

Rural SAFE Response

SART Listserv

March 2007

States are listed as points of reference and do not necessarily reflect statewide perspectives.

Topic: Recruitment and retention of SANE programs in rural areas.

Issue: A community has one hospital that is supportive of the SART concept and willing to dedicate a SAFE room, but there are no locally trained SANEs. However, there is little interest by local nurses to train as SANEs.

Background: For the last two years, victims have been transported to a designated exam facility two hours away. Law enforcement (LE) officers and prosecutors both want SANEs performing exams and they do not see a problem transporting victims the distance. The National Protocol states that ‘healthcare facilities should familiarize themselves with the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to turn away patients with emergency medical conditions.’ (pg.57) Could this be used in a positive way to encourage the hospital to promote and train their staff as SANEs?

The national protocol also states that SARTs should avoid transferring sexual assault victims when possible, as every transfer can destroy evidence and cause patients further stress. Despite the protocol, law enforcement and prosecution apparently support the current system of transporting victims for two hours.

Colorado (Evergreen)

- Completing a community-based needs assessment and determining the feasibility of sexual assault medical/forensic programs is important.
- Meeting rural recruitment needs for rural areas means mobilizing services, working with health care providers who are in private practice, working with the county health departments, collaborating with local community members and working "outside the box".
- Nurses in rural communities want compensation and need ongoing educational opportunities to maintain their skills.
- To train emergency room staff to perform sexual assault exams is unrealistic if the theory is that this person will be doing the exam while staffing the emergency room as a "regular" staff.
- Caveat: The standards set in rural Alaska or rural West Virginia may not meet the same needs in rural Colorado, rural Florida, and rural Wyoming.

Florida (Tallahassee)

- Recruitment is also a problem in our area.

Georgia (Duluth)

- In addition to a full-time SANE Services Coordinator, we have 6 to 8 “on-call” contract SANEs.
- Although the national burnout rate is about 3 to 5 years, we have some nurses who have been dedicated and reliable for 8 to 11 years.
- After 20 years, our “free-standing” community-based program is “shifting” in order to meet the challenges of providing a 24/7 program in a community of over 800,000 people.
- We are rebuilding our SANE program with new role definitions and compensation incentives such as on-call pay and increased exam payments. There are other incentives pertaining to court and continued education to maintain a standard of dependable, proficient, and skilled examiners that work with other SART members.
- We are moving from volunteer advocates to a 24/7-paid staff (professional advocates).
- The systemic and prolific shortage of nurses within the professional healthcare field is a shared challenge for both rural and urban SANEs. The value and *importance* of SANE programs is a “community” problem. Public awareness campaigns need to stress that alternatives are not an option.
- Currently we cannot meet the needs and demands for services. We are scaling back from a 24/7 SANE program to a 12/7 or 16/7 SANE program.

Kansas (Wichita)

- Our program has found that offering two four-hour in-service programs for RN's, ARNP's, PA's, and physicians (and sometimes administrators, legal, and risk management) has prompted many to become interested in the SANE program.
- The seminar helps healthcare providers understand the role of the examiner, the role of each team member, and helps to dispel many of the common myths around victimization, evidence collection, and testifying in court.
- The seminar underscores the fact that victims deserve to have a safe environment to go for treatment and evidence collection (and a place that is close/local, not hours away).

Michigan

- In order to have a successful SANE component of your SART, you will need strong nursing support and leadership as a foundation. I have worked with communities that try to develop SARTs and even SANE programs without nursing leadership, and it does not work.
- I would encourage the SART team members, especially victim advocates, to meet with the hospital's ER staff and nurses to ask for their help. Include one of the SANEs from the neighboring area to approach the concept as a best practice standard of patient care, as opposed to investigative tool.

- Cite the American College of Emergency Physicians Evaluation and Management of the Sexually Assaulted Patient and the International Association of Forensic Nurses as sources of best practice information.
- Avoid any approach that appears coercive or imposing.
- Hospitals can certainly mandate training for their staff and include SANE as a job expectation, but there is a very high level of professional commitment that is required in order to be an effective and proficient SANE.

Military

- If there are nurse practitioners (NP) at the facility, they or perhaps some MD's, may be willing to be trained to perform examinations if the facility is supportive.
- Are there providers within Women's Health or Family Health that would be willing to be a primary Point of Contact (POC) for this, and would the hospital be willing to pay people extra to come in to do exams as needed?
- If a case only occurs occasionally, then an NP or MD should have no problem with this. Many rural hospitals receive as little as one call a month or less.
- The common argument about retaining SANEs in rural areas is that they do not perform enough cases to stay qualified. However, healthcare trains people to do CPR and Advanced Cardiac Life Support (ACLS) every day without practicing on real cases. For example, a DVD on how to do a Sexual Assault exam using a simple CPR resusa-Annie, a GYN mannequin/model (Simulaids), a sexual assault exam kit, a camera and a couple of case scenarios is all an active experienced nurse practitioner or physician need to stay qualified if they do one or two of these practice exams every 6 months.
- A SANE may not be necessary. Clinicians who perform examinations every day (2000-3000 paps a year), and who have knowledge in how to do a sexual assault examination may be as qualified as SANEs to perform forensic medical exams. Clinicians have a high baseline experience in what is normal. They have experience treating STIs (sexually transmitted infections) and provide emergency contraception.
- If the hospital supports examinations done by their providers, they need to support training, overtime, and time for expert witness testimony.
- It is also important to remember that the Joint Commission of Accreditation of Hospitals requires that a medical facility have a sexual assault response program in place, so regardless of what they choose, it should be an agreed upon process that is written and followed.
- In general, an ER may not have enough staff to enable a nurse or a physician to be gone for 3-8 hours.
- The best providers equipped to handle this type of care (and the ones with the greatest flexibility) are often the family practice physicians, nurse practitioners and physician assistants (PA). Many have administrative time set aside so that they could be on-call during the day.
- There are other groups of RN's that enjoy moonlighting to do this work, but it is important to find NP's, PA's, MD's or RN's who want to be involved.

National consultant's recommendations for recruitment

- More targeted outreach.
- Bring the SANE to the victim.
- Build relationships that can turn into support.
- Provide regular training programs that provide a continuum of intervention (some communities are beginning to discuss the possibility of telemedicine).
- A barrier to rural reporting is confidentiality. It may be beneficial if sexual assault patients leave the community and go outside the area to get the examination done.
- Widen the scope for recruitment. While Emergency Dept. nurses are certainly a target, this kind of work could be an interesting change of pace for nurses from other hospital departments (e.g., medical/surgical, maternity, psychiatric nurses) and outside the hospital (e.g., home health, hospice, and retired nurses).
- Recruit regionally, if this is geographically feasible (e.g., considering travel time for response).

New Jersey (Broome County)

- We are addressing recruitment and retention of examiners as a priority.
- Currently, the local hospitals encourage emergency department staff to take the training, but few respond.
- We recently recruited a retiree. She has the ability to move independently in and out of hospitals on a per diem basis, and is available for on-call, meetings, excursions, etc. Our hope is to hire her directly through the CVAC.

New Jersey (Trenton)

- In 2004, we closed the only site in a rural county because there were not enough cases to keep the nurses competent or interested. The SANE Coordinator took 24/7 call for a few years!
- We are working to re-open that site again. One idea is to pay experienced examiners from another county to travel to do the exam. Of the eight nurses who live close enough to make the trip, two are willing.
- SANEs who travel will not be provided on-call pay, but will be paid a substantially higher case pay to travel into another county to do the case. We expect 7 to 10 cases a year.
- We will also recruit locally for SANEs. The County Prosecutor's Office will employ a SANE Coordinator (very limited hours) to oversee clinical practice.

New York (Bronx)

- One of the most important qualifications for this job is to recruit examiners who want to be in that room! I have worked with school nurses, psych nurses, nurse midwives, PAs, and residents who are excellent and compassionate.
- You might want to try to recruit from any local professional medical associations, schools of nursing, etc.

Wisconsin

- In Wisconsin, we have a considerable amount of rural areas. Recruiting is not one of our dilemmas. We have waiting lists for our adult/adolescent classes (2/per year).
- We are planning a 4-hour pre-conference to identify and create a mentorship program to help communities without SANE programs, and to create leadership of SANE programs around the state.
- Our thought is that we would regionalize the state and identify the SANE programs that would be willing to mentor new SANE's and to assist the programs with set up.
- It will consist of a coordinator workshop, orientation or preceptor program and technical assistance portion.
- We work very closely with our coalition
- We are still struggling with the full buy-in from hospital administration. We are considering doing a hospital administration workshop to get the full buy-in.
- One of my biggest concerns is equitable pay for these providers.
- Telemedicine works but as a consult to a practitioner who needs a second opinion.

Wisconsin (Madison)

- We have a very large state with lots of rural areas, but not all hospitals are open to housing a SANE program.
- In some cases, this is despite the fact that nurses in the EDs want the program and training, and that hospital administrative staff have had meetings with local sexual assault programs and SANES.
- I was wondering if anyone is familiar with training programs designed to increase the knowledge and expertise of the non-SANE evidence collector. If so, could you please send any information you might have? While they may not be receiving the multitudes of reports that other areas are (and I fully agree that the SANE program is the best way to go), the reality is that staff in these hospitals are doing the exams right now with no training.
- We made a DVD designed for non-SANE ED staff who do exams, which the crime lab provided to all hospitals, but ED staff needs so much more.

South Carolina

- Mobile colposcope/traveling SANE concept might work. Why not have the SANE/FNE/SAFE come TO the hospital?

Texas (Anderson and Cherokee Counties)

- We have several ER nurses, as well as OB and home health nurses.
- The only issue that you may run into is pay for the nurses that do not work at a hospital. Where the hospital will pay a nurse to be off for training, smaller companies do not have that luxury.
- In our case, we (the Crisis Center) are paying for one of the nurses who is on unpaid leave during training.

Resources

Addressing America's Forgotten Crime Victims: Model Strategies and Practices for Rural Victim Assistance

http://www.washburn.edu/ce/jcvvs/research/rural_crime_victimization/full.shtml

Discusses survey results of rural programs.

Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons

http://www.unfpa.org/upload/lib_pub_file/373_filename_clinical-mgt-2005rev1.pdf

This guide is intended for use by health care professionals who are working in emergency situations (with refugees or internally displaced persons – IDPs), or in other similar settings, and who wish to develop specific protocols for medical care of rape survivors.

Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient

http://www.acep.org/NR/rdonlyres/11E6C08D-6EE7-4EE2-8E59-5E8E6E684E43/0/sxa_handbook.pdf

This document was created under the leadership of the American College of Emergency Physicians (ACEP). The intent was to prepare a set of useful and practical recommendations that will standardize the evaluation and management of sexual assault patients.

Guidelines for Medico-Legal Care for Victims of Sexual Violence

<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>

These guidelines will be of interest to a wide range of health care professionals who come into contact with victims of sexual violence or have the opportunity to train health care providers that will attend victims of sexual violence. Health care professionals who come into these categories may include health service facility managers, medico-legal specialists, doctors and nurses with forensic training, district medical officers, police surgeons, gynecologists, emergency room physicians and nurses, general practitioners, and mental health professionals. Health professionals can use the guidelines as a day-to-day service document and/or as a tool to guide the development of health services for victims of sexual violence.

National Victim Assistance Academy on Rural Victims

<http://www.ojp.usdoj.gov/ovc/assist/nvaa2000/academy/chap22-6.htm>

This section of the report examines the unique challenges to providing basic victim services in rural-remote regions and promising practices that seek to improve victims' rights and services.

Online Medical Forensic Exam Forms

http://www.sdfi.com/sdfi_telemedicine_esignature_solutions.html

SDFI®-TeleMedicine provides SART, SANE & SAFE eforms. There is no charge for the forms and the forms are generic; not state specific.

Rural America at a Glance

Economic Research Service

<http://www.ers.usda.gov/publications/rdr94-1/rdr94-1.pdf>

Provides the most current indicators of social and economic conditions in rural areas for use in developing policies and programs to assist rural people and their communities.

Rural Health Information Network Directory 2003, U.S. Department of Health and Human Services

<http://www.raconline.org/pdf/RHINdirectory.pdf>

This Directory was designed to facilitate information sharing and networking among individuals and organizations with interests in rural health care in America. The directory lists 600 organizations, businesses and offices, largely in the Nation's capital area, with members who are interested in rural health issues. These include associations, foundations, and federal offices.

Rural Assistance Center (RAC)

<http://www.raconline.org/>

The Rural Assistance Center (RAC) was established in December 2002 as a rural health and human services "information portal." RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents.

SANE Development and Operational Guide

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>

The goal of the guide is to provide the necessary information to develop and operate a SANE by incorporating forms, policies, procedures, protocols, training options, and program evaluation tools. Standards of practice are provided when there is a recognized standard. When program options are a choice, advantages and disadvantages for each option are discussed.

Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims (April 2001)

http://www.ojp.usdoj.gov/ovc/publications/bulletins/sane_4_2001/welcome.html

This OVC bulletin (NCJ 186366) provides an overview of Sexual Assault Nurse Examiner (SANE) programs and their contributions to improving community response to sexual assault victims, identifies promising practices in such programs, and provides practical guidelines for establishing a SANE program.

Unspoken Crimes: Sexual Assault in Rural America

http://www.vawnet.org/SexualViolence/Research/VAWnetDocuments/AR_RuralSA.pdf

This booklet considers sexual assault from a rural perspective including data on the prevalence of rural sexual assault, rural characteristics that deter reporting, and difficulties encountered by advocates. Also offers insight and best practices of rural advocates.