



Testimony of Sara Jennings

on behalf of the International Association
of Forensic Nurses

Before the Subcommittee on Oversight
and Investigations of the House Energy
and Commerce Committee

Wednesday, December 12, 2018, at
10:00 a.m. in 2123 Rayburn House Office
Building

For a hearing entitled "Examining the
Availability of SAFE Kits at Hospitals in the
United States."

Summary of Comments

- Dr. Sara Jennings is a forensic nurse and the President-elect of the IAFN.
- A forensic nurse is a Registered or Advanced Practice nurse who has received specific education and training. Forensic nurses provide specialized care for patients who are experiencing acute and long-term health consequences associated with victimization or violence, and/or have unmet evidentiary needs relative to having been victimized or accused of victimization. In addition, forensic nurses provide consultation and testimony for civil and criminal proceedings relative to nursing practice, care given, and opinions rendered regarding findings.
- Sexual Assault Nurse Examiners (SANE) are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse.
- The Bureau of Justice Statistics within the Department of Justice reports in its National Crime Victimization Survey for 2016 that there were 298,410 rape or sexual assault in the United States. There were also 1,068,120 incidents of domestic violence. (see chart from 2016 report below. <https://www.bjs.gov/content/pub/pdf/cv16re.pdf>)
- In March of 2016, the General Accountability Office (GAO) issued a report investigating the availability of trained examiners on a national level. The report identified major flaws in survivor access to sexual assault examination services. Specifically, the report showed a disturbing lack, and in some cases a complete absence, of information and data on the number of sexual assault examiners in most states.
- IAFN is pleased that Congress is increasingly aware of the problem and the need to ensure appropriate access to necessary services and supplies. Several bills have been introduced to try to address the problem. IAFN is supportive of the Survivors' Access to Supportive Care (SASCA) and also encourages efforts to improve the Violence Against Women Act in several ways described below.
- IAFN strongly supports the SASCA (S.3203/H.R.6387), which was introduced in the Senate by Senator Patty Murray (D-WA) and Senator Lisa Murkowski (R-AK), and in the House by Rep. Pamila Jayapal (D-WA) and Rep. Peter King (R-NY).

Chairman Harper, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to testify today. On behalf of the 4,300 forensic nurses who make up the membership of the International Association of Forensic Nurses (IAFN) I am pleased to be here this morning to testify in relation to the availability of SAFE kits at hospitals in the United States and to discuss issues impacting patients' access to essential services following an assault. This is an important topic and IAFN appreciates the active role of the Committee to address it.

My name is Sara Jennings. I am a forensic nurse and the President-elect of the IAFN.

Forensic Nursing

First, let me tell you a bit about forensic nursing. A forensic nurse is a Registered or Advanced Practice nurse who has received specific education and training. Forensic nurses provide specialized care for patients who are experiencing acute and long-term health consequences associated with victimization or violence, and/or have unmet evidentiary needs relative to having been victimized or accused of victimization. In addition, forensic nurses provide consultation and testimony for civil and criminal proceedings relative to nursing practice, care given, and opinions rendered regarding findings. Forensic nursing care is not separate and distinct from other forms of medical care, but rather integrated into the overall care needs of individual patients.

Since forensic nursing is a recognized nursing specialty of the American Nurses Association, a person must first become a registered nurse before becoming a forensic nurse. Forensic nurses

work in a variety of fields, including sexual assault (as Sexual Assault Nurse Examiners or SANEs), domestic or intimate partner violence, child abuse and neglect, elder maltreatment, human trafficking, death investigation, corrections, and in the aftermath of mass disasters. In the United States, forensic nurses most frequently work in hospitals, community anti-violence programs, coroner's and medical examiners offices, corrections institutions and psychiatric hospitals. Forensic nurses may also be called on in mass disasters or community crisis situations.

Sexual Assault Nurse Examiners

Sexual Assault Nurse Examiners (SANE) are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse.

To become a SANE, you must first be a registered nurse (or advanced practice), with two years or more experience in areas of practice that require advanced physical assessment skills, such as emergency, critical care and maternal child health. The SANE training should meet the IAFN SANE Education Guidelines and will consist of both classroom and clinical components. The classroom training is completed either live or online and consists of either 40 hours for the adult/adolescent patient, 40 hours for the pediatric/adolescent patient or a combined 64-hour course that addresses all patient age categories. The clinical training often occurs in both a simulation lab and clinical setting with experienced preceptors who can prepare the new SANE for practicing competently in the role. In addition, nurses should understand their local

community requirements as they vary significantly between state, province, or country Boards of Nursing and/or Colleges of Nursing as it relates to SANE practice.

After beginning practice as a SANE, nurses who have obtained SANE training and meet the clinical practice requirements have the opportunity to take a board certification examination through the Association. The Sexual Assault Nurse Examiner-Adult/Adolescent (SANE-A®) and the Sexual Assault Nurse Examiner-Pediatric (SANE-P®) board certification tests are for SANEs who care for specific population of patients.

The Problem of Sexual Assault and Domestic Violence is Immense

The Bureau of Justice Statistics within the Department of Justice reports in its National Crime Victimization Survey for 2016 that there were 298,410 rape or sexual assault in the United States. There were also 1,068,120 incidents of domestic violence. (see chart from 2016 report below. <https://www.bjs.gov/content/pub/pdf/cv16re.pdf>)

TABLE 1
Violent victimization, by type of crime, 2015 and 2016

Type of crime	2015*		Original 2016 ^a		Revised 2016	
	Number	Rate per 1,000 ^b	Number	Rate per 1,000 ^b	Number	Rate per 1,000 ^b
Violent crime^c	5,006,620	18.6	5,749,330	21.1	5,353,820	19.7
Rape or sexual assault ^d	431,840	1.6	323,450	1.2	298,410 †	1.1 †
Robbery	578,580	2.1	500,680	1.8	458,810	1.7
Assault	3,996,200	14.8	4,925,200	18.1	4,596,600 ‡	16.9 ‡
Aggravated assault	816,760	3.0	1,084,340	4.0	1,040,580 ‡	3.8 ‡
Simple assault	3,179,440	11.8	3,840,860	14.1	3,556,020	13.1
Domestic violence ^e	1,094,660	4.1	1,109,610	4.1	1,068,120	3.9
Intimate partner violence ^f	806,050	3.0	597,740	2.2	597,200 ‡	2.2 ‡
Stranger violence	1,821,310	6.8	2,232,260	8.2	2,082,410	7.7
Violent crime involving injury	1,303,290	4.8	1,366,250	5.0	1,220,640	4.5
Serious violent crime^g	1,827,170	6.8	1,908,470	7.0	1,797,790	6.6
Serious domestic violence ^e	460,450	1.7	402,430	1.5	359,740	1.3
Serious intimate partner violence ^f	333,210	1.2	272,380	1.0	265,770	1.0
Serious stranger violence	690,550	2.6	789,370	2.9	780,580	2.9
Serious violent crime involving a weapon	977,840	3.6	1,267,810	4.7	1,203,200	4.4
Serious violent crime involving injury	658,040	2.4	746,850	2.7	668,230	2.5

Access to SAFE/SANE Services and Kits in Hospitals and Other Settings

In March of 2016, the General Accountability Office (GAO) issued a report investigating the availability of trained examiners on a national level. The report identified major flaws in survivor access to sexual assault examination services. Specifically, the report showed a disturbing lack, and in some cases a complete absence, of information and data on the number of sexual assault examiners in most states.

Federal funding from three key Department of Justice (DOJ) grant programs can be used to train or fund sexual assault forensic examiners and for a range of other activities related to sexual assault, domestic violence, dating violence, and stalking. In 2013, at least one grantee in 49 states used such funds to provide training to examiners and at least one grantee in 26 states funded examiner positions. In 49 states, approximately 227 grantees or subgrantees—referred to collectively as grantees—reported providing training for over 6,000 examiners in 2013. The type of training examiners received ranged from comprehensive examiner training to training on specific topics, such as courtroom testimony. The extent of examiner training efforts supported with funds from the three DOJ grant programs varied by state. For example, in about half of the states, fewer than 100 examiners received training. In addition, in the states where at least one grantee funded examiner staff positions in 2013, grantees funded less than one position, on average. Approximately 75 grantees in 26 states funded roughly 50 full-time equivalent examiner positions in 2013.

On the basis of the literature GAO reviewed as well as interviews with experts and state officials, data on the number of examiners nationwide and in selected states are limited or unavailable. However, officials in all six selected states told GAO that the number of examiners available in their state did not meet the need for exams, especially in rural areas. For example, officials in Wisconsin explained that nearly half of all counties in the state do not have any examiners available. In health care facilities where examiners are available, they are typically available in hospitals on an on-call basis, though the number available varies by facility and may not provide enough capacity to offer examiner coverage 24 hours, 7 days a week.

The GAO found there are multiple challenges to maintaining a supply of examiners, according to interviews with officials in six selected states. These include:

Limited availability of training. Officials in five of six selected states reported that the availability of classroom, clinical, and continuing education training opportunities is a challenge to maintaining a supply of trained examiners. IAFN finds that the classroom training is readily both available and affordable, but access to clinical training and continuing education opportunities pose a significant challenge to achieving and maintaining competency, and therefore staying in practice.

Weak stakeholder support for examiners. Officials in five of six selected states reported that obtaining support from stakeholders, such as hospitals, was a challenge. For example, hospitals may be reluctant to cover the costs of training examiners or paying for examiners to be on-call.

Often hospitals view sexual assault patients as criminal justice or social issues versus patients with significant acute and long-term health consequences. In addition, many rural communities have a low volume of sexual assault patients making it difficult for hospitals to devote the necessary resources to establishing and maintaining a SANE program.

Low examiner retention rates. The above-mentioned and other challenges, including the emotional and physical demands on examiners and the fact that most examiners do this as a second job, contribute to low examiner retention rates. Officials in one state estimated that while the state trained 540 examiners over a two-year period, only 42 of those examiners were still practicing in the state at the end of those 2 years.

In addition to the challenges outlined in the GAO report, an emerging issue in addressing the care needs of sexual assault patients is telemedicine. Telemedicine is being utilized in sexual assault care in a variety of ways but in particular providing support to the provider in the live clinical setting with the patient. Telemedicine comes with many practical challenges that must be addressed up front in order to be utilized in an effective manner. Licensure and privacy regulations differ from state to state, and whether or not the consulting telemedicine provider will be necessary for expert testimony in court has not yet been tested, but must be considered. Lastly, the evidence base is lacking relative to patient perception of telemedicine during a sexual assault medical forensic examination. That said, telemedicine stands to dramatically improve the care of the sexually assaulted patients in rural and low volume

communities if an evidence-base for its effective use from trauma through trial can be established.

Legislation to Address the Problem

IAFN is pleased that Congress is increasingly aware of the problem and the need to ensure appropriate access to necessary services and supplies. Several bills have been introduced to try to address the problem. IAFN is supportive of the Survivors' Access to Supportive Care (SASCA) and also encourages efforts to improve the Violence Against Women Act in several ways described below.

The Survivors' Access to Supportive Care (SASCA) Act

IAFN strongly supports the SASCA (S.3203/H.R.6387), which was introduced in the Senate by Senator Patty Murray (D-WA) and Senator Lisa Murkowski (R-AK), and in the House by Rep. Pamila Jayapal (D-WA) and Rep. Peter King (R-NY).

IAFN believes this bill would expand access to qualified examiner services and help strengthen national standards of care for survivors of sexual assault. SASCA would provide guidance and support to states and to hospitals providing sexual assault examination services and treatment to survivors. Because data on the availability of sexual assault nurse examiners (SANE) and sexual assault forensic examiners (SAFE) is severely limited, SASCA would provide for state-level reviews of current practices in order to better understand care, develop best practices and guidelines, and provide public awareness of sexual assault examinations. SASCA also requires

hospitals to report on SAFE/SANE training and access to medical forensic examinations. This is important as many states and health systems are not tracking the availability of SAFE/SANE services and thus not providing adequate access to these essential services to citizens.

SASCA will authorize \$2 million per year for state-level surveys to better understand barriers to accessing sexual assault care and services, the availability of sexual assault examiners, the costs of training, the spectrum of state-training requirements and standards, and the status of funding at the state level for sexual assault examinations.

Currently, no federal programs exist for the sole purpose of expanding access to health care for survivors of sexual assault, and the Department of Health and Human Services (HHS) does not oversee any national standard or certification protocol for sexual assault examiners. SASCA starts to address both of these by directing HHS to establish a pilot program to develop, test and implement training and continuing education which expands and supports the availability of SANEs, including in rural areas where access to sexual assault examinations is limited due to provider and hospital shortages.

The Violence Against Women Reauthorization Act (VAWA) of 2013 identified gender-based violence and sexual assault as ongoing threats to women, children, and families. SASCA will establish a pilot grant program to expand medical forensic exam training and services to new providers as well as to expand access in rural areas. SASCA will also establish a national sexual

assault taskforce of government agencies and key stakeholders to better understand sexual assault and address the gaps in care for survivors.

SASCA requires that hospitals provide information about their capacity to provide sexual assault care and services to survivors and calls for the Agency for Healthcare Research and Quality and individuals states to establish and keep an updated online map of where survivors can access SAFE/SANE Services.

SASCA provides training grants to entities that serve rural and tribal communities, with 15% of the funding allocated for these grants set aside for Indian-affiliated organizations. SASCA also calls for the development of tools and best practices that will address the unique features and cultural sensitivities within these communities.

SASCA will require that institutions of higher education make students aware of SAFE/SANE services on campus, including by providing information on the nearest hospital with SAFE/SANE services for student as well as information on transportation costs.

SASCA will create a new resource center, available to any hospital receiving federal funds, which aims to support access to sexual assault forensic examinations and encourage training. In addition, the center will facilitate interstate learning collectives to help share and learn best practices.

Violence Against Women Act

IAFN strongly supports swift reauthorization of the Violence Against Women Act (VAWA).

However, IAFN believes there are several key improvements that must be made to the law.

These include:

- Establishing a Standardized National Sexual Assault Evidence Collection Kit
- Ensure the Kit is Trackable
- Requiring health insurance to be the primary payor for sexual assault medical forensic examinations, when available, except in instances where patient safety would be compromised.
- Establishing an evidence-based, trauma-informed National Medical Forensic Exam Protocol for intimate partner violence (IPV).

Establishing a Standardized National Sexual Assault Evidence Collection Kit

Since May 2010 when the Office on Violence Against Women hosted a roundtable discussion, *Eliminating the Rape Kit Backlog: A Roundtable Discussion to Explore a Victim Centered Approach*, recommendations were made to formally address the lack of uniformity in sexual assault evidence collection kits. This lack of uniformity was causing issues with reimbursement and processing of the kits across the country. The creation of a single kit that could be collected at any facility in any jurisdiction would help to eliminate barriers to payment and analysis by different forensic laboratories.

In the *SAFER ACT National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach*, the following recommendations were made: in the current absence of minimum national standards, states and territories should create a single, standardized kit for sexual assault cases in accordance with the minimum criteria specified in *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*. Doing so will allow for consistency in terminology, content, and structure, which will in turn reduce the variability seen in laboratory processes, thereby improving analysis.

Ensure the Kit is Trackable

In the previously mentioned recommendations, it is clear that the most victim-centered approach would allow for a standardized kit where its contents would be uniform regardless of where the kit was collected or analyzed. In an age where virtually any purchase or shipment can be easily tracked online, there is no reason this same technology cannot be employed to keep sexual assault victims informed about where their kit is, and whether or not it has been analyzed. Having a standardized national sexual assault kit with tracking from collection through trial is reasonable and easily achievable.

Requiring Health Insurance to Be the Primary Payor for Sexual Assault Examinations

There are serious short and long-term health implications associated with sexual violence victimization. Funding through VAWA to cover the costs associated with the medical forensic examination of sexual assault victims varies dramatically from jurisdiction to jurisdiction. In some instances, only the kit itself is being covered, despite the understanding that victims

routinely have extensive medical needs such as HIV and STD testing and prevention medications. When health insurance (including Medicaid and Medicare) is available, it should be the primary payor except in instances where the safety of the patient may be at risk (e.g. a college student on a parent's health plan; a patient on their spouse's plan). For any patient where safety is a factor, or where no health insurance exists, funding under VAWA should cover the exam in its entirety.

Establishing an Evidence-based, Trauma-informed National Medical Forensic Exam Protocol for Intimate Partner Violence (IPV)

Nearly 1 in 4 women (23%) and 1 in 7 men (14%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime. Nearly, 14% of women and 4% of men have been injured as a result of IPV that included contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime.¹ Fifty-one percent of female victims of rape reported being raped by an intimate partner.² Sexual assault by an intimate partner is associated with higher rates of nongenital trauma.³ In 2010, 241 males and 1095 females were murdered by an intimate partner.⁴ Throughout health systems, IPV

¹ Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

² Black, M. C., Basile, K. C., Breiding, M. J., Smith, S .G., Walters, M. L., Merrick, M. T., Stevens, M. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Retrieved from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf

³ Seyller, M., Denis, C., Dang, C., Boraud, C., Lepresle, A., Lefevre, T., & Chariot, P. (2016). Intimate Partner Sexual Assault: Traumatic Injuries, Psychological Symptoms, and Perceived Social Reactions. *Obstetrics and Gynecology*, 127(3).

⁴ United States Department of Justice. Crime in the United States, 2010. Federal Bureau of Investigation, Uniform Crime Reports, Washington, DC, 2011.

continues to be treated as a social problem versus one needing a standardized medical forensic response. It is imperative for the long-term health and recovery of these patients that a standardized approach be developed with a plan for effective implementation.

Thank you for the opportunity to present this testimony today. I am available to answer any questions you might have today or in the future.