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Sexual Assault Nurse Examiners

Study of Sexual Assault Nurse Examiner Availability, Adequacy, Costs, and Training

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Executive Summary

This study assesses the statewide availability of sexual assault nurse examiners (SANEs). These nurses may conduct an examination, collect forensic evidence, and provide expert testimony. Pursuant to RCW 43.280 and [Substitute House Bill 2711](#)¹ (Chapter 50, Laws of 2016), the Washington State Department of Commerce (Commerce) and its Office of Crime Victims Advocacy measured SANE availability in consultation with experts in the fields of sexual assault victims' advocacy, sexual assault investigation, and medical service provision.

The study team met with stakeholders and completed its initial research over the summer of 2016. The research consisted of a national literature review of best practices and protocols for successful SANE service delivery, and a review of successful programs in Alaska and Oregon, both of which have well-developed SANE practices.

The recommendations offered by study participants, the lessons of neighboring states, and best practices within the sexual assault community guide the strategies in this report for increasing SANE availability and improving the response to sexual assault.

Key Findings

This report is part of a larger effort to understand and improve the delivery of sexual assault services statewide. We know that many survivors of sexual assault do not report the crimes committed against them and others choose not to report after an examination due to several factors. Some of those factors relate to inefficiencies in the medical and legal systems, such as lack of clarity during the complex sexual assault examinations process, and to emotional factors, such as a perceived likelihood of re-traumatization and victim blaming, and the perception that perpetrators are rarely convicted.²

This study aims to increase our shared understanding of the sexual assault response system, and to address the availability of sexual assault services at a critical moment in the life of a survivor. Key findings include:

- Rural areas do not have adequate facilities or personnel to respond to the demand for examinations.
- Urban areas absorb the demand for examinations from rural areas, and serve as multi-county referral hubs, as observed in Benton, Clark, Snohomish, Spokane, Thurston and Kitsap counties. As a result, the resources in such areas are stretched to meet that additional service demand.
- These first two key findings result in skewed data that do not effectively communicate where the demand for examinations originates. Urban areas that serve as multi-county

¹ <http://lawfilesexext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2711-S.SL.pdf>

² Rape, Abuse, and Incest National Network. <https://www.rainn.org/statistics/criminal-justice-system>
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referral hubs experience inflated demand for examinations, which clouds our understanding of which areas of the state are underserved.

- Strategies that emphasize community capacity building and regulation of SANE training and standards offer the most direct pathways to integrating a victim-centered service delivery that sustainably addresses SANE availability.
- Officials interviewed for this study agreed that an adequate response time to any survivor of sexual assault was no more than one hour from the initial request for an examination to the provision of the examination.

Challenges

Officials, practitioners, and experts interviewed during the review process agreed that there are many challenges to achieving a stable base of sexual assault nurse examiners. The primary challenges to achieving adequate provision of SANE services relate to data silos, funding levels and structures, limited training opportunities, and communication between sexual assault service providers.

In 2015, 5,254 incidents of sexual assault were reported statewide.³ As of September 2016, 74 hospitals throughout Washington offered a sexual assault examination or employed SANE-trained nurses. However, these services are not uniformly distributed and accessible statewide. Eight counties do not have a hospital that employs SANEs. Hospitals in four counties offered SANE services but could not confirm a trained SANE was currently on staff, and hospitals in two counties contract directly for SANE services. From this snapshot, urban areas have the greatest SANE availability, and the adequacy of SANE coverage county-to-county is unevenly distributed and not well documented.

Key Challenges

- **Data silos prevent consistent data collection.** Sexual assault data is historically underreported⁴ – and SANE location, availability, and service data is no different. Data is maintained by individual stakeholder groups and is inconsistently collected.
- **Limited availability for SANE training opportunities.** It is difficult for nurses to secure funds for training or receive time off to attend training or continuing education classes. The only SANE training provider in Washington – the Harborview Center for Sexual Assault and Traumatic Stress – trains about 125 nurses each year.
- **Nurses do not receive consistent support from hospital administrators.** This may include gaps in shift or on-call coverage, lack of consultation and case review, or inadequate case compensation.
- **Providers are paying for about 60 percent of SANE services.** Funding sources that reimburse hospitals for delivery of SANE services do not cover the program costs for an

³ Email from Washington Association of Sheriffs and Police Chiefs dated August 1, 2016.

⁴ GAO report #16-546, 2016. GAO report #16-546, 2016. <http://www.gao.gov/assets/680/678511.pdf>

exam. When accounting for the entire range of program costs, about 40 percent of all exam costs are reimbursed by [Crime Victims Compensation](#)⁵ (CVC) program, the balance by providers.

- **Lack of a community-based response leads to uneven outcomes.** Communities that do not have the organized support of stakeholder groups have the least cohesive response to sexual assault. For example, without a shared understanding with community-based advocates, hospitals may underutilize SANE services and deter survivor disclosures.

Strategies

Successful and sustainable community-driven strategies to increase SANE availability must:

- Build on stakeholder capabilities and strengths.
- Emphasize the creation of joint processes and information sharing.
- Allow room for the implementation of local innovations.
- Focus on improving stakeholder relations and engaging the needs of communities and survivors directly.

The challenges reported by officials offering SANE services throughout Washington communities are no different than those reported by communities nationwide. Improving access to training and resources are proven strategies that increase the number of trained SANEs and their availability. Shared strategies for increasing SANE availability include:

- **Strategy 1** – Mobile SANE teams.
- **Strategy 2** – Multi-disciplinary teams that serve adult sexual assault survivors.
- **Strategy 3** – Remote training opportunities and consultation via electronic means.
- **Strategy 4** – A SANE training fund that supplements the cost of sexual assault exams.
- **Strategy 5** – Marketing materials for CVC funds, SANE programs, Children’s Advocacy Centers, and Community Sexual Assault Programs.
- **Strategy 6** – State-supported SANE data collection efforts.
- **Strategy 7** – State accreditation of SANE hospitals as centers of excellence.
- **Strategy 8** – SANE report card that requires hospitals to report information on SANEs, their availability, and level of training or certification to an independent agency.

The recommended strategies for increasing SANE availability and creating a SANE culture are widely practiced, and this study will use relevant examples, where available, to describe their function.

To supplement these shared strategies, this report contains a proposal for increasing the availability of SANE training, creating web-based resources, and developing a core consultation team at the Harborview Center for Sexual Assault and Traumatic Stress.

⁵ <http://www.lni.wa.gov/claimsins/crimevictims/about/>

Introduction

The purpose of this study is to assess the statewide availability of sexual assault nurse examiners (SANEs). These are nurses that may conduct an examination, collect forensic evidence, and provide expert testimony. In conducting this study, pursuant to [Substitute House Bill 2711](#)⁶ (Chapter 50, Laws of 2016), the Office of Crime Victims Advocacy (OCVA) in the Department of Commerce (Commerce) worked in consultation with experts on sexual assault victims' advocacy, experts on sexual assault investigation, and medical providers.

The legislation identified eight stakeholders and approximately 25 additional stakeholders during the data-collections process. Through a series of interviews, this study consolidated and reviewed available data and stakeholder feedback to construct a statewide overview of the availability of sexual assault nurse examiners. In addition to determining SANE availability, the responsibilities of the study under RCW 43.280 are to:

- Identify areas of the state that have an adequate or inadequate number of SANEs.
- List the available resources for facilities in need of SANEs or SANE training.
- Consider strategies for increasing the availability of SANEs in underserved areas, including remote training or consultation via electronic means (telemedicine or telehealth) and mobile SANE teams.
- Consider costs, SANE reimbursement rates, and funding options.

The central theme of “adequacy” dominated this study. What stakeholders perceived as adequate varied from county to county and among SANE programs.⁷ This is because adequacy in one location often looks different in another. The goal of an adequate response is to limit further trauma to every survivor. Thus, adequacy is not just a number – it is contextual. In effect, stakeholders noted that adequacy ensures that *services are reasonably available when needed*.

SANEs stand out as a bright spot at a critical point in time in the life of a survivor. When combined with active victim-centered advocacy, the trauma-informed care of the SANE presents a positive support structure that enhances a survivor's capacity for recovery.⁸ By increasing SANE availability and integrating a comprehensive community support infrastructure, the opportunities to receive care and the quality of this care will also improve. This study highlights underserved areas of the state and discusses major factors that could increase collaborative responses to sexual violence. It also informs a strategy for the continued

⁶ <http://lawfilesexext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2711-S.SL.pdf>

⁷ SANE programs are established units of care with a stable staff of SANEs that regularly receive training and maintain the capacity to deliver services. According to the Office for Victims of Crime, the goal of a SANE program is to provide victim-centered services in support of a survivor's recovery.

⁸ R. Campbell, D. Patterson, and L. R. Lichty, “The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs: A Review of Psychological, Medical, Legal, and Community Outcomes,” *Trauma, Violence, & Abuse* vol. 6, no. 4 (2005)

development of SANE availability. The recommendations offered by study participants, the lessons of neighboring states, and best practices within the sexual assault community guide the strategies for increasing SANE availability and the response to sexual assault; a response, moreover, that will rely on thoughtful public and private interventions.

Background

In 2015, law enforcement agencies across Washington recorded 5,254 sex offenses that may have resulted in a sexual assault examination (examination). Sexual assault nurse examiners (SANEs) are medical providers⁹ that conduct an examination and collect forensic evidence after a sexual assault occurs. SANEs are also responsible for providing expert testimony when a case advances to court. Sexual assault examinations are optional, require informed consent, and come at no cost to survivors.¹⁰ This study identified 74 hospitals that may have the personnel and the facilities to provide an examination (see Appendix B).

The number of SANEs performing examinations and the number of examinations performed statewide is not clear. This study, in combination with the Washington State Hospital Association, identified approximately 233 SANEs working statewide. However, an examination is not available in every county, nor can every hospital sustainably staff SANEs.

The immediate purpose of the exam is to provide treatment for any injuries and to offer preventative care, such as prophylaxis for sexually transmitted infections and an emergency contraceptive. The institutional purpose of the exam is to gather forensic evidence via a sexual assault kit for the potential identification and prosecution of the perpetrator, while the purpose of the SANE is to prevent further trauma to survivors.

For adult survivors, an examination and the collection of physical evidence is preferred within the first 120 hours following an assault. For pediatric survivors, the window for an examination is smaller at 72 hours because the primary aim of the examination is disclosure of abuse, not forensic evidence collection. The SANEs that provide examinations generally receive specialized training in forensic evidence collection, and may receive an adult or pediatric certification. In Washington state, pediatric-focused SANEs are nurses that provide forensic nursing services in cooperation with child advocacy centers (CACs). Both adult and pediatric-certified SANE nurses fill other roles in preventative care and coordination across hospital departments. Put differently, nurses with SANE certifications are nurses first and SANEs second.

⁹ SANEs are often registered nurses (RNs), advanced nurse practitioners (ARNP), or other medical professionals, such as physicians or physician assistants. SANEs may be conducted by nurses or physicians that have not had SANE training.

¹⁰ The Violence Against Women Act (VAWA) requires that survivors of sexual assault receive free access to examinations with the costs assumed by the state. These funds are paid through the Crime Victim's Compensation fund, as distributed by the Washington State Department of Labor and Industries.

The effectiveness of SANEs and the examination process extends beyond the provision of immediate medical care to focus on the emotional care and recovery of each survivor. An early intervention and thorough medical response are the bridge that connects a survivor's immediate trauma to long-term emotional well-being. The SANE supports the work of community-based advocates, such as those that may be found in Community Sexual Assault Programs (CSAPs) located in counties throughout Washington.¹¹

In effect, SANEs help soften barriers to comprehensive care during the window immediately after a sexual assault in the same way community-based advocates do for survivors at all steps in the medical and legal processes. The literature surrounding the effectiveness of SANEs and of advocates confirm positive psychological outcomes for survivors, increased prosecution rates of perpetrators, and collection of higher-quality forensic evidence.¹²

Stakeholder Groups

Four general types of stakeholders are closely involved in sexual assault examinations, the investigations process, or provide service and care to survivors of sexual assault:

- **Medical** – A system of medical treatment, referral, and consultation that may include emergency room nurses and doctors, surgeons, and preventative care; exemplified by SANEs that collect forensic evidence.
- **Advocacy** – Community-based advocates are a survivor's direct link to information and emotional support, while systems-based advocates provide system-specific assistance to survivors of sexual assault.
- **Legal** – Prosecutors and the court system, which determine the sufficiency of evidence. In select jurisdictions and organizations – namely children's advocacy centers – prosecutors guide survivors and the other stakeholders throughout the process.
- **Justice** – Law enforcement agencies and officials that respond to sexual assault and collect other forensic or physical evidence in support of presenting case evidence to prosecutors.

After a sexual assault, survivors may present their injuries to any one or more of the four primary stakeholder groups. Survivors may present at various locations, including at hospitals, police stations, or by direct contact with community advocates, or attorneys. There are no predictive models for when or where a sexual assault will occur or when a survivor will require services. The variance between where a survivor presents is a product of stakeholder collaboration and communication, and the availability of information on sexual assault and sexual assault services.

¹¹ The Washington Coalition of Sexual Assault Programs (WCSAP) provides resources, training, and technical assistance to members, partners, and policy makers alike. Currently, 38 out of 39 counties host a CSAP.

¹² Ibid 3.

To illustrate, the medical community – through the SANE – plays a critical role in the medical and legal processes, while advocates are ideally present at each step of the process from start to finish. Participants in this study pointed to the legal system and prosecutors in particular as the “go between” in coordinating the justice, medical, and advocacy communities once a survivor enters the sexual assault investigation process. This is common in select jurisdictions and is a primary response to the overlap between the medical and justice communities during forensic evidence collection.

Sexual Assault Kits

In 2015, approximately 6,000 sexual assault kits (kit) remained untested in Washington state.¹³ After forming in 2015, the Sexual Assault Forensic Examination Best Practices Task Force organized an extensive statewide kit review. The task force found that the local capacity and process to collect, store, and transfer kits is not the same everywhere. As a result, “most jurisdictions do not have systems for tracking or counting unsubmitted [kits].”¹⁴

Following the passage of House Bill 2530 in 2015 and to improve the current storage and processing practices, a statewide kit tracking system – as operated by the Washington State Patrol’s Crime Laboratory Division – is working to uniformly enhance the capacity of kit testing, and the positive outcomes of quality forensic evidence collection, including increased prosecution and conviction rates. In addition, the tracking system’s legislative mandate is to test all kits that receive survivor consent within 30 days and all kits received on or after July 24, 2015.

The statewide kit tracking system must:

- Track the location and status of kits from the point of collection and then throughout the criminal justice process.
- Allow participants in the system to update and track the status and location of kits;
- Allow victims of sexual assault to anonymously track or receive updates regarding the status of their kit.
- Use electronic technology or technologies allowing continuous access.¹⁵

The creation of a kit tracking system moves the state toward a more transparent and victim-centered response to sexual assault. The state allocated \$2.5 million to implement these policies. The distribution of funds for kit testing includes dollars exclusively for SANE training, with 15 percent of funds appropriated from the newly created Washington Sexual Assault Kit

¹³ <http://www.endthebacklog.org/sites/default/files/WASPC%20Unsubmitted%20Sexual%20Assault%20Kit%20Survey%20Results%20Summary.pdf>

¹⁴ <http://leg.wa.gov/JointCommittees/USAEK/Documents/USAEK-PrelimRpt2015-11.pdf>

¹⁵ Final Bill Report 2SHB 2530. <http://lawfilesextra.leg.wa.gov/biennium/2015-16/Pdf/Bill%20Reports/House/2530-S2%20HBR%20FBR%2016.pdf>

account. Such a distribution is common for sexual assault funds, with appropriations for SANE training often a secondary consideration to a primary purpose.

In addition, recent changes to the distribution of federal funds from the Victims of Crime Act (VOCA) Crime Victims Fund¹⁶ created additional resources for SANE services, and represents an increased focus on sexual assault services. The VOCA Crime Victims Fund modifications represent a short-term funding increase that may not be sustained in future appropriations.

The Governor and the Legislature provided leadership in understanding and responding to sexual assault within the state. Recent legislative actions have included:

- [HB 2530 \(2015\)](#)¹⁷ – Developed the statewide kit tracking system.
- [HB 1307 \(2013\)](#)¹⁸ – Sexual assault protection orders may be sent via mail or notice may be posted in widely-circulated newspapers.
- Maintained funding levels in the state budget for sexual assault resources.

These policies aim to improve outcomes for all sexual assault survivors and complement the ongoing work of the Sexual Assault Forensic Examiner Task Force, which addresses issues both within and adjacent to the purpose of this study, such as the handling, storage, and testing of anonymous sexual assault kits.

¹⁶ Historically, between \$7 and \$10 million is distributed to the State of Washington to provide grants for victim's assistance, but in FY 2016 the statewide VOCA distribution will reach \$40 million.

¹⁷ <https://app.leg.wa.gov/billinfo/summary.aspx?year=2015&bill=2530>

¹⁸ <http://apps.leg.wa.gov/billinfo/summary.aspx?year=2013&bill=1307>

Methodology

This study used five steps in the collection and review of quantitative and qualitative data: problem identification, literature review, stakeholder review and identification, data evaluation, and data analysis. The primary mode of data collection was through interviews with experts in the fields of sexual assault victims' advocacy, investigation, and medical provision. Qualitative data collection complemented outreach through phone and email, and a national literature review of sexual assault and forensic nursing. The selection of stakeholders beyond those initially identified in the legislation included stakeholder groups representing marginalized populations that disproportionately experience sexual assault. These stakeholders include:

- **Pediatric** – Children's Advocacy Centers of Washington (CACWA), regional children's advocacy centers, and pediatric SANEs.
- **Tribal** – Regional health organizations that offer healthcare services to Tribes.
- **Rural** – Critical Access Hospitals (CAH) and SANEs in rural health clinics.

Each stakeholder group received open-ended questions tailored to address their respective role(s) in the sexual assault examinations process. In addition, each stakeholder received two identical baseline questions. The first sought to understand how many SANEs are necessary to provide a standard of adequacy, while the second asked interview participants to provide a definition of "adequacy." The summary responses of these two inquiries did not provide concrete recommendations on what quantity of SANEs are adequate, but stakeholders did provide a common theme for defining "adequacy:" *Services that are reasonably available when needed.*

In addition, aggregate data from a survey conducted by the Washington State Hospital Association (WSHA) was used to better grasp both the availability of sexual assault exams in a hospital setting, as well as provider capabilities to supply forensic nurses. The WSHA survey accepted responses from parent hospitals on behalf of network members. In addition, a survey administered by the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) identified which Washington State hospitals offer SANE services, including descriptions of SANE services for each of these hospitals. The availability of SANEs at these locations was measured by the current presence of SANE-trained staff or the existence of contractual agreements to receive SANE services from external providers.

To assess the reliability of the WSHA and HCSATs surveys, the study team verified the presence of SANEs or contracted SANEs at a representative sample of provider locations across the state. Although verification data is not comprehensive, all of the contacted providers confirmed the accuracy of individually verifiable information, such as whether SANEs were currently on staff.

Limitations

Sexual assault data is neither readily available nor uniformly tracked across the nation. A July 2016 report from the Governmental Accountability Office (GAO) noted that the “[d]ifferences across the data collection efforts may address specific agency interest, but collectively, the differences lead to varying estimates of sexual violence.”¹⁹ Washington State is no different.²⁰

WASPC provided extensive quantitative data on the prevalence of reported sexual assault offenses statewide. The National Incident-Based Reporting System (NIBRS) was the main reporting tool used to convey the relative incidence of sexual assault in Washington State. NIBRS data is supplemented by Uniform Crime Report (UCR) Summary data. The difference between the two reporting systems is that NIBRS contains reportable sex offenses, both forcible and non-forcible, while the Summary data reflects rape or attempted rape. That is, NIBRS contains a greater range of criminal sex offenses, and UCR Summary data is more narrowly defined. Many law enforcement jurisdictions utilize NIBRS to report sex offenses, while other law enforcement jurisdictions continue to report sex offense data to the FBI via UCR Summary data.

Each of the reported criminal sex offenses may have led to a sexual assault examination and collection of a sexual assault kit. Because of this, the aggregate NIBRS and UCR Summary figures present the maximum number of potential known sexual assaults that may have resulted in a sexual assault examination. However, we express caution about relying on prevalence data in attempting to understand whether an area is underserved or has adequate SANE staff. The key to understanding the true extent of the problem rests in the use of overlapping data points to create an outline of demand for services in a given area.

To illustrate, law enforcement agencies within Snohomish County in 2015 reported 260 criminal sex offenses. The Providence Intervention Center for Assault and Abuse (PICAA) in Everett performs the majority of examinations in Snohomish County and recorded 835 adult sexual assault examinations during the same period. We know that sex offenses are underreported, but we also know some agencies and select communities track data better than others. In addition, while some data points, such as the number of examinations performed at a hospital are indicators of demand for SANE services, they do not demonstrate a program’s effectiveness.

Moreover, the statewide organization that accredits regional Children’s Advocacy Centers (CACs) also gathers data on the number of child physical abuse and sexual assault survivors that receive a forensic examination. The reporting period for the Children’s Advocacy Centers of

¹⁹ GAO report #16-546, 2016. GAO report #16-546, 2016. <http://www.gao.gov/assets/680/678511.pdf>

²⁰ Administratively, there are many barriers to an effective collection and dissemination of sexual assault incidence and service data. There are also purposeful structural barriers to data collection in this area due to the sensitive nature of the information being collected.

Washington (CACWA) records sexual assault and physical abuse data over the state fiscal year (July 1 to June 30), while both NIBRS and regional CACs report each calendar year. In addition, at the regional level, each regional CAC and their associated medical providers also compile data on the number of physical abuse and sexual assault medical examinations provided. CACWA's data does not distinguish between forensic examinations for physical or sexual abuse, while data points from individual CACs may make this distinction. Because of this, CACWA data cannot speak to the prevalence of child sexual abuse examinations, nor accurately estimate whether physical abuse or sexual abuse is driving the demand for pediatric forensic examinations.

Note that a CAC may receive requests from multiple counties for exams. For instance, the CAC in Kitsap County treats children from throughout Kitsap, Clallam, Jefferson, and Mason counties, as well as parts of Pierce County. This is common throughout SANE service areas. Hospitals and sexual assault clinics alike accept survivors from multi-county areas, with this practice being most common in urban areas with the facilities to accommodate large service areas or in areas, like Kitsap County, where there are no other resources available. Another example is PICAA in Everett which serves Snohomish County and the larger region.

The system's complexity can lead to confusion about the true demand for SANE services statewide. For example, medical providers that serve as regional hubs for SANE services will experience demand from outside of that facilities' immediate area. This distorts where the demand for service exists. To illustrate, Snohomish County is one of these regional SANE hubs. If a survivor travels from Skagit County for an examination, the data will record Snohomish County as the examination location. This will overinflate the perceived demand for services in Snohomish County and convey less need for services in Skagit County. Disparate SANE service levels county to county can also pose challenges to survivors. "It is a hardship to travel from counties away,"²¹ stated a SANE at a high-demand sexual assault clinic.

This study was not able to fully document the system's complexity. Most notably, limited data was available about SANEs and the impact of sexual assault on traditionally marginalized populations, such as inmates and tribal communities. The Department of Justice publishes an annual report on the incidence of sexual assault in prisons, following the Prison Rape Elimination Act. Tribal communities do not possess similar reporting tools to assess the potential gaps in sexual assault services. Select tribal entities that operate facilities that respond to sexual assault were contacted during this study. One such entity, the Tulalip Tribes' Legacy of Healing: Children's Advocacy Center, reported that they were not equipped to provide examinations, and instead PICAA in Everett delivers those services.

Moreover, the Northwest Portland Area Indian Health Board concluded a multi-year grant in 2012 that aimed to increase the capacity of Tribal communities throughout the Pacific Northwest to serve as sexual assault resources. As many as 16 Washington Tribes participated

²¹ Phone interview with the Providence Intervention Center for Assault & Abuse dated July 28, 2016.

in the work, which was supported by the Oregon Sexual Assault Task Force. Yet, the board's partial response to the outcomes of this grant, and to the question of SANE availability in tribal areas, limits inclusion within the study. Partial responses suggest that tribes rely on the same facilities, such as CACs, CSAPs, and hospitals in the same manner as non-tribal populations. A lack of resources, a lack of engagement with local communities, and a lack of approximate medical facilities with SANEs were noted as key barriers to tribal access of sexual assault services, including examinations.

Sexual Assault Nurse Examiners in Washington State

The number of Sexual Assault Nurse Examiners (SANEs) employed in Washington is not known. A September 2016 survey of SANE hospitals conducted by the Washington State Hospital Association (WSHA) found approximately 233 known SANEs working statewide.²² In addition, this study identified 64 SANEs, many located at the same SANE hospitals sampled, which supply SANE services to Children's Advocacy Centers (CAC).

However, in combination with this recent WSHA survey is a March 2016 Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) survey that found as many as 74 hospitals offer SANE services (see Appendix G for a geographical distribution of SANE hospitals). This number could rise or fall based on staffing changes, the progress of SANE training, and a host of other factors such as access to a sustainable source of funding.

A Community Response to Sexual Assault

SANEs contacted during this study from Alaska, Oregon, and Washington, agreed that the efforts of individual medical providers and advocacy organizations to track and support sexual violence services and prevention drives community responsiveness to sexual assault. Accredited Community Sexual Assault Programs (CSAPs) and CACs are among the advocacy resources available to survivors in many of Washington's counties.

These groups are not the sole providers of engaged advocacy, as additional community support organizations connect survivors to these services. As of September 2016, there were 38 CSAPs offering advocacy and assistance and adults and children in all counties, along with a mix of 18 accredited and developing CACs²³ offering pediatric services. See Appendix C for a map of Washington's CACs and CSAPs.

CACs operate in a structured environment pursuant to RCW 26.44 and must form an organized multi-disciplinary team that harnesses the combined powers of prosecutors, advocates, law enforcement, and SANEs to provide sexual assault support services for children. Each child to enter a CAC typically received a referral from either a law enforcement agency or child protective services. In such an organized and collaborative environment, the survivor can more easily access the services and resources available. More broadly, the CAC's understanding of the community's specific sexual assault demands and responses allows for an evolving

²² This WSHA survey included 74 hospitals that are known to either employ SANEs or have employed SANEs in the recent past. Of the 74 hospitals contacted, only 47 completed the survey. In addition, within that number, 11 providers reported contracting for SANE services with RSI based in Oregon. These 11 providers did not submit information on the number of contracted SANEs capable of providing services.

²³ There are 18 CACs in Washington State. Two CACs, those in Lewis and Jefferson counties, are developing members, while the CAC in King County is a non-member CAC.

engagement with stakeholders to generate actionable processes, and help survivors navigate the services and resources available.

CSAPs embody high survivor engagement and well-coordinated confidential support services for survivors of all ages and their families. The early and continued intervention of advocates educates external stakeholders about survivor's needs and lowers the likelihood that a survivor must seek services alone, devoid of the support of the system to guide them through to engaged, victim-centered advocacy. This is the ideal, and as the literature on the effectiveness of sexual assault advocacy demonstrates, a survivor that receives coordinated and compassionate support heals better, faster²⁴ (see Appendix F for the distribution of CSAP services, by county).

Individuals in need of general, medical, or legal advocacy may seek direct advocacy 24 hours a day from a CSAP. However, where CACs typically receive survivor referrals from an authorizing source, a CSAPs referrals window is wider and admits survivors from various points of entry. See Appendix H to review how the Office of Crime Victim's Advocacy (OCVA) works with CACs and CSAPs.

A comprehensive community-based collaboration is essential to effective SANE service delivery. Because we do not know where sexual violence may occur or where a survivor will present, a shared understanding of the survivor's needs is critical to organizing a uniform response to sexual assault. For example, since 2011 SANEs working with the CAC in Snohomish County (Dawson's Place) reported collaborating with more than 72 individual law enforcement jurisdictions, with an additional 349 cases where the agency was unidentified.²⁵

In such a chaotic environment, where the composition of the key players is fluid and survivors may present at multiple points, a joint understanding of the examinations process is vital to instituting and adhering to a uniform response procedure. The implementation of common practices, such as an interagency stakeholder management plan, will inevitably vary by CSAP or CAC because the needs and capabilities of each organization and community are as different as the demands and pressures that complicate an effective service delivery.

Where there is a capacity to deliver services, there are users of these services. Where the systems and capacity to deliver sexual assault services are scarce, survivors may appear scarce. but based on the nature of reporting sexual assault offenses and the structure of sexual assault services, this is not the case. See Appendix D for a distribution of pediatric examinations, by county.

²⁴ Ledray, L. (2001). Evidence Collection and Care of Sexual Assault Survivors. Violence Against Women Online Resources

²⁵ Email from CACWA dated July 28, 2016.

Nine urban counties and 10 rural counties²⁶ currently host 18 CACs statewide.²⁷ More children receive survivor services at a CAC in an urban county than at a CAC in a rural county, and this is a byproduct of population and the concentration of resources available in urban counties. That is, urban counties are more likely to have access to a substantial medical service provider and thereby SANEs, which are key indicators of an organized response to sexual assault²⁸, in addition to a motivated base of advocates, prosecutors, and law enforcement.

Furthermore, multi-disciplinary teams are not the only victim-centered collaborative units for sexual assault responsiveness. For more information on the multi-disciplinary team process, please review Appendix I for a look inside the Monarch Children's Advocacy Center.

Sexual Assault Nurse Examiners in Rural and Urban Washington

Washington State has a considerable divide between the capacity of rural and urban areas to provide sexual assault forensic exams. As the preceding discussion noted, the resources and physical infrastructure necessary to offer SANE services are largely contained within urban counties. This discrepancy places the approximately 1.5 million rural county residents at a deficit when a sexual assault occurs and there is a request for a forensic exam (See Table 1). Rural healthcare providers maintain a high level of expertise across an array of topics because they are the first and last stop for a rural community. Out of 39 critical access hospitals²⁹ statewide, 27 of these rural medical providers indicated to HCSATS and WSHA that they may have the capacity to offer a SANE-trained nurse.

Appendix B outlines the location where hospitals with the potential to offer SANE services reside. The distribution of SANE-capable hospital facilities centralizes around transportation routes and population centers. Most notable are a clustering of hospitals along the northern portion of the I-5 traffic corridor and in counties with a high number of reported criminal sex offenses.

This is especially evident for CACs in rural areas. Of the nine CACs located in rural areas, only 140 pediatric examinations were conducted. This represents approximately 5 percent of all pediatric examinations conducted in 2015. While there are considerably less hospitals in rural areas, there is the same number of CACs in both rural and urban areas.

²⁶ What it is to be rural and urban follows the Office of Financial Management's definition of rural and urban, pursuant to RCW 82.14.370. In addition, one rural CAC covers both Chelan and Douglas counties, and organizes under the Chelan-Douglas Community Action Council.

²⁷ There are 18 CACs in three operational categories. There are 15 accredited members, two developing members in Jefferson and Lewis counties, and a non-member in King County.

²⁸ Little, Kristin (2001). Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response To Sexual Assault Victims. OVC Bulletin. U.S. Department of Justice. Office for Victims of Crime.

²⁹ A CAH is a medical facility that contains no more than 25 beds, does not support care for longer than 96 hours, provides 24-hour emergency care seven days a week, and must be located in a rural area.

Table 1: Snapshot of Rural and Urban Sexual Assault Forensic Exams

	Urban Counties	Rural Counties	Total	Urban Prevalence (per 1,000 residents)	Rural Prevalence (per 1,000 residents)
Criminal Sex Offenses Reported in FY 15	3,786	1,468	5,254	0.688	0.943
Adult Examinations ³⁰	2,948	589	3,537	0.536	0.378
Pediatric Examinations	2,525	140	2,665	0.459	0.090
Population	5,504,640	1,556,770	7,061,410	-	-

Source: Washington Association of Sheriffs and Police Chiefs (WASPC), Washington State Department of Labor and Industries, Children's Advocacy Centers of Washington (CACWA) and the Office of Financial Management (OFM).

The urban areas of Washington State possess significantly more infrastructure and capacity to provide sexual assault services. This is because of a diverse network of sexual assault services that often overlap and complement one another. In addition, while the indicators of demand are high for urban areas, the per capita prevalence of criminal sex offenses is higher in rural areas and access to services is lower. To illustrate, in 2015 urban areas had more:

- Medical facilities that may employ SANEs.
- Requests for CVC reimbursement after an examination.
- Pediatric forensic examinations.
- Reported criminal sex offenses.
- Community-based advocacy services for children and adults.

Urban areas edge closest to providing an adequate level of sexual assault resources and SANEs. However, by no measure of the available data does any one area of the state appear to have an adequate SANE response. To illustrate, Table 2 below provides a comparative sample, with a varied presence of support infrastructure, such as a SANE hospital, and demand factors, such as the number of adult examinations. What this table demonstrates is resources are not evenly distributed or available for access county to county, and in some cases urban areas soak up a disproportionate share of the requests for examinations from rural areas. That is, facilities that operate in urban areas often serve as a referral hub for a multi-county area and as a result urban areas appear to provide more sexual assault services than actually occur in those areas.

In addition, where SANE and sexual assault-oriented facilities are concentrated, service utilization appears to increase; namely via the total number of adult and pediatric examinations. However, despite Benton County hosting four potential SANE hospitals and serving as a regional hub for SANE services, the factors of demand for forensic exams were lower than Thurston County, which also serves as a regional hub for SANE services. The service

³⁰ These figures each represent a CVC reimbursement for an examination.

disparity between these two urban counties reflects the disparity between counties in general, which is in part to population and in part to the proximity to other developed SANE facilities.

Table 2: Comparison of Sexual Assault Forensic Exams in Rural and Urban Counties

	Rural		Urban	
County	Franklin	Mason	Benton	Thurston
Population	82,150	62,200	188,590	267,410
Reported Criminal Sex Offenses	132	51	216	239
Adult Examinations	20	43	36	223
Pediatric Examinations	28	-	20	247
SANE Hospital Count	1	1	3	1

Sources: WASPC, L&I, CACWA, and the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS).

Where survivors find limited options to report sexual assault or receive services after a sexual assault occurs, the community response to sexual assault suffers. As the literature on sexual assault conveys, survivors are acquainted with their assailants in the majority (51 percent) of incidents.³¹ In rural communities, the proportion of survivors that fit this description is expected to be higher. In response, communities that consolidate services and develop strong ties with advocacy groups, local law enforcement, prosecutors, sex offender management groups, and state and local governments experience heightened reporting of sexual assault and have a stable operational capacity and staff base to support survivors. The challenge is in generating a comprehensive and sustainable support infrastructure.

³¹ Black et al. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Lessons from Neighbor States

The states of Alaska and Oregon offer innovative approaches to sexual assault and SANE availability that could inform policy development in Washington state. The selection of these states reflects their leadership in the field of SANE, and although both Oregon and Alaska operate from different theoretical and practical points of view, positive outcomes have resulted. Oregon, for instance, developed a state governance-backed solution to SANE that emphasizes public systems in the provision of services. In contrast, Alaska emphasized Sexual Assault Response Teams (SARTs)³² and community-driven responsiveness.

The differences between the approaches in Oregon and Alaska speak directly to the differences in how communities perceive, organize, and respond to sexual assault. What works in one location may not work in another, but the commonality that exists between each states' strategy grounds itself in the collaborative principles from which each strategy was borne. In other words, where there is a comprehensive community solution in place, there is an active community engagement to carry solutions forward.

Oregon: Governance-Backed Solutions

Oregon has a highly developed and centralized response to SANEs. At the forefront of this is the Oregon Sexual Assault Task Force (task force), whose mission is “to facilitate and support a collaborative, victim-centered approach to the prevention of and response to adolescent and adult sexual violence.”³³ The task force is organized under the Oregon Attorney General’s Office and inspired by a grassroots movement of community advocates that sought to improve the statewide response to sexual assault.

The task force organizes primary stakeholders, including medical, legal, justice, and advocacy groups to offer three main programs that support SANEs and sexual assault services statewide. They are:

- **The Sexual Assault Training Institute** – Provides MDT-style training to a range of advocates, law enforcement, prosecutors, SANEs, and SARTs throughout the state.
- **Prevention Program** – Seeks to develop resources and raise awareness, while also providing education funding to groups engaged in local prevention.

³² Sexual Assault Response Teams (SARTs) are a community-sponsored form of collaborative response to sexual assault, which organize and function in the same way as MDTs. The biggest difference between a prescribed MDT, as found in a CAC, and a SART is the style of the work. Typically, a SART will have the same key players, but they may not review sexual assault services in the same way as a CAC. For example, MDTs regularly meet and discuss service issues, while a SART may not meet formally and may choose to engage survivors in the field as a mobile team.

³³ Oregon Sexual Assault Task Force. Oregon SART Handbook. July 2009.
<http://www.nsvrc.org/sites/default/files/SART-Handbook-Oregon-09.pdf>

- **Sexual Assault Nurse Examiner Program** – This is the SANE support wing of the Task Force, and includes a discussion forum via the Oregon SANE Listserv and technical assistance. This is also where SANEs are certified by the Oregon SAE/SANE Certification Commission.

The Oregon State Legislature has also been active in expanding access to survivor services. From 2003 to 2009, the task force helped to pass eight pieces of legislation designed to increase victim rights and improve policy options in response to sexual assault. Chief among them was the creation of the Sexual Assault Emergency Medical Response (SAVE) Fund, which helps to pay for medical exams, the collection of forensic evidence, and the provision of emergency contraception and prophylaxis for sexual assault patients. The SAVE Fund operates similarly to the Crime Victims Compensation (CVC) program, and covers the costs of a range of services and supplements the maximum allowable benefit amount reimbursed by CVC.

When asked how Washington State may learn from the Oregon experience, one task force official offered the following guidance:

*It depends on the overall goals. In attempting the goal of increasing the efficacy of SANEs: training is the critical component. There must be an infrastructure that sustains this. Are hospitals putting time, energy, space to this patient population, and truly see them as trauma patients? This often gets overlooked. Some hospitals are very supportive and on board, some have a lot of restraints. [SANEs] are a huge commitment. Are there champions to support the efforts there?*³⁴

To task force officials, training is the key to expanding SANE availability. However, training is only one component of a supportive SANE environment. For example, uniform, adaptable, and actionable protocols are critical to disseminating information and communicating expectations. The task force embraced this to develop guidelines and best practices for communities seeking to develop their own SART. In addition to the training and protocols, a supportive hospital environment is also vital to carrying a SANE program forward.

To engage and focus community efforts in support of sexual assault services, community champions are necessary. They may be community members, advocates, SANEs, prosecutors, police officers, or champions from the field of social work. Throughout this study of SANE availability, countless communities and the SANEs that serve them demonstrated a keen understanding of the unique need within their community and designed solutions according to that need. However, no community exemplified the need for individual solutions for individual communities more so than the State of Alaska.

³⁴ Phone interview with Oregon Sexual Assault Task Force dated August 15, 2016.

Alaska: A Community of Practice

The state of Alaska is a national leader in organizing a stable community response to sexual assault. This is a byproduct of the size and remoteness of the state, which necessitates that each community has an adequate response mechanism to meet the needs of survivors. As Alaska has the highest reporting rate for sexual assault incidents nationwide, the state's community-based model has purposefully sought to communicate and collaborate with each segment of the community to understand and improve the capacity to deliver SANE services.

The philosophy of this work is that a strong community response to sexual assault often creates a safe atmosphere for survivors to disclose and results in higher reporting. Alaska has recognized such results-based practice as aligned with the needs of individual communities, and invested in a significant community-based presence of SARTs that maintain the availability of services, even in remote areas, to keep information flowing to each stakeholder group.

Presently, there is no state-level oversight of SART programs in Alaska. Each SART has complete autonomy to modify membership or the protocol to suit the evolving needs of the community at any time. Stakeholders statewide recommend that communities follow voluntary SART guidelines and adapt them to their local needs, as necessary. A core training team, as provided by the Department of Public Safety and the Alaskan Network on Domestic Violence and Sexual Assault, provides the financing necessary to train and retrain SANEs. These funds are supplemented by grants from the Indian Health Council and the International Association of Forensic Nurses (IAFN).

Moreover, there are no statewide staffing protocols, and each SART and hospital will set a SANE schedule that fits the need of their individual community. At Fairbanks Memorial Hospital, for example, there are seven SANEs with two of these working in an on-call format for an average examination caseload of 10 total adults per month. SANEs cooperating in the Fairbanks SART conduct all examinations in the hospital, with survivors transported onsite by a combination of advocates, friends, family, or Alaska State Troopers.

In the remoteness of the Alaskan frontier, small communities cannot routinely access SANEs and SARTs cannot routinely access survivors. A long-serving Alaskan SANE official noted that troopers and local law enforcement groups go to great lengths to ensure survivors receive access to quality care, and have, in limited situations, airlifted survivors to hospitals or escorted survivors via snowmobile to an appropriate examination site. In addition, hospitals may bill law enforcement for the forensic components of a sexual assault examination if the survivor files a police report.³⁵

Community is the engine that drives the Alaskan response to sexual assault, but communities that engineer success ultimately have to pay for continued success. To illustrate, in its 2015

³⁵ Email from Fairbanks Memorial Hospital staff dated September 6, 2016.

state budget requests, the Municipality of Anchorage formally requested \$300,000 from the state to supplement its existing SART program. The request notes that “the cost of the program is now much higher with the increased caseloads. Currently, there is no consistent stream of funding to support these exams.”³⁶

Alaska is the living representation of a community that recognizes a problem, implements a solution, has success, and loses ground, because community alone cannot build enduring solutions. The innovation and motivation of a community are simultaneously enough to begin a community-led response to sexual assault, but are not enough to sustain that response.

³⁶ <http://www.muni.org/Departments/Mayor/Documents/2015%20Legislative%20Program%20PowerPoint.pdf>

Cost Considerations and Reimbursement Rates

Data on costs and considerations of funding were relatively scarce throughout this study. Many Sexual Assault Nurse Examiner (SANE) program staff members and administrators did not know the precise costs for their institutions to perform a sexual assault examination. In select cases, this data was not tabulated to reflect a per-exam cost. In other environments, only a partial understanding of costs existed. Officials interviewed noted that costs are “difficult to pin down,” and may vary site to site, administrator to administrator, and by the providers’ own policies. For example, one medical official with a staff of two SANEs stated that the cost to deliver services reflected staff time and equipment only, because of the relative infrequency of requests for an examination. In short, provider costs are not well understood.

The Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) provided the most comprehensive information on the relative costs to perform an examination. However, a distinction between program costs, such as direct staff time and space for the examination, and administrative costs, such as overhead, was noteworthy. Part of the uncertainty around program and administrative costs reflects what costs can be reimbursed through by the Crime Victims Compensation (CVC)³⁷ program. Generally speaking, administrative costs are not available for reimbursement, while program costs are. This is why program costs are better understood than administrative costs.

An official from the Department of Labor and Industries (L&I), which disburses CVC funds, stated that medical providers have historically attempted to request CVC reimbursement for both program and administrative costs. To remedy this inconsistency, L&I performed extended outreach to providers and created informational tools to guide providers through the reimbursement process. This increased providers’ efficiency when requesting CVC reimbursement, but it did not change the basis from which most providers operated SANE programs or employed SANEs. That is, SANE programs are not cost recoverable and all medical providers that offer SANE services do so at cost to the organization (see Appendix E for the distribution of CVC reimbursements for each county).

Generally, CVC pays for approximately half of program expenses for a sexual assault exam. HCSATS reports that they receive \$425 in CVC reimbursement per exam and their program costs approximate \$850. After adding administrative costs, CVC may reimburse approximately 40 percent of all costs associated with a sexual assault exam. Smaller medical providers that are not comprehensive SANE programs may experience lower cumulative costs and a greater share of exam costs reimbursed by CVC.

³⁷ In this context, a sexual assault examination is the only CVC claim that does not require an application. Hospitals submit a one-page document to LNI on the examination, including costs, which are later reimbursed directly to providers. The use of CVC funds fulfills the state’s responsibility to provide examinations at no cost to survivors.

Review Table 3 for a historical analysis of claims filed and benefits expended. Review Appendix J for a breakdown of the schedule of fees for CVC reimbursement and a description of the levels of service provided in a number of medical environments.

Table 3: Distribution of CVC Funds, 2011 to 2015³⁸

Year	Number of CVC Reimbursements	Total Funds Expended	Average Reimbursement
2011	3,634	\$1,861,376	\$512
2012	3,501	\$1,833,520	\$523
2013	3,378	\$1,865,348	\$552
2014	3,427	\$1,748,876	\$510
2015	3,589	\$1,960,872	\$546
Total	17,327 ³⁹	\$9,269,994	\$535*

Source: The Washington State Department of Labor and Industries

In 2015, survivors of sexual assault in all but one Washington county received CVC funds to pay for an examination. However, the distribution of CVC reimbursements follows closely to the distribution of SANE-capable hospitals statewide. That is, CVC reimbursements centered along the I-5 corridor and in counties with a greater incidence of criminal sex offenses. In addition, approximately 15 percent of all CVC reimbursements for a sexual assault examination occurred in Eastern Washington, with almost half of those centered in Spokane County. This may relate to the totality of the rural and urban divide in Washington, in which urban areas display a larger proportion of the critical infrastructure necessary to support survivors of sexual assault, and offer examinations.

Funding Options

Funding for SANE-related services is a limited field. Many of the medical institutions that participated in this study of availability noted that CVC was the primary funding mechanism that reimbursed SANE services. There are also other funding options available for SANE services and training. These include:

Training Scholarships

Training scholarships for select nurses that may serve rural areas or nurses from areas which are not well represented in the field of SANE. The two largest SANE training bodies in Washington, the Harborview Center for Sexual Assault and Traumatic Stress and the

³⁸ Data is a product of the Department of Labor and Industries dated August 18, 2016.

³⁹ The total of CVC claims and the average reimbursement do not match, as 222 claims were double counted.

International Association of Forensic Nurses (IAFN) may either reduce or waive training fees for participants.

Community, Corporate, or Foundation Grants

The Harrison Medical Center Foundation raised money to pay for the initial funding of the SANE program at Harrison Medical Center, and continues to raise money in support of SANE services.

In addition, three primary federal grant programs fund SANE training. The most widely utilized funding source is the STOP Grant, and training is but one of 20 purpose areas where dollars may be spent.⁴⁰ The number of SANEs trained in Washington state using federal funds from January 2013 to December 2014 is shown in Table 4.⁴¹

Table 4: Federal Grant Programs for SANE Training in Washington State

Federal Grant Program	SANEs Trained
Services-Training-Officers-Prosecutors (STOP) Grant Program*	46
Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program	7
Rural Sexual Assault, Domestic Violence, Dating Violence, and Stalking Assistance Program	0
Total SANEs Trained	53

* Period under exploration is from January to December of 2013

Source: General Accountability Office, Report # GAO-16-334

⁴⁰ The Department of Justice reports that from 2011 to 2012, the STOP Grant expended between 1.4 percent and 1.5 percent of total funds for the training of forensic nurse examiners.

⁴¹ Each of these federal grant programs that may fund SANE training received extensive analysis in the 2016 GAO report, Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners. GAO Report #16-334. March 2016.

Strategies and Recommendations

There are too few SANEs in Washington State to provide an adequate range of trauma-informed care. This has potentially resulted in prolonged emotional and psychological distress for survivors, including no forensic evidence collection, and no medical care in the aftermath of a sexual assault. The intent of strategies listed below is to increase SANE availability and create a SANE culture that delivers timely medical services. Access to training and resources are proven strategies that increase the number of trained SANEs and their availability. However, strategies designed to empower individual communities hold great promise, especially where resources are scarce.

Many of the recommended strategies for increasing SANE availability and creating a SANE culture are practiced in other communities nationwide and offer a lens from which to view programs in action. Officials interviewed during the study stated that successful strategies to increase SANE availability must edge toward the following criteria:

- Layer multiple strategies that overlap with stakeholder capabilities and strengths.
- Emphasize the creation of joint processes and information sharing.
- Allow room for the implementation of local innovations.
- Focus on improving stakeholder relations and engaging the needs of communities and survivors directly.

Changing the culture within SANE service delivery, moreover, is more complex and will require time and each stakeholder within the medical, legal, justice, and advocacy communities working in collaboration. Identified strategies arrive via four distinct pathways: community, telehealth, resources, and regulatory responses. The legislation requires review of both mobile SANE teams, and remote training and electronic consultation. Overall, the strategies for increasing SANE availability include:

- **Strategy 1** – Mobile SANE teams.
- **Strategy 2** – Multi-disciplinary teams (MDTs) that serve adult sexual assault survivors.
- **Strategy 3**– Remote training opportunities and consultation via electronic means.
- **Strategy 4** – A SANE training fund that supplements the cost of sexual assault exams.
- **Strategy 5**– Marketing materials for CVC funds, SANE programs, CACs, and CSAPs
- **Strategy 6** – State-supported SANE data collection efforts.
- **Strategy 7** – State accreditation of SANE hospitals as centers of excellence.
- **Strategy 8** – SANE report card that requires hospitals to report information on SANEs, their availability, and level of training or certification to an independent agency.

An ideal approach layers multiple strategies with stakeholder strengths. By focusing in on strategies where the most overlap exists among stakeholders, survivors may experience the most immediate and tangible benefits. That, in turn, could generate momentum to further improve collaboration that expands survivor access to SANE services.

In the text below, a general assessment of the rationale for the recommended strategy and its operating mechanism will accompany a short discussion of the benefits or challenges of each approach along with feedback from study participants, where available.

In brief, the power of the community to stabilize SANE services and create an awareness of sexual assault and available services proposes to harness collaborative energy, while a regulatory response is more adversarial in aligning stakeholders and communities behind joint solutions. The top strategies within the areas of community capacity building and regulation offer the most direct path to improving SANE availability and service delivery.

The remaining strategic areas, telehealth and resources, focus on incremental improvements to SANE availability and program capacity by emphasizing training SANEs, marketing services, and funding programs. These middle strategies for increasing SANE availability may emphasize the creation of joint processes and information sharing, and some will receive less explanation than others, because of the relative freshness of the idea, a lack of comparable programs, or programmatic complexity.

Community Capacity Building

Strategy 1: Mobile SANE Teams

A mobile SANE unit is a collaborative team approach to delivering sexual assault services. Typically, a mobile SANE unit comprises a SANE and an advocate, but it may also contain elements of prosecutors and law enforcement officials as well. Mobile teams respond to a call for a sexual assault exam at nearby hospitals or sexual assault clinics, and the SANEs that perform the examinations may or may not be directly associated with the medical provider. In other situations, a specific medical provider utilizes their SANEs and their facilities and serves as a “host” for a mobile team. The precise response time for a mobile team will vary jurisdiction to jurisdiction, and depend on the demand for examinations, the geographic coverage area, and the availability of on-call SANEs. Officials interviewed for this study noted that an adequate response to any survivor of sexual assault, regardless of approach, was no more than one hour.

Table 6 presents some of the challenges and benefits of organizing and operating mobile SANE teams. The key takeaway is that the benefits are largely administrative, in addition to increasing SANE availability and accessibility. In contrast, challenges relate to financial sustainability and to common issues in managing complex inter-organizational relationships, such as communication gaps.

Table 5: Benefits and Challenges of Mobile SANE Teams

Benefits	Challenges ⁴²
Batch Training	Recruitment and training
Peer review networks	Availability of on-call SANEs
Develop best practices and disseminate them	Communication gaps (dispatch systems)
Responsive and flexible sexual assault service delivery	Hospital space constraints
Defined coverage areas	Involvement of multiple hospitals and clinics
Survivors receive faster, more regular treatment	Inconsistent workload may reduce skills retention
Cost-sharing among medical providers	Who employs and finances SANEs?

The Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) is responsive to the needs of four, and soon to be five, Seattle area hospitals including Valley Medical, UW Medicine, Swedish – First Hill, and Seattle Children’s, while service to Northwest Medical is set for later in 2016. The distance from each of these partner hospitals ranges from 0.2 miles to 15.9 miles away from HCSATS and two SANEs are on-call at all times. In Washington State, this

⁴² West Virginia Mobile SANE Project (10/2002 to 09/2005). West Virginia Foundation for Rape Information and Services. <http://www.fris.org/Resources/PDFs/Books/SANEMobile-Final.pdf>

was the only mobile SANE team discovered in operation. However, this was not a self-described mobile team, but rather “a [nurse] response team that coordinated care amongst local hospitals [with] elements built into the contract, like storage and processing of kits and [staff] to provide support and direction to advocacy and other resources.”⁴³

When the call for a sexual assault examination arrives, an on-call SANE is dispatched to the hospital where the expectation of service is for a survivor to wait less than one hour for the SANE’s arrival. This practice “reinforces critical coordination between hospitals.”⁴⁴ One HCSATS official indicated that contracting for SANE services allowed for a dynamic mix of specializations to develop, which frees up resources. For example, “Swedish [First Hill] doesn’t have to have SANEs. They contract with [Harborview] to receive that service.”⁴⁵

Officials that participated in this study provided the following feedback on mobile SANE teams:

- “Spreading out this knowledge makes it harder to provide the best care possible” (a SANE from a sexual assault clinic).
- “I have a concern about mobile SANE teams...you have to look at how long it takes to train, mobilize, and send mobile teams to different areas. If you did it on the cheap, of if you had too big an area to cover, it might not result in any benefits” (a prosecuting attorney)
- Multi-county teams that cover wide areas are more experienced and can leverage that to assert “comfortableness” for survivors and a knowing attitude toward what “may be expected from the SANE beyond the examination, including testifying” (an advocacy official).
- Mobile teams do serve a purpose and are cost effective “if you are active enough to forget about overhead [costs]” (a SANE Program Coordinator).

This strategy is recommended in communities that support this model.

Strategy 2: Create Multi-Disciplinary Teams to Serve Adult Sexual Assault Survivors

Multi-disciplinary teams (MDTs) demonstrate an effective approach to building collaborative environments that support the delivery of trauma-informed care to survivors of sexual assault. Currently, MDTs are pervasive in the child sexual assault services community, exemplified by the work in Children’s Advocacy Centers (CACs). However, there are few MDTs focused on adult sexual assault survivors. Creating an adult MDT from the model established in CACs would enhance stakeholder communication, improve the delivery of sexual assault services, and most critically engage medical providers directly on issues of response and service adequacy.

⁴³ Interview with Harborview Center for Sexual Assault and Traumatic Stress dated July 19, 2016.

⁴⁴ Interview with Harborview Center for Sexual Assault and Traumatic Stress dated August 22, 2016.

⁴⁵ Ibid. 14

The value of the MDT model is in combining stakeholder expertise under one roof to help survivors understand and access services with a victim-centered design. In addition, quality outcomes result from sharing information and process knowledge with both survivors and stakeholders. This includes a higher percentage of survivors that remain in the system, which improves prosecution and conviction rates.⁴⁶ To illustrate, if advocates are notified when a survivor presents at a hospital, the working relationship between providers and advocates will allow providers to collaborate in real-time to improve responsiveness and ensure advocates are involved, where requested, to support and guide survivors.

In contrast, the two highlighted weaknesses of the MDT model are its rigidity and cost effectiveness. That is, there is a detachment between administrators who may serve on MDTs and the line staff who implement services. SANEs at several Western Washington medical institutions that serve CACs commented that SANE-led recommendations for improving joint-service delivery faced a difficult time receiving consideration. The disconnect between administrators and SANEs was described as “a matter of priorities.”⁴⁷

The creation of a MDT does not follow a singular path. As part of this study two types of MDTs were observed. The first is the highly structured format of CAC-centric MDTs, which are a common design for a response team that regularly meets to work through the issues in coordinating services. These are also the most common form of collaborative units statewide, with 18 certified CACs actively practicing the MDT model. In the MDT-based structure, a comprehensive engagement of all stakeholders that play active roles for survivors is critical to improve services.

However, SARTs may also follow a Mobile SANE Team approach, whereby a combination of advocates, prosecutors, SANEs, and police officers provide a uniform and consistent response to the process surrounding a request for an examination. Regular meetings are less of a focus in these SARTs, as a simultaneous interagency response at or near the time a survivor presents is the priority. This form of SART offers the most room for a variable community-centric design and places medical providers at the center of the response. That is, interagency agreements, memorandums of understanding, and other contractual tools emphasize which providers will host examinations and which will provide SANEs.

This approach is best observed in Alaska, where there is little distinction between a Mobile Team and a SART. Resource scarcity and a small number of SANEs requires a mobile response unit, while at the same time MDT-style ongoing communication and collaboration allow continuing improvements to service efficacy. SART/Mobile SANE Team hybrid models like those in Alaska are more common in communities that recognize the need for expanded sexual assault services and develop their own individual responses.

⁴⁶ Ledray, L. (2001). Evidence Collection and Care of Sexual Assault Survivors. Violence Against Women Online Resources

⁴⁷ Interview dated August 8, 2016

Throughout this study, one common thread overlapped the formation of community sexual assault response teams (SARTs) and MDTs reviewed: the SANEs responsible for providing sexual assault examinations served as the organizing force that propelled the active engagement of the team. For example, SARTs in Alaska developed out of an identified community need from the nurses that treated survivors of sexual assault.

Officials that participated in this study provided the following feedback on MDTs:

- The “challenge is to pay on-call staff time and travel” for the nurses on the team (a SANE Program Coordinator).
- Small communities are “trying a collaborative approach” similar to MDTs, with a focus on capacity building and outreach among sexual assault clinics and rural hospitals (rural county SANE).
- “Coordinated care is a priority and inpatient care is more coordinated, more personalized service of care than a response team” (a SANE Program Administrator).
- There are “troubles in working with local law enforcement and prosecutors” in non-MDT areas, which include “communication and access” (a CAC Official).

This strategy is recommended in communities that support this model. As noted in the findings, SANEs are an “organizing force” that propels engagement of a team. In addition, SANEs do not have to be the centerpiece of the MDT, which would encourage stakeholder participants to assume the mantle of “organizing force.”

Telehealth

Strategy 3: Remote Training and Electronic Consultation

Telehealth or telemedicine employs web-based remote healthcare technology to extend the reach of SANE training into rural and otherwise underserved areas. The format of telehealth training is variable, but may include Skype, GoToMeeting, or any other secure videoconferencing platform to reach new and continuing SANEs. On one end of the camera is a trained and experienced SANE to provide instruction, while the other end will display a “class” of SANEs set to receive instruction.

Structurally, remote training and electronic consultation are a low-cost and effective means both for training SANEs and in reaching marginalized or underserved populations, including rural and Tribal areas, correctional institutions, and institutions of higher education. Remote training and electronic consultation may also complement existing online SANE training service providers, such as that provided by the International Association of Forensic Nurses (IAFN).

Presently, many hospitals utilize telehealth in the provision of healthcare services across a range of medical areas, including pediatric medicine, emergency care, and behavioral medicine. No hospital or medical provider regularly utilizes telehealth to train SANEs, but several MDTs and SARTs were found to use electronic means to gather ad-hoc peer review and consultation groups on a semi-regular basis. SANEs and other healthcare officials reported that the singular purpose of such meetings was to share information and seek additional opinions on particularly challenging or unique cases.

Through telehealth services, officials may exchange information, receive second opinions, and otherwise collaborate in the same fashion as in-person meetings. However, the limitations of using telehealth for remote consultation and expanding access to SANE training are two-fold. First, remote training and electronic consultation services depend on reliable broadband access, and underserved areas may not have an adequate broadband accessibility or reliability, especially in rural areas. Second, a reliance on remote training may diminish the experiential training components that provide SANEs with tactile experience collecting forensic evidence. The improper collection of forensic evidence was the primary concern raised by law enforcement officials and prosecutors.

Officials that participated in this study provided the following feedback on telehealth as it relates to remote training:

- It is hard to keep up training, even in an area like ours [with moderate intake volume]” (a CAC SANE).
- “Telehealth is training and continuing education, not necessarily the examination [component]” (a healthcare administrator).

- Telehealth will allow rural clinics to “keep their skills up, meet the areas’ need and be responsive to the emergent need in other nearby communities” (a Department of Health official).
- “There is a real need in rural areas for education and up-to-date nursing. I think that is a definite thing where we can get SANE education” (a rural county SANE).

The use of secure web-based training for continuing education, consultation, and/or case review is recommended.

Remote Examination

An emerging issue within SANE telehealth services is the feasibility of sexual assault examinations by remote. A remote examination places an experienced and SANE-trained physician or nurse in position to guide and supervise an examination conducted by an inexperienced physician or nurse.

With the passage of Senate Bill 5175 in 2015, Washington State’s Telemedicine Parity Law provides the same level of telehealth coverage offered by private insurance, state health plans, and Medicaid. Such a law equalizes the insurance field and allows many different types of healthcare users to utilize telehealth services, including the potential for an examination by remote. Without such a law, medical providers would have no incentive to offer telehealth services, and would instead bear the cost burden or pass it along to users.

The National TeleNursing Center (NTC) in Massachusetts utilizes both training and examinations by remote processes. NTC hosts 24/7 on-call SANEs that respond within one hour of a request for a remote examination, and support nurses and physicians on the use of sexual assault kits(kit), and review forensic evidence collection practices, including chain of custody procedures. The early success of this program spawned the creation of six additional pilot sites nationwide that may connect with NTC SANEs.

Sites in Arizona, California, and Massachusetts receive training support and kit guidance. However, there are limitations to using telemedicine for any activity outside of remote training. These include, but are not limited to, the following:

- Legal questions about consistency and quality of forensic evidence collection.
- CVC may not reimburse both providers for their role in a remote examination. This may create cost-sharing uncertainty regarding which provider would receive reimbursement.
- Services may be subject to prior authorization, a deductible, or copayment and the law does not require reimbursement for professional fees charged by the originating site.

These limitations outline concerns for cost reimbursement and evidentiary integrity in addition to ease of access and the legitimacy of the service from the perspective of the survivor.

No hospital in Washington State offers remote examination, while many do offer telehealth services. Officials that participated in this study provided the following feedback on telehealth as it relates to remote examinations:

- On an examination without an experienced SANE: “Why is the person who knows what they’re doing not here with me!” (a healthcare administrator).
- “Other [Critical Access Hospitals are] on the verge of closing, because of staffing shortages. We have two physicians that want to retire and if they do, care grinds to a halt” (a rural county SANE at a critical access hospital).

Exploration of the option of remote exams should be studied in more detail in order to assess the appropriateness as a victim-centered service, including nurse availability, secure and reliable telehealth services, legal and justice considerations, and cost feasibility.

Resources

Strategy 4: Marketing Crime Victims Compensation and Sexual Assault Nurse Examiner Programs

The Crime Victims Compensation (CVC) program is the primary mechanism in Washington State that alleviates a survivor's financial burden from the costs associated with an examination and for continuing medical services after a sexual assault. CVC funds are also the primary mechanism of cost recovery for hospitals that administer examinations and provide continuing care to survivors. However, information on the availability of CVC funds is not uniformly distributed.

An official from Labor and Industries (L&I) stated that "some advocates call us and tell us, we thought you closed."⁴⁸ Officials interviewed confirmed that the visibility of CVC statewide decreased in recent years, and where some law enforcement officers do carry business cards with CVC information on them, this only informs that small sample of the population that is both a victim of crime and reports the offense.

The benefits of increasing the visibility of CVC are twofold. First, victims of crime will have direct knowledge of options regarding what to do next. Second, by encouraging the use of these resources, our shared knowledge of the prevalence and location of crimes will increase. Conversely, by expanding visibility and encouraging the use of these funds and services, they may be depleted and retreat into resource scarcity. Developing marketing materials and getting the word out about the availability of CVC, and how SANEs, and advocacy organizations support victims of crime is critical to raising awareness of available services, as is the sustainability of these programs.

The Violence Against Women Act requires that states coordinate with regional healthcare providers to notify sexual assault survivors about no-cost examinations. Data from L&I confirmed that approximately 70 percent of survivors that received CVC funded examinations applied for additional CVC benefits. This demonstrates that where there are strong partnerships with providers, advocates, and the state, there is active utilization of CVC benefits. In short, a measured response that combines input from key stakeholders, with principal collaboration among regional providers and the state is vital to the creation of a shared message that reaches more survivors in a timely manner.

Exploration of the options for promoting CVC more broadly to the public, and medical, advocacy, legal and justice stakeholders is recommended.

⁴⁸ Interview with the Department of Labor and Industries dated August 18, 2016

Strategy 5: Sexual Assault Nurse Examiner Training Fund

When confronted with the reality that the SANEs are in a high stress, high trauma, and high turnover profession, additional support can increase nurse interest in SANE and expand the current pool of providers. Officials at several large medical providers noted that a certified SANE can earn an extra \$1 per hour. The cost for certification alone can range between \$300 and \$500, with many providers unable or unwilling to fund the costs of staff time, travel, and the certification test. Considering the time of an average sexual assault examination is three hours, it would require a SANE that self-funded certification to complete approximately 100 examinations to cover the costs of the certification test alone. This illustrates how concerns about funding sustainability drive dysfunction for SANEs and SANE programs.

The creation of a sexual assault fund would complement existing funding sources, and support innovative compensation strategies that incentivize SANEs and increase SANE retention. Oregon's SAVE Fund is a comparable program that provides financial resources to support the cost of a sexual assault medical exam up to seven days after the assault. Funds disbursed by the Oregon Department of Justice cover a forensic exam conducted up to 84 hours after an assault and up to five counseling sessions.

In many of the hospitals and sexual assault clinics interviewed for this study, several compensation strategies emerged, with case-by-case compensation for SANEs being the alternative technique most widely practiced. For example, a provider in Kitsap County was reported to offer \$400 in compensation for each exam completed, while a provider in Snohomish County offered \$300.

The limited financial capacity of other providers, particularly in rural areas, to implement a compensation strategy requires a dedicated funding stream for SANE training.

There are few incentives other than self-motivation for nurses to provide SANE services. In the same way that free training incentivized nurses to seek out training, an innovative compensation model incentivizes SANEs to commit to the training and continue to provide a needed service.

Reliable and stable funding is needed for SANE training. This will help to ensure an adequate number of SANEs are available. Furthermore, training, continuing education, and consultation will aid in the retention of SANEs. The Washington State Sexual Assault Kit account begins to address this need by offering 15 percent of the fund amount to SANE training and services (see Appendix A). It is recommended that the set-aside for SANE training and services be maintained with the ability to carry forward balances year to year. Any balance remaining in the fund will allow for SANE trainings to be implemented on a regular basis.

Regulatory

Strategy 6: State-supported Data Collection

Washington State does not have oversight responsibilities of SANEs, and SANE data is inconsistently collected. To unify both of these gaps with a unit of state government charged with the collection and dissemination of SANE data would increase the understanding of SANE service availability, and pinpoint with greater accuracy areas of the state that are experiencing sexual assault. In contrast, the challenges in organizing a unit of state government to collect data on this scale would require a moderate amount of time to create systems, policies, and engage stakeholders that receive data. A comparable program is the Washington State Department of Health's (DOH) aforementioned injury data tables that track the number of injuries by category.

More information is needed before a recommendation can be made.

Strategy 7: State Accreditation of Sexual Assault Nurse Examiner Hospitals

The creation of a SANE hospital accreditation or certification is a strategy that could result in a consistent flow of SANE services statewide. The accreditation may be administered by a governing health body such as the Nursing Care Quality Assurance Commission, whose focus is the regulation of nurses and the maintenance of nurse competency in the provision of nursing services. Similarly, the Joint Commission accredits hospitals and certifies providers across a range of specialized healthcare services and may serve as a model for a SANE accreditation.

The benefits in receiving a SANE accreditation would serve to align the provision of SANE services at each participating hospital. That is, each hospital will have passed through a uniform approval process that documents the number of SANEs, guarantees SANE availability, and allows providers and their SANEs to demonstrate a high standard of service. An accreditation may also set measureable performance targets and design internal procedures for delivering SANE services in an accountable way. These are but a few of the potential benefits of a SANE accreditation.

The challenges in implementing an accreditation process relate to the hiring and training of staff capable of auditing accreditation requirements and processes. This body would also require a sustainable revenue source to ensure the continuity of the program.

A comparable program was found in New York, where there are SAFE 24-hour Centers of Excellence, which require a range of services and response protocols similar to those the Joint Commission requires for other units of medicine. The New York State Department of Health administers the program and develops the standards. For example, each center of excellence

must collect SANE relevant data, measure program effectiveness, and provide SANE services within 60 minutes of a survivor's arrival.⁴⁹

More information is needed before a recommendation can be made.

Strategy 8: Sexual Assault Nurse Examiner Report Cards

Medical providers with SANE trained nurses must annually report on the state of their SANE availability to a unit of government or governing health body such as the Office of Crime Victim's Advocacy or DOH. This governing body will then provide a "report card" and rate SANE providers' coverage adequacy, SANE availability, and collaborative presence with key stakeholder groups. The product of a SANE report card is similar to that of a SANE center of excellence, in which there is public recognition that a medical provider is SANE capable. The challenge with this proposal is to secure funding to cover the staff costs necessary to provide and confirm these assessments.

More information is needed before a recommendation can be made.

Suggestions for Further Study

Recommended for further study are a series of outreach and data collection efforts that organize stakeholders and increase the understanding in area where there are data gaps. Study topics include:

- The regulatory frameworks that guide hospital accreditation and nursing certification to see what overlap exists with SANEs.
- Partnering with the Oregon Sexual Assault Task Force to determine how state involvement with SANEs has influenced SANE availability and coverage adequacy.
- The extent of forensic medical training or coursework offered in Washington's academic nursing programs.
- Medical provider's compliance to WAC 246-320-286 in the provision of emergency contraception to survivors.
- The effectiveness of adult-centered MDTs through a pilot program in two counties, one rural and one urban.
- The practice and utilization of subcontracted SANEs statewide, especially if nurses are located or trained out of state.

⁴⁹ https://www.health.ny.gov/professionals/safe/hospital_requirements.htm

Appendix A: List of Available Resources

Throughout the study period, Sexual Assault Nurse Examiners (SANEs) and SANE programs were queried on the SANE training requirements, if any, for their programs. The variability in responses of what constitutes a “trained” SANE speaks volumes about the level of inconsistency within the world of forensic examination. To illustrate, each SANE program contacted by the study (5) noted that it required a nurse, either an advanced nurse practitioner (ARNP) or a registered nurse (RN), to receive SANE training. Predominantly, training for SANEs at SANE programs derived from either the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) or the International Association of Forensic Nurses (IAFN).

In contrast, nurses working as SANEs for hospitals without a SANE program offered a varied perspective on their training. Some SANEs noted that they received training from HCSATS and IAFN, while others noted they received in-house training or arrived with SANE training from out-of-state.

Typically, SANE training involves 40 hours of didactic training that is in-person and supplemented by live-fire practicums that offer an opportunity to refine the educational process in real-time. The initial classroom training accompanies clinical requirements, which requires hands-on training, including observing examinations, courtroom testimony, and may require observation of law enforcement or prosecutors in the course of work on sexual assault cases. In other trainings, noting IAFN and other less prevalent training sources, a combination of classroom and online training accompanies the same clinical training requirements contained in both IAFN and HCSATS training.

Table 6: Number of SANE Nurses Trained by Harborview (since 2012)

Training Type	Participants	Annual Training Frequency
5-Day Core SANE Training	129	3
3-Day Regional SANE training	204	6
SANE-P Training	55	2
1-Day Advanced SANE Training	119	5
Total SANEs trained since 2012	507⁵⁰	

Source: Harborview Center for Sexual Assault and Traumatic Stress

Overall, SANE training in Washington State is reliant on HCSATS (see Table 7). Since 2012, HCSATS trains approximately 125 nurses each year, with this number expected to increase in

⁵⁰ This number may double count some nurses that received training in more than one course or enrolled multiple years.

2016 and 2017. A precise distribution of the nurses that received training from either HCSATS or IAFN is not currently available, as there is not a comprehensive data source on SANE training. Both HCSATS and IAFN track those that participate in their trainings but cannot confirm the continuity of service for SANEs they train. The field of SANE is not only a high turnover environment, but SANEs are also particularly nomadic, and may do so freely, unless they enter one of the seven states that requires a state-level SANE certification.⁵¹ The nomadic behavior of SANEs is a combination of the fluid nature of nursing and the intense vicarious trauma associated with the work.

Sexual Assault Nurse Examiner Training and Certification

Upon conclusion of SANE training, a SANE may opt to receive a certification. In Washington State, only IAFN offers a SANE certification. The IAFN certification process occurs twice each year in April and September and establishes a variable payment (between \$275 and \$400) to take the SANE certification test. Certification may also come in one of two forms. A SANE-A, or certified adult SANE; and the SANE-P, the certified pediatric SANE are the two types of certifications. During the study period, seven nurses self-identified as SANE-P certified, with each working in tandem with children's advocacy centers (CACs).

A SANE at a sexual assault clinic noted that the certification was widely viewed as a "credentialing tool" useful to gain legitimacy while giving testimony in court. However, many SANEs interviewed during the study stated that there was not enough emphasis on courtroom training during the initial SANE training process. During HCSATS' advanced SANE trainings, courtroom testimony is an area of added emphasis.

Proposal for Increasing Sexual Assault Nurse Examiner Training Statewide

Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) is the regional leader in providing Sexual Assault Nurse Examiner (SANE) services and SANE training throughout Washington state. HCSATS has provided sexual assault medical training to medical providers across Washington since 1989, historically through funding from the state Department of Social and Health Services (DSHS). The full amount of DSHS funding ended in 2010. Since then, HCSATS has been able to continue to offer SANE training through a variety of other short-term funding sources, including Justice Assistance Grant (JAG), Grants to Encourage Arrest (GTEA), and King County STOP. This funding has allowed HCSATS to continue to provide a minimal level of SANE trainings but remains limited in its capacity to meet and sustain the larger needs of Washington State.

⁵¹ Seven states require SANEs within their borders to be certified by the state. The process and requirements for these certifications varies, but generally requires the same 40 hours of didactic training. The following states currently require a SANE certification: Illinois, Kentucky, Massachusetts, New York, Oregon, Texas, and Wisconsin.

The newly established statewide sexual assault kit tracking system sets aside a portion of funds for SANE training, which are deposited into the Washington Sexual Assault Kit account. As a current recipient of these funds through June 30, 2017, HCSATS will continue to provide SANE training and enhance access and availability as a statewide resource for the forensic and medical care of sexual assault victims.

Specifically, HCSATS will provide training and consultation on sexual assault forensic examinations of sexual assault victims to medical providers across Washington State. These consultations will include in-person SANE adult and pediatric Core Learning Collaboratives that include twice monthly consultation (telephone or web-based); 1-day advanced and refresher courses; child maltreatment peer reviews; SANE peer reviews; and on-site technical assistance and consultation.

HCSATS is also developing a Medical Only website with public access to forensic sexual assault information as well as a secure, confidential link for providers needing more technical assistance and consultation on adult and child sexual assault medical forensic and patient centered care. These efforts will result in a significant increase in the number of trained professionals to provide quality SANE services across the state.

1. Training for Sexual Assault Nurse Examiners in Medical Care and Forensic Evidence Collection.
2. Peer Review.
3. Monthly Telephone and/or Web-based Group Consultation.
4. Website for SANE Programs and Medical Providers.
5. Develop and provide webinars on relevant topics.
6. Host, coordinate, and/or participate in updates to the Washington State Guidelines for Medical Forensic Care for Sexual Assault.
7. Disseminate any new Washington State Guidelines and post on the Harborview SANE website

Appendix A: List of Available SANE Training Resources			
Training	Cost	Description	Website
Harborview Center for Sexual Assault & Traumatic Stress (HCSATS)	Trainings are currently free, but have ranged \$350; reduced cost scholarships also available	On-site SANE training available in 5 select locations, including Seattle, Spokane, Wenatchee, etc.	https://depts.washington.edu/hcsats/training.html
International Association of Forensic Nursing (IAFN)	\$350 to \$600	Online SANE trainings are available for both adult and pediatric specializations.	http://www.forensicnurses.org/
SAFeta.org	Variable training costs with free online resources, webinars, and on-demand training material	AN extension of the IAFN training program. SAFeta.org contains a host of live and on-demand webinars, including in-person workshops available in Maryland only.	http://www.safeta.org/
National Center on Domestic and Sexual Violence (NCDsv)	Variable training costs with free online resources, webinars, and on-demand training material	A combination of online trainings and out-of-state SANE trainings from around the nation. The focus of the trainings is variable and may encompass subjects from across the field of SANE.	http://www.ncdsv.org/ncd_upcomingtrainings.html
SANE-SART Online + Clinical	Variable training costs with free online resources, webinars, and on-demand training material	A repository of online and on-site training that relies on experts from the medical, law enforcement, advocacy, and legal fields to offer a variety of trainings for each group. Trainings range from beginning SANE training to sexual assault investigation for law enforcement to mock trials and lessons for beginning a SART.	http://www.sane-sart.com/
Rapid Save Investigation (RSI)	Costs vary based on service(s) rendered	Provides contracted SANE services for facilities in need of SANES. Based in Oregon, RSI guarantees a 2-hour response time and offers continuing SANE education training.	http://rsipdx.com/
Midwest Regional CAC	Variable training costs with free online resources, webinars, and on-demand training material	A sexual assault resource that provides pediatric SANE training, and has ondemand webinars across a variety of subjects relative to SANES, including colposcopic photodocumentation and forensic interviewing. This resource offers a host of pediatric sexual assault services.	https://coursecatalogmidwestregionalcac.desire2learn.com/
Tribal Forensic Healthcare	Variable training costs with free online resources, webinars, and on-demand training material	A host of resources directed at medical professional that provide care to American Indian or Alaska Native patients. Services include fee-based live trainings around the country, webinars across a range of topics from SANE case review, abuse, and the neurobiology of trauma.	http://www.tribalforensichealthcare.org/
SAFESTAR	Trainings are free for American Indian and Alaska Native communities that complete the applications process.	Live 40-hour training courses for American Indian and Alaska Native communities. Trainings are held on-site at the requesting Tribe's location.	http://www.safestar.net/

Appendix B: Washington State Hospitals by SANE Service Offerings

Washington State Hospitals by SANE Service Offerings				
Hospital	City	County	SANE Services	SANEs on staff
Harborview Medical Center (HMC)	Seattle	King	Adult & Pediatric	24
Valley Medical Center (Served by HMC)	Renton	King	Adult & 13+	
University of Washington Medical Center (Served by HMC)	Seattle	King	Adult & 13+	
Swedish First Hill (Served by HMC)	Seattle	King	Adult & 13+	
Northwest Hospital & Medical Center (Served by HMC)	Seattle	King	Adult & 13+	
Seattle Children's (Served by HMC)	Seattle	King	Pediatric Only	3 additional SANEs on staff
Providence Regional Medical Center Everett	Everett	Snohomish	Adult & Pediatric	11
Swedish Edmonds (Served by PRMCE)	West Edmonds	Snohomish	Adult & Pediatric	
Swedish Mill Creek (Served by PRMCE)	Everett	Snohomish	Adult & Pediatric	
EvergreenHealth Monroe (Served by PRMCE)	Monroe	Snohomish	Pediatric Only	2 additional SANEs on staff
Cascade Valley Hospital and Clinics	Arlington	Snohomish	Adult & Pediatric	6
Columbia Basin Hospital*±	Ephrata	Grant	Adult Only	3
Confluence Health, Wenatchee Valley Hospital	Wenatchee	Chelan	Adult & Pediatric	5
Coulee Medical Center*±	Grand Coulee	Grant	Adult & Pediatric	N/A
Deaconess Hospital/Rockwood Health System*	Spokane	Spokane	Adult & Pediatric	N/A
EvergreenHealth	Kirkland	King	Adult & 14+	10
Forks Community Hospital±	Forks	Clallam	Adult Only	4
Grays Harbor Community Hospital	Aberdeen	Grays Harbor	Adult & Pediatric	4
CHI FHS Harrison Medical Center	Bremerton	Kitsap	Adult & Pediatric	12
CHI FHS Highline Medical Center**	Burien	King	Adult & 14+	N/A
CHI FHS St. Anthony Hospital**	Gig Harbor	Pierce	Adult & 14+	N/A
CHI FHS St. Clare Hospital**	Lakewood	Pierce	Adult & 14+	N/A
CHI FHS St. Elizabeth Hospital**±	Enumclaw	King	Adult & 14+	N/A
CHI FHS St. Francis Hospital**	Federal Way	King	Adult & 14+	N/A
CHI FHS St. Joseph Medical Center**	Tacoma	Pierce	Adult & 14+	N/A
Island Hospital	Anacortes	Skagit	Adult Only	10
Kadlec Regional Medical Center*	Richland	Benton	Adult & Pediatric	8
Kittitas Valley Healthcare*±	Ellensburg	Kittitas	Adult & Pediatric	3
Klickitat Valley Health*±	Goldendale	Klickitat	N/A	N/A
Legacy Salmon Creek Medical Center*	Vancouver	Clark	N/A	N/A
Lourdes Medical Center*±	Pasco	Franklin	N/A	N/A

Washington State Hospitals by SANE Service Offerings				
Hospital	City	County	SANE Services	SANEs on staff
Mason General Hospital & Family of Clinics*±	Shelton	Mason	N/A	N/A
Mid-Valley Hospital*±	Omak	Okanogan	Adult & Pediatric	N/A
Morton General Hospital±	Morton	Lewis	N/A	0
MultiCare Allenmore Hospital**	Tacoma	Pierce	Adult & 14+	N/A
MultiCare Auburn Medical Center**	Auburn	King	Adult & 14+	N/A
MultiCare Good Samaritan Hospital**	Puyallup	Pierce	Adult & 14+	N/A
MultiCare Mary Bridge Children's Hospital &	Tacoma	Pierce	Adult & 14+	N/A
MultiCare Tacoma General Hospital**	Tacoma	Pierce	Adult & 14+	N/A
Naval Hospital	Bremerton	Kitsap	Pediatric Only	N/A
Newport Hospital & Health Services*±	Newport	Pend Oreille	N/A	N/A
North Valley Hospital±	Tonasket	Okanogan	Adult & Pediatric	N/A
Ocean Beach Hospital*±	Ilwaco	Pacific	N/A	N/A
Othello Community Hospital±	Othello	Adams	Adult Only	N/A
Overlake Medical Center	Bellevue	King	Adult Only	N/A
PeaceHealth Peace Island Medical Center±	Friday Harbor	San Juan	N/A	2
PeaceHealth Southwest Medical Center±	Vancouver	Clark	Adult & 14+	N/A
PeaceHealth ST. John Medical Center*	Longview	Cowlitz	Adult Only	11
PeaceHealth St. Joseph Medical Center	Bellingham	Whatcom	Adult & Pediatric	10
PeaceHealth United General Medical Center±	Sedro-Woolley	Skagit	Adult Only	3
Prosser Memorial Hospital Medical Center*±	Prosser	Benton	Adult Only	3
Providence Centralia Hospital*	Centralia	Lewis	Adult Only	N/A
Providence Holy Family Hospital*	Spokane	Spokane	Adult & Pediatric	9
Providence Mount Carmel Hospital±	Colville	Stevens	Adult & Pediatric	2
Providence Sacred Heart Medical Center &	Spokane	Spokane	Adult & Pediatric	10
Providence St. Mary Medical Center*	Walla Walla	Walla Walla	Adult Only	N/A
Providence St. Peter Hospital*	Olympia	Thurston	Adult 14+	12
Pullman Regional Hospital*±	Pullman	Whitman	Adult & Pediatric	6
Quincy Valley Medical Center*±	Quincy	Grant	Adult Only	N/A
Samaritan Healthcare*	Moses Lake	Grant	Adult & Pediatric	N/A
Skagit Valley Hospital	Mount Vernon	Skagit	Adult & 14+	12
Skyline Hospital*±	White Salmon	Klickitat	Adult & Pediatric	N/A
Sunnyside Community Hospital &	Sunnyside	Yakima	Adult & Pediatric	4
Three Rivers Hosoi*±	Brewster	Okanogan	N/A	N/A
Toppenish Community Hospital*	Toppenish	Yakima	Adult & Pediatric	14
Trios Health*	Kennewick	Benton	Adult Only	N/A
Tri-State Memorial Hospital*±	Clarkston	Asotin	Adult Only	1.5
Valley Hospital/Rockwood Health	Spokane Valley	Spokane	Adult Only	N/A
Walla Walla General Hospital	Walla Walla	Walla Walla	N/A	2

Washington State Hospitals by SANE Service Offerings				
Hospital	City	County	SANE Services	SANEs on staff
Whidbey General Hospital±	Coupeville	Island	Adult & 12+	3
Whitman Hospital and Medical Center±	Colfax	Whitman	Adult Only	6
Willapa Harbor Hospital*±	South Bend	Pacific	Adult & Pediatric	2
Yakima Regional Medical and Cardiac Center*	Yakima	Yakima	Adult & Pediatric	10
Yakima Valley Memorial Hospital*	Yakima	Yakima	Adult & Pediatric	5
Total SANEs				232.5

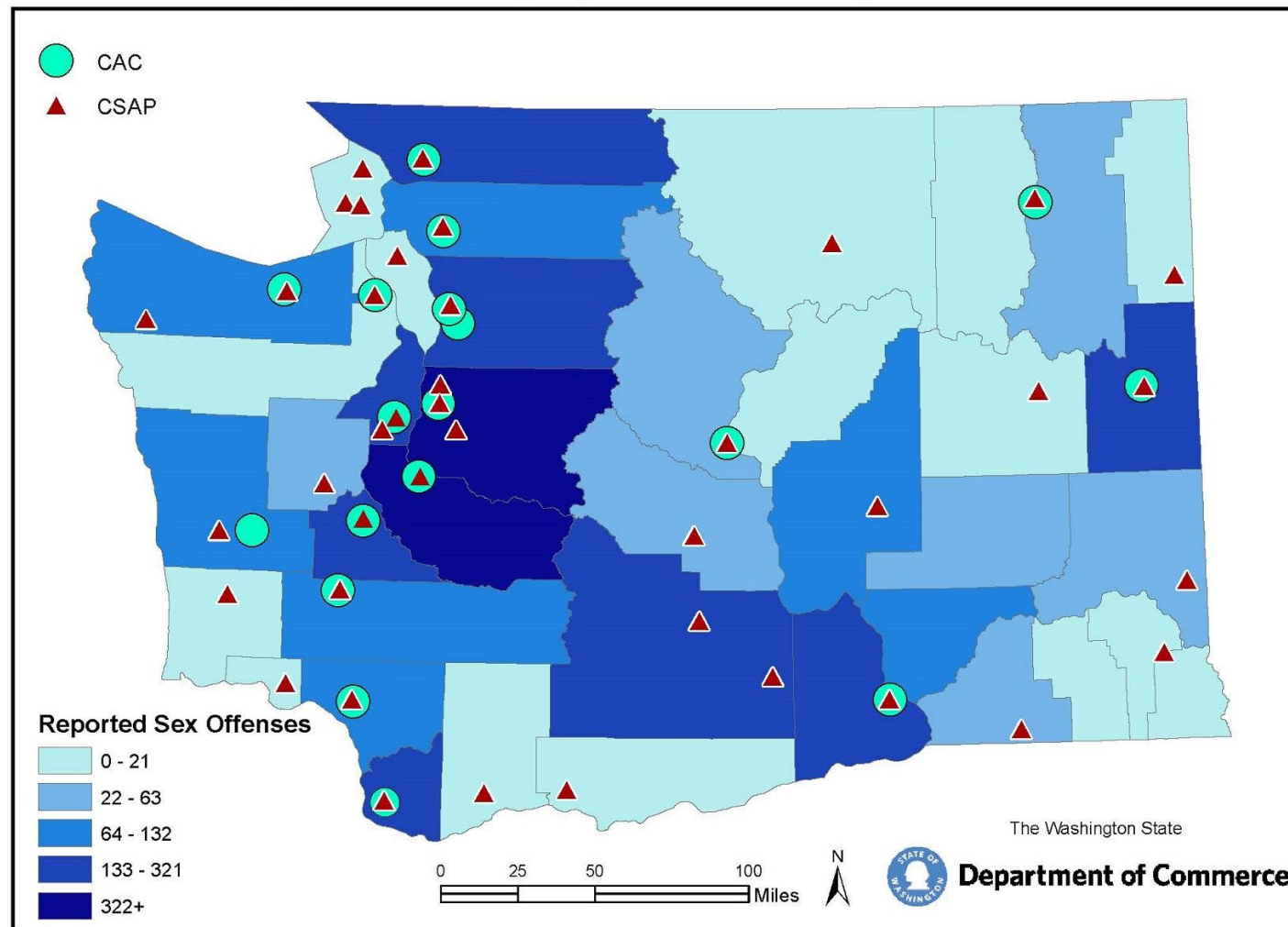
* Sexual assault exams may not be available based on current staffing

** Sexual assault exams are provided by RSI, a contracted company providing

± Provider is a Critical Access Hospital (CAH).

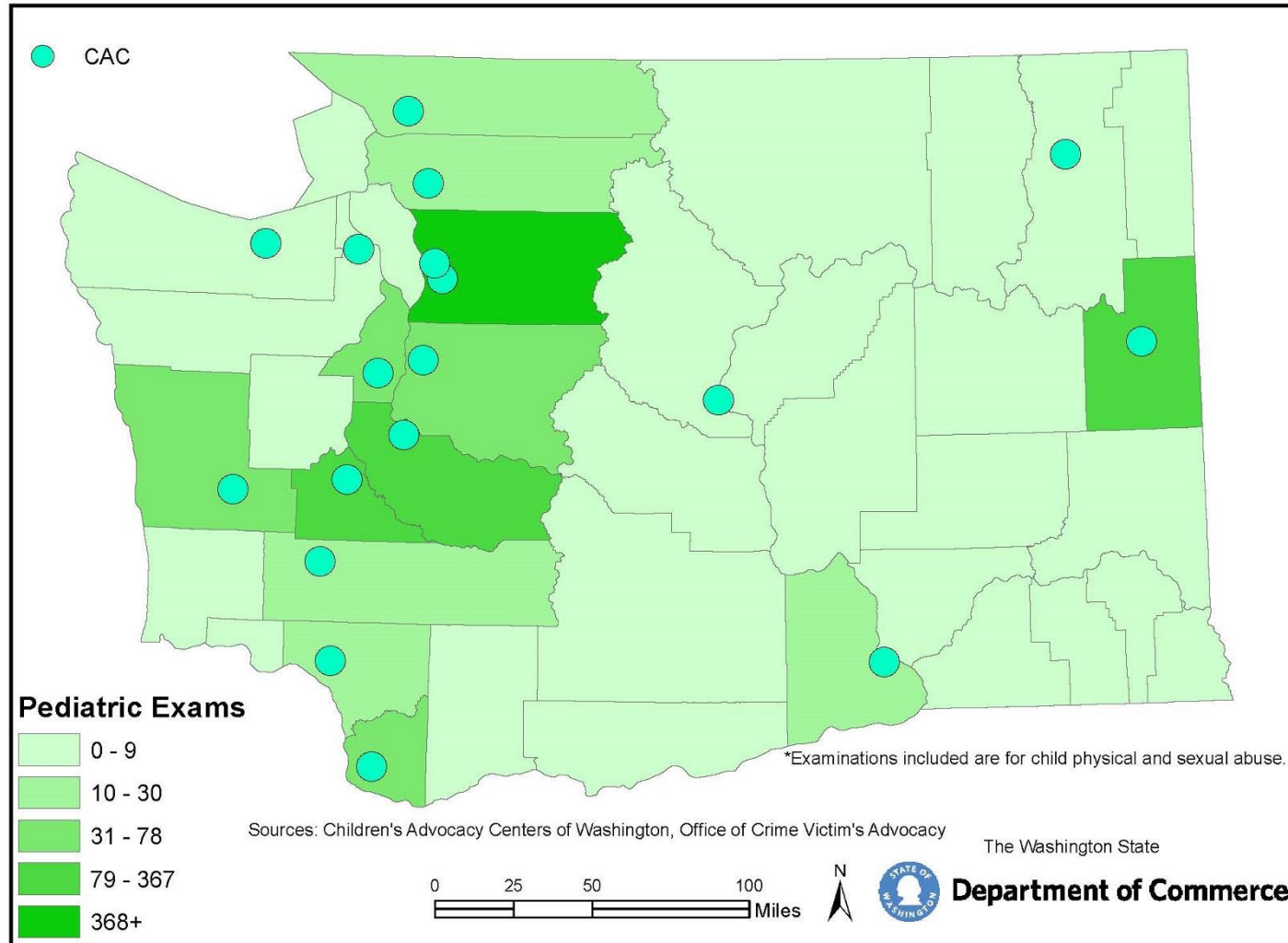
Source: Washington State Hospital Association (WSHA) and Harborview Center for Sexual Assault and Traumatic Stress (HCSATS)

Appendix C: Advocacy Organizations in Washington State, 2015



Sources: Washington Association of Sheriffs & Police Chiefs, Office of Crime Victim's Advocacy

Appendix D: Pediatric Examinations by County, 2015



Reported Sex Offenses

- 0 - 21
- 22 - 63
- 64 - 132
- 133 - 321
- 322+

CVC Reimbursements

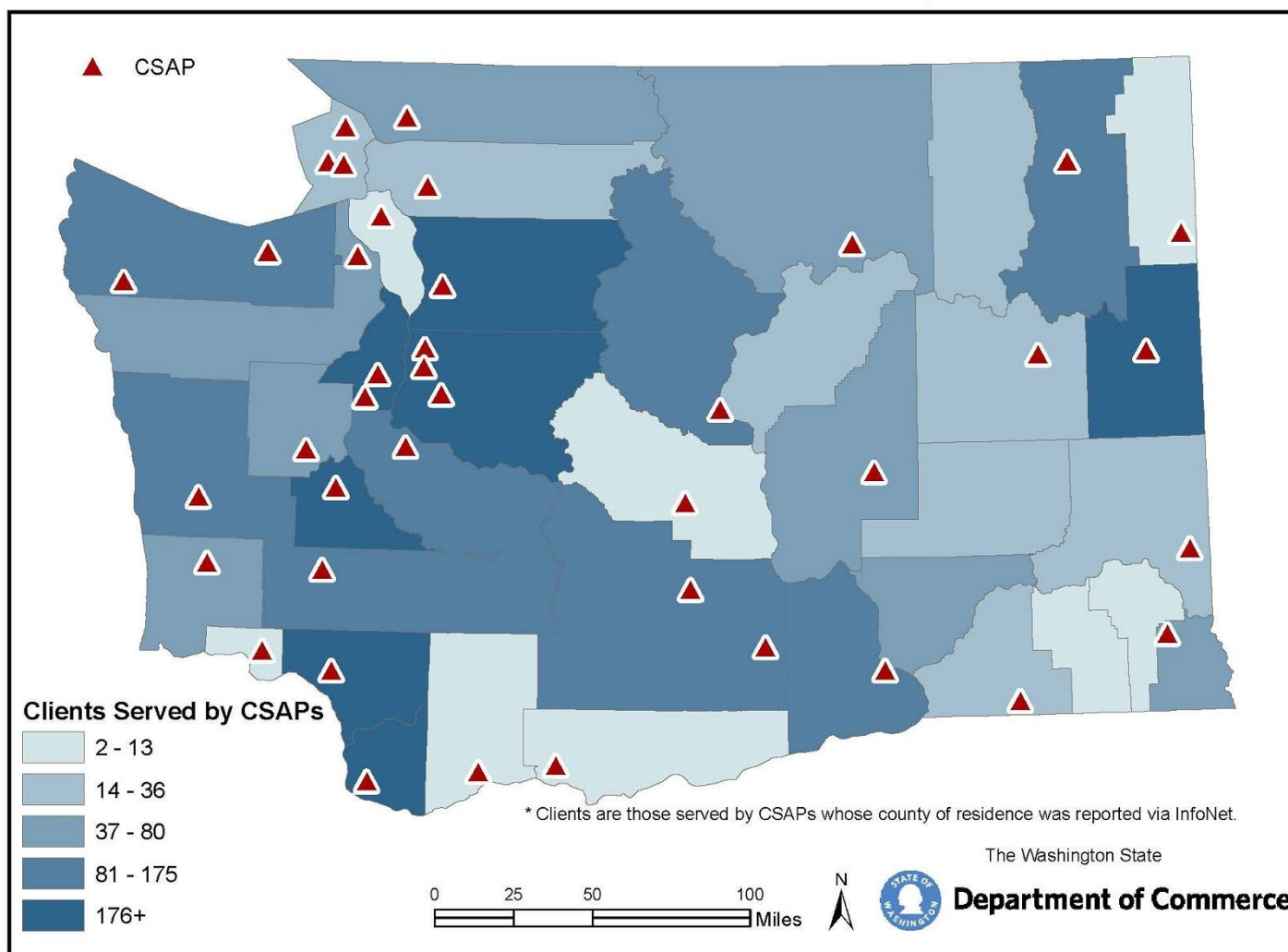
- 0 - 10
- 11 - 25
- 26 - 100
- 101 - 200
- 201 - 700
- 701 - 1000

0 25 50 100 Miles

The Washington State Department of Commerce

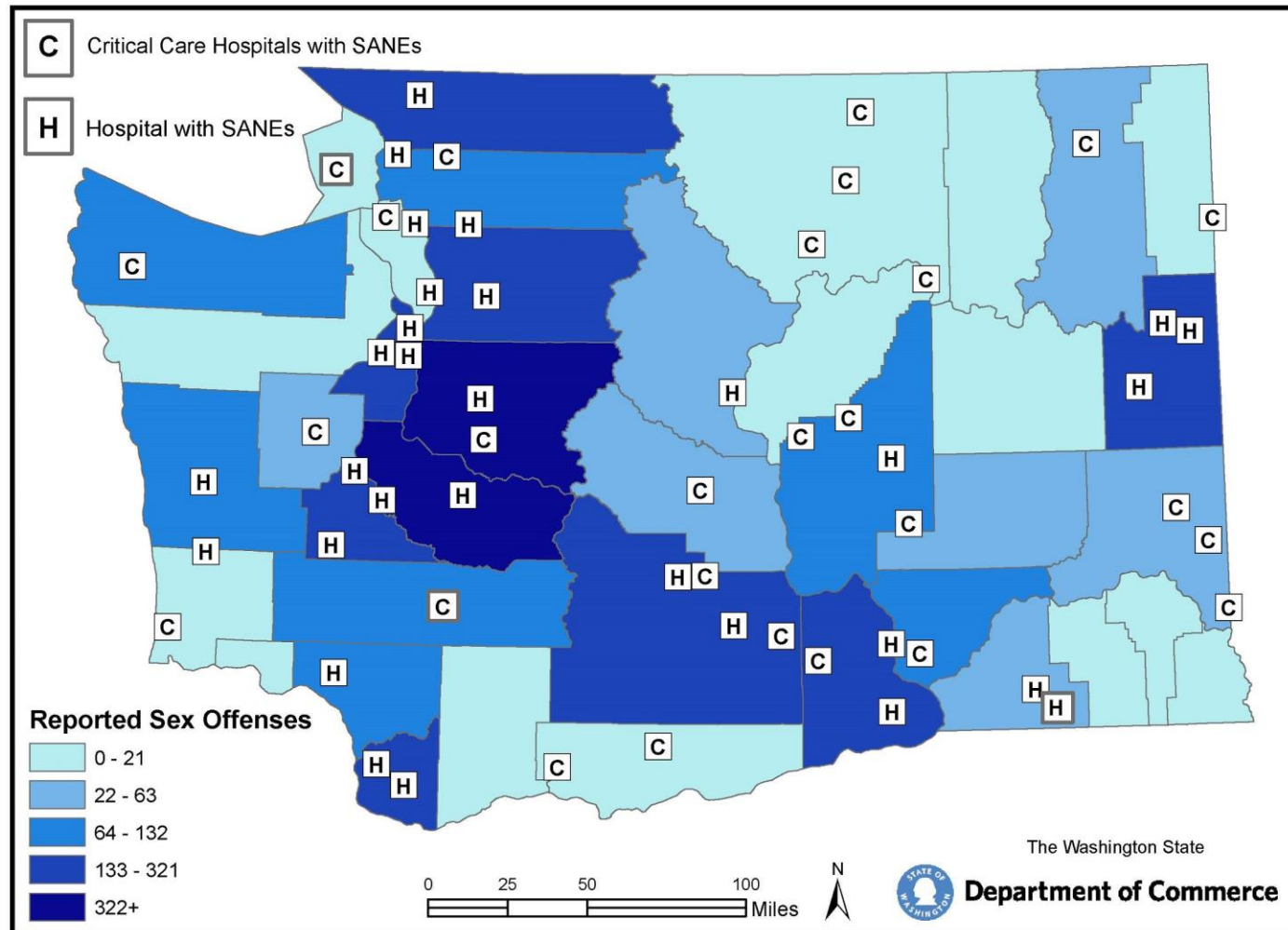
Sexual Assault Nurse Examiner Availability Study

Appendix F: Clients of Sexual Assault Services, 2015



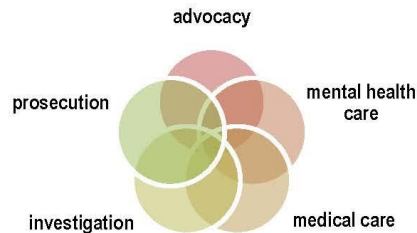
Sources: InfoNet, Office of Crime Victim's Advocacy

Appendix G: Hospitals That May Employ SANEs, 2016



Sources: Washington Association of Sheriffs and Police Chiefs, Harborview Center for Sexual Assault & Traumatic Stress, Washington State Hospital Association

Appendix H: Services to Child and Youth Survivors of Sexual Assault



Sexual Assault Services for Children and Youth in Washington State

An Overview of OCVA Funded Sexual Assault Service Providers and their Work With Child Advocacy Centers

The Framework

- The Office of Crime Victims Advocacy (OCVA), located at the Department of Commerce, oversees and administers federal and state funding to organizations providing sexual assault services to children, youth and adults. Services are provided in accordance with the Washington State Sexual Assault Services Plan service standards and funding formula.
- Thirty-eight accredited Community Sexual Assault Programs (CSAPs) serve every county in Washington, 24/7. CSAPs are funded fully or in part by OCVA. These programs provide advocacy services to child, youth and adult survivors of sexual assault and engage in prevention, community education, and system coordination efforts (these are core services). CSAPs also provide support groups and/or therapy services for survivors (these are specialized services).
 - *In order to be eligible for Core funding, CSAPs must pass accreditation every four years. The accreditation review requires that the organization meets 40 management and service standards.¹*
- 32 Specialized² and/or culturally and community-specific³ service providers are funded in part through OCVA, and serve children, youth and adults per the Washington State Sexual Assault Services Plan.
 - *As noted above, CSAPs also provide these specialized services in their community; CSAP services are in addition to the 32 providers noted above.*

Total Number of CSAPs <i>All CSAPs are mandated to provide Core services⁴</i>	CSAPs That Also Provide Specialized Services	Specialized Services Providers (non-CSAP)	Culturally and Community Specific Providers	Total Number of Providers Funded by OCVA for SA Services
38	37	13	19	70

¹ http://www.commerce.wa.gov/Documents/OCVA_SA_Accreditation_Standards_2012.pdf

² Specialized services include therapy, medical social work, and support groups

³ Culturally and community specific services include community organizing, training and education; prevention; community responding; and therapy

⁴ Core services include general, legal and medical advocacy; crisis intervention, information and referral; systems coordination; and building skills prevention

- Fourteen accredited Children’s Advocacy Centers (CACs) serving 16 counties provide services to children who have experienced abuse (physical, sexual, and/or maltreatment). There are an additional seven developing (non-accredited) CACs in Washington. CACs coordinate investigation and intervention services, bringing together a multidisciplinary team with a child-focused approach to abuse cases.⁵ Eleven CACs are also OCVA -funded SA service providers (the CAC is either a CSAP or a specialized SA service provider), an additional seven CACs rely on OCVA-funded service providers to deliver one or more of the CAC services.
 - *To be an accredited CAC, the organization must meet 10 service and organizational capacity standards.*⁶

Total Number of Accredited CACs	Total Number of Non-Accredited (Developing) CACs	Total Number of CACs (Accredited and Developing)	CACs (Accredited and Developing) Directly Funded by OCVA for SA Services	CACs (Accredited and Developing) that Rely on an OCVA-Funded Provider for a CAC SA service
14	7	21	11	7

Services, Clients, and Approach

While many CACs and CSAPs across the state work closely together and are often co-located under a shared umbrella agency, the types of services, clients, and approach differ.

Justice and healing will look different for each sexual assault survivor. CACs and CSAPs each provide survivors a different array of valuable services. CAC services are rooted in child protection and treatment along with criminal justice response. CSAPs offer a different range and duration of services to survivors, with a focus on advocacy and mental health services.

- CACs are mandated (per accreditation) to provide [services connected to the investigation and prosecution of a child abuse, sexual abuse, or maltreatment case](#)⁷. CACs aim to reduce the trauma experienced by children who report abuse, hold offenders accountable, and provide support to both children and nonoffending family members. For example:
 - CACs have intentionally created facilities that are child friendly, helping to reduce the stress children and families feel while reporting abuse and seeking services.
 - CACs bring together multidisciplinary teams (MDT) and coordinate case reviews to discuss the investigation, prosecution and treatment options in child abuse cases⁸.

⁵ <http://www.cacwa.org/services.html>

⁶ <http://www.cacwa.org/assets/nca-revised-standards-for-cacs.pdf>

⁷ <http://www.nationalchildrensalliance.org/cac-model>

⁸ <http://www.cacwa.org/mission.html>

- This approach reduces the number of times a victim has to tell their story, and helps make sure everyone involved in the case is working together.
 - The CAC can connect the child and family to additional resources and/or support, such as connecting them to mental health and advocacy resources.
 - In WA State, some CACs have elected to offer additional services based on community need and available resources.
- CSAPs are mandated (per accreditation) to offer survivors crisis intervention and general, legal and medical advocacy. They must also engage in system coordination efforts. This provides an essential level of support and services to children and families affected by sexual assault. For example:
 - CSAPs offer families/children support and assistance with civil legal remedies and/or additional advocacy based support during the criminal legal process. CSAPs are mandated to provide legal advocacy.
 - CSAPs help families that need assistance securing housing, requesting a leave of absence from work or school, finding childcare, accessing resources for food and clothing, accessing psycho-educational support groups, connecting to trauma-informed ongoing medical care, etc.
 - Families/children may feel uncertain or uncomfortable working within a multidisciplinary response that includes the child protection and criminal justice systems. This is common in historically marginalized communities, immigrant and refugee communities, and at times when the survivors may be experiencing complex and conflicted feelings about charges against the offender (common when the offender is a family member or friend). These families may benefit from CSAP support.
 - CSAPs also help to coordinate support and resources for families in communities where it is not possible for there to be an MDT response for each case (such as in urban areas). Advocacy plays an important part in troubleshooting the specific systems the person is working with.

Overall, CSAPs and CACs in Washington State are working well together, and are often looked to nationally as a model for collaboration and comprehensive service delivery for children and families surviving sexual violence.

- CACs specialize in coordinating and supporting the initial multidisciplinary response, and CSAPs provide an integral component of the MDT response. Additionally, CSAPs can provide the longer term support, treatment (by either ensuring it exists or providing it directly), and advocacy to children and families.
 - This is not identical in each county, and there can be barriers to collaboration, however most providers agree that a collaborative model is effective and best practice.
 - Each community in WA State approaches this a bit differently, as the model is based on the individual community's need ([see the Sample of Seven Counties below](#)).
- CACs are well equipped to address the issues a child and/or family may be facing specific to child sexual abuse and the investigation of the abuse; CSAPs are well equipped to address the child sexual abuse and the additional traumas and issues the family may be facing. For example:

- The CAC may be conducting the forensic interviews with the family, while the CSAP provides legal advocacy as the case moves through the criminal justice system.
 - The CSAP can offer the non-offending caregivers advocacy support specific to their own abuse history, if needed.
 - Siblings often need support regarding their feelings about the abuse, pending case, and the family dynamic and relationships that may be impacted by this traumatic experience; this is a support the CSAP can provide to the family as the CAC focuses on the needs of the primary victim.
 - Child and teen survivors who need support and resources unrelated to the investigation and prosecution of their case may be best served by the CSAP.
- CSAPs are well equipped to work with teen survivors of sexual violence, while CACs are more focused on child survivors.
 - [According to a survey completed by the Child Advocacy Centers of WA State](#)⁹ in 2013, 74% of the children they worked with were 12 and under.
 - [86% of sexual abuse incidents perpetrated against 12-17 year olds](#)¹⁰ were not reported to any authority. CSAPs are well positioned to provide these victims with needed services, at a time when they may be unable to disclose the details of their abuse (needed to initiate an investigation) and/or may be seeking information and resources prior to a disclosure of abuse.
 - Together CACs and CSAPs can coordinate, co-locate and collaborate to provide the full range of responses and services the children and families affected by sexual assault need.

CSAP advocacy services are available 24/7 in every county in Washington State.

- CACs are more limited in their hours and geographic location. A continuation of services is usually available when the CAC is connected to a CSAP.
 - *It is uncertain how this looks in communities when the CAC stands alone.*

CSAPs provide families confidential advocacy services, which is of the utmost importance to sexual abuse survivors.

- Like other system based advocates, whether CAC employed advocates can provide the legally protected confidential services that a CSAP can is inconsistent throughout the state.

Specialized and culturally and community-specific service providers are essential partners in the the overall service provision for children, youth and families.

- Both CSAPs and CACs rely on specialized and culturally and community-specific sexual assault service providers in their community to help meet the needs of survivors.

⁹ <http://www.cacwa.org/assets/washington-jan-to-dec-2013-oms-report.pdf>

¹⁰ <https://www.ncjrs.gov/pdffiles1/nij/194972.pdf>

- Specialized and community-specific sexual assault providers can work with survivors independent of the services they are receiving from a CAC or a CSAP.
- For many, a provider that is culturally or community specific is a powerful ally; that organization not only provides culturally appropriate direct services, they also advocate with system partners to ensure they are working with that survivor in a culturally sensitive manner.
- Specialized services (therapy, medical social work, and support groups) are often accessed in the immediate aftermath of an assault, and years down the road. They are an essential resource in the continuum of care.

A Sample of Seven Counties

The following provides seven examples of the integration of CAC, CSAP, and Specialized services in Washington State.



Benton/Franklin

- The CAC (Kids Haven) is a joint program of the local CSAP (Support Advocacy and Resource Center) and local city and county governments; the CSAP and CAC share management and direct services staff
- Forensic interviews are conducted at the CAC
- Partnerships have been developed with local therapists who provide therapy services and, on a case-specific basis, participate in the multidisciplinary team meetings
- Forensic sexual assault exams and other medical care is addressed at one of four local hospitals

Clark County

- The CAC (Arthur D. Curtis Children's Justice Center) has an investigative unit, a prosecution unit, and a systems based advocate*
- Therapy services are provided by an OCVA-funded SA specialized provider
- Forensic interviews are conducted at the CAC
- Forensic sexual assault exams are conducted at a local hospital, other medical care is also available if needed
- The CAC provides a trained service dog who is available to all clients, at any point of service, for emotional support

**The system based advocate position at the CAC is a recent change in structure. Prior to this the local CSAP (YWCA of Vancouver Sexual Assault Program) provided the advocacy services; currently the CSAP provides community based general, legal and medical advocacy to survivors, as needed.*

Stevens County

- The Community Action agency houses and administers both the CSAP (Family Support Center) and the CAC (Kids First), the programs share management and direct services staff
- Law enforcement and Child Protective Services staff are also onsite, they conduct the forensic interviews
- This design creates multiple points of entry for clients
- Partnerships have been developed with local therapists, who provide therapy services and participate in the multidisciplinary team meetings as needed
- Forensic sexual assault exams and other medical care is addressed at the local hospital

Appendix I:

Profile of SANEs and their work in Children's Advocacy Centers

By: Alice Zillah

Thurston County's Providence St. Peter Hospital Sexual Assault Clinic (SAC) helps children, teens, and adults recover from the nightmare of sexual assault, using an approach that is person-centered and trauma-informed. Today, law enforcement, CPS, and medical providers know to refer individuals to the Clinic when they suspect sexual abuse. In addition, the Clinic's Sexual Assault Nurse Examiners (SANEs) serve a five-county area as well as Madigan Army Medical Center, providing medical care and forensic evidence collection for adolescents and adults in an emergency setting.

The first step is usually a forensic interview conducted by law enforcement officers. Astro, a calm Labrador service dog, is available to accompany the patient during the interview. The interviews are video-recorded, and will be shared with prosecutors if charges are litigated.

The next step is a non-invasive medical exam, done in a warmly-decorated room just down the hall. The medical provider explains exactly what will happen at each step of the way. A high-tech colposcope allows the provider to identify and photograph genital injuries not readily visible to the unaided eye. Fortunately, many offenders do not inflict visible injuries, or injuries have healed since the offense occurred.

As part of the healing process, children, teens, and adults are encouraged to take advantage of free, on-site therapy for them and family. Astro makes himself available for canine companionship during sessions, and in the courtroom if the case proceeds to a trial.

Finally, if the investigation results in charges against the perpetrator, two Thurston County Special Victim Team prosecutors have their offices at the Clinic and will litigate the cases.

The well-coordinated services provided to patients are no accident – a lot of work happens behind the scenes to ensure the process runs smoothly, from the time they walk through the door to the day they leave their last therapy session.

Key to the unified approach is a weekly multidisciplinary team (MDT) meeting involving everyone who will be staffing the cases. "Multidisciplinary meetings provide communication and expert care for the kids every step of the way," says Dr. Joyce Gilbert, SAC Director. "Being able to communicate very openly with health and welfare, law enforcement, prosecutors, is really what aids [the patients], and helps get the best outcome." Confidential, community-based advocates are also integral to MDTs.

The MDT meetings, held every Friday, allow all team members to both collaborate on individual cases and

hash out policy issues. “It’s so amazing to have these meetings,” adds Nancy Young, the Nurse Practitioner who oversees the Clinic’s SANE program. “We used to operate in a vacuum. Now we work together as a team.”

An MDT approach enables SAC and SANE staff to follow up on cases with the police and prosecutors directly, and together the group makes system modifications for better outcomes. For instance, they developed a form that is mailed with every Sexual Assault Kit to the Washington State Patrol Crime Lab. The WSP fills out the form and returns it, indicating that they received all the evidence and providing feedback about packaging and methodology.

The collaboration leads to more referrals, since law enforcement agencies in the region know exactly where to refer victims. “The answer is good education and community partnering,” says Young.

One challenge the MDT cannot surmount is a consistent funding stream. “Our SANE program is a money-loser for the hospital,” explains Young, referring to Providence St. Peter Hospital, which manages the program. Providence provides approximately \$700,000 per year in subsidized services to the Clinic. Additional costs are covered by a hodge-podge of sources, including the Crime Victims Compensation Program and grants from DSHS and the Attorney General’s Office. The funding instability contributes to a high degree of turnover in SANE practitioners, which leads to the need for ongoing training for new SANE providers – an additional expense.

Fortunately, the individuals served by the SAC and its SANE program are unaware of the search for funding sources going on behind the scenes. They experience a well-organized facility staffed by kind and caring individuals – and one amiable dog – that make it possible to heal from the trauma of sexual abuse.

Appendix J: Crime Victim's Compensation Reimbursement

Electronic Billing

The Crime Victims Compensation Program can accept Direct Entry electronic bills. To start the process go to: www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/Electronic/directentry.asp

For detailed instructions on how to submit Direct Entry electronic bills to the Crime Victims Compensation Program go to: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2545

Procedure Codes

Medical Providers

Providers who perform the initial sexual assault examination should bill using the Local Codes 0131C-0133C. If no sexual assault examination is performed, bill 0130C. Alternatively, providers may bill customary CPT® and/or HCPC codes.

The cost of supplies (e.g. forensic evidence collection kit) is bundled into the Local Codes 0131C through 0133C.

Local Codes

0130C — Sexual Assault — Vitals Only, No Physical Exam

0131C — Sexual Assault Examination Level 1

5 to 45 minutes face-to-face with patient by medical provider(s). Requires a history and a physical examination. Include supplies (e.g. forensic evidence collection kit).

0132C — Sexual Assault Examination Level 2

46 to 119 minutes face-to-face with patient by medical provider(s). Requires a history and a physical examination. Includes supplies (e.g. forensic evidence collection kit) and prolonged services.

0133C — Sexual Assault Examination Level 3

120 minutes or more face-to-face with patient by medical provider(s). Requires a history and a physical examination. Includes supplies (e.g. forensic evidence collection kit) and prolonged services.

Sexual Assault Examination Local Codes and Fees

Code	Physician Non-Facility	Physician Facility	Nurse Non-Facility	Nurse Facility
0130C	72.64	43.35	65.37	39.01
0131C	3	235.26	299.79	21
0132C	5	414.65	475.93	37
0133C	5	466.39	529.57	41