's IPV experience, not just as a one-time incident, but rather any violence that occurred across the life of the relationship and its impact on the patient's health.
4. Program staff will need training in formal safety planning. Verifying that safety planning can be accomplished with community-based advocacy or social work is critical. Programs functioning outside the hospital setting may be required to travel to sites such as shelters or police stations in order to serve the patient.

5. Testimony in IPV frequently involves civil as well as criminal court proceedings, and, as a result, program staff may be involved in order of protection or restraining order hearings. These cases can and do occur rapidly following the incident of care, unlike testimony following a sexual assault. This may create issues with staff coverage to be able to respond to the needs of the criminal justice system while maintaining services at the hospital.
6. Program staff will need to be familiar with the mandatory reporting requirements surrounding IPV-specific issues. These requirements may be specific to types of injury sustained, or even involve reporting when animal abuse is part of the overall IPV. Although animal abuse is not normally a mandatory report, being familiar with your local resources for animals living within violent homes will give program staff the ability to provide more information to the victim.
7. Programs will need to be aware that providing information to IPV patients may increase their risk for continued abuse. Documentation tools, referrals, and safety planning information to give to a patient should be in a format that can be hidden (such as information contained in a lipstick tube).
8. Coordination with law enforcement and hospital security is important to assure that perpetrators of IPV do not pose a safety risk to staff or patients.

10.2 Expanding Your Program To Include Strangulation

Identification of strangulation is a standard part of the sexual assault assessment. Expanding assessment and documentation to other victims of strangulation may not require additional education on the part of the SANEs, depending on what the baseline education included; however, program managers will want to ensure training for staff on strangulation that presents outside the scope of sexual assault, such as with young people who play the "choking game."

Challenges to this type of expansion—

1. How will patients be identified and referred to care?
2. How will SANEs and/or facilities be reimbursed for providing this care?
3. How will SANEs collaborate with emergency department physicians to ensure proper diagnostic testing and treatment, or when the program is community-based, how and where that patient will receive the necessary testing and treatment?

10.3 Child Maltreatment

Another area for expansion is working collaboratively with medical staff to identify, document, and treat child maltreatment more effectively. Additional didactic and clinical education is required of program staff. Programs will need to work closely with their medical staff partners to outline the role of the SANE in these cases, which may vary considerably from one community to another.

Challenges to this type of expansion—

1. How will patients be identified and referred to care?
2. How will SANEs and/or facilities be reimbursed for providing this care?
3. When the program is community-based, how and where will that patient receive the necessary testing and treatment?
4. Does the community have access to trained child abuse pediatricians?

10.4 Injuries (Major Trauma, Non-Accidental and Accidental, Occupational)

Depending on the location of the program (acute care hospital versus community clinic versus family justice center), one area of expanded practice is consultation in injury cases. The injuries may be the result of major trauma such as physical assaults, gunshot wounds, stabbings, or pedestrians struck, or from motor vehicle crashes, a fall down the stairs, or work-related injuries. The use of a forensically trained SANE can identify accidental versus inflicted injuries, improve documentation and treatment, and provide a variety of testimony, as necessary.

Considerations for this type of expansion include, but are not limited to—

1. Which types of patients can be seen given the setting and what is the scope of services that can be delivered (e.g., will deceased patients become the legal responsibility of the coroner or medical examiner)?
2. What response time will be required, and can the program handle the expectation? Where will the services be provided (e.g., in the ICU when the program typically functions in the emergency department)?
3. What training of program staff will be necessary?
4. What collaborators will need to be part of the program?
5. How will others (departments and staff) be trained in the use of the SANE program?

10.5 Iatrogenic Injuries/Risk Management

Some hospitals are using forensic nurses to document occurrences within the health care facility that result in injury to patients, staff, or visitors. This may include getting a history of the event and documenting both the injuries obtained in the event and the scene where the event occurred.

Challenges to this type of expansion—

1. Creating a system for notifying nurses and a plan for how they will respond to an event.
2. Dealing with potential conflicts of interest if the nurse is part of the investigation of alleged errors by a colleague.

10.6 Human Trafficking

Many team partners, such as law enforcement and prosecution, are beginning to understand the significant health needs of victims of human trafficking. At the same time, health care is providing more education regarding the provider's ability to identify trafficking victims in the health setting. As a result, forensic nurses are being asked to evaluate these victims, identify their health needs, and collect forensic evidence. Many human trafficking responses lack a medical forensic component. The approach commonly used for sexual assault victims in a SANE program are not always effective in working with victims of trafficking. Victims may have been beaten, tortured, exposed to a wide range of violence, confined, and deprived of food, water, and sanitary needs. Victims may also be subjected to narcotics to create addiction and dependence.[110] The involvement of mental health professionals in the care of trafficked victims can be critical. Some victims of human trafficking are unable to perceive that they are victims of crime. This can result in a lack of capacity to trust providers. It may be difficult to establish groundwork for the victim to feel safe enough to disclose the details of their victimization.[111] Exams may need to be delayed to meet the emergency physical and mental health needs of the survivor, which may be profound. The typical sexual assault victim reporting for an exam usually has one episode with one perpetrator; however, victims of human trafficking, particularly those who are victims of sex trafficking, often have been assaulted multiple times by various perpetrators during their captivity.[112]

Challenges to this type of expansion—

1. **Education for staff:** The first challenge in expanding services to meet the need of trafficking victims is the need for additional education required by both the program staff and the larger emergency department staff. Because trafficking victims can be hidden in the general patient population, it is crucial that all staff know what to suspect so that proper referrals to the program can occur. Legal considerations should be anticipated because there may be issues with obtaining informed consent for the exam, as many victims of human trafficking are minors.
2. **Additional responders:** There will be a need to include mental health providers on the response team for this patient population.
3. **SANE and staff safety:** Coordinate with law enforcement and hospital security to assure that perpetrators of human trafficking do not have access to victims.
4. **Vicarious trauma management for staff:** Victims of human trafficking have often been subjected to multiple forms of victimization and may have been subjected to torture.

5. **Reimbursement for services:** The program may need to expand the sources of reimbursement to cover medical costs for services beyond just sexual assault-specific reimbursement.
6. **Civil needs for victims:** The program may need to include access to civil resources for legal assistance for patients.
7. **Commercial sexual exploitation of minors:** This is a serious form of child abuse, as indicated in CAPTA (Child Abuse Prevention and Treatment Act), in which case mandatory reporting laws would apply.

10.7 Suspect Examinations

Because SANEs have expertise in evidence collection from a person, many SANEs and SANE programs are assisting law enforcement in the collection of evidence from suspects. There are many considerations that a program should evaluate when determining their participation in this practice.

Challenges to this type of expansion—

Legal considerations

Unlike other forms of program expansion, the collection of evidence from a crime scene and from a suspect in a sexual assault case is a law enforcement investigative function. Following rules of evidence and preserving the suspect's constitutional rights against unlawful search and seizure are major considerations when collecting evidence. Evidence must be obtained legally and hold up in court under close scrutiny. SANEs who collect this type of evidence do so under the direction of law enforcement. They are acting as an agent of law enforcement and should communicate with law enforcement to ensure that all legal standards are met. While a SANE may be acting as an agent of law enforcement, he or she is still obligated to comply with all aspects of their Nurse Practice Act.

Under most circumstances, evidence from a suspect can be obtained legally through consent. Law enforcement can collect if probable cause exists, a judge has issued a court order or search warrant, or if evidence has been abandoned. Some states allow the collection of forensic evidence from a suspect under the *exigency exception* without any order. The SANE should communicate with their law enforcement partner to determine which method is being used.

If a search warrant or court order is obtained, the SANE should understand exactly the items/evidence to be collected from the suspect as outlined in the order. They should stay within those parameters when collecting. It is important for the nurse to understand that a search warrant orders the suspect to submit to evidence collection. It is not an order requiring the nurse to collect evidence. Even with a search warrant, a nurse may be required to get some form of consent before collecting from a suspect in order to not be in violation of their Nurse Practice Act. A few states specify when a nurse can collect without the consent of a suspect. SANE programs should have protocols in place that clearly state when and how suspect examinations will be performed (particularly evidence collection from a minor), and they should be reviewed and approved by hospital or agency legal counsel.

If consent is the legal method, prior to collection, the suspect should sign a law enforcement form allowing the SANE to complete this. At any time, a suspect may withdraw their consent, which would then require law enforcement to obtain some type of court order or a search warrant.

SANE Safety

There should be no circumstance in which a SANE is alone with the suspect. If there are concerns that the SANE could be at risk of injury from the suspect during an examination, evidence collection should not be completed by the SANE. If a suspect refuses to have evidence collected, the SANE should not continue any processing. Law enforcement must determine how to continue with any collection process when a suspect is refusing to cooperate.

Collection costs

These types of collection processes fall outside the SANE's scope of victim sexual assault examinations. Payment for the victim examination is generally predetermined and a process is in place; however, existing laws and statutes may not cover the costs for suspect collection. If the SANE program is involved in suspect collections, a fee schedule and a payment process should be discussed with law enforcement or the prosecuting agency (See section 6.2).

When to do a suspect exam

Many jurisdictions have set policies on the when exams on suspects should be completed. As with any type of forensic evidence, examination times will vary depending on the individual circumstances of the crime. As a general starting point, many jurisdictions are aligning the suspect collection timeframes with the timeframes for a forensic exam on a victim.

Where to do a suspect exam

It is important to prevent any cross-contamination between evidence collection from a victim and evidence collection from a suspect. This may mean having the evidence from a suspect collected at a different location or using a different SANE to perform the collection. It is important to have a protocol that addresses issues of collection and prevention of cross-contamination. When a suspect is in custody, law enforcement generally has a secure location to complete this process.

Suspect collection kit

Creating a standardized collection kit for suspects is a good practice. This ensures consistency in collection and administering the process across multiple jurisdictions. SANEs should work with law enforcement to determine the types of collection equipment needed to identify, collect, package, and preserve all items obtained from the suspect.

Types of evidence collected

Based on the assault history and the parameters of any court order, there are many possibilities for collecting evidentiary samples from a suspect. They may include documenting and photographing injuries, swabbing various body locations, collecting hair, debris, and fibers.

Establishing a protocol for collecting evidence by the SANE is a necessary tool. In some circumstances, law enforcement may simply be seeking to obtain a DNA reference sample (generally called a buccal swab) from the suspect for comparison purposes. In situations when other evidence (finger swabs, penile swabs) is not going to be collected, law enforcement can collect this item without the necessity of involving a SANE.

Documentation

As important as the collection of evidence from a suspect is, it is equally important to ensure this process is properly documented. Chain of custody and evidentiary, as well as injury documentation can prove to be a critical component when cases enter the court system. As with victim examinations, a standard form should be in place to make certain that all exams are completed in a consistent manner.

SANEs should be in ongoing discussions with other disciplines (law enforcement, prosecution, crime lab) in order to provide a clear understanding within the multidisciplinary team of when, where, what, and how a SANE will be utilized in the event there is a need to collect evidence from a suspect.

Conclusion: The Successful SANE Program

All SANE programs should provide comprehensive and compassionate nursing care to survivors of sexual assault. This Guide provides a framework and not a blueprint for making this type of care a reality. While steps are provided to help communities through the process, each program should incorporate aspects of care that reflect the unique needs of the survivors they serve.

Throughout the process of program development, the SANE must maintain a nursing focus that recognizes the importance of caring for the patient and their family, other members of the multidisciplinary team, the community, and finally, the value of self-care for the nurses themselves. The success of a SANE program cannot be fully measured by the number of patients seen or the number of cases prosecuted. A successful program will maintain a patient-centered approach as their nurses provide care to women, men, and children after an event that has been described by one researcher as "one of the most psychologically damaging forms of crime that anybody could experience."[113] The ultimate outcome for a program is to have every survivor feel cared for in a manner that allows them to start rebuilding their life after the assault. The reward for having done the job right is to hear a patient say,

"The respect they give you, the humanizing qualities that they try to bring to the situation, it makes it easier to take each small step at a time... ."[114]

Glossary of Key Terms

Assent – the expressed willingness to participate in an activity (e.g., examination procedures). For younger children who are, by definition, too young to give informed consent to care, but old enough to understand and agree to anticipate, the child's "informed assent" is sought. (IRC, 2012)

Authorization – is an individual's signed permission to allow a covered entity to use or disclose the individual's protected health information (PHI) that is described in the Authorization for the purpose(s) and to the recipient(s) stated in the Authorization.

Colposcope – is a lighted instrument originally used to magnify the female cervix for the purpose of identifying disease that is also used to identify genital trauma in child and adult sexual assault and abuse cases.

Community Needs Assessment – is the process of gathering information about a community in order to identify existing needs and services. Assessments are performed prior to initiating change in a community.

Emergency Contraception – medications or medical devices given or used in the first few days after unprotected intercourse to prevent a pregnancy.

Evidence-Based Practice – involves the incorporation of three components to improve outcomes and quality of life. *External evidence* includes systematic reviews, randomized control trials, best practice, and clinical practice guidelines that support a change in clinical practice. *Internal evidence* includes health care institution-based quality improvement projects, outcome management initiatives, and clinical expertise. *Accounting for patient preferences and values* is the third component of this equation. (Lippincott's Nursing Center.com)

Guardian – an individual who is authorized under applicable state or local law to give permission on behalf of a child to general medical care [45 CFR 46.402(3)]. A guardian is also someone who has the legal responsibility to care for a person or their property.

Historical Trauma – the collective emotional and psychological injury both over the lifespan and across generations, resulting from cataclysmic history of genocide. (Maria Yellow Horse Brave Heart)

Human Trafficking – is a modern-day form of slavery involving the illegal trade of people for exploitation or commercial gain. (U.S. Department of Homeland Security)

Incapacitation – is the inability to make decisions for oneself.

Indian Country – is land within an Indian reservation and all such other dependent Indian territories, and all land acquired by Indians in which tribal and federal laws normally apply and state laws do not.

Indian Health Service (IHS) – is the federal health program that provides health care services to American Indians and Alaska Natives.

Informed Consent – legal concept that adults of sound mind should be able to make decisions about their own health care.

Institutional Review Board (IRB) – is a committee established to review and approve research involving human subjects. The purpose of the IRB is to ensure that all human subject research be conducted in accordance with all federal, institutional, and ethical guidelines.

Intimate Partner Violence – describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. (Centers for Disease Control and Prevention)

Jurisdiction – is a community that has power to govern or legislate for itself. For example, a jurisdiction may be a local area, state, territory, or tribe. Jurisdiction also describes the authority to interpret and apply laws; it is used in this context when identifying who has jurisdiction over particular case.

Logic Model – is a tool used for program planning and evaluation.

Mandatory Reporting Laws – require health care providers to share information with law enforcement or other agencies that would otherwise be considered a breach of confidentiality. All states have laws requiring the reporting of suspected child abuse. In addition to child abuse, some states require the reporting of elder abuse, the abuse of vulnerable adults, specific types of inflicted injuries, and some infectious diseases.

Medical Forensic Examination – The sexual assault medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients. The examination includes gathering information from the patient for the medical forensic history; an examination; coordinating treatment of injuries, documentation of biological and physical findings, and collection of evidence from the patient; documentation of findings; information, treatment, and referrals for STIs, pregnancy, suicidal ideation, alcohol and substance abuse, and other nonacute medical concerns; and follow up as needed to provide additional healing, treatment, or collection of evidence. This exam is referred to as the "forensic medical examination" under the Violence Against Women Act (VAWA). (A National Protocol for Sexual Assault Medical Forensic Examinations)

Medical Screening Examination (MSE) – an examination required by the Emergency Medical Treatment and Active Labor Act to determine whether or not a patient has an emergency medical condition or is in active labor. All emergency departments are required to provide this examination to every patient presenting to the emergency department requesting care, unless the patient meets the limited exceptions described in the rules interpreting the law.

Memorandum of Understanding (MOU) – is a written agreement between two parties. It is less formal than a contract.

Mental Capacity – is the ability for a person to make their own decisions. A patient can lack capacity either temporarily or permanently.

Mental Competency – is a legal term that indicates a person has the legal ability to make decisions for themselves.

Mission Statement – a statement that defines the purpose of an organization.

Multidisciplinary Approach – involves working with several disciplines to create a comprehensive approach to a problem.

Multidisciplinary Teams – are agencies partnering together to provide interagency, coordinated responses that make victims' needs a priority, hold offenders accountable, and promote public safety. (OVC)

Non-Accidental Trauma (NAT) – in an injury deliberately inflicted on a child.

Nurse Practice Act – is a state law that defines the scope of practice for nurses.

Office for Victims of Crime (OVC) – administers the **Crime Victims Fund** (the Fund), which is financed by fines and penalties paid by convicted federal offenders, not from tax dollars. Federal revenues deposited into the Fund also come from gifts, donations, and bequests by private parties. OVC channels funding for victim compensation and assistance throughout the United States, **raises awareness** about victims' issues, promotes compliance with **victims' rights laws**, and provides **training and technical assistance** and **publications and products** to victim assistance professionals. OVC is part of the Office of Justice Programs at the U.S. Department of Justice.

Office on Violence Against Women (OVW) – a component of the U.S. Department of Justice, provides federal leadership in developing the national capacity to reduce violence against women and administer justice for and strengthen services to victims of domestic violence, dating violence, sexual assault, and stalking.

Patient-Centered Care – is care that is respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions. (IOM)

Patient Confidentiality – is an ethical principle associated with medical and social services professions.

Peer Review – is the evaluation of work by other members of the field.

Polivictimization – Polyvictimization occurs when a person is harmed through multiple co-occurring or sequential types of abuse such as sexual, physical, or psychological abuse, exploitation, bullying, and exposure to family violence, as well as identity theft or fraud, especially in older adults.

Quality Caring Model © – is a midrange nursing theory that emphasizes the value of caring relationships to quality health outcomes.

Rape – is penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. (Uniform Crime Report)

Recognition of Community Uniqueness – is a concept used in this Guide to encourage communities to develop programs and services that are compatible and sustainable with the populations served and the available resources.

SANE Sustainability Project – is a project funded by the Office on Violence Against Women to provide programmatic technical assistance to SANE programs struggling to maintain operation. The project continues to provide information about program development and operation. (NSVRC)

Sexual Assault Nurse Examiner (SANE) – is a specialized Registered Nurse who is trained to provide care for survivors of sexual assault, including a medical-forensic exam to collect evidence, treat injuries, and offer support and resources.

Sexual Assault Response Team (SART) – is a group of specially trained members of health care, law enforcement, prosecution, and advocacy that work together to provide health care and advocacy

services to victims of sexual assault, while investigating sexual assault cases for the purpose of criminal prosecution.

Sexual Violence – is a sexual act committed against someone without that person's freely given consent. (Centers for Disease Control and Prevention)

Sex Workers – are individuals whose work involves sexually explicit behavior.

Trauma-Informed Care – is care that involves seeking to understand the connection between presenting symptoms and behaviors and the individual's past trauma history. (Hoda)

Unconscious patient – is a patient who, due to trauma, illness, or ingestion of drugs or alcohol, is not able to respond verbally or in a purposeful way physically.

Victim Advocate – member of the multidisciplinary team whose only responsibility is to provide support to the sexual assault survivor.

Violence Against Women Act (VAWA) – is a comprehensive legislative package designed to end violence against women. It was first enacted in 1994.

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