

EXAMINING THE AVAILABILITY OF SAFE KITS AT HOSPITALS IN THE UNITED STATES

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

DECEMBER 12, 2018

Serial No. 115-175



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

36-850 PDF

WASHINGTON : 2019

COMMITTEE ON ENERGY AND COMMERCE

GREG WALDEN, Oregon

Chairman

JOE BARTON, Texas

Vice Chairman

FRED UPTON, Michigan

JOHN SHIMKUS, Illinois

MICHAEL C. BURGESS, Texas

MARSHA BLACKBURN, Tennessee

STEVE SCALISE, Louisiana

ROBERT E. LATTA, Ohio

CATHY McMORRIS RODGERS, Washington

GREGG HARPER, Mississippi

LEONARD LANCE, New Jersey

BRETT GUTHRIE, Kentucky

PETE OLSON, Texas

DAVID B. MCKINLEY, West Virginia

ADAM KINZINGER, Illinois

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

BILL JOHNSON, Ohio

BILLY LONG, Missouri

LARRY BUCSHON, Indiana

BILL FLORES, Texas

SUSAN W. BROOKS, Indiana

MARKWAYNE MULLIN, Oklahoma

RICHARD HUDSON, North Carolina

KEVIN CRAMER, North Dakota

TIM WALBERG, Michigan

MIMI WALTERS, California

RYAN A. COSTELLO, Pennsylvania

EARL L. "BUDDY" CARTER, Georgia

JEFF DUNCAN, South Carolina

FRANK PALLONE, JR., New Jersey

Ranking Member

BOBBY L. RUSH, Illinois

ANNA G. ESHOO, California

ELIOT L. ENGEL, New York

GENE GREEN, Texas

DIANA DeGETTE, Colorado

MICHAEL F. DOYLE, Pennsylvania

JANICE D. SCHAKOWSKY, Illinois

G.K. BUTTERFIELD, North Carolina

DORIS O. MATSUI, California

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

JERRY McNERNEY, California

PETER WELCH, Vermont

BEN RAY LUJAN, New Mexico

PAUL TONKO, New York

YVETTE D. CLARKE, New York

DAVID LOEBSACK, Iowa

KURT SCHRADER, Oregon

JOSEPH P. KENNEDY, III, Massachusetts

TONY CARDENAS, California

RAUL RUIZ, California

SCOTT H. PETERS, California

DEBBIE DINGELL, Michigan

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

GREGG HARPER, Mississippi

Chairman

H. MORGAN GRIFFITH, Virginia

Vice Chairman

JOE BARTON, Texas

MICHAEL C. BURGESS, Texas

SUSAN W. BROOKS, Indiana

TIM WALBERG, Michigan

MIMI WALTERS, California

RYAN A. COSTELLO, Pennsylvania

EARL L. "BUDDY" CARTER, Georgia

GREG WALDEN, Oregon (*ex officio*)

DIANA DeGETTE, Colorado

Ranking Member

JANICE D. SCHAKOWSKY, Illinois

KATHY CASTOR, Florida

PAUL TONKO, New York

YVETTE D. CLARKE, New York

RAUL RUIZ, California

SCOTT H. PETERS, California

FRANK PALLONE, JR., New Jersey (*ex officio*)

C O N T E N T S

	Page
Hon. Gregg Harper, a Representative in Congress from the State of Mississippi, opening statement	1
Prepared statement	3
Hon. Diana DeGette, a Representative in Congress from the State of Colorado, opening statement	4
Prepared statement	6
Hon. Greg Walden, a Representative in Congress from the State of Oregon, opening statement	7
Prepared statement	9
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	10
Prepared statement	11

WITNESSES

A. Nicole Clowers, Managing Director, Healthcare, Government Accountability Office	13
Prepared statement	15
Sara Jennings, President-elect, International Association of Forensic Nurses ..	29
Prepared statement	31
Lynn Frederick-Hawley, Executive Director, Sexual Assault and Violence Intervention Program, Mount Sinai Hospital	46
Prepared statement	48
Kiersten Stewart, Director of Public Policy and Washington Office, Futures Without Violence	51
Prepared statement	53

SUBMITTED MATERIAL

Subcommittee memorandum	80
Responses from hospitals and associations to letter from committee, submitted by Mr. Harper ¹	
List of databases of SANE programs and SAFE-ready facilities, committee staff document, December 12, 2018, submitted by Mr. Harper	84

¹The information has been retained in committee files and also is available at <https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=108782>.

EXAMINING THE AVAILABILITY OF SAFE KITS AT HOSPITALS IN THE UNITED STATES

WEDNESDAY, DECEMBER 12, 2018

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:04 a.m., in room 2123, Rayburn House Office Building, Hon. Gregg Harper (chairman of the subcommittee) presiding.

Members present: Representatives Harper, Griffith, Burgess, Brooks, Walberg, Costello, Carter, Walden (ex officio), DeGette, Castor, Clarke, Ruiz, Peters, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Karen Christian, General Counsel; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Brighton Haslett, Counsel, Oversight and Investigations; Zach Hunter, Communications Director; Sarah Matthews, Press Secretary, Energy and Environment; Jeff Carroll, Minority Staff Director; Chris Knauer, Minority Oversight Staff Director; Jourdan Lewis, Minority Policy Analyst; Perry Lusk, Minority GAO Detailee; Andrew Souvall, Minority Director of Communications, Member Services, and Outreach; and C.J. Young, Minority Press Secretary.

OPENING STATEMENT OF HON. GREGG HARPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. HARPER. The subcommittee will come to order.

Today, the subcommittee on Oversight and Investigations is holding a hearing entitled “Examining the Availability of SAFE Kits at Hospitals in the United States.”

Sexual assault is a vicious and deeply traumatizing crime inflicted against hundreds of thousands of Americans each year. As policymakers, it is our responsibility to do everything we can to help those survivors and hold the perpetrators of those crimes accountable. To accomplish that, we must improve and expand access to critical forensic and healthcare services that survivors seek after an assault.

In 2016, the Bureau of Justice Statistics reported that more than 323,450 people were the victims of sexual assault. However, the actual number of survivors may be much higher. According to the National Crime Victimization Survey, sexual assault is the most underreported crime in the country. In fact, aggregate data from

the FBI and DOJ indicates that only 23 percent of rapes were reported between 2012 and 2017.

The first step towards prosecuting these vicious crimes is often the collection of a sexual assault forensic exam or commonly known as a rape kit. A rape kit can be performed by a specially trained sexual assault nurse examiner, a SANE, or by a nurse or medical professional that does not have SANE training. However, rape kits performed by trained SANEs, what we shall call SAFE kits, result in better outcomes for patients, including shortened exam time, better quality healthcare, higher quality forensic evidence collection, and certainly higher prosecution rates.

These kits can be vital to securing a prosecution and conviction. But in many areas of the country, it can prove shockingly difficult for a survivor of sexual assault to obtain a SAFE kit. One of our witnesses today, the International Association of Forensic Nurses, estimates that only about 15 percent of hospitals in the United States provide SAFE kits. We don't know what happens to many of the survivors that visit a hospital that does not have SANE nurses available.

In 2016, the GAO published a report entitled Sexual Assault: Information on Training, Funding, and Availability of Forensic Examiners. The report examined the challenges that hospitals face in providing access to SANEs and SAFE kits, including limited availability of SANE training, weak stakeholder support for examiners, and low examiner retention rates. We need to explore each of these issues today.

Over the course of our work, we sent letters to 15 hospitals and 10 hospital associations across the country to assess what services those hospitals offer and what challenges they face in making those services available. Their responses were enlightening, and have not only helped the committee better understand the challenges to provide access to SANEs and SAFE kits, but also identifies some of the solutions.

I want to thank all of those hospitals and groups for their assistance. And without objection, I ask unanimous consent to enter these 25 responses to the committee's letters into the record.

Without objection, they are so entered.¹

Finally, adding to the issue of lack of access is the fact that very little data is available about where survivors can find SAFE kits. The nationwide database compiled by the Forensic Nurses appears to be the best in the country, but it is not comprehensive. For example, the database lists only two locations in my home State of Mississippi, but my staff was able to locate at least 10 SANE programs online. That is not a criticism at all of the Forensic Nurses, but a call to action. And I hope that one result of today's hearing will be to motivate communities around the country to raise awareness of where SAFE kits can be found, and move towards making that information widely available.

To that end, I'd also like to ask unanimous consent to enter into the record a statement—or a document that the committee created,

¹The information has been retained in committee files and also is available at <https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=108782>.

which includes every list or database our staff could find for SANE programs and SAFE-ready facilitates across the country.

Without objection, so entered.

[The information appears at the conclusion of the hearing:]

Mr. HARPER. I would also like to submit into the record a letter from the Joyful Heart Foundation about SAFE kits, which we received actually this morning.

Without objection, so entered.

It is our hope that this can be a resource to survivors across the country and that we can lead the charge in educating the public about this important issue.

I'd like to thank all of our witnesses for joining us in sharing your expertise and perspectives today. I know this is a very sensitive topic, but it's a very important one for our country, and we look forward to hearing your testimony shortly.

Before I introduce the ranking member for her statement, I would like to take a moment of personal privilege. This will be my last hearing chairing this subcommittee before I begin my eagerly anticipated retirement in a few weeks, not from work, just from Congress. I would like to thank Chairman Walden for the opportunity to chair this subcommittee through so many important hearings, including this one. And I would also like to thank the ranking member and all of my colleagues on both sides of the aisle for their assistance on so many important matters that face this committee and our country.

[The prepared statement of Mr. Harper follows:]

PREPARED STATEMENT OF HON. GREGG HARPER

The subcommittee will come to order. Today, the Subcommittee on Oversight and Investigations is holding a hearing entitled "Examining the Availability of SAFE Kits at Hospitals in the United States."

Sexual assault is a vicious and deeply traumatizing crime inflicted against hundreds of thousands of Americans each year. As policymakers, it is our responsibility to do everything we can to help those survivors and hold the perpetrators of those crimes accountable. To accomplish that, we must improve and expand access to critical forensic and healthcare services that survivors seek after an assault.

In 2016, the Bureau of Justice Statistics reported that more than 323,450 people were the victims of sexual assault. However, the actual number of survivors may be much higher. According to the National Crime Victimization Survey, sexual assault is the most underreported crime in the country. In fact, aggregate data from the FBI and DOJ indicates that only 23 percent of rapes were reported between 2012 and 2017.

The first step toward prosecuting these vicious crimes is often the collection of a sexual assault forensic exam, more commonly known as a rape kit. A rape kit can be performed by a specially trained Sexual Assault Nurse Examiner - a "SANE"—or by a nurse or medical professional that does not have SANE training. However, rape kits performed by trained SANEs - what we will call "SAFE kits"—result in better outcomes for patients, including shortened exam time, better quality health care, higher quality forensic evidence collection, and higher prosecution rates.

These kits can be vital to securing a prosecution and conviction, but in many areas of the country, it can prove shockingly difficult for a survivor of sexual assault to obtain a SAFE kit. One of our witnesses today, the International Association of Forensic Nurses (IAFN), estimates that only about 15 percent of hospitals in the United States provide SAFE kits. We don't know what happens to many of the survivors that visit a hospital that does not have SANE nurses available.

In 2016, the GAO published a report entitled "Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners." The report examined the challenges that hospitals face in providing access to SANEs and SAFE kits, including limited availability of SANE training, weak stakeholder support for exam-

iners, and low examiner retention rates. We intend to explore each of those issues today.

Over the course of our work, we've sent letters to 15 hospitals and 10 hospital associations across the country to assess what services those hospitals offer, and what challenges they face in making those services available. Their responses were enlightening, and have not only helped the committee better understand the challenges to providing access to SANEs and SAFE kits, but also identify some of the solutions. I want to thank all of those hospitals and groups for their cooperation and, without objection, I ask unanimous consent to enter their responses into the record.

Finally, adding to the issue of lack of access is the fact that very little data is available about where survivors can find SAFE kits. The nationwide IAFN database appears to be the best in the country, but is not comprehensive. For example, the IAFN database lists only 2 locations in my home State of Mississippi, but my staff was able to locate at least 10 SANE programs online.

That is not a criticism of IAFN, but a call to action; I hope that one result of today's hearing will be to motivate communities around the country to raise awareness of where SAFE kits can be found and move toward making that information widely available. To that end, I'd also like to ask unanimous consent to enter into the record a document the committee created which includes every list or database our staff could find for SANE programs and SAFE-ready facilities across the country. It is our hope that this can be a resource to survivors across the country, and that we can lead the charge in educating the public about this important issue.

I'd like to thank all of our witnesses for joining us and sharing your expertise today. I know this is a sensitive topic, but it's a very important one. We look forward to hearing your testimony.

Before I introduce the ranking member for her statement, I would like to take a moment of personal privilege. This will be my last hearing chairing this subcommittee before I begin my eagerly anticipated retirement in a few weeks. I would like to thank Chairman Walden for the opportunity to chair this subcommittee through so many important hearings, including this one. I would also like to thank the ranking member and all of my colleagues on both sides of the aisle for their assistance on so many important matters.

Mr. HARPER. With that, I will yield to recognize Ranking Member DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman.

And taking a moment of personal privilege myself, I will say that it's been a real privilege to work with you as the chairman. This is a venerable committee of Energy and Commerce. I think it's the best subcommittee in the House, and I'm really happy that you got the opportunity to chair it.

We've had a number of really solid and important investigative hearings. I think it's really fitting and a reflection on you and your commitment to Americans that the last hearing that we're going to have is a hearing about keeping patients safe and getting the evidence we need.

So please join me, colleagues, in thanking the chairman for his wonderful service.

[Applause.]

Mr. HARPER. Thank you so much.

Ms. DEGETTE. For a survivor of sexual assault, it's critical to protect people's health in the aftermath of an attack and to receive critical timely medical services that address the unique needs of each victim. Compassionate care and the diligent collection of evidence are essential for the victims' well-being and for the hopes for justice.

The Department of Justice estimates that, nationwide, over 160,000 people were raped or sexually assaulted in 2016, the last year for which we have data. Yet these crimes go woefully under-prosecuted. According to the Rape, Abuse, and Incest National Network, only 230 out of 1,000 rapes are reported to the police. Forty-six out of 1,000 leads to an arrest. And only nine are ever referred to a prosecutor for trial.

One important tool for successfully treating and prosecuting sexual assault is to have a trained sexual assault examiner collect a wide variety of forensic evidence from the victim, and, of course, that's what's called a sexual assault evidence collection kit. This kit include a victim's clothes, hair, blood, and saliva for DNA testing and analysis. DNA evidence significantly increases the likelihood of identifying a perpetrator, it increases the likelihood of holding the perpetrator accountable, and it can even prevent further assaults by identifying repeat offenders.

And, shockingly, though, if a victim shows up to a hospital after an assault today, it's far from guaranteed that she would be able to get a sexual assault examination, even if she knows to ask for one. In 2016, the GAO conducted a study assessing the availability of sexual assault forensic examiners nationwide. As part of this study, GAO found that only one of the 23 sexual assault programs in Colorado is large enough to have examiners available 24 hours a day, 7 days a week.

Furthermore, according to the GAO, officials in the six States they reviewed did not know exactly how many practicing examiners there were in their States. There was no national database of sexual assault examiners. And what databases did exist were often out of date and did not cover all of the settings where an exam might occur. This suggests to me that we must do more to get good data on our Nation's capacity for sexual assault examinations so we can then evaluate these programs and ensure they have the resources they need to serve victims.

Keep in mind, these are the barriers that exist just for getting a kit done in the first place. While not the focus of this hearing, there's also a huge backlog of kits that were either never sent to a crime lab to be tested or were sent to a lab but were left to linger for a period of months or longer. This is, to say the least, disturbing.

Today, I look forward to hearing from the witnesses about what we can do to train additional examiners to do this difficult but necessary work and also to retain the examiners that we do have. I also want to hear more about how successful sexual assault examination programs are built and what we can do to address the unique challenges inherent in providing these services in rural areas.

I hope the committee can shed some light on these problems and find ways that will make it easier for any American to get a sexual assault kit from a trained examiner in a time that is admittedly a very emotionally stressful and difficult time for these victims.

And, finally, Mr. Chairman, I have to note the importance of the Violence Against Women Act. This act supports a number of programs that address health issues associated with sexual assault,

including three grant programs that can be used to fund or train sexual assault forensic examiners.

Unfortunately, this law, which has enjoyed bipartisan support for over 20 years, is going to expire in a little over a week. We've got to act to reauthorize this law before the 115th Congress ends so that the programs can continue the important work they're doing and to make sure the victims get the care they need.

Thank you, and I yield back.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Addressing the problem of rape and sexual assault is of critical importance. The Department of Justice estimates that nationwide, over 160,000 people were raped or sexually assaulted in 2016, the last year for which we have data.

And yet these crimes go woefully under-prosecuted. According to the Rape, Abuse & Incest National Network, only 230 out of 1,000 rapes are reported to the police, 46 out of 1,000 leads to an arrest, and only 9 are referred to a prosecutor for trial.

One important tool for successfully prosecuting sexual assault is to have a trained sexual assault examiner collect a wide variety of forensic evidence from the victim, through what's called a sexual assault evidence collection kit.

This can include a victim's clothes, hair, blood and saliva for DNA analysis and testing. DNA evidence significantly increases the likelihood of identifying a perpetrator, increases the likelihood of holding a perpetrator accountable, and can even prevent future assaults by identifying repeat offenders.

And yet today, if a victim shows up to a hospital after an assault, it is not at all guaranteed that she would be able to get a sexual assault examination if she asks for one.

In 2016, GAO conducted a study assessing the availability of sexual assault forensic examiners nationwide. As part of this study, GAO found that there are only 23 programs with trained sexual assault examiners covering my entire home State of Colorado. Furthermore, GAO reported that only one of the sexual assault programs in Colorado is large enough to have examiners available 24 hours a day, 7 days a week. In certain places in western Colorado, victims may have to travel well over an hour to get to a facility that has an examiner on staff.

Unfortunately, according to GAO, officials in the six States in their review did not know exactly how many practicing examiners there were in their States. There was no national database of sexual assault examiners, and what databases did exist were often out-of-date and did not cover all settings where an exam might occur. This suggests to me that there's more we need to do to get good data on our Nation's capacity for sexual assault examinations, so that we can evaluate these programs and ensure that they have the resources they need to serve victims.

Keep in mind, these are the barriers that exist just for getting a kit done in the first place. While not the focus of this hearing, there is also an enormous backlog of kits that were either never sent to a crime lab to be tested, or that were sent to a lab but were left to linger untested for prolonged periods.

This is all, to put it bluntly, disturbing. Today, I look forward to hearing from our witnesses about what we can do to train additional examiners to do this difficult but necessary work, and to retain those examiners that we do have. I also want to hear more about how successful sexual assault examination programs are built, and what we can do to address the unique challenges inherent in providing access to these services in rural areas.

I hope this committee can shed some light on these problems and find ways to make it easier for all Americans to get a sexual assault kit from a trained examiner in the unfortunate event that they need one.

Finally, Mr. Chairman, I must again note the importance of the Violence Against Women Act. The act supports a number of programs that address health issues associated with sexual assault, including three grant programs that can be used to fund or train sexual assault forensic examiners.

Unfortunately, this law—which has enjoyed bipartisan support for over 20 years—is set to expire in a little over a week. We must act quickly to reauthorize this law so that these programs can continue the important work that they are doing, and to make sure that victims get the care they need.

I yield back.

Mr. HARPER. The gentlewoman yields back.

The Chair will now recognize the chairman of the full committee, Chairman Walden, for 5 minutes for the purpose of an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Well, thank you very much, Mr. Chairman.

And I too want to thank you for your great leadership and service, your civil demeanor, your intellectual curiosity on the issues that have come before the Oversight and Investigations Subcommittee, and the great way you've worked to get things done here. It really has made a difference for the country, and you've left the place far better than you found it. And so we thank you for your service and wish you Godspeed in doing your next bit of service with family and elsewhere. So thanks for all you've done, Gregg. You've done a great job. We really appreciate it.

And I want to follow up on Ms. DeGette's comments as well, because in September, I wrote to the Speaker, along with others, saying we need to reauthorize VAWA. It's very, very important to do. I've supported it every time. It's essential. And I think on this SAFE kits issue that we're dealing with today, this will be a perfect priority going forward, it would have been if we were in the majority first thing up in the next year, and I think we should be able to find common ground on this matter as well. And I greatly appreciate the witnesses coming today.

This is the last, I think, subcommittee hearing on Oversight, although in talking to some of my friends from the Senate, it appears they're going to come back the day after Christmas. So maybe we'll have time for another hearing, Mr. Harper, just before New Year's or something. I thought I'd throw that out.

Over the past year, the committee has been investigating access to SANEs and SAFE kits at hospitals across the U.S., as you've heard. And throughout our investigation, we've spoken to more than 40 trauma Level I and II hospitals. Some of these hospitals have very robust SANE programs that are well-equipped to provide the best care to survivors of sexual assault, including one of our witnesses today, Mount Sinai Health Systems. So we appreciate what you're doing.

Others, however, seemed ill-prepared to address the needs of sexual assault survivors. One hospital even asked a member of my staff, and I'm going to quote, "what is a rape kit," close quote. There are currently no Federal requirements regarding SANEs in the healthcare facilities. As is made clear in the responses to the committee's letters, some States and hospital associations have made great strides, while others have not put the same emphasis on the problem.

I'd like to commend hospitals in my home State of Oregon for being forthcoming and helpful in our push to expand access to services for survivors of sexual assault in communities urban and rural. Their partnership with the Oregon District Attorney Sexual Assault Task Force is an example of the work we hope to see spread across the Nation.

As Chairman Harper mentioned, we don't know what happens to many of the survivors that visit a hospital and are unable to obtain a SAFE kit. Some survivors may be forced to travel several hours to the nearest SAFE-ready hospital to obtain a kit. Others may simply return home and choose never to report this horrific crime.

There's currently no data or tracking of these trends at the Federal level; however, through the course of our investigation, we've spoken with several survivors who have faced just that situation. One survivor we spoke to, Leah Griffin, shared her experience of trying to get a SAFE kit in 2014 after being drugged and raped. When she went to her local hospital, she was told, quote, "we don't do rape kits here," close quote. The hospital told Leah that her options were to drive herself to another hospital or to pay out of pocket for an ambulatory transfer. Leah told us, and I quote, "I was so shocked, I just went home."

Hours later, Leah drove to the other hospital to get a SAFE kit, where it was discovered that she had internal injuries. Ultimately, the prosecutors in Leah's case declined to bring charges because the delay in obtaining a rape kit meant the evidence in her case was weak. Leah asked herself, and again I quote, at her—by the way, she allowed us to share her name—"how do we have a justice system that demands empirical evidence from survivors of sexual assault and then denies access to that evidence collection?"

Leah's is not the only such story we've heard and read about; there's also Megan Rondini, Dinisha Ball, and unfortunately, many others. The day that an individual is sexually assaulted can be the worst day in her or his life. The thought of turning to a hospital after such a trauma and then being told, sorry, we can't help you, is unimaginable and, frankly, unacceptable.

These stories are heartbreaking. And, unfortunately, due to the lack of data and tracking within hospitals, we cannot estimate how many sexual assault survivors face this very same experience when they attempt to report these crimes.

I want to thank Leah and the other survivors we spoke to for sharing their experiences with us, I know that cannot have been easy, as well as those hospitals, hospital associations, and survivor advocacy groups that shared their expertise and experience with us over the course of this investigation. I hope that we can begin identifying some successful models that other hospital systems can apply to their own communities. And in particular, I hope the use of technology, such as online training programs and telehealth, can begin to solve the issues of access in our rural communities. Many health centers and hospitals in my district have a hard time recruiting healthcare professionals already, so expanding options for these communities is an extra challenge that we have to take on.

And, finally, I want to thank Representative Poe, who is in the audience today, who has been a real leader on this, along with Mr. Griffith and others on the committee. But, Ted, we thank you for your leadership on this, and I know there's legislation that's being put together here that hopefully we can move before the end of the year, if we can get everybody on the same page.

Again, Mr. Chairman, thanks for your wonderful leadership on this and so many other topics. And I yield back the balance of my time.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Mr. Chairman, thank you for holding this important hearing today.

Over the past year, the committee has been investigating access to SANEs and SAFE kits at hospitals across the United States. Throughout our investigation, we've spoken to more than 40 Trauma Level I and II hospitals. Some of these hospitals have robust SANE programs that are well equipped to provide the best care to survivors of sexual assault—including one of our witnesses today, Mount Sinai Health System. Others seemed ill-prepared to address the needs of sexual assault survivors. One hospital even asked a member of my staff, "What is a rape kit?"

There are currently no Federal requirements regarding SANEs in healthcare facilities. As is made clear in the responses to the committee's letters, some States and hospital associations have made great strides, while others have not put the same emphasis on the problem. I'd like to commend hospitals in my home State of Oregon for being forthcoming and helpful in our push to expand access to services for survivors of sexual assault, in communities urban and rural. Their partnership with the Oregon District Attorney's Sexual Assault Task Force is an example of the work we hope to see more of across the country.

As Chairman Harper mentioned, we don't know what happens to many of the survivors that visit a hospital and are unable to obtain a SAFE kit. Some survivors may be forced to travel several hours to the nearest SAFE-ready facility to obtain a kit. Others may simply return home and choose not to report the crime. There is currently no data or tracking of these trends at the Federal level. However, through the course of our investigation we've spoken with several survivors who have faced just that situation.

One survivor we spoke to, Leah Griffin, shared her experience of trying to get a SAFE kit in 2014 after being drugged and raped. When she went to her local hospital, she was told, "We don't do rape kits here." The hospital told Leah that her options were to drive herself to another hospital or to pay out of pocket for an ambulatory transfer. Leah told us, "I was so shocked, I just went home." Hours later, Leah drove to the other hospital to get a SAFE kit, where it was discovered that she had internal injuries. Ultimately, the prosecutors in Leah's case declined to bring charges because the delay in obtaining a rape kit meant the evidence in her case was weak. Leah asked herself, "How do we have a justice system that demands empirical evidence from survivors of sexual assault and then denies access to that evidence collection?"

Leah's is not the only such story we have heard or read about. There is also Megan Rondini, Dinisha Ball, and, unfortunately, many others.

The day that an individual is sexually assaulted can be the worse day in her or his life. The thought of turning to a hospital after such a trauma and being told "We can't help you" is unimaginable and, frankly, unacceptable.

These stories are heartbreaking. Unfortunately, due to the lack of data and tracking within hospitals, we cannot estimate how many sexual assault survivors face this very same experience when they attempt to report these crimes.

I want to thank Leah and the other survivors we spoke to for sharing their stories with us, as well as those hospitals, hospital associations, and survivor advocacy groups that shared their expertise and experience with us over the course of this investigation. I hope that we can begin identifying some successful models that other hospital systems can apply to their own communities. In particular, I hope the use of technology, such as online training programs and telehealth, can begin to solve the issue of access in rural communities. Many health centers and hospitals in my rural district have a hard time recruiting healthcare professionals already, so expanding options for these communities is an extra challenge that we must take on.

I want to thank our witnesses for being here with us today. We look forward to hearing your testimony. I yield back.

Mr. HARPER. The gentleman yields back.

The Chair will now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes for the purposes of an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

Sexual assault is a horrific crime, and we must continue to work to end the cycle of violence. Sexual assault forensic examiners, otherwise known as SAFEs, play an important role in helping those who are victims of these crimes. SAFEs provide care to victims of sexual assault, and with the use of a forensic exam kit, can collect a wide variety of DNA evidence that can be used to prosecute an offender.

Thanks to the Violence Against Women Act, States must provide sexual assault kits free of charge to anyone who needs it. The law also authorizes three Department of Justice grant programs that fund and train sexual assault forensic examiners.

Despite the strides we've made in the last 20 years, it can still be quite difficult for a victim to find a trained examiner when they need one. For example, according to media reports, only one hospital here in the DC area has a program with sexual assault nurse examiners on staff. Unfortunately, the problem is occurring nationwide. For example, according to a 2016 report from the GAO, officials in the six States they studied said there were not enough examiners in their States to meet the demand for exams, particularly in rural areas.

In some States, entire counties do not have any SAFE programs available. In some cases, victims must travel over an hour to a facility with a trained examiner. In that time, a victim must avoid bathing, showering, using the restroom, or changing clothes, or else risk damaging the evidence before it can be collected. And this is unacceptable, and we must find ways to make these services more widely available.

The GAO report also found that there was no national database that captures the number of examiners, where they are, and what their capabilities are. The only data available is limited in scope and collected on a voluntary basis. And this means that victims do not have to update information and cannot easily identify all healthcare settings where sexual assault forensic exams might be conducted. This kind of information should be easily accessible to victims in their most vulnerable moments,

Moreover, even when a facility provides these kits and related SAFE services, States and hospitals have struggled to retain enough examiners. State officials reported to GAO that they face challenges such as limited availability of classroom and clinical training, weak support for programs from stakeholders, and the emotional and physical demands on examiners. And taken together, these findings demonstrate the challenges we still face in ensuring that all victims of sexual assault can get access to a forensic exam kit and services provided by a trained examiner, should they request it.

This is not to say there are no success stories. Clearly, there are many hospitals and other facilities that provide sexual assault kits and SAFE services for those who need it, and we should learn from those cases and determine what we can replicate on a broader scale.

So I look forward to hearing from each of our witnesses here today about what we can do to get our arms around this problem and what we can do to expand and retain our workforce of trained sexual assault forensic examiners.

And, finally, I just would like to reiterate the importance of the Violence Against Women Act. This act is a critical part of the Federal Government's response to sexual assault and it funds many of the programs we'll be talking about today, but the law is set to expire in just over a week. We must ensure this act is reauthorized so that these critical programs continue to receive funding and victims can receive the care and services they need.

So I want to thank our panelists for sharing their expertise on this important issue as we move forward.

I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you, Mr. Chairman. Sexual assault is a horrific crime, and we must continue to work to end the cycle of violence.

Sexual Assault Forensic Examiners, otherwise known as SAFEs, play an important role in helping those who are victims of these crimes. SAFEs provide care to victims of sexual assault, and—with the use of a forensic exam kit—can collect a wide variety of DNA evidence that can be used to prosecute an offender.

Thanks to the Violence Against Women Act states must provide sexual assault kits free of charge to anyone who needs it. The law also authorizes three Department of Justice grant programs that fund and train sexual assault forensic examiners.

Despite the strides we have made in the last 20 years, it can still be quite difficult for a victim to find a trained examiner when they need one. For example, according to media reports, only one hospital here in the DC area has a program with sexual assault nurse examiners on staff.

Unfortunately, his problem is occurring nationwide. For example, according to a 2016 report from the Government Accountability Office (GAO), officials in the six States they studied said there were not enough examiners in their States to meet the demand for exams, particularly in rural areas. In some States, entire counties did not have any SAFE programs available.

In some cases, victims must travel over an hour to a facility with a trained examiner. In that time, a victim must avoid bathing, showering, using the restroom, or changing clothes, or else risk damaging the evidence before it can be collected. This is unacceptable, and we must find ways to make these services more widely available.

The GAO report also found that there was no national database that captures the number of examiners, where they are, and what their capabilities are. The only data available is limited in scope and collected on a voluntary basis.

This means that victims do not have up-to-date information and cannot easily identify all healthcare settings where sexual assault forensic exams might be conducted. This kind of information should be easily accessible to victims in their most vulnerable moments.

Moreover, even when a facility provides these kits and related SAFE services, States and hospitals have struggled to retain enough examiners. State officials reported to GAO that they face challenges such as limited availability of classroom and clinical training, weak support for programs from stakeholders, and the emotional and physical demands on examiners.

Taken together, these findings demonstrate the challenges we still face in ensuring that all victims of sexual assault can get access to a forensic exam kit and services provided by a trained examiner, should they request it.

That is not to say that there are no success stories. Clearly, there are many hospitals and other facilities that provide sexual assault kits and SAFE services for those who need it. We should learn from those cases and determine what we can replicate on a broader scale.

I look forward to hearing from each of our witnesses here today about what we can do to get our arms around this problem, and what we can do to expand and retain our workforce of trained sexual assault forensic examiners.

Finally, I would like to reiterate the importance of the Violence Against Women Act. This act is a critical part of the Federal Government's response to sexual assault. It funds many of the programs we will be talking about today but the law is set to expire in just over a week. We must ensure this act is reauthorized so that these critical programs continue to receive funding, and victims can receive the care and services they need.

I thank our panelists for sharing their expertise on this important issue.
Thank you, I yield back.

Mr. HARPER. The gentleman yields back.

I ask unanimous consent that the Members' written opening statements be made part of the record. Without objection, will be entered into the record.

Additionally, we welcome non-Energy and Commerce Committee members who are with us today. Pursuant to House rules, Members not on the committee are able to attend our hearings but not ask questions, and we've already recognized Representative Ted Poe from Texas, who is the only other Member that I see, and that's just the way it is.

I would now like to introduce our witnesses for today's hearing. Today, we have Ms. Nicole Clowers, managing director of healthcare at the GAO. Next is Ms. Sara Jennings, president-elect of the International Association of Forensic Nurses. Then we have Ms. Lynn Frederick-Hawley, executive director of the SAVI Program at Mount Sinai Hospital. And, finally, Ms. Kiersten Stewart, director of Public Policy and the Washington Office of Futures Without Violence.

As you are aware, the committee is holding an investigative hearing, and when doing so, has had the practice of taking testimony under oath. Do any of you have any objection to testifying under oath?

All witnesses have indicated no.

The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Do any of you desire to be accompanied by counsel during your testimony today?

All of the witnesses have indicated no.

In that case, if you would, please rise and raise your right hand and I will swear you in.

Do you swear that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

All the witnesses have anticipated—have answered and responded in the affirmative.

You're now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement, and I will now first call on Nicole Clowers, managing director of healthcare for the U.S. Government Accountability Office.

You are recognized for 5 minutes, Ms. Clowers.

STATEMENTS OF A. NICOLE CLOWERS, MANAGING DIRECTOR, HEALTHCARE, GOVERNMENT ACCOUNTABILITY OFFICE; SARA JENNINGS, PRESIDENT-ELECT, INTERNATIONAL ASSOCIATION OF FORENSIC NURSES; LYNN FREDERICK-HAWLEY, EXECUTIVE DIRECTOR, SEXUAL ASSAULT AND VIOLENCE INTERVENTION PROGRAM, MOUNT SINAI HOSPITAL; AND KIERSTEN STEWART, DIRECTOR OF PUBLIC POLICY AND WASHINGTON OFFICE, FUTURES WITHOUT VIOLENCE

STATEMENT OF A. NICOLE CLOWERS

Ms. CLOWERS. Thank you.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for having me here today to discuss our 2016 report on the availability of sexual assault forensic examiners.

Studies have documented the benefits of using trained examiners in the cases of sexual assault. As the chairman noted, these benefits include shorter exam times, more comprehensive medical care, better health outcomes for the victims, better collection and documentation of the evidence, and higher prosecution rates. However, concerns have been raised about the availability of examiners to meet the need for exams.

To help inform today's discussion, I will summarize key findings from our 2016 report, which include what is known about the availability of sexual assault forensic examiners nationwide, as well as in selected States, as of 2016, and the challenges selected States face to maintaining a supply of sexual assault examiners.

With respect to the availability of examiners, we found that only limited nationwide data exist on the availability of sexual assault examiners; that is, both the number of practicing examiners and the number of healthcare facilities that have examiner programs. While some national estimates are available, they are not comprehensive, as they only capture examiners with select certifications or program information that is voluntarily reported.

We also found limited information at the State level. While officials from all six States that we contacted were able to provide information on the number of examiner programs located within their States, only three could provide estimates of the number of practicing examiners. And the State data available at the time of our audit were likely incomplete, as only one of the six States had a system in place to formally track the number and location of examiners.

Despite these data limitations, officials in all six States told us 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 the counties in the State do not have any examiner programs available. As a result, officials said victims may need to travel long distances to be examined by a trained examiner. The challenge of long travel distances can be further complicated for rural residents due to weather-related travel restrictions during certain times of the year.

Finally, we found that there are multiple challenges to maintaining the supply of examiners, including, one, the limited availability of training, which includes limited classroom, clinical, and con-

tinuing education training opportunities; two, low retention rates of examiners due to the emotional and physical demands of the job, coupled with low pay; and, three, weak stakeholder support for examiners, such as hospitals being reluctant to cover the cost of training or paying for examiners to be on call.

Officials told us about a number of strategies they have used to help address these challenges, such as web-based training and mentoring programs. For example, officials in Colorado told us that an examiner program coordinator in an urban hospital provides volunteer, on-call technical assistance and clinical guidance to the examiners in rural parts of the State where those resources are not otherwise available.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, this completes my prepared statement. I would be pleased to respond to any questions at the appropriate time. Thank you.

[The prepared statement of Ms. Clowers follows:]



United States Government Accountability Office

Testimony before the Subcommittee on
Oversight and Investigations,
Committee on Energy and Commerce,
House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Wednesday, December 12, 2018

SEXUAL ASSAULT

Information on the Availability of Forensic Examiners

Statement of A. Nicole Clowers, Managing Director,
Health Care

GAO Highlights

Highlights of GAO-19-259T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

In 2016, about 323,000 individuals age 12 or older were reported victims of sexual assault, according to the Bureau of Justice Statistics. Studies have shown that exams performed by sexual assault forensic examiners—medical providers trained in collecting and preserving forensic evidence—may result in better physical and mental health care for victims, better evidence collection, and higher prosecution rates. Yet, concerns have been raised about the availability of such examiners. The Department of Justice administers grant programs that can be used by states and other eligible entities to train and fund examiners.

This statement summarizes GAO's findings from its March 2016 report (GAO-16-334) describing (1) what was known in 2016 about the availability of sexual assault forensic examiners nationally and in selected states and (2) the challenges selected states faced in maintaining a supply of sexual assault forensic examiners. For that report, GAO reviewed literature on the availability of examiners and challenges training and retaining them. GAO also interviewed knowledgeable officials, including recipients of federal sexual assault examiner related grants and officials from sexual assault coalitions in six states (Colorado, Florida, Massachusetts, Nebraska, Oregon, and Wisconsin) selected to achieve variation in factors such as population and geographic location.

View GAO-19-259T. For more information, contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov.

December 2018

SEXUAL ASSAULT

Information on the Availability of Forensic Examiners

What GAO Found

GAO's March 2016 report examining the availability of sexual assault forensic examiners found that only limited nationwide data existed on the availability of sexual assault forensic examiners—both the number of practicing examiners and health care facilities that had examiner programs. At the state level, GAO found that, in three of the six states it selected to review, grant administrators or officials from sexual assault coalitions were able to provide estimates of the number of practicing examiners and, in all six states, they were able to provide information on the estimated number of examiner program locations in their state. 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 did not have any sexual assault examiner programs available and officials in Nebraska told GAO that most counties in the state did not have examiner programs available. As a consequence, officials said victims may need to travel long distances to be examined by a trained examiner. In health care facilities where examiners were available, they were typically available in hospitals on an on-call basis, though the number available varied by facility and may not provide enough capacity to offer examiner coverage 24 hours, 7 days a week.

GAO's March 2016 report also found there were multiple challenges to maintaining a supply of examiners, according to its review of the literature and interviews with officials in the six selected states. These challenges include:

- **Limited availability of training.** Officials in five of the six selected states reported that the limited availability of classroom, clinical, and continuing education training opportunities is a challenge to maintaining a supply of trained examiners. For example, officials told us that there is a need for qualified instructors to run training sessions.
- **Weak stakeholder support for examiners.** Officials in five of the 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 pay for examiners to be on call.
- **Low examiner retention rates.** The above-mentioned and other challenges, including the emotional and physical demands on examiners, contribute to low examiner retention rates. Officials in one of the selected states 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.

Officials described a variety of strategies they have employed that can help address these challenges, such as implementing web-based training courses, clinical practice labs, mentorship programs, and multidisciplinary teams that respond to cases of sexual assault.

Chairman Harper, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the availability of sexual assault forensic examiners. An estimated 323,450 individuals age 12 or older were victims of rape or other sexual assault in 2016, according to the most recently available data from the Bureau of Justice Statistics.¹ When victims of sexual assault receive a medical forensic examination, the exam may be provided by either a trained sexual assault forensic examiner—that is, a medical provider who has received specialized training in properly collecting and preserving forensic evidence—or a medical provider who has not received such specialized training. Studies have shown that exams performed by trained sexual assault forensic examiners may result in shortened exam time, higher quality health care delivered to victims, higher quality forensic evidence collection, as well as better collaboration with the legal system and higher prosecution rates. However, concerns have been raised about the availability of examiners to meet victims' needs for exams.

To help inform today's discussion, my testimony will focus on findings from our March 2016 report examining information on the training, funding, and availability of sexual assault forensic examiners.² In particular, this statement will address:

1. what was known about the availability of sexual assault forensic examiners nationally and in selected states as of 2016, and
2. the challenges selected states faced in maintaining a supply of sexual assault forensic examiners.

For our March 2016 report, we conducted a literature review to identify studies that measured the availability of sexual assault forensic examiners, examined challenges to training and retaining examiners, and strategies that could be used to address these challenges. We interviewed experts, recipients of federal grants to train sexual assault forensic examiners, and state sexual assault coalition officials in six selected states about data on the availability of examiners or examiner

¹Data presented are from the Bureau of Justice Statistics' 2016 National Crime Victimization Survey. See R.E. Morgan and G. Kena, *Criminal Victimization, 2016*, NCJ 251150 (Washington, D.C.: Department of Justice, December 2017).

²See GAO, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (Washington, D.C.: March 18, 2016).

programs; the extent to which examiner availability meets the need for exams; challenges they experienced in training or retaining examiners; and strategies that could be used to overcome these challenges.³ We also interviewed officials from the International Association of Forensic Nurses (IAFN) about these issues. Our March 2016 report includes a full description of our scope and methodology. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Victims of sexual assault may receive a sexual assault forensic examination by a medical provider who may or may not be a trained sexual assault forensic examiner. Medical providers assess victims' clinical conditions; provide appropriate treatment and medical referrals; and, given consent by the victim, collect forensic evidence through a sexual assault forensic examination that may follow steps and use supplies from a sexual assault evidence collection kit. Under its protocol for sexual assault forensic examinations, the Department of Justice (DOJ) recommends that medical providers collect a range of physical evidence.⁴ In addition, sexual assault forensic exams typically include documenting biological and physical findings such as cuts or bruises and a victim's medical forensic history, such as the time and nature of the assault. Once the exam is complete, medical providers preserve the collected evidence, which may include packaging, labeling, and sealing evidence collection kits and storing kits in a secure location. Medical providers typically

³State sexual assault coalitions of rape crisis centers and other organizations provide direct support to members through funding, training and technical assistance, public awareness activities, and public policy advocacy. To select the six states (Colorado, Florida, Massachusetts, Nebraska, Oregon, and Wisconsin), we considered the number of grantees in each state that received funding from selected federal grant programs; whether states had unique policies or programs in place regarding the training of examiners; and state population size and geographic location. We sought to achieve variation in these characteristics when selecting the six states. In the six selected states, we interviewed a total of nine grantees that received federal funds in fiscal year 2014. Information from these interviews cannot be used to generalize beyond the six selected states.

⁴Department of Justice, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, NCJ 228119 (Washington, D.C.: U.S. Department of Justice, 2013).

perform such exams only for acute cases of sexual assault, such as in cases where the assault occurred within the previous 72 to 96 hours, when the physical and biological evidence on a person's body or clothes is considered most viable.

DOJ, IAFN, and the American College of Emergency Physicians (ACEP) recommend that sexual assault forensic exams be performed by specially trained medical providers—known as sexual assault forensic examiners (examiners). These examiners include physicians, physician assistants, nurse practitioners, and other registered nurses who have been specially educated and have completed clinical requirements to perform sexual assault forensic exams. Sexual assault nurse examiners (SANE)—a particular type of sexual assault forensic examiner—are registered nurses, including nurse midwives and other advanced practice nurses, who have received specialized education and have fulfilled clinical requirements to perform sexual assault forensic exams. Examiner programs have been created in hospital or non-hospital settings whereby specially trained examiners are available to provide first-response care and exams to sexual assault victims. DOJ, IAFN, and some states have issued guidelines pertaining to the minimum level of training examiners should receive in order to properly collect and preserve evidence, identify victims' medical and emotional health care needs, and provide counseling and referrals for victims. These guidelines include recommendations of objectives and topics that training programs should cover.

DOJ administers several grant programs that aim to, among other things, improve response to and recovery from four broad categories of victimization—domestic violence, sexual assault, dating violence, and stalking. In our March 2016 report we describe three key grant programs administered by DOJ's Office on Violence Against Women that could be used by grant recipients—including states or other eligible entities—to fund or train sexual assault forensic examiners.⁵

⁵These grant programs were the Services-Training-Officers-Prosecutors Violence Against Women Formula Grant Program; Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program; and the Rural Sexual Assault Domestic Violence, Dating Violence, and Stalking Assistance Program. See GAO-16-334 for additional information on the use of these grant programs to train and fund sexual assault forensic examiners.

Nationwide Data on the Availability of Sexual Assault Forensic Examiners Are Limited; Officials in Selected States Reported a Need for Additional Examiners

In our March 2016 report examining the availability of sexual assault forensic examiners, we found that only limited nationwide data exist on the availability of sexual assault forensic examiners—that is, both the number of practicing examiners and health care facilities that have examiner programs. While IAFN reported that, as of September 2015, there were 1,182 nurses with an active IAFN SANE certification in the United States, such data do not represent all practicing examiners nationwide. For example, the data do not account for examiners who completed training through an IAFN or a state training program but never became certified or were certified through another entity, such as a state board of nursing. IAFN also collects data on examiner programs nationwide—that is, data on hospitals, clinics, and other sites where examiners practice. Such data provide an indication of the availability of examiners, but the data are also limited. While 703 examiner programs nationwide voluntarily reported to IAFN's examiner program database, as of September 2015, IAFN officials noted that the database is often not up to date; and some health care settings where sexual assault forensic exams are conducted, such as child advocacy centers, are not represented. In addition, data collected on staffing characteristics of examiner programs are often unavailable in the IAFN examiner program database. For example, only about one-third of the examiner programs reported on the number of examiners practicing in their program, and about one-third reported on whether examiners were available on-site versus on-call.

In three of the six selected states we reviewed in our March 2016 report, grant administrators or officials from sexual assault coalitions were able to provide estimates of the number of practicing examiners, and, in all six states, they were able to provide information on the estimated number of examiner program locations in their state. Of states that reported, the number of practicing examiners and examiner programs varied by state. (See table 1.) However, such data may also present an incomplete picture of the availability of examiners. For example, only one of the six selected states has a system in place to formally track the number and location of examiners. Instead, officials generally reported on the estimated number of examiners or examiner locations that were part of a statewide examiner program or were identified through an ad hoc data collection effort.

Table 1: Estimated Number of Practicing Sexual Assault Forensic Examiners and Examiner Programs in Selected States, As of January 2016

State	Estimated number of practicing examiners	Estimated number of examiner program locations
Colorado	Not Available	23
Florida	Not Available	15 ^a
Massachusetts	141	29
Nebraska ^b	61	7
Oregon	140	12 ^c
Wisconsin	Not Available	18

Source: GAO analysis of state data. | GAO-19-259T

^aThe reported number of examiner programs is limited to those located in certified rape crisis centers in Florida. It does not include examiner programs that are located in other facilities, such as hospitals.

^bData presented for Nebraska does not account for examiners who may be located in child advocacy centers. There are seven child advocacy centers in Nebraska that provide sexual assault forensic exams, including to adult victims.

^cOne of the 12 examiner programs is a mobile examiner program that serves five counties in Oregon.

Although data are limited, grant administrators and sexual assault coalition officials in all six selected states nevertheless told us that the number of examiners available does not meet the need for exams within their states. For example, coalition officials in Wisconsin told us that nearly half of all counties in the state do not have any examiner programs available, and coalition officials in Nebraska told us that most counties in the state do not have examiner programs available. In addition, in four of the six selected states—Colorado, Florida, Nebraska, and Wisconsin—state grant administrators and coalition officials told us that few or some health care facilities in their state have examiners available. As a consequence, officials said victims may need to travel long distances to be examined by a trained examiner or be examined by a medical professional without specialized training. While in the other two selected states—Massachusetts and Oregon—state grant administrators and coalition officials stated that some or most facilities have examiners available, they noted that there is still a need for additional capacity to reduce the burden on those examiners who are available, or to make examiners available in a number of areas where examiners are currently unavailable.

In health care facilities where examiners are available, they are typically available through hospitals on an on-call basis, according to literature we reviewed as well as all grant administrators and coalition officials we interviewed for our report. In addition, among facilities that have

examiners available, the number of examiners available varies and may not provide enough capacity for facilities to offer examiner coverage 24 hours, 7 days a week, according to state grant administrators and coalition officials we interviewed. Nebraska coalition officials, for example, told us that while one hospital in Omaha has a team of 26 examiners available, other facilities in the state may have as few as three examiners available. Further, officials from Florida and Colorado told us that there are few facilities in their states able to offer full coverage with examiners available 24 hours, 7 days a week.

**Selected States
Faced Challenges
Training Examiners,
Maintaining
Stakeholder Support,
and Retaining
Examiners**

In our March 2016 report, we found that maintaining a supply of trained examiners that meets communities' needs for exams is challenging for multiple reasons, and that state officials have employed a variety of strategies to address these challenges, as described below.

Limited availability of training. Officials in five of the six selected states told us that the limited availability of classroom, clinical, or continuing education training is a barrier to maintaining a supply of trained examiners. Regarding classroom training, some officials told us that training may only be offered once per year in their states. Additionally, officials from both Florida and IAFN told us that there is a need for qualified instructors to run training sessions. Experts and officials from Colorado, Nebraska, and Oregon also told us that medical professionals in rural areas may have difficulty completing the clinical training necessary to become an examiner. Obtaining clinical experience, such as performing exams under the supervision of a trained examiner, is a particular challenge in rural areas where hospitals may treat only a few sexual assault cases per year. One official in Nebraska told us that trained examiners in rural areas might not feel competent to perform exams due to the low number of cases they treat. A lack of continuing education opportunities may also pose a challenge for examiners in maintaining the skills necessary to perform exams. For example, the National Sexual Violence Resource Center (NSVRC) reported that—based on common challenges identified through a survey of, and group discussions among, examiner program coordinators—maintaining competency may be difficult for nurses in rural areas due to a low volume

of patients presenting in need of exams and limited access to ongoing and advanced training.⁶

Officials told us they have been able to increase the availability of examiner training through alternative training methods such as web-based training courses and simulated clinical training. For example, officials in Colorado told us their state's web-based examiner training program has made training less expensive and has increased examiner recruitment. Officials in Wisconsin told us they developed a clinical training lab that allows examiners to gain hands-on experience by performing elements of exams on experienced teaching assistants hired for the purpose of training new examiners. Further, in 2014, a DOJ-funded evaluation of examiner training programs found that a web-based training course may help increase the availability of trained examiners; the study also found that implementing web-based training had benefits such as decreasing the costs associated with attending in-person training, expanding training opportunities to remote areas, and allowing examiners to be trained by national experts.⁷

Lack of technical assistance and other supportive resources.

Officials in four of the six selected states told us that the limited availability of technical assistance and other supportive resources for examiners poses a challenge to maintaining a supply of trained examiners. For example, officials in Florida, Nebraska, Oregon, and Wisconsin explained that, in general, there is a lack of mentorship opportunities and leadership within the examiner community. Officials also noted that the sustainability of examiner programs may be threatened by a lack of internal capacity, such as not having a full-time, paid examiner program coordinator available. Further, in its survey of and group discussions with examiner program coordinators, NSVRC found that examiners and examiner programs needed technical assistance and support in the following areas: aspects of performing exams, training,

⁶National Sexual Violence Resource Center, *First National SANE Coordinator Symposium: Final Report and Recommendations* (Portland, Oregon, 2009).

⁷D. Patterson, S. Resko, J. Pierce-Weeks, and R. Campbell, *Delivery and Evaluation of Sexual Assault Forensic (SAFE) Training Programs*, Doc. No. 247081 (Washington, D.C.: Department of Justice, June 2014).

leadership development and policy issues, and examiner program sustainability.⁸

Officials we spoke to told us about strategies that can be used to increase support for examiners and examiner programs, such as offering web-based technical assistance. For example, officials in Massachusetts told us that, through their National Sexual Assault TeleNursing Center, trained SANEs provide remote clinical guidance to two hospitals in the state that do not have trained examiners available.⁹ In addition, officials from Colorado told us an examiner program coordinator in an urban hospital in the state provides volunteer on-call technical assistance and clinical guidance to examiners in rural parts of the state, where those resources are not otherwise available. Further, one study we reviewed found several states were engaged in promising practices to increase support for examiners, such as implementing state-wide mentorship programs, developing regional examiner list-serves and online discussion boards, creating formal leadership positions within the examiner community, and requiring examiner program evaluations.¹⁰

Weak stakeholder support for examiners. Officials in five of the six selected states told us that limited stakeholder support for examiners and examiner programs, such as from hospitals and law enforcement, is a challenge to maintaining a supply of trained examiners. Some officials told us that hospitals may be reluctant to support examiners and examiner programs due to a low number of sexual assault cases treated each year. One official told us that hospitals may be reluctant to send nurses to examiner training, as it takes away from their regular shift availability. Additionally, some hospitals do not pay examiners to be on call. Officials in three states told us that hospitals typically either do not pay examiners to be on call or pay on-call examiners significantly less than other on-call medical professionals.

⁸National Sexual Violence Resource Center, *First National SANE Coordinator Symposium*.

⁹The National Sexual Assault TeleNursing Center is funded by the DOJ Office of Justice Programs, Office for Victims of Crime, and is aimed at providing live access to expert medical forensic examiners via telemedicine.

¹⁰National Sexual Violence Resource Center, *First National SANE Coordinator Symposium*.

Apart from hospital support, officials in Colorado and Oregon explained there is a need for more multidisciplinary support for examiners, such as increased law enforcement, prosecutor, and first-responder understanding of examiners' role. The literature we reviewed also shows that ambiguity around the role of the examiner in responding to sexual assault may be a source of conflict between examiners and other professionals.¹¹ For example, examiners were found to have experienced instances where victim advocates or law enforcement questioned examiners' medical decisions, speed of evidence collection, or asked examiners to comment on the credibility of a victim's case. One nationally representative survey of examiner programs found that examiner program coordinators felt ongoing education of community stakeholders on sexual assault and examiner programs was needed due to the high turnover in staff at relevant community institutions and agencies, such as law enforcement officers, victim advocates, and prosecutors.¹²

Through our interviews with officials, we learned of strategies selected states have used to increase or mitigate limited stakeholder support for examiners and examiner programs. For example, officials in Colorado, Florida, Nebraska, Oregon, and Wisconsin told us that sexual assault response teams have been developed in their states to help community stakeholders to understand examiners' role and better coordinate to meet the medical and legal needs of sexual assault victims.

Low examiner retention rates. Officials in four of the six selected states told us that low examiner retention rates can be an impediment to maintaining a supply of trained examiners. In addition to the challenges of limited training opportunities, technical assistance and other supportive resources, and stakeholder support for examiners, the physically and emotionally demanding nature of examiner work contributes to low examiner retention rates. Further, studies have indicated that

¹¹See, for example, R. Campbell, M. Gresson, and D. Patterson, "Defining the Boundaries: How Sexual Assault Nurse Examiners (SANEs) Balance Patient Care and Law Enforcement Collaboration," *Journal of Forensic Nursing* vol. 7, no. 1 (2011); J. Cole and T.K. Logan, "Negotiating the Challenges of Multidisciplinary Responses to Sexual Assault Victims: Sexual Assault Nurse Examiner and Victim Advocacy Programs," *Research in Nursing & Health* vol. 31, no. 1 (2008); and S. L. Maier, "Sexual Assault Nurse Examiners' Perceptions of Their Relationship with Doctors, Rape Victim Advocates, Police, and Prosecutors," *Journal of Interpersonal Violence* vol. 27, no. 7 (2012).

¹²T. K. Logan, J. Cole, and A. Capillo, "Sexual Assault Nurse Examiner Program Characteristics, Barriers, and Lessons Learned," *Journal of Forensic Nursing* vol. 3, no. 1 (2007).

dissatisfaction with compensation, long work hours, and lack of support, among other things, may contribute to examiner burnout. Examiners typically work on call in addition to their full time jobs as, for example, emergency department nurses. Officials in Florida told us that examiners may be on call for 6-hour, 12-hour, or even 24-hour shifts. Further, one survey of examiner programs in Maryland found that examiners were required to be on call for an average of 159 hours per month.¹³ Wisconsin officials estimated that, although 540 SANEs were trained over a 2-year period, only 42 (less than 8 percent) were still practicing in the state at the end of those 2 years.

Chairman Harper, Ranking Member DeGette, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the contact named above, key contributors to this statement were Kristi Peterson (Assistant Director), Patricia Roy, Katherine Mack, Laurie Pachter, and Emily Wilson.

¹³Maryland Coalition Against Sexual Assault, *The State of the State: Sexual Assault Forensic Examiner (SAFE) Programs in Maryland* (Arnold, Md.: 2012).

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<https://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <https://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at <https://www.gao.gov>.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <https://www.gao.gov/fraudnet/fraudnet.htm>

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800, U.S. Government Accountability Office, 441 G Street NW, Room 7149, Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707, U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548



Please Print on Recycled Paper.

Mr. HARPER. Thank you so much for your testimony.

The Chair will now recognize Sara Jennings, RN—and I'm partial to RNs since I'm married to one—who is the president-elect of the International Association of Forensic Nurses.

You are hereby recognized for 5 minutes for testimony.

STATEMENT OF SARA JENNINGS

Ms. JENNINGS. Thank you.

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, I am pleased to be here this morning 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 the IFN appreciates the active role of the committee to address it.

My name is Sara Jennings, and I'm a forensic nurse since 2006, and I'm the president-elect for the IFN. First, let me tell you a bit about forensic nursing. A forensic nurse is a registered nurse or advanced practice nurse who's received specialized education and training. Forensic nurses provide specialized care for patients who are experiencing acute or 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.

Since forensic nursing is a recognized nursing specialty of the American Association of Nurses, a person must first become a registered nurse before becoming a forensic nurse. Forensic nurses work in a variety of fields, including sexual assault, domestic or intimate partner violence, child abuse and negligent, elder maltreatment, human trafficking, death investigations, corrections, and in the aftermath of mass disasters. In the United States, forensic nurses most frequently work in hospitals, community anti-violence programs, coroners, or medical examiners' offices, corrections institutions, and psychiatric hospitals.

Sexual assault nurse examiners, or SANEs, 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 with 2 years or more of experience in areas of practice, such as emergency department nursing. The same training should meet the IFN SANE educational guidelines and will consist of both classroom and clinical components.

The Bureau of Justice Statistics within the Department of Justice reports in its National Crime Victimization Survey for 2016 that there were 298,410 rapes or sexual assaults in the United States. There were also 1,068,120 incidents of domestic violence.

In March of 2016, the General Accountability Office issued a report investigating the availability of trained examiners on a national level. The report identified major flaws and 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.

The IFN 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 this problem. The IFN is supportive of the Survivors' Access to Supportive Care, or SASCA, and also encourages efforts to improve the Violence Against Women Act. IFN strongly supports the SASCA, which was introduced in the Senate by Senator Patty Murray and Senator Lisa Murkowski.

IFN believes this bill would expand access to qualified examiner services and help strengthen national standards of care for survivors of sexual assault. SASCA would also provide guidance and support to States and to hospitals providing sexual assault examination services and treatment to survivors.

IFN also strongly supports the swift reauthorization of the Violence Against Women Act; however, IFN does believe that there are several key improvements that must be made to this law, including establishing a standardized national sexual assault evidence collection kit, requiring health insurance to be the primary payer, and establishing evidence-based, trauma-informed national medical forensic exam protocols for intimate partner violence. It is imperative for the long-term health and recovery of these patients that a standardized approach be developed and a plan for effective implementation.

Thank you for this opportunity to testify today, and I'm available at the appropriate time for questions.

[The prepared statement of Ms. Jennings follows:]



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 ^a		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 ^h	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.

Mr. HARPER. Thank you for your testimony.

The Chair will now recognize Lynn M. Frederick-Hawley—that's Hawley, I'm sorry, my apologies.

Ms. FREDERICK-HAWLEY. No problem.

Mr. HARPER [continuing]. Executive director at SAVI Program at Mount Sinai Hospital.

And you're now recognized for 5 minutes.

STATEMENT OF LYNN FREDERICK-HAWLEY

Ms. FREDERICK-HAWLEY. Thank you.

Good morning. Chairman Harper, Ranking Member DeGette, and members of the committee, thank you for the opportunity to testify before you today. I would also like to acknowledge Representative Tonko and Representative Clarke from New York.

My name is Lynn Frederick-Hawley. I am the executive director of the Sexual Assault and Violence Intervention Program of the Mount Sinai Hospital, otherwise known as SAVI. Makes it easier for you to say it. Founded in 1852, the Mount Sinai Hospital is one of the Nation's largest and most respected hospitals, acclaimed internationally for excellence in clinical care. Ranked among the top hospitals nationwide, we serve one of the most diverse populations in the world as well.

It has been a priority at the Mount Sinai Hospital for decades to maintain a comprehensive program to address the needs of sexual assault survivors. Our goal is to provide the highest quality medical care and compassionate client-centered services to address both the patient's physical and psychological trauma. We believe it's critical to validate, heal, and empower survivors and their supporters to lead safe, healthy lives through advocacy, free and confidential therapy and counseling, and education.

The Mount Sinai Hospital is one of the few institutions with a dedicated program exclusively focused on providing outreach, comprehensive training, emergency department advocacy, and counseling services to address the needs of past and present victims of sexual assault and intimate partner violence. SAVI was founded in 1984, and we have grown exponentially in the past 34 years to meet the evolving needs of survivors and our communities, including creating our sexual assault forensic examiner program.

I should emphasize that this evolution has been made possible by the support of Mount Sinai leadership, the availability of funding for this kind of programming, and the backing of the communities we serve. We work very intensively with our community. Our sexual assault forensic examiner program has been designated a center of excellence since 2006 by the New York State Department of Health.

In addition to the SAFE program, we maintain over 150 highly trained volunteer advocates who are certified and go on call 24/7 to respond to all instances of sexual assault in our hospitals. The advocates, together with the trained SAFE clinician, work seamlessly to provide comprehensive services to the sexual assault survivors seeking care at the Mount Sinai Hospital. SAVI therapists are then available to support the survivor beyond the immediate crisis services received in the emergency department.

Specifically, the Mount Sinai Hospital and its affiliate medical school, the Icahn School of Medicine at Mount Sinai, employ 24 medical professionals who have decided to take the additional steps to become a SAFE examiner with the SAVI program. Currently that includes 10 nurses, 7 physicians assistants, and 7 physicians, including residents. All are employed by the Mount Sinai Hospital in other capacities, they are then screened by SAVI for this particular role, have completed extensive additional 40-hour training to qualify as a SAFE, and then they complete a preceptorship with our program specifically. Many of the SAFE-trained staff work in the emergency department, and they are able to provide services to a patient if the on-call SAFE clinician, for whatever reason, is unexpectedly unavailable.

I would like to take you through the protocol quickly for treating survivors of sexual violence in our program. As an initial matter, we have a strong protocol in place for clinicians and staff to identify potential survivors of sexual assault and respond sensitively. Once a patient discloses sexual assault, they are triaged to a private, safe equipped room. Both the on-call SAFE and the SAVI advocate are contacted to come to our hospital to provide care and treatment to the patient.

The advocate is a certified volunteer who provides counseling, support, information, referral, advocacy, safety planning to the survivor and any family member or supportive person who is there. The advocate remains with the survivor throughout their stay in the hospital. The SAFE conducts the medical and evidence collection exam consistent with the patient's consent and their wishes.

Specific medical protocols and regimens are followed in the event the survivor is a candidate for a variety of prophylaxis treatment. The patient receives detailed discharge instructions and treatment counseling options, including followup for any medical care or continued prescriptions they need.

SAVI follows up with every patient after they have spent time in the emergency department. We also work closely with the NYPD and with our security department in the event that the survivor hasn't yet let the kit go over to the police department.

In order to provide this multilayered response, many resources must be invested. This is not care that survivors should be expected to underwrite. None of SAVI services, including our SAFE program, generate income. So it's the vision of an institution like Mount Sinai that sees the overarching benefit and necessity of providing the care to survivors and provides the context in which it can happen, as well as the availability/accessibility of funding from our city, State, Federal, and community partners that makes this even possible.

On that note, 36 seconds over, I'll be quiet, and I'm happy to answer any questions as we go forward.

[The prepared statement of Ms. Frederick-Hawley follows:]

*Examining the Availability of SAFE Kits
at Hospitals in the United States*

Statement of

Lynn Frederick-Hawley
Executive Director
Sexual Assault and Violence Intervention Program
Mount Sinai Hospital

Testimony before the
U.S. House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

December 12th

Washington, DC

Chairman Walden, Ranking Member DeGette, and Members of the Committee, thank you for the opportunity to testify before you today. I would also like to acknowledge and thank Representative Tonko and Representative Clarke from New York.

My name is Lynn Frederick-Hawley and I am the Executive Director of the Sexual Assault and Violence Intervention Program at The Mount Sinai Hospital in New York City.

Founded in 1852, The Mount Sinai Hospital is one of the nation's largest and most respected hospitals, acclaimed internationally for excellence in clinical care. Ranked among the top hospitals nationwide, we serve one of the most diverse populations in the world.

It has been a priority at The Mount Sinai Hospital for decades to maintain a comprehensive program to address the needs of sexual assault survivors. Our goal is to provide the highest quality medical care and compassionate, client-centered services to address both the patient's physical and psychological trauma. We believe it is critical to validate, heal and empower survivors and their supporters to lead safe, healthy lives through advocacy, free and confidential counseling, and education. In fact, The Mount Sinai Hospital is one of the few institutions with a dedicated program exclusively focused on providing outreach, comprehensive training, emergency room advocacy and counseling services to address the needs of past and present victims of sexual assault and domestic violence. SAVI was founded in 1984, and we have grown exponentially in the past 34 years to meet the evolving needs of survivors and our communities, including creating our Sexual Assault Forensic Examiner Program. I should emphasize that this evolution has been made possible by the support of Mount Sinai leadership, the availability of funding for this kind of programming and the backing of the communities we serve.

Our Sexual Assault Forensic Examiner (SAFE) program has been designated a "center of excellence" since 2006 by the New York State Department of Health. In addition to the SAFE Program, we maintain over 150 highly trained volunteer Advocates who are on call 24/7 to respond to all instances of sexual assault. The Advocates, together with the trained SAFE clinicians, work seamlessly to provide comprehensive services to the sexual assault survivors seeking care at The Mount Sinai Hospital. SAVI therapists are then available to support the survivor beyond the immediate crisis services received in the Emergency Department.

Specifically, The Mount Sinai Hospital and its affiliate medical school, the Icahn School of Medicine at Mount Sinai, employ 23 SAFEs – medical professionals who have decided to take additional steps through SAVI to be able to expertly serve survivors of sexual assault in acute settings. These include ten nurses, seven physician assistants and six physicians. All are employed full time by Mount Sinai, screened by SAVI for this role, have completed extensive additional training to qualify as a SAFE, and completed a preceptorship. In addition, many of the SAFE trained staff work in the Emergency

Department and they are able to provide services to a patient if the on-call SAFE clinician is unexpectedly unavailable.

I would like to take you through the protocol for treating survivors of sexual violence who seek care at our Hospital. As an initial matter, we have a strong protocol in place for clinicians and staff to identify potential survivors of sexual assault and respond sensitively. Once a patient discloses sexual assault, they are triaged to a private, designated SAFE-equipped room. Both the on-call SAFE and SAVI Advocate are contacted to come to our hospital to provide care and treatment to the patient. The Advocate is a certified volunteer who provides counseling, support, information, referral, advocacy and safety planning to the survivor. The Advocate remains with the survivor throughout their stay in the hospital. The SAFE conducts the medical and evidence collection exam, consistent with the patient's consent and wishes. Specific medical protocols and regimens are followed in the event the survivor is a candidate for and chooses a prophylaxis medication. The patient receives detailed discharge instructions and treatment/counseling options including follow-up for any medical care or continued prescription medication.

The SAVI staff then follow up with every patient to provide ongoing support including free therapy, advocacy and referral information. If an evidence collection kit is completed, the survivor can choose whether to report the assault to the New York City Police Department and sign the kit over to them immediately or to have the kit held with Mount Sinai Security until they decide if they want to file an official police report. New York State recently passed a new law requiring the preservation of the kit for a minimum of 20 years. We are fully complying with the new law. Additionally, the SAFE and Advocate are debriefed following every case to which they respond in order for us to support the providers, address any questions that arose, and conduct ongoing quality assurance.

In order to provide this multilayered response to sexual assault survivors, many resources must be invested. This is not care that survivors should be expected to underwrite, and none of SAVI's services, including our SAFE Program, generate income. So it is the vision of an institution like Mount Sinai that sees the overarching benefit and necessity of providing this care to survivors and provides the context in which it can happen, as well as the availability/accessibility of funding from our city, state, federal and community partners, that makes this even possible. It is not just raising a child that takes a village.

On that note, I want to thank the Committee for their attention to this matter. The safety and support of these patients is of utmost importance.

I will be happy to answer any questions you have. Thank you.

Mr. HARPER. The chair wants to thank Ms. Frederick-Hawley, the executive director of the SAVI program at Mount Sinai Hospital, for your testimony.

And the chair now recognizes Kiersten Stewart, who's the director of public policy and the Washington office for Futures Without Violence.

STATEMENT OF KIERSTEN STEWART

Ms. STEWART. Thank you, Mr. Chairman, thank you, Ranking Member DeGette, and thank you members of the committee for your leadership in paying attention to this issue. I would also like to call out Congresswoman Clarke and Congresswoman Castor, who, along with Mrs. Walters and Mr. Costello, recently introduced the Violence Against Women Health Act, which will also make progress on this goal.

For those of you who do not know FUTURES, we are a national nonprofit organization that works to end violence against women and children here in the U.S. and around the world. We also house the National Health Resource Center on violence against women. Less well known is that our work actually began—we began as an organization about 35 years ago simply with a chair in an emergency room at San Francisco General Hospital, trying to provide whatever help we could to every woman who came in a victim of violence. I'm proud to say we've progressed since then, but the mission remains the same.

Some things to understand. Please know that sexual assault is painfully common and a crime largely committed against young people. More than 80 percent of rapes are committed against those under the age of 25, and about half of those are committed against those under the age of 18, children. While young girls and women are those most likely to be victims of rape and sexual assault, men and boys are also victims, as are individuals who do not always fit our traditional norms of male and female.

American Indian and Alaska Native women, people who live in rural areas, as well as individuals with disabilities, also experience higher rates of sexual violence. As we analyze who has access to forensic exams, as well as all healing services for sexual violence, it is important to keep in mind the needs of all victims.

The consequences of sexual violence are often severe and often long lasting. While different people respond differently to sexual violence, sexual violence often leaves a deeply painful mark that some never fully heal from. New economic estimates also create a staggering picture of the cost associated with rape. Using 2014 dollars, the estimated lifetime cost of rape at a population level is nearly \$3.1 trillion. This is based on the fact that 25 million Americans have been raped.

The Government, our tax dollars, pay an estimated \$1 trillion, or about a third of that lifetime economic burden. These numbers do not capture the personal pain of rape and sexual assault on individuals or their families, but they do create a call for action.

Forensic examines, as you've heard, help improve prosecution of sexual assault, but training is essential. I will not duplicate the testimony you've heard from others, but we can't just view training as a one-off act. It needs to be integrated into broader hospital

quality improvement measures, attention needs to be paid to the vicarious trauma often experienced by the nurse examiners, and training needs to engage the entire health entity, from intake to billing to risk management to the front line medical personnel. We also strongly recommend models that are patient-centered and trauma-informed.

We also believe we need to expand training for healthcare providers beyond the forensic exam. Most victims still never make it to the emergency room. Providers need to be trained. Mental health providers, adolescent health, and OB/GYNs, as well as campus health centers, need training to understand and address the impacts of sexual abuse and trauma.

As you've already heard, sexual violence is also an often unrecognized element of abusive relationships. In fact, maybe as much as half of sexual assaults are actually perpetrated by partners. So that's about 22 million women who've experienced sexual violence by an intimate partner, nearly 3 million a year.

Importantly, we have evidence-based clinical interventions that improve the health outcomes and can reduce the violence. So we also need to be putting resources into those.

Specifically, what can we ask you to do in the next year? One, increase funding. The Health Resources and Services Administration has an advanced nursing education SANE program out of the Bureau of Healthcare Workforce. There was \$8 million that recently went out. That is an important first step, but we need to do more.

Provide dedicated funding to project catalysts out of the Office of Women's Health at HRSA. Pass legislation like the Megan Rondini Act that would increase requirements on hospitals to provide all survivors access to a SANE or information on how to get a rape kit if it is not at their hospital. As you've heard, though, we can't do the requirements if we don't have the workforce. We need to do both.

Pass the Violence Against Women Act, as we've heard by many of you, but include this new and improved health. As the GAO report pointed out, there is a VAWA health program, it has no dedicated funding, so we would ask for your help in supporting, creating a designated funding line.

We also have the Family Violence Prevention and Services Act that is also up for reauthorization. This is out of the Department of Health and Human Services, and so that is also awaiting reauthorization similar to VAWA.

And the final thing I would ask. As you heard me say, Native American and Alaska—Alaska Native victims experience violence at the highest rates. So we would ask included in VAWA the protections for Native women who are victims of sexual assault and child abuse.

Thank you.

[The prepared statement of Ms. Stewart follows:]



**Testimony on:
"Examining the Availability of SAFE Kits at Hospitals in the United States"**

**U.S. House of Representatives Energy and Commerce Committee
Subcommittee on Oversight & Investigations**

December 12, 2018

**Delivered by Kiersten Stewart
Director of Public Policy and Washington Office
Futures Without Violence**

Good Morning. My name is Kiersten Stewart and I'm the Director of the Washington Public Policy Office for Futures Without Violence (FUTURES).

I'd like to thank you for the opportunity to speak with you today on the need to improve access to forensic exams for sexual assault victims as well as other actions you might consider to reduce sexual assault and improve the health system's response to victims.

For those of you who don't know us, FUTURES is a national non-profit organization dedicated to ending violence against women and children here in the United States and around the world. We design public education campaigns to increase awareness about these issues, help parents and other caring adults prevent and address child trauma, work to improve systems' response to victims and survivors of violence, and provide extensive technical assistance to health systems on how to improve their response to physical and sexual violence. We actually began as an organization about 35 years ago simply with a chair in the emergency room at San Francisco General Hospital.

It is from this experience that we offer the following information and suggestions.

Sexual assault is painfully common and a crime committed largely against the young.

According to the Centers for Disease Control and Prevention, more than 80 percent of rapes are perpetrated against those under the age of 25 and about half of those are committed against those under the age of 18... children.¹ While girls and young women are overwhelmingly the victims of rape and sexual assault, we also know that men and boys are victims, as are individuals who don't fit our traditional definitions of male and female. Gender non-conforming youth are at higher risk for rape and sexual assault, and our health care responses need to catch up to meet their needs.

Others who experience higher rates of sexual assault are American Indian and Alaska Native women and children, people who live in rural areas, as well as individuals with disabilities. As we analyze who has access to forensic exams and how we need to improve the reach of this important law enforcement tool, we need to keep in mind the needs of all victims, particularly the most vulnerable.

Sexual assault has life-long consequences.

The consequences of sexual assault and sexual violence are often severe and long-lasting. While different people respond to sexual assault differently, and I have seen directly how services and support can help victims go on to live full and joyful lives, sexual violence leaves a painful mark that some never fully heal from.

The full extent of the physical and mental health effects of rape and sexual assault are only beginning to be fully understood, but we have new estimates that create a staggering picture.

Using 2014 US dollars, the estimated lifetime cost of rape was \$122,461 per victim, or a population economic burden of nearly \$3.1 trillion over victims' lifetimes. This is based on data showing that more than 25 million U.S. adults have been raped. This estimate included \$1.2 trillion (39% of total) in medical costs; \$1.6 trillion (52%) in lost work productivity among victims and perpetrators; \$234 billion (8%) in criminal justice activities; and \$36 billion (1%) in other costs, including victim property loss or damage. Government sources pay an estimated \$1 trillion (32%) of the lifetime economic burden.¹¹

These numbers do not even fully capture the costs given that they don't fully capture the consequences of sexual violence and rape on children, such as costs to the foster care system, as well as the often intergenerational effects of violence we see when survivors who were never treated for their trauma become parents.

Given this, it is essential that we do all we can to prevent sexual violence, help victims heal, and hold perpetrators accountable. This is why this hearing today is so important – forensic exams are a powerful tool in bringing perpetrators to justice. They can help victims by providing additional evidence, should they choose to bring charges, and they can keep rapists off the streets, preventing further harm. When done well they can also be an important first step to helping a victim begin to heal.

Forensic exams help improve prosecutors responses to sexual assault but training is essential.

Given the expertise of my colleagues on the panel from IAFN on what an exam entails and how they improve prosecution, I will keep my remarks in this area brief. Forensic exams are important tools in prosecuting sexual assault crimes, but a good forensic exam requires training. While we believe that others in the health care system can be trained to effectively do exams, we agree that nurses are well-placed within the health care infrastructure to perform them and importantly are often the most trusted health care provider by the patients most likely to be sexually abused.

Hospitals Need to Invest in Hiring and Supporting SAFE

Sadly, we have also seen what happens when exams are not properly done or when rape kits are left to languish untested or even destroyed by law enforcement uninterested in the time or expense required to test them.

Your colleague, Congressman (Judge) Ted Poe, in partnership with Rep. Carolyn Maloney, last year introduced a bill to respond to this issue, the Megan Rondini Act. Megan was a college student who reported being sexually assaulted by a man from a prominent and wealthy family in Tuscaloosa, Alabama. After jumping out of a second-story window and fleeing to escape him, Megan went to the hospital for a rape kit, and contacted the police. The hospital did not have a trained examiner on site, and the evidence from her rape kit was never properly examined. Law enforcement officers also immediately challenged her report, telling her she hadn't been raped because she didn't physically fight

and kick back enough. Deeply traumatized by the assault, dealing with threats from law enforcement to prosecute her for actions she took when escaping her assailant, feeling unbelievably with no way to prove her claims, she later took her own life. This bill, HR. 3415 would require hospitals to have a SAFE – Sexual Assault Forensic Examiner – available 24 hours a day/7 days a week or have a plan in place to get that victim to another nearby hospital with a SAFE.ⁱⁱⁱ While I recognize that the “how” we make this happen is important, I would encourage your support for this legislative goal.

Other recommendations include *ongoing* training for forensic examiners, attention to the vicarious trauma often experienced by SAFEs, and to ensure that training engage the entire health entity, from intake to billing to risk management to the frontline care provided by all medical personnel. These exams take time to be done well, and billing rates we are told often do not make doing them profitable for a hospital or clinic. That is not an excuse, but it is why we must strengthen requirements that trained examiners are available, as well as address financial incentives --- or at least remove financial disincentives --- to doing a sexual assault forensic exam.

Use a Patient-Centered, Trauma Informed Approach

We also strongly recommend that as hospitals and clinics bring on more trained SAFEs, that they adopt a patient-centered, trauma –informed model. Brigham and Women’s Hospital in Boston serves as a national model for this approach and they have found that by adopting it they are addressing many of the concerns identified by the GAO Report that helped inform this hearing.^{iv} This model allows more follow-up care for the clients and better coordinated care, which often goes well-beyond the specific steps of a forensic exam.^v It involves simple steps like ensuring a client has a phone so they can receive a text message, to follow up on care. This model also reduces costs for things like missed visits and illnesses that develop as a result of not taking medications. Staff also report they are more satisfied by their jobs when they feel like they can treat a whole person. Many sexual assault survivors also show up in emergency rooms for things that aren’t the sexual assault, but then when a good patient-centered, trauma-informed interview is done, the person may be far more likely to disclose the assault and in so doing allow a forensic exam to be done in the timeframe necessary.

High Need for Training for Pediatric Providers

Services for pediatric sexual assault victims are particularly lacking. Only a small number of board certified, child abuse pediatricians exist in the country, so we also support the use of specially trained SANES as a means to help fill that gap. Again, though, training is essential. While victim services dollars from the Victims of Crime Act can be used to provide services, their use for training is severely limited.^{vi}

Beyond Exams: Promoting Prevention and Early Intervention

As Congress considers its role in responding to sexual assault and improving the response to victims, it is important to understand that most victims never make it to an emergency room, and the cases that do are often the exception rather than the rule.

We need to expand training for health care providers beyond forensic exams. Providers need to be trained to help victims who may be seeking care for the mental, behavioral or physical health effects of sexual violence that happened in the past.

Substance use and mental health providers need to understand the role of sexual abuse and trauma in healing and treatment, particularly for women who may be clients. Adolescent health and OB/GYN providers also, in particular, need training to understand the health impacts of sexual abuse and trauma.

College campuses, including community colleges, need to better address sexual assault prevention and response, moving beyond solely Title IX and Clery Act obligations, to actually reduce rates of sexual violence experienced by their students and staff.

Sexual violence and coercion also are often a part of abusive relationships – in fact about 22 million women have experienced sexual violence by an intimate partner, a little less than 3 million a year according to recent data.^{vi}

Importantly, we also have evidence-based clinical interventions that have been shown to both improve health outcomes and actually reduce abusive behavior.^{vii}

The “CUES” intervention involves training providers and health staff to provide education about violence and health to all patients regardless of the reason for a visit, to provide health promoting and healing strategies, and for those who ask for more information, provide coordinated referrals to community based programs for ongoing support. Larger clinical trials of this approach are ongoing.

Recommendations for VAWA, Appropriations and Maternal and Child Health/HRSA

Federal lawmakers are uniquely positioned to improve access to sexual assault forensic exams, reduce sexual violence and promote survivor healing.

The following are five specific actions we would encourage you to take in the next year that would have an immediate impact.

Specifically, we would recommend:

1. Increase funding for HRSA’s Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program, out of the Bureau of Health Care Workforce. The most recent RFA was for \$8 million to fund approximately 16 programs. While this is an important investment, the need is ongoing. This is a newer program, developed in response to concerns being addressed today.
2. Provide \$5 million in dedicated funding for Project Catalyst, out of the Office of Women’s Health at HRSA, to improve the response of community health centers to sex trafficking and sexual and intimate partner violence;
3. Increase funding for VAWA programs that support training for sexual assault nurse examiners and services for sexual assault victims, such as the STOP Grants, Rural Grants, Campus Grants and the Sexual Assault Services Program (SASP), and create designated funding for the VAWA Health program to train health care providers on addressing sexual and physical violence and building partnerships with community-based organizations and health and public health agencies;
4. Increase funding for prevention and youth programs, such as the Rape Prevention and Education Program and VAWA Youth Program; and
5. Reauthorize the Violence Against Women Act, including:
 - a. Continue to make funding available for sexual assault training and services for victims in core VAWA programs;
 - b. Expand the campus grants program to reach more colleges and universities and improve coordination between campus health centers and other campus providers and programs;
 - c. Increase authorization levels for sexual assault prevention programs such as the Rape Prevention and Education Program and VAWA Youth program; and

- d. Expand tribal programs to include the ability of tribal courts to prosecute non-Tribal members who commit sexual assault and violence against children.

Thank you for the opportunity to provide these comments, and I look forward to answering any questions you may have.

ⁱ Smith, S.G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

ⁱⁱ Peterson C, DeGue S, Florence C, Lokey CN. (2017) Lifetime Economic Burden of Rape Among U.S. Adults, American Journal of Preventive Medicine, Jun;52(6):691-701.

ⁱⁱⁱ <https://poe.house.gov/2017/7/congressman-poe-introduces-the-megan-rondini-act>.

^{iv} <https://www.gao.gov/assets/680/675879.pdf>.

^v Lewis-O'Connor, A. & Chadwick, M. (2015). Voice of the patient: informing research, policy and practice on violence against women. Journal of Forensic Nursing, 11:4, 188-197. In addition, personal correspondence with Professor Lewis-O'Connor.

^{vi} Questions and Answers Victims of Crime Act (VOCA) Victim Assistance Program Rule <https://www.gpo.gov/fdsys/pkg/FR-2016-07-08/pdf/2016-16085.pdf>.

^{vii} Smith, et al. , p.20.

^{viii} Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach, Elizabeth Miller, Brigid McCaw, Betsy L. Humphreys, Connie Mitchell
J Women's Health 2015 Jan 1; 24(1): 92–99.

Mr. HARPER. I want to thank each of you for your testimony. We look forward to asking you questions. I think this is such an important hearing, and we appreciate your attendance today. This is very helpful to us. We know we have some challenges, but this is not really a bipartisan topic; it's really a nonpartisan topic. This is something that has to be done to make sure that we improve greatly on what we're doing right now. So thank you.

This is now the opportunity for the Members to have the chance to ask each of you questions. I'll begin by recognizing myself for 5 minutes for questions at this time.

You know, I certainly think that it's important that everyone understand why access to SANEs and SAFE kits is so important. According to the GAO report, when a survivor of sexual assault receives a sexual assault forensic exam, that exam can be done by a SANE that has specialized training in how to collect those kits or by a nurse or medical professional that does not have that training. But GAO, I believe, correctly noted that exams performed by SANEs have several advantages, including higher quality healthcare, and from a prosecution standpoint, a much higher quality evidence collection.

So, Ms. Jennings, I'd like to start with you, if I may. Explain to us briefly, what does SANE training entail and does that vary State by State?

Ms. JENNINGS. Sure. Thank you for the question. Our SANE training is two parts. So there is the adult component and then the pediatric component. The adult component consists of a 40-hour training, the didactic, so your actual classroom training. The pediatric is another 40-hour training in the classroom setting. And then there's a combined training of both adult and pediatrics, which is a 64-hour class that you can also take.

There are many options for both in-live classroom settings and there's also an option with IFN to attend an online training, which is very accessible to anyone in any setting. Once you complete the classroom setting, there is a clinical component, and that's where we see the biggest struggle to actually find sites to do the clinical training. We have a really good access to the classroom component, but we have a very hard time finding sites for the clinical component.

Mr. HARPER. You raised an interesting point because you have a separate training for pediatric.

Ms. JENNINGS. Yes.

Mr. HARPER. But you may only have one staffer that's trained that may be there available on-call or at that time. Do you recommend that someone complete both components in the shorter combined class?

Ms. JENNINGS. In rural areas where there is smaller patient populations that they may not see large numbers of pediatric patients, that would probably be the best route to go so that you have both the adult and the pediatric component. Pediatric patients, from a forensic perspective and sexual assault perspective, are very different than adult patients. So it does take a bit more time to be very familiar and very competent with the pediatric patient population.

Mr. HARPER. Are you able to tell us generally the cost for this training or certification?

Ms. JENNINGS. Sure. So if you take the training through the IFN, it's roughly \$500, based off of the online training. There are trainings that are State specific in addition to that that may cost an additional amount. I'm not familiar with that. I apologize.

Mr. HARPER. Sure. You know, as we noted and I spoke of in my opening statement, the GAO found that limited availability of training is one of the major impediments that hospitals face in providing access to these services. So my question—follow-up question, Ms. Jennings, would be, where is training generally available? And how does availability—and you said online, of course, but how does availability of training vary across different regions? Is there an urban versus rural component or is it a State-by-State issue? Can you elaborate a little bit?

Ms. JENNINGS. Sure. So the training I mentioned is through the IFN, the online component, which is both the adult, the pediatric component, the combined course. However, there are States that choose to do actual in-person trainings; those can be approved by the IFN. Some of those trainings are just done by providers within certain facilities.

Mr. HARPER. Approximately, how many States offer in-person training? Do you have a general idea?

Ms. JENNINGS. I don't. I can tell you, I'm from Virginia, and we do offer several trainings throughout the State several times a year, but of course, that varies State to State.

Mr. HARPER. Thank you very much. I appreciate that.

Another challenge that hospitals identified to the committee was the financial challenge of administering a SAFE program; however, several of the letter recipients were able to identify grant programs to fund SANE training.

So, Ms. Clowers, if I could ask you. The GAO report touched on various sources of funding for SANE training. Could you briefly describe how those funding sources and how hospitals can take advantage of those opportunities?

Ms. CLOWERS. Yes, sir. We identified three key grant programs at the time of our audit. All were administered by the Department of Justice, with the STOP grants being the largest, that's a formula-based grant, where all territories and States receive a set amount. At the time it was \$600,000, and then could get additional funding based on population.

And what we found is that the amounts that locations receive varied greatly depending on the size of the population. And we also found that the entities that received those grants typically used the money for training. Forty-nine States reported—grantees in 49 States reported using funding for training, which would include types of training that Ms. Jennings mentioned, whether it be classroom training, clinical training, and then importantly, the continuing education as well. In addition to the training, States reported using some funding for funding of positions. But less States reported using funds for those purposes. Only about—grantees in about half of the States reported using funds for positions. And if they were using them for positions, it was typically for a program coordinator.

Mr. HARPER. Thank you very much.

The Chair will now recognize the ranking member, Ms. DeGette, for 5 minutes.

Ms. DEGETTE. Thank you very much.

Well, Ms. Clowers, following up on your testimony about the grant programs at the Department of Justice, those programs are of course included in the Violence Against Women Act reauthorization, which is set to expire December 21. So I want to ask you about—and everybody here agrees, all of the witnesses, everybody in the audience, all of the Members of Congress sitting up here on the dais, we all agree this needs to be reauthorized. This is kind of one of the mysteries of Congress to me, why we have haven't done it.

So maybe you can tell me, Ms. Clowers, about the effectiveness of these three grant programs through DOJ, and why it would be important to reauthorize those in a timely fashion.

Ms. CLOWERS. Thank you. We heard from the officials from the States that we interviewed and contacted for our review that these funds are very important. While some States have used—grantees use State money or other types of sources of funding, the Federal dollars are a primary source of funding, and they go for the purposes that I just mentioned in terms of the training, the classroom training, the clinical training, the continued education, as well as funding needed positions.

Ms. DEGETTE. Ms. Stewart, are these—some of the hospital associations told us that the hospitals did not have more robust sexual assault programs because of the cost of maintaining the programs. Are these programs costly to hospitals, and it is a prohibitive issue? What are the possible solutions to that barrier?

Ms. STEWART. So they certainly have a cost. Doing a good exam requires time. To be honest, when we talked to hospitals, there are so many things that they do that are so much more expensive.

Ms. DEGETTE. Right, that's what I would think.

Ms. STEWART. And, if anything—you know, we are just having conversation, you know, that they lose far more on certain other things. And so we do not view this as prohibitive. Plus, as you pointed out, the Violence Against Women Act, can cover costs. Private insurance can cover many of the costs. We also share the view that victims themselves should not have to share the cost, but there are—Victims of Crime Act funding also can cover some of the costs.

So we do believe this issue of training and ongoing certification is important and needs to get figured out. I think the other pieces are largely fairly easily fixable.

Ms. DEGETTE. And do you think there's some kind of bias in some of the hospitals against providing these services?

Ms. JENNINGS, you're nodding, maybe you want to tackle that.

Ms. JENNINGS. The reason I nod is I think hospitals historically see this as a criminal justice issue as opposed to a health issue. And there is significant health consequences that are surrounding victims of sexual assault, and, therefore, we very much see it as a health determinant that we need to address as opposed to a separate criminal justice issue.

Ms. DEGETTE. Right. Well, I mean, it's health and it is criminal justice, but if you do it correctly, then it's patient centered, and that's what we really care about in the hospitals. And I've also got to say, you know, I'm from Denver, Colorado, where I have a really wonderful district attorney, Beth McCann, who is working quite closely with all of our hospitals, and then we have a wonderful hospital association, and we have—and everybody understands how important it is to have these kits and how important it is to have trained people.

But the challenge, I would think, Ms. Clowers, is to expand that everywhere, not just in places where there's a certain number of people who think it's important, particularly in rural areas, I would think.

Ms. CLOWERS. Absolutely. In your State, I think we found that in the five rural counties in central Colorado, there was only one examiner program.

Ms. DEGETTE. Right.

Ms. CLOWERS. And so it's—the need for the consistency across the State, making sure that victims, regardless of where they live, have access to timely care. I would say that it's also, though, capacity is needed in urban areas as well, even when there's an examiner program. What we found is there's not sufficient capacity to offer 24/7 care.

Most of the trained examiners are often wearing multiple hats, and so they're doing two jobs at once and more than two jobs. In addition, they're on call quite a bit. One study that we reviewed found, in Maryland, for example, trained examiners are on call 160 hours a month.

Ms. DEGETTE. Yes. Ms. Jennings, do you have some thoughts about how we could expand the accessibility to people for SANEs, the nurse examiners?

Ms. JENNINGS. To follow up with Ms. Clowers, the piece of that, the program that I work for is a 24/7 operation with 14 full-time forensic nurses. So our model has shifted from a PRN on-call basis to truly being in-house 24/7, which has been very key in sustaining our nurses. We saw a 2-year turnover prior to that. And now we've had nurses that have been with us 4 and 5 years. So we've been able to retain those nurses, continue with their continuing education, and be able to have true competency within that group as opposed to constantly turning over staff.

So I think that a model shift from being an ER nurse that gets pulled out of staffing to take care of a sexual assault patient really needs to be the shift of the hospital focus.

Ms. DEGETTE. Thank you very much, Mr. Chairman. I yield back.

Mr. HARPER. The ranking member yields back.

I have a quick question before I recognize the next Member. And, Ms. Frederick-Hawley—

Ms. FREDERICK-HAWLEY. Yes.

Mr. HARPER [continuing]. I know you, looking at your response, the committee's letter, you had talked about the cost of the program, the SAVI program—

Ms. FREDERICK-HAWLEY. Yes.

Mr. HARPER [continuing]. That had been slowly rising for the past few years. I think you indicated it was \$294,000 in 2017. Could you tell me how much of that cost was covered by grants and other outside funding opportunities?

Ms. FREDERICK-HAWLEY. Sure. The vast majority of the grants that we use for the SAFE program cover the cost of the coordination of it. So it's our full-time staff that manage the SAFE scheduling, the recruitment, the training, the support of those SAFE examiners, and the advocates. Some of it goes towards training, some of it goes towards equipment in the emergency department.

Up to this point this year, we have spent \$111,000 on the stipends that cover the on-call payment and the additional payment to the SAFE for when they come in on an actual case. We pay them both. We pay them just for being on call and also for coming in on a case.

Mr. HARPER. Thank you very much. That's helpful.

The Chair will now recognize the vice chairman of the subcommittee, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. What a personal privilege to begin with. I do want to thank you, Mr. Chairman. It has been great serving as your vice chairman, and if we have another hearing that would be great, too, but you have been a great chairman and just all-around good guy. I appreciate having worked with you these years. Thank you.

I do think that—and I forget now who the testimony was from, but I do think it is important that we recognize it is both a health concern and a law enforcement concern, and so I have rearranged the way I'm asking my questions, but, Ms. Frederick-Hawley, can you tell me a little bit about how your hospital and the Sexual Assault and Violence Intervention, SAVI, Program partnered with law enforcement and how that partnership benefits your patients?

Ms. FREDERICK-HAWLEY. Absolutely. One of our funding sources, the New York State Division of Criminal Justice Services implemented that we have sexual assault task forces in all of the boroughs of New York City. So for instance, the work that we do in Manhattan once a month it is the special victims bureau of the Manhattan DA's office, it is the special victims division of NYPD for Manhattan, it is us, it is other SAFE Programs, it is other community partners that all come around a table and discuss different issues that arise. It has a benefit in two ways. We get to discuss cases and ongoing issues, but we also get to develop relationships such that if there is a concern about something that is going on with law enforcement around a particular case I can very easily pick up the phone and call special victims in Manhattan and say, I need help with this. And they're very responsive. So we have the good fortune where I work that it is sort of built into our model that we work with law enforcement.

Mr. GRIFFITH. And as a part of that have you found that—I mean, obviously the victim when they first present themselves to the medical providers are distraught and not necessarily thinking clearly, has it been your experience that it is later that they realize how important it is or how they want to have some emotional closure or solace from the fact that the case is brought forward and that the evidence is preserved?

Ms. FREDERICK-HAWLEY. The last time we did a statistical analysis it was about 67 percent of our sexual assault survivors report to NYPD during the time that they're in our emergency department and turn the kit over. The rest we hold them in security and then we continue to follow up with them until they make a decision. Many times they don't. Lots of times without certain supports in place they could fall through a crack, so if it is just them working with NYPD the likelihood of being able to carry forward under that kind of condition of trauma is—it is very challenging, so the more we can be involved and support them the better the outcome.

Mr. GRIFFITH. I appreciate that. Ms. Jennings, we have heard about the lack of appropriate transportation to the nearest sexual assault forensic examiner and that that is sometimes a barrier. I know you work in the Richmond area. My district is between 3 and 7 hours away from Richmond. One hospital that received our letter noted that they may provide a sexual assault patient with a taxi voucher. Obviously that can create problems on the criminal justice side because it can corrupt—possibly corrupt the evidence. You got to go through a whole line of what happened in the taxicab, what kind of taxicab was it, you know, et cetera. And so that creates a real problem in the criminal justice system.

So that being said, for survivors that visit a hospital that doesn't have a SANE nurse on staff or does not provide that how do we best transport these victims to another facility?

Ms. JENNINGS. And it is interesting that you actually asked that question. Recently in Virginia we do have about 13 healthy forensic nursing programs, and our program experienced a patient that presented to us after travelling to three different hospitals being told there's not a forensic nurse here, there's no way to do a SANE exam here, go somewhere else, and not provided with an actual facility.

In regards to the transportation what we primarily see is the patient either being transferred by ambulance so they'll go from one facility to our facility via an ambulance provider, so there's two people in the back potentially with the patient, but also law enforcement does transport some of these patients. Best case scenario is that the patient knows what hospital to go to, obviously.

Mr. GRIFFITH. Right. Right. And obviously I represent a large and very rural district. Telemedicine, you touched on that in your written comments, and I'm a big fan, it may mean more witness time for certain SANE nurses, but what do you suggest on telemedicine if there's a rural hospital that doesn't have somebody, doesn't have the money to have somebody with the training?

Ms. JENNINGS. I do see benefits of telemedicine. I think that one piece of it there needs to be a very well trained forensic nurse on one end and then the nurse on the other end does need to have some basic training in forensic nursing. It may be a very brief course on evidence collection, but they need to have a little bit of knowledge prior to having that telemedicine piece set up.

Mr. GRIFFITH. And my time is up, but I do want to find out, at some point I may ask a written question later about the clinical component of what we can do to make that better. Thank you. I yield back.

Mr. HARPER. The gentleman yields back. The Chair will now recognize Ms. Clarke for 5 minutes for the purposes of questions.

Ms. CLARKE. I thank you, Mr. Chairman, and I thank our ranking member. Good morning, everyone, and good morning to our panelists. The subject matter that we're discussing here today is so very important. I want to thank the chairman and the ranking member for today's hearing on such a very important, sensitive topic that's often gone woefully unaddressed with long lasting harmful impact on our Nation's survivors.

The subject of sexual violence in our country impacts millions of Americans, more specifically 23 million women and 1.7 million men that we know of. These staggering numbers do not even take into account the incidence of unreported assault survivors, who live in fear, in shame and in the shadows, and are often afraid to even come forward.

One of the major reasons individuals who have survived sexual assault are scared to report their attack is because the process is arduous and retraumatizes victims, causing them anxiety to face their assailant. That is why we are gathered in this room today to understand how the Congress can provide support to those who need it the most and to obtain justice.

There is both a shortage of supply of sexual assault forensic examination kits, SAFE as we have been talking about, as well as sexual assault nurse home examiners, SANE. As one of the wealthiest most advanced civil societies in the world there should be no barriers to care for the most vulnerable in society, especially at the critical stage of collecting forensic evidence to provide justice to those brave women and men.

To add insult to injury victims of sexual assault should not be required to pay for the forensic exam or emergency room visit. In the Ninth Congressional District of New York that I proudly represent just as recent as November 30 of 2018 the New York Attorney General Barbara Underwood announced that at least 200 sexual assault survivors were illegally sent bills from seven New York City hospitals requiring payments ranging from \$46 to \$3,000. Thankfully the New York State Attorney General committed to righting this wrong and protecting survivors, as well as their rights.

And I'm so proud to hear from Ms. Frederick-Hawley today of Mount Sinai who has a hospital site in my district here today, and I want to open with my questions to Ms. Hawley.

I would like to take a few minutes to discuss the details of Mount Sinai's program and to see what best practices you would offer to other hospitals looking to develop and expand a sexual assault program. Ms. Frederick-Hawley, could you tell us a bit more about how your program got started?

Ms. FREDERICK-HAWLEY. Well, originally in 1984 we had a sexual assault survivor come into the emergency department, and there were a couple of medical students working that evening. And after this patient was discharged they looked at each other and said, We have got to be able to do better than that. And so they started to think through what a rape crisis program would like. They found a donor for the hospital. They sat at her kitchen table and developed SAVI. So it was a very grassroots based out of the need to

do more for survivors sort of effort, and we carry it forward from there.

The moment we hear of an emerging need we try to address it the best way possible, and I'm fortunate that I get to do this work at the Mount Sinai Hospital because they have been incredibly supportive and have always recognized that this is an important aspect of the kind of medical care that we want to provide.

Ms. CLARKE. Absolutely. And would you tell us a bit more about the services that SAVI provides through this program and the impact it's had on victims?

Ms. FREDERICK-HAWLEY. Absolutely. So since 1984 we are not just a rape crisis program anymore. We currently send advocates of—our certified volunteer advocates that we train on a 40-hour basis, it is a DOH-certified training curriculum that we have developed. We send them to eight hospitals, including some city hospitals, private hospitals and throughout the Mount Sinai system to service survivors of any kind of sexual violence and intimate partner violence.

We have a court program and an ongoing therapy program for sex trafficking survivors, both domestic and international. We have a three full-time staffed education and training department where we're working on primary prevention. We have a component called Talkanote, which is specifically for Orthodox Jewish survivors of any kind of sexual violence or intimate partner violence.

We have therapists, trauma therapists in six different locations in Manhattan and Queens who provide mostly short-term brief trauma therapy, but it can go on a longer term depending on what the person needs, and also we do all of this extensive emergency department care with our SAFE's and our advocates in terms of providing anything they need in that moment from a medical and psychological standpoint to any ongoing need that is going to come up that we want to be able to help empower them to either find service for or that we can provide service for. All of our services are free, and we provide them in 10 different languages currently.

Ms. CLARKE. Outstanding. I thank you for all of your service. And I yield back, Mr. Chairman.

Mr. HARPER. The gentleman yields back. The Chair will now recognize the chairman of the full committee, Mr. Walden, for 5 minutes.

Mr. WALDEN. Thank you, Mr. Chairman. Again, I want to thank our witnesses for being here today and for the testimony you submitted for the record.

Ms. Jennings, you noted in your testimony that telemedicine can be used to improve care for patients in rural and low volume communities, and I certainly know that my—just point of reference my district is bigger than almost any State east of the Mississippi, so it is enormous territory, very rural.

Would you tell us a little more about telemedicine and how it can be used to expand access to these types of services and what are some of the challenges you see facing telemedicine to treat survivors of sexual assault?

Ms. JENNINGS. Absolutely. Thank you. Telemedicine is for sure an answer to some of the more rural communities that don't have access to forensic nursing care. They could have to travel, as we

mentioned before, as many as 3 to 7 hours to have a trained provider. Telemedicine would allow a nurse or another provider in the ED setting to care for that patient via telemedicine with another trained provider on the opposite end, walking them through the evidence collection process, walking them through injury identification, walking them through any prophylactic medications that the patient may need at time of discharge and then go through discharge planning, whether it be follow-up with a rape crisis advocate or whomever. The person on the other end would be able to elaborate on those services and care via telemedicine.

Mr. WALDEN. Are there any statutory barriers, regulatory barriers either at the State or Federal levels you're aware of that would—that hamper this ability?

Ms. JENNINGS. I'm not aware of specifics, but I do know that there are some challenges specific to that, and it will vary State-by-State.

Mr. WALDEN. Any other panelists want to weigh in on that from your experiences on telemedicine?

Because it is really hard again in a district such as mine just to recruit healthcare providers period, nurses, et cetera, and then when you get into something specific and the more we regulate the training the less likely it is they can find somebody like that to be there.

Ms. CLOWERS. We through our work in talking to officials from different States this was one of the best practices or promising practices we heard about. Using web-based training, for example, to get both the sort of classroom as well as some clinical training opportunities, but then as Ms. Jennings was describing too providing that clinical guidance real time.

We heard about examples in Colorado where a program coordinator in an urban area will be on call to help those in rural communities that don't have an examiner program. And then also we heard about the program, the SANE program in Massachusetts, which provides clinical guidance real time to nurses across the State.

Mr. WALDEN. Very good. In addition to the challenges noted in the GAO report on volume versus competency issues one issue we have heard expressed by hospitals is that they're able to have SANEs on staff because they have so few—or they're not able because they have so few patients seeking kits each year that their nurses are not able to maintain competency in performing the SAFE kits. So I wonder, I understand at Mount Sinai you have had 23 SANEs on staff. How many kits do you perform on an average basis annually?

Ms. FREDERICK-HAWLEY. Year to date as of this morning we had 55 cases of sexual assault at the Mount Sinai Hospital.

Mr. WALDEN. Wow.

Ms. FREDERICK-HAWLEY. And only one of them did not have a SAFE examiner, person got sick at the last minute.

Mr. WALDEN. Ah. So 23 nurses and about 55 cases this year. Is it fair to say you may have some nurses that do not perform any kits at all then?

Ms. FREDERICK-HAWLEY. Absolutely. And I should clarify that there are now 24, and they're not all nurses on our particular program.

Mr. WALDEN. OK.

Ms. FREDERICK-HAWLEY. So I have physicians assistants, RNs, APRNs and residents and—

Mr. WALDEN. So other healthcare providers.

Ms. FREDERICK-HAWLEY. Other healthcare providers. It is possible there are some times when we allow our SAFE examiners who are on the roster to take a leave, they need kind of a break from that work.

Mr. WALDEN. I'm sure.

Ms. FREDERICK-HAWLEY. And so we have an intensive number of people who take many more on-call shifts. So there are periods of time sometimes when one of the SAFE's hasn't done an exam in quite a while. We do have things in place for them where our assistant medical director for our SAFE Program is available to talk them through if they're back to do a case for the first time after a hiatus.

Mr. WALDEN. I was going to ask about that. How do you maintain that competency in training then in the interim?

Ms. FREDERICK-HAWLEY. There's also always a SAVI staff person on call to the SAFE examiner in case any questions come up or if they just want to kind of touch base and know that they're not out there alone. Often times, too, our SAFE examiners work in the emergency department, so you will often find that while the person who is on call is coming in to respond to that patient there is another SAFE-trained person there that they can bounce things off of if they need to. So there are a lot of layers of support for our particular examiners.

Mr. WALDEN. Excellent. Thank you. And thanks again for your testimony, all of you. I appreciate that. Mr. Chairman, I yield back.

Mr. HARPER. The chairman yields back. The Chair will now recognize the gentlewoman from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Well, thank you, Mr. Chairman, and I have to say, Mr. Chairman, it has been a pleasure serving with you and working with you on legislation. Thank you for your service on the committee and to the country.

Mr. HARPER. And if the gentlewoman will yield, it was certainly a pleasure for me to be able to serve with you at the very beginning on our Ethics Committee and the great work that you did there.

Ms. CASTOR. Especially the caregivers bill.

Mr. HARPER. That's right. Particularly that. That was this year. Thank you.

Ms. CASTOR. And thank you to our witnesses for being here and helping raise awareness to this critical issue for sexual assault survivors. Back home in Florida in the Tampa Bay area we're very fortunate, we have an outstanding crisis center of Tampa Bay that has been a leader for decades, and I guess I was naive in assuming that a lot of this the services the integrated services with hospitals and providers and on-call experts and forensic nurses and specialists that was just the standard across the country, but it is clear that it is not, and we have got to do more to make sure that profes-

sional forensic specialists are available to everyone in America no matter where they live.

The other issue that has been an issue in the State of Florida and other areas is actual processing of the sexual assault kits. And for anyone that's interested in this, the State of Florida, the Florida Department of Law Enforcement posted on their website a progress report because it came to light a few years ago they had over 8,500 kits that had not been processed. And to their credit, they appropriated some money, and right now they have completed over 7,000 of those kits but still have a thousand waiting.

Ms. CLOWERS. How are we doing on processing kits across the country?

Ms. CLOWERS. We have an ongoing work looking at the issues of processing kits and the backlog of kits that are out there and I'm happy to arrange a briefing for you or your staff on that work as it comes to fruition.

Ms. CASTOR. Good. Thank you very much. The other big issue as Ranking Member DeGette has mentioned is the impending expiration of the Violence Against Women Act. It is December 21 that it would lapse, and this Congress has got to get it together to pass this landmark law and reauthorize it. It contains several provisions that address health issues associated with sexual violence, including the grant programs that we previously discussed that help fund and train sexual assault forensic examiners and address the public health response to domestic abuse.

Ms. STEWART. Your organization has had a long history in advocating on behalf of Violence Against Women Act. Again, why is it so important that the act be reauthorized as soon as possible?

Ms. STEWART. So VAWA serves as a cornerstone of the Nation's response to domestic and sexual violence as you have pointed out. It includes both provisions that set standards for the law but it also provides grant programs to do exactly the things you have heard us discuss today. We also would advocate—I know we're talking primarily about the response after a sexual assault has happened and the effort to try to prosecute and hold offenders accountable. VAWA also has numerous programs that fund what we call the coordinated community response, which is really the ideal response to these forms of violence. We can't just wait until people are raped, and we need—we appreciate this hearing, we appreciate the focus on giving people the best care and holding offenders accountable, but that cannot be our Nation's response to sexual assault.

We need to stop it through prevention and early intervention programs, through programs that bring law enforcement together with health, together with advocates, which we haven't really touched on yet, but so much of the success of these programs really is these partnership issues, how do we bring healthcare and law enforcement together? VAWA does that.

Ms. CASTOR. I strongly agree, and I also—as you mentioned before I also believe it is time to improve the VAWA health title as you mentioned Mrs. Dingell and Mr. Costello along with Ms. Clarke, who was here and I we have filed legislation and that is to do more on the behavioral health side, but clearly we have got

to help, we have got to put more dollars into training sexual assault examiners.

And you mentioned—you all mentioned a bill by Senator Murray. Is that—that I believe has been replicated here by in legislation by Rep Jayapal. Are there other bills that you would highlight to us today that we need to work on as soon as possible?

Any of the witnesses.

Ms. STEWART. You know, we still obviously look to VAWA and the VAWA health provisions as you said, and I think what's important that you pointed out was the relationship between suicide prevention—you know, we're looking at a lot of the report language in some cases, and we look at we have a huge epidemic in this country primarily of male suicides. What we see from some of the data is really unaddressed sexual violence in childhood in some of those cases.

Our opioid addiction, which I know, you know, so many frankly, Members on this committee have been focused on, how do we address violence as a driver as that and as part of our treatment. So some of those laws, some have passed, some are still sort of close to the final stretches, and integrating violence prevention language into those other programs is critical.

We have also obviously discussed the Megan Rondini Act that Judge Poe has been advocating, and we think that that's an important legislative goal that we would encourage the committee to pursue.

Ms. CASTOR. Thank you very much.

Mr. GRIFFITH [presiding]. I thank the gentlelady. I now recognize the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. I was going to recognize your long service as chairman and how much I regret the fact that you're leaving, but you're not the one who is leaving, so I'll save that.

Mr. HARPER. I am here.

Mr. BURGESS. Oh, you are here. I do regret that you're leaving, Mr. Harper.

Let me just ask, and this has been a fascinating discussion this morning, but just to orient me, Ms. Frederick-Hawley, you're in New York at Mount Sinai Hospital. Is that correct?

Ms. FREDERICK-HAWLEY. Yes.

Mr. BURGESS. Ms. Stewart, San Francisco General Hospital?

Ms. STEWART. Our organization is based in San Francisco, I'm here in DC.

Mr. BURGESS. You're here in DC, OK. And Ms. Jennings, your hospital?

Ms. JENNINGS. Bon Secours in Richmond, Virginia.

Mr. BURGESS. Very good. I was a medical student 10 years before your medical students that you discussed in 1984. I did my residency training at Parkland Hospital in Dallas, and even back in the seventies and early eighties Parkland had I thought at the time a very forward leaning program in this regard. And I'll tell you one of the things that always impressed me about it as an OB/GYN resident. We were not tasked with covering a case when a patient came in complaining of sexual assault. That immediately went to a faculty member, who was onsite in hospital 24 hours day and

available. And part of me at the time always resented having a faculty member in hospital, but in these cases it was clear that—and I think Norman Gant and Jack Pritchard, at the time, recognized that in order to have the availability of someone to precisely collect the information and then provide expert testimony in the courtroom was critical in the satisfactory resolution of these cases.

And I don't have numbers, but I remember getting the impression that some defendants would plead before getting to the courtroom because the case would be so strong against them. And again, you had a faculty member from Southwestern Medical School as the expert witness, so that was always pretty powerful to take that into court.

And then, of course, as a resident I ended up staying in the area, but I certainly recognize that somebody completes their residency after 4 years they may be gone miles and miles and miles away and not available for a court case, and then a case could be lost because of lack of the availability of the person who is to present the testimony. So I became convinced early even before I began my private practice that this was the correct approach.

Now, I did not practice in Dallas County. I was a county removed, and I remembered trying to set up a similar program in our hospital, community hospital, and there was significant barriers to doing so. At the time there were not the advanced nurse practitioners who were—who you talk about this morning as available to do this.

Of course in 1988 this Congress, not this Congress, but Congress passed a law called EMTALA. Can any of you speak to me as to whether or not your screening exams, for somebody who comes in complaining of sexual assault, does that satisfy the EMTALA requirements as set forth by Congress in 1988?

And anyone who feels that they can answer that.

Ms. JENNINGS. Thank you. So our facilities that we do receive transfers from we do ask that they follow the EMTALA process. There are some facilities that, again, don't see this as a healthcare issue, therefore, they don't follow the appropriate EMTALA proceedings.

So we ask for a doc-to-doc transfer, and we do ask for a nurse-to-nurse report, but many times that's not happening, they're just telling the patient we don't have that here and you need to go elsewhere, so it is not occurring.

Mr. BURGESS. Yes, Ms. Frederick-Hawley, were you going to say something?

Ms. FREDERICK-HAWLEY. We don't have an EMTALA issue in New York State because of sexual assault. It is actually required that if a patient presents in an emergency department in New York State saying they have been raped and they would like to have a kit done there every hospital has to be able to conduct a kit. It is not necessarily done by someone who is SAFE trained, but someone's got to figure out what to do and how to do it.

Fortunately for the most part in New York City there are ways that people can be trained or they have exposure to the idea of providing a sexual assault forensic exam. A lot of it is anxiety on the part of someone. They want to do the right thing, they want to do it well—

Mr. BURGESS. Sure.

Ms. FREDERICK-HAWLEY [continuing]. And are concerned that they won't be able to, and their instinct may be to we need to send this patient to some place else, but if the patient wants to stay in that particular ED and that's where they want their exam done then that hospital needs to figure out how to do it, and every hospital has to have kits on hand to perform.

Mr. BURGESS. And will you generally because if a patient is a regular patient of a practice in your communities will you call the doctor or practitioner who is the regular provider of care for that patient?

Ms. FREDERICK-HAWLEY. Call their like their OB/GYN, for instance, into the emergency department to do——

Mr. BURGESS. Even to let them know their patient is being seen with that complaint?

Ms. FREDERICK-HAWLEY. Everything that we do is based on what that survivor, that patient wants and allows us to do at that moment.

Mr. BURGESS. So if they request you call their doctor——

Ms. FREDERICK-HAWLEY. If they request it we would call anyone that they wanted us to, yes.

Mr. BURGESS. And I know I have gone over time, but how do you address the freestanding emergency rooms that we see so frequently cropping up in our communities, are these facilities equipped to handle these types of exams that you all provide?

Ms. FREDERICK-HAWLEY. I think it varies. So, for instance, Mount Sinai has several urgent care centers that we will send our SAFEs to if someone presents and wants to have their evidence collection done there. But I can't speak for all of those kinds of——

Ms. JENNINGS. I don't see freestanding EDs as being a barrier to care, to service. We also in our facility we have two freestanding emergency departments, and we provide the same care and have not seen it as barrier, but it differs, of course, from State-to-State.

Mr. BURGESS. And I recognize that, and, of course, I'm in full favor of States being in charge of their sovereignty, but CMS is a national—I mean, Medicare is a national program so CMS oversees the EMTALA, so it seems like there's—I'll be the last person to say I want EMTALA to be bigger, or stronger, or harder, but at the same time they do exist, and CMS is the oversight of that program not State-by-State. Thanks. Mr. Chairman. I'll yield back.

Mr. HARPER [presiding]. The gentleman yields back. The Chair now recognizes the gentleman from Michigan, Mr. Walberg, for 5 minutes.

Mr. WALBERG. Thank you, Mr. Chairman. And I, too, want to say thank you for your service, your leadership, your friendship. We're going to miss you, and every time I go back to the base of my district in Jackson, Michigan I'll think of you in Jackson, Mississippi.

Thanks to the panel for being here as well on this important topic, and it is a shame that it continues to be such a massive concern, but it is a concern, and we have to address it so thank you for your efforts and probably your sacrifice that you go through in dealing with this topic and these issues.

GAO's report noted that only limited nationwide data exists on the availability of SANEs and that only one of the six States exam-

ined had a system in place to formally track the number and location of the SANEs. Some States, including Massachusetts, Colorado and Texas I'm told make public a list of SAFE ready facilities. Other States do not appear to make these sorts of resources publicly available.

Let me ask each of you if you care to answer would this kind of national database or at least statewide databases be helpful to survivors?

Ms. CLOWERS. I would think a national database or some type of centralized information about the availability would be helpful to patients. It would eliminate some of the challenges that were discussed earlier about arriving at a hospital maybe after a long distance, especially if you're in a rural area you have traveled an hour, 2 hours to get to a hospital after a very traumatic experience only to be told we can't serve you here, you need to go somewhere else and being told to get in a taxi or to drive yourself.

You know, what we heard is once the patient leaves the hospital the chances of them returning to the hospital for care diminishes.

Mr. WALBERG. OK.

Ms. JENNINGS. I would also agree. Many hospitals are already scored based on services that they provide, and I think this should be something that's included and something that is very accessible to patients. We're in a digital age, and if someone can flip open their phone and say where is the closest facility to receive this type of care I think the care would be much more accessible, and that could then also be translated to law enforcement and to many other of our community partners so that they immediately know if they are referred a patient where they need to send them to very quickly.

Mr. WALBERG. Jumping on that, what other digital resources could be offered online, for instance, to assisting that type of information getting out?

Ms. JENNINGS. Sure. Something that we have seen is within our college student patient population they have apps from their school that will say if this happens to you this is what you need to do, whether it talks about evidence preservation or it talks about what type of medical services they could receive, whether it be a forensic nurse or the student health center. So some of those types of apps that are very accessible—I know many of the rape crisis centers also utilize some of those similar resources.

Mr. WALBERG. How widely is that used or known, those apps?

Ms. FREDERICK-HAWLEY. In my experience running into college students who know is kind of like running into a polar bear on the street of Manhattan. It is kind of rare at this point, but I think that it is potentially growing, but there are always glitches to figure out with that, and then how to get the education and the availability of it to those students and to the larger population when you have a sort of technology divide. Not everybody has the same access to technology, which is problematic when you're talking about a really important basic service that you want everyone to have.

Mr. WALBERG. We're so app-based today——

Ms. FREDERICK-HAWLEY. I know.

Mr. WALBERG. It seems like that would be just an automatic, but something to think about. Thank you.

Ms. FREDERICK-HAWLEY, does Mount Sinai track information relative to data available for SANE programs? I guess what I would say is one of the questions the committee asked in our letter to hospitals was whether each hospital tracked any data as it relates to sexual assault such as number of sexual assault survivors treated each year and how many kits are requested and completed.

Does Mount Sinai track this information as it relates to patients?

Ms. FREDERICK-HAWLEY. Yes, we track an incredible amount of information on our sexual assault patients, the relationship they had to the assailant, how acute was the assault before they came into the emergency department, whether they were eligible for emergency contraception and other kinds of prophylaxis and beyond eligibility whether they decided to avail themselves of it, including HIV prophylaxis.

We track, you know, who the SAFE examiner was that saw them, who was the advocate, other kinds of services they needed at the moment and then all of our follow-up care, as well.

Mr. WALBERG. I'm certain that that shapes your SAVI Program then to a great degree.

Ms. FREDERICK-HAWLEY. Absolutely. Yes. And we have to report that at this point to a variety of our funders all confidentially; we don't include any kind of identifying information, but that's the kind of data that the New York State Department of Health and New York State Division of Criminal Justice Services and to a certain extent the New York State Office of Victims Services because of our funding streams requires us to provide to them.

Mr. WALBERG. Thank you. I yield back.

Mr. HARPER. The gentleman yields back. The Chair will now recognize the gentleman from Georgia, Mr. Carter, for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman. I certainly would be remiss, Mr. Chairman, if I didn't offer my thanks to you as well for your leadership in this committee and for your service in Congress. Thank you.

Ladies, thank you for being here today. This is a very important subject and it is very important to me personally because we have had this issue in the State of Georgia. We have had a problem here.

And I want to start off by asking about the shortage of kits. Is that a problem, just the shortage being able to get the kits to where you can perform the—and I would offer this to anyone who wants to answer to where you can perform the examination?

Ms. FREDERICK-HAWLEY. It is sort of our responsibility as a program. We keep track of how many kits we have on hand both drug facilitated sexual assault kits and the sort of more general forensic evidence collection kit. And as we start to get low we have to reach out to the Division of Criminal Justice Services and say, hey, send us some more—

Mr. CARTER. So is it their responsibility, the criminal services to provide the kits, is it the State's responsibility, is it health systems responsibility? Whose responsibility?

Ms. FREDERICK-HAWLEY. The Division of Criminal Justice Services in the State of New York is the one responsible for pulling the

kit together and—every few years we review what's in the kit, and if there are changes that need to be made to the samples or the envelopes or the content or anything like that it is up to them to build what kit is used in a standardized way across the State, and then it is up to the facilities to identify—

Mr. CARTER. Make sure that they have enough. Is anybody different from that?

Ms. JENNINGS. We receive our kits in Virginia from the Department of Forensic Science.

Mr. CARTER. OK.

Ms. JENNINGS. So very similar, once we recognize that we are running low on our kits we call and have a courier bring us to do, but it is our responsibility to actually have those kits in our facility.

Mr. CARTER. OK. One of the things that I wanted to touch on, and I recognize that this is not necessarily why you were here or your responsibility but is the processing of the kits. We had a big problem in the State of Georgia, I think it was also alluded to by one of my colleagues in their State, but we had a big backlog, and that was causing all kind of problems. This whole system doesn't work until we complete it.

I mean, we need SANE nurses. We need the whole process to work, including processing the kits. We had examples in the State of Georgia where we had, you know, a serial rapist, if we had simply processed the kit from before we could have identified him. Is that a problem anywhere else that you're aware of?

And, by the way, we have caught up in the State of Georgia, so I'm very proud to say that and to report that.

Ms. STEWART. So thank you so much, Congressman, and congratulations to the State of Georgia, as well. I was actually going to commend Congressman Walden because Oregon is also one of those States that made a concerted effort and has reduced their backlog. It varies tremendously by State, but you identify a critical issue, which is why in some cases many—I shouldn't say many.

Some victims do not go and why to get the kit is if the kit isn't going to be processed anyway or why law enforcement themselves sometimes and why we have burnout. And we hear from some of the providers that if the kit is not even going to be tested it is a very difficult, difficult thing for a victim to go through a rape kit. You don't do it lightly or easily—

Mr. CARTER. OK. Let me ask you this, and please bear with me on this. I'm not suggesting that the program itself is not needed or valid, but I'm a pharmacist and right now I'm cramming in 30 hours of continuing ed by the end of the year so that I can keep my license, OK, but are there any continuing ed programs out there that perhaps even if you don't get the certification it would certainly help to have some kind of knowledge for the nurse to be able to have a continuing ed program or something?

Ms. JENNINGS. There are many opportunities for continuing education specific to the forensic component sexual assault many other types of victims of violence, so yes, that is definitely an opportunity.

Mr. CARTER. And I would ask you this to take it just a little bit further, what are we doing to educate other healthcare profes-

sionals besides nurses and law enforcement, making sure that, you know, because again as I stated earlier this process only works if it is completed. If we have a law enforcement officer who is trying to determine whether there was a rape involved here and whether this person needs this help, are there programs like that available?

Ms. CLOWERS. There are. In talking to officials from the States that we interviewed this gets back to the multidisciplinary teams. Bringing law enforcement and healthcare providers together to make sure they understand each others' roles, to make sure they understand the availability of the examinations and the process that they'll go through. So, again, that was an important element that we saw in the States.

And to your question about continuing education while there are opportunities available this goes to one of the challenges we found was weak stakeholder support for that training. Because some hospitals may receive only a low volume of patients not a great number of patients that need this care, hospitals may be reluctant to send their nurses or other practitioners to the training. And, in fact, some cases won't pay for the training so the providers if they go to the training they're taking annual leave, they're paying for all the costs associated with the training.

Mr. CARTER. Right, right, right. The last thing I would add, and I know we have talked about it, but I represent the coast of Georgia in Southern Georgia, a very rural area telemedicine, telehealth we need to look at that. That's our only option in the rural areas because we just, you know, we have enough trouble attracting physicians and healthcare professionals, much less specialists like this, so I hope that you'll continue to work on that because it is vital to rural areas in our country.

Thank you, Mr. Chairman. I yield back.

Mr. HARPER. The gentleman yields back. The Chair will now recognize Mrs. Brooks for 5 minutes for the purposes of questions.

Mrs. BROOKS. Thank you, Mr. Chairman, and I want to thank you for your leadership of the committee, but I also want to thank you and the ranking member for bringing this topic to our last hearing of the year. And I want to thank all of the panelists for this incredibly important work.

Many, many years ago in the late nineties when I was deputy mayor in Indianapolis and focused on crime issues I had the opportunity to have a SANE nurse or people demonstrate for me what the SANE project was in the late nineties and what the concept was and how it worked and how incredibly important it is, but I have to admit until there was that big article about the lack of testing of rape kits and so forth there hasn't been tremendous amount of attention on the lack of SANE and SAFE Programs and on all of the challenges, and so I want to thank you for the recommendations you have been giving to us.

I also want you to know that we have been and are going to continue to push for the Violence Against Women Act to get included in whatever package comes at the end of this year. Myself and others have written letters to the leadership asking them and imploring them to please ensure that the Violence Against Women Act is included and that the funding continues. And so we're going to continue to push on that.

But I want to just ask a couple of questions about the retention rates and the challenges because when people finally agree, and you might have to convince people to enter into this work because it is so incredibly difficult, but I know that there has been and Ms. Jennings you mentioned some significant retention issues but your hospital system is doing a lot.

Ms. Frederick-Hawley, is your system, what are you doing for the retention of the people who finally agree to go through because GAO found that in one situation 540 SANEs were trained over a 2-year period in one State, fewer than 8 percent stayed because of the difficulty of the work.

So what are you doing? Is it compensation, what are you doing to keep the retention rates high first at Mount Sinai and then if you would like to go on further?

Ms. FREDERICK-HAWLEY. We see it as a multi pronged effort to keep people on the roster, recognizing what my colleagues up here have said about it being very difficult and taxing psychologically and physically to do the SAFE exams. We try to provide as much support as possible as close to the time of the case as possible.

So every SAFE is required to call our SAFE coordinator and debrief everything about that case after they have gone in on it. And it is not just were there, you know, how did the camera work, were there any problems with anything like that, how was law enforcement, all of those other pieces.

But how are you, how did this go for you. We keep track. It is why coordination is so important in my opinion because we can keep track of who is taking an absurd number of on-call shifts and say maybe we can ratchet that back a little bit and to take care of them as a person.

We also provide in-house ongoing continuation education. We do a monthly support meeting. We bring in outside speakers, but we also will sit them down and, you know, retrain them or reorient them to the colposcope equipment, so we try to do a lot of things that are on an ongoing basis to—

Mrs. BROOKS. Are they compensated in any way for their additional training or do you have any incentives to at Mount Sinai or at your system?

Ms. FREDERICK-HAWLEY. We pay the SAFE examiner for being just on call.

Mrs. BROOKS. OK.

Ms. FREDERICK-HAWLEY. And then we also pay them an additional amount when they are called in to do an actual case. So their time is always important to us and considered valuable, which I think makes a difference. We pay for their certification training so they don't have to worry about that. And we also will provide resources to be able to cover their ongoing continuing education.

Mrs. BROOKS. And Ms. Jennings—

Ms. FREDERICK-HAWLEY. I'm sorry, if they're called in to testify we will also work out compensation for the time for preparation and things like that.

Mrs. BROOKS. Good. And, Ms. Jennings, anything that your organization is promoting relative to compensation of—

Ms. JENNINGS. Absolutely. Very similar to Ms. Frederick we compensated for any training. We provide compensation for their SANE-A and their SANE-P certification from the IAFN, so that's the certification exam once they have completed their clinical and didactic training.

We also compensate for any time that they're coming into the hospital for meetings. We keep them very engaged within the hospital system, but we also keep them very engaged with our community partners. So we have our nurses assigned to our sexual assault response team. Our program serves 26 different counties and jurisdictions within the Commonwealth of Virginia. So each of our nurses has a jurisdiction that they partner with, and so those relationships are extremely important.

One other thing that we have done that's been huge for our retention rates we have transitioned from more 12-hour shifts to 8-hour shifts. We saw that nurses truly were having high burnout rates when they were there for 12 hours. A shift typically didn't end at the 12-hour mark, it was going into the 13th and 14th hour, so we have transitioned back to 8-hour shifts.

Mrs. BROOKS. Thank you. I may submit a couple of written questions for our witnesses because I had more, but thank you for your work. I yield back.

Mr. HARPER. The gentlewoman yields back. The Chair will now recognize the gentleman from Pennsylvania, Mr. Costello, for 5 minutes.

Mr. COSTELLO. Thank you. First, I just want to recognize the leadership and service of the subcommittee chairman here as he winds down. It has been a pleasure to work with you, and I want to thank you for your service as well as those testifying here today.

My question is for Ms. Clowers and for Ms. Jennings. I'm going to try and speed through these. In your testimony, Ms. Jennings, you mentioned that one of IAFN's goals would be to establish a standardized national sexual assault evidence collection kit. Could you tell us what makes up the actual kit and some of the discrepancies you have seen in different localities? Can this lead to issue with prosecution if a kit is collected in one State but the crime is prosecuted in another State?

Ms. JENNINGS. Thank you for your question. One of the issues that we see is that there are many variations in the kits themselves. Some are received from the Department of Forensic Science, some are received from actual online ordering options, so the kits can vary by State. I would venture to say, yes, that could create issues with them being different, but that also creates a huge barrier in training. If we had one standardized kit it would be much easier to educate—

Mr. COSTELLO. To train. To train, good point.

Ms. JENNINGS. To train.

Mr. COSTELLO. What's in the actual kit?

Ms. JENNINGS. In the actual kit, many different swabs from areas, so when we're obtaining a history from a patient we're asking them what actually occurred so it guides our evidence collection, whether it be an oral assault or a vaginal assault we know where to collect our swabs from very much like a Q-tip and a slide

you would use in biology class. We do take hair samples, and we take blood samples also.

Mr. COSTELLO. What are the most notable discrepancies, most common discrepancies?

Ms. JENNINGS. For example, the kit in Virginia is about a shoe box size, but a kit that may be in another State is the size of an envelope. So the actual number of the swabs in the kit may be less or there may be not blood samples in one but there would be blood samples in another.

Mr. COSTELLO. How about reimbursement or processing of kits, difference?

Ms. JENNINGS. I can't speak for every State. In Virginia we go through our Virginia Victims Fund for our compensation for our sexual assault exams.

Mr. COSTELLO. OK. If there's nothing to add I'll go to the next question. Anyone else want to add to that?

Is there a need to create a national standard of care for the treatment of sexual assault survivors, whether that means a standardized training program as you mentioned or standardized procedures for hospitals that are not equipped to collect SAFE kits?

Ms. JENNINGS. Yes. We think that that is very important. That would also create the consistency amongst trained providers so that everyone is practicing the same.

Mr. COSTELLO. Anyone else? You can't really add to a yes, can you? OK.

In addition to a lack of standardization of the kits themselves one issue we heard expressed by a hospital association is that, quote, "lack of reciprocity to allow nurses who are not part of an independent team to go from one hospital to another," end quote.

For any of our witnesses, is this a problem you have seen in your experience and can you identify a solution to this issue?

It is a problem would you agree? And so the challenge becomes what's the solution.

Ms. JENNINGS. It is a problem. I don't have a necessary solution at the moment in our particular area. It would be difficult to go from I work for Bon Secours, but if I went to another healthcare system that I was not employed by that could create some issues.

Mr. COSTELLO. Could I ask each of you to submit in writing, just think about that a little bit and share with the committee some thoughts, just kind of brainstorm it through.

Ms. Frederick, you were shaking your head, which presumably means you agree and you probably struggle with that issue, as well. Anything to add from what Ms. Jennings said?

She said it expertly. OK.

Let me see if I have anything else that I would like to ask. OK. One of our letter recipients noted that they have used an online training program to train their nurses. How can we overcome the issue of making clinical training available even if we can make the classroom training available online? How can we overcome the issue of making clinical training available?

Ms. FREDERICK-HAWLEY. In my opinion to be honest I don't think you should ever overcome the clinical training part. I believe that maybe moving away from didactic in some ways and doing online modules, and we do a combination of those things, but the hands-

on work with a patient that you are going to be seeing in a much more traumatized state the first time you're doing a real exam it is invaluable to use a gynecology teaching associate in a clinical setting to actually go through what kind of sensitive approaches you're going to need, what your anxieties are that come up in that sort of—

Mr. COSTELLO. That's an excellent point. In other words, do not ever supplant entirely or only up to a certain percentage the amount of—and related to that I know I'm out of time, can you tell us more about the practice transporting nurses from rural low volume areas having them spend more time in more urban high volume settings in order to gain expertise and experience, do you recommend that and how does that take shape?

Ms. CLOWERS. It is certainly a strategy for maintaining clinical expertise, but it would require the support of the hospitals. And again, that's one of the challenges we found is that there is weak stakeholder support for those types of initiatives.

Mr. COSTELLO. Very good. I know that what we have heard is some groups have advocated that as being a thing, and you have identified what the chief impediment of having that be a solution.

Ms. CLOWERS. Yes.

Mr. COSTELLO. Thank you very much. I yield back.

Mr. HARPER. The gentleman yields back. I want to thank each of the witnesses for being here for the valuable insight and suggestions that you have given to us.

One thing that we can say is that no victim of sexual assault should ever be turned away from any hospital, bottom line.

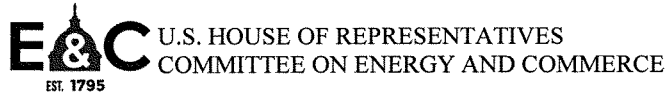
Certainly I thank the Members for their input today as well, and as I conclude what in theory should be my last hearing to chair for this term, I want to thank our staff at Oversight and Investigations, what a great job they have done. They have succeeded in making me look a whole lot smarter than I am, and I am most grateful for their hard work and dedication to all that they have done for our country and specifically for this committee.

I want to remind Members that they have 10 business days to submit questions for the record, and I ask the witnesses to agree to answer those as promptly as you can should you receive any written questions.

Again, we thank you, and this subcommittee is adjourned.

[Whereupon, at 11:57 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



December 10, 2018

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Examining the Availability of SAFE Kits at Hospitals in the United States."

The Subcommittee on Oversight and Investigations will hold a hearing on Wednesday, December 12, 2018, at 10:00 a.m. in 2123 Rayburn House Office Building entitled, "Examining the Availability of SAFE Kits at Hospitals in the United States." The purpose of the hearing is to examine the availability of nurses and medical professionals trained to conduct rape kits and the challenges hospitals face in providing access to rape kits.

I. WITNESSES

- Nicole Clowers, Managing Director, Health Care, U.S. Government Accountability Office;
- Sara Jennings, RN, President-elect, International Association of Forensic Nurses;
- Lynn M. Frederick Hawley, MA, Executive Director, SAVI Program, Mount Sinai Hospital; and
- Kiersten Stewart, Director of Public Policy and the Washington Office, Futures Without Violence.

II. BACKGROUND

In the United States, 135,755 rapes were reported in 2017.¹ However, according to the Department of Justice, only about 23 percent of rapes were reported to the police.² Of those reported rapes, roughly 20 percent lead to an arrest, and roughly 2 percent lead to a conviction.³ A sexual assault forensic exam, or "rape kit," can be instrumental in securing an arrest and conviction. A rape kit is a specialized kit designed to collect evidence of a sexual assault, which

¹ Federal Bureau of Investigation, *Crime in the United States*, <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/rape>.

² Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *National Crime Victimization Survey, 2010-2016* (2017).

³ Federal Bureau of Investigation, *National Incident-Based Reporting System, 2012-2016* (2017).

Majority Memorandum for December 12, 2018, Subcommittee on Oversight and Investigations
Hearing
Page 2

can include swabs, a comb, and materials for blood samples.⁴ However, it can prove difficult for some sexual assault victims to obtain a rape kit due to the shortage of medical professionals trained to collect such a kit.

In 2016, the Government Accountability Office (GAO) published a report entitled “Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners.”⁵ The report examined the challenges hospitals face in hiring and retaining specially trained professionals to collect rape kits and the availability of those rape kits in various states.

According to the GAO, a rape kit may be performed by a specially trained Sexual Assault Forensic Examiner (SAFE), a Sexual Assault Nurse Examiner (SANE), or by a medical professional that lacks SAFE training. However, rape kits collected by professionals with SAFE/SANE training “may result in shortened exam time, better quality health care delivered to victims, higher quality forensic evidence collection, [and] better collaboration with the legal system and higher prosecution rates.”⁶

Not all hospitals employ SANEs or provide SAFE rape kits to patients,⁷ and there are no federal requirements regarding SANEs in health care facilities.⁸ According to the GAO, a Joint Commission accreditation standard requires that hospitals “establish policies for identifying and assessing possible victims of sexual assault and to train staff on those policies, [but] each hospital is responsible for determining the level of specificity of such policies, including the minimum level of training required of its medical staff that performs exams.”⁹ In other words, hospitals may simply choose not to provide these services.

Recent news reports indicate that victims of sexual assault often have trouble obtaining a rape kit.¹⁰ GAO found that the lack of SANEs can be particularly acute in rural areas, where there may be just one SANE or one SANE program to serve multiple counties, and a patient may have to travel several hours to reach a facility that offers SAFE rape kits.¹¹ However, the issue is

⁴ *What is a Rape Kit*, RAINN, <https://www.rainn.org/articles/rape-kit>.

⁵ U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016).

⁶ *Id.* at 1-2.

⁷ *What is a Rape Kit?*, RAINN, <https://www.rainn.org/articles/rape-kit>.

⁸ U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 8.

⁹ *Id.* at 9.

¹⁰ Liv Osby, *At Least Half of Rape Victims in SC Aren’t Seen by a Sexual Assault Nurse*, GREENVILLE NEWS (July 20, 2017), <https://www.greenvilleonline.com/story/news/2017/07/20/sexual-assault-nurses-short-supply/492935001/>; Emry Dinman, *Lawmakers Want Easier Access to Rape Kits*, COLUMBIA BASIN HERALD (Jan. 29, 2018),

http://www.columbiabasinherald.com/local_news/20180129/lawmakers_want_easier_access_to_rape_kits; Jillian Keenan, *Why Did It Take Nine Hours and Three Emergency Rooms For This Woman to Get a Rape Kit?*, COSMOPOLITAN, <http://www.cosmopolitan.com/politics/a58941/dinisha-ball-rape-kit-texas-emergency-room/>.

¹¹ U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 23. See also, *You have to drive an hour for a rape kit in rural America*, The Washington Post, <https://www.washingtonpost.com/news/wonk/wp/2016/04/19/you-have-to-drive-an->

Majority Memorandum for December 12, 2018, Subcommittee on Oversight and Investigations
Hearing
Page 3

not isolated to rural areas.¹² In some metropolitan areas, including Washington, DC and Las Vegas, NV, there may be only one facility that provides SAFE rape kits,¹³ requiring a rape victim to go to that specific hospital to get the most appropriate treatment.

Data on the availability of SANEs and SAFE rape kits nationwide is limited.¹⁴ According to the Department of Justice, the most comprehensive database on SAFE facility locations is administered by the International Association of Forensic Nurses (IAFN). However, this database is based on self-reporting by facilities with SAFE programs and, as such, is incomplete. The IAFN database lists as few as two locations in some states, including Connecticut, Hawaii, South Dakota, and Wyoming. IAFN estimates that between 13 and 15 percent of hospitals in the United States provide SAFE rape kits.¹⁵ It is not clear what happens to a victim of sexual assault if he or she visits one of the roughly 85 percent of hospitals that do not provide these vital services.

GAO found that one of the primary challenges to maintaining a supply of SANEs was “weak stakeholder support for examiners,” specifically, that hospitals are reluctant to cover the cost of employing or training SANEs.¹⁶ According to PBS, in 2014, “[o]f the top 100 colleges as ranked by U.S. News and World Report for 2014, only four provided the exams in their student health centers, and twenty-two schools offered them at university-affiliated hospitals.”¹⁷

On March 13, 2018, the Committee on Energy and Commerce sent letters to 15 hospitals across the United States inquiring about the availability of SANEs at each hospital. The responses varied widely. Several hospitals reported that SANEs were available within the hospital around the clock. At the hospitals that do employ SANEs, the number of SANEs on staff ranged from 6 to 23. The reported costs of administering those SANE programs ranged from roughly \$158,000 to \$220,000 annually. Several hospitals reported that SANEs were available on an on-call basis through a contract with a local SANE service or crisis center. Finally, several hospitals reported that they do not employ or contract with SANEs, and victims would be referred to a local crisis center. In such cases, the victim may be provided transport by the hospital, though at least one hospital reported that such transport could include providing a victim with a taxi voucher, and at least one hospital did not offer transport services for victims. The distance from the hospitals to those crisis centers ranged from 5 miles to more than 60 miles.

hour-for-a-rape-kit-in-rural-america/?utm_term=.29e3af0fe722 (April 19, 2016); *Where Are The Rape Kit Nurses?*, New York Times, <https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html> (June 20, 2017).

¹² U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 24.

¹³ *Why Are There No Rape Kits at the George Washington University*, WJLA, <http://wjla.com/news/education/rape-kits-at-the-george-washington-university-9776> (March 25, 2011); *Where Are The Rape Kit Nurses?*, New York Times, <https://www.nytimes.com/2017/06/20/opinion/rape-kit-nurses.html> (June 20, 2017).

¹⁴ U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 21.

¹⁵ U.S. Gov’t Accountability Office, *Sexual Assault: Information on Training, Funding, and the Availability of Forensic Examiners*, GAO-16-334 (March 2016), at 29.

¹⁷ *Rape Kits Can be Hard to Find for College Students*, PBS, <http://www.rmpbs.org/blogs/news/rape-kits-can-be-hard-to-find-for-college-students/> (Nov. 17, 2014).

Majority Memorandum for December 12, 2018, Subcommittee on Oversight and Investigations
Hearing
Page 4

On June 21, 2018, the Committee on Energy and Commerce sent letters to 10 hospital associations across the United States inquiring about efforts to expand access to SAFE rape kits at hospitals within each state and any challenges to doing so. Again, the responses varied widely. Most of the hospital associations that received the Committee's letter do not actively partner with law enforcement. In addition, most hospital associations that received the Committee's letter do not provide guidance to hospitals on expanding access to or assist in developing standards of care for SAFE rape kits. Several associations pointed the Committee toward a statewide database of facilities that provide SAFE rape kits, with the number of facilities ranging from eight to 110. However, not all such databases are publicly available. Challenges identified by hospital associations included staff shortages, financial challenges, insufficient training opportunities, trouble retaining trained staff, and rural and geographical challenges.

Some promising models to expand access to SAFE rape kits were identified. Several associations highlighted grant programs to fund SANE training, including one online training program. Another association noted that the association held a webinar to educate hospital staff on their obligations with respect to sexual assault victims. Finally, several associations pointed to telemedicine as one way hospitals are able to overcome some challenges to providing SAFE rape kits.

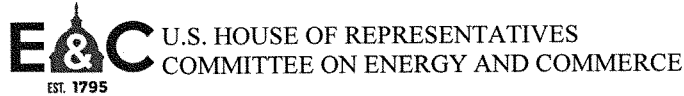
III. ISSUES

The following issues may be examined at the hearing:

- Cost and availability of SANE training;
- Hospital coordination with law enforcement;
- Reciprocity and standardization between states and hospitals with regard to SAFE rape kits and SANE training or certification; and
- The availability of information on where to find a SAFE-ready facility.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Brighton Haslett or Jen Barblan of the Committee staff at (202) 225-2927.



List of Databases of SANE Programs and SAFE-Ready Facilities

Prepared by Staff, Committee on Energy and Commerce
December 12, 2018

National Databases

- **Rape, Abuse & Incest National Network (RAINN)**
 - **List of State Resources**
 - **Find Help Near You**
- **International Association of Forensic Nurses**
 - **Search SANE Program Listing**

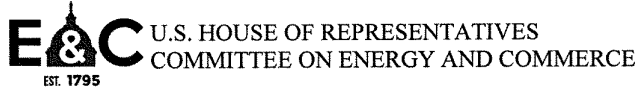
State Databases

- **Alabama:** Crisis Center Birmingham – Sexual Assault Support Services, Sexual Assault Nurse Examiner (SANE), Rape Response
- **Arkansas:** Arkansas Coalition Against Sexual Assault – list & map of Crisis Centers
- **Colorado:** SANE facilities
- **Connecticut:** Connecticut Alliance to End Sexual Violence – Member Center Locator & Service Area Map
- **Florida:** The Florida Council Against Sexual Violence – Find Your Local Center
- **Georgia:** Georgia Network to End Sexual Assault – Rape Crisis Centers
- **Illinois:** Illinois Coalition Against Sexual Assault (ICASA) – Crisis Center Locator
- **Iowa:** Iowa Coalition Against Sexual Assault (IowaCASA) – Service Program Locator
- **Kentucky:** Kentucky Association of Sexual Assault Programs – Rape Crisis Centers
- **Louisiana:** Hearts of Hope – Sexual Assault Services Directory (pg. 55-56)
- **Massachusetts:** MA Sexual Assault Nurse Examiner (SANE) Program
- **Michigan:** Michigan.gov – Find Services in Your Area
- **Minnesota:** Minnesota SANE Programs
- **Mississippi:** Mississippi Coalition Against Sexual Assault: List of Crisis Center Locations



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

- **Missouri:** Missouri Department of Public Safety: [Victim Services Directory](#)
- **New Hampshire:** [New Hampshire Crisis Centers](#)
 - [Downloadable New Hampshire Domestic and Sexual Violence Crisis Center Map](#)
- **New Jersey:** State of New Jersey Department of Children and Families – [Sexual Violence Programs by County](#)
- **New Mexico:** Albuquerque SANE Collaborative
 - [Only offer a 24/7 Hotline](#)
- **New York:** New York State Department of Health – [Sexual Assault Forensic Examiner \(SAFE\) Designated Hospitals by County](#)
- **North Carolina:** North Carolina Coalition Against Sexual Assault – [NC Rape Crisis Centers](#)
- **North Dakota:** Assault Services Knowledge North Dakota – [List of North Dakota hospitals that offer SANE exams](#)
- **Ohio:** Ohio Crime Victim Justice Center – [SANE Programs](#)
- **Oklahoma:** Tulsa Police – [Oklahoma SANE Programs](#)
- **Oregon:** SATF Oregon – [Services in the State of Oregon by County/Area](#)
- **Pennsylvania:** Pennsylvania Coalition Against Rape – [Locations](#)
 - [PA Rape Crisis Centers by County](#)
- **Rhode Island:** Rhode Island Department of Health – [List of emergency rooms in the event of sexual assault](#)
 - No explicit mention of rape kit availability
- **South Carolina:** South Carolina Coalition Against Domestic Violence and Sexual Assault – [Member Organizations](#)
- **South Dakota:** South Dakota Network Against Family Violence and Sexual Assault – [List of local Sexual Assault Response Teams \(SARTs\)](#)
- **Tennessee:** Tennessee Coalition to End Domestic & Sexual Violence – [Interactive map of Sexual Assault Programs](#)
 - [List of Sexual Assault Programs](#)
- **Texas:** Department of State Health Services, [Information for Sexual Assault Survivors](#)
- **Utah:** Utah Department of Health – [Rape Crisis Resources](#)
- **Virginia:** [Domestic Violence and Sexual Assault Crisis Programs by Locality](#)



- **Washington:** Washington State Resource for Sexual Assault Forensic Medical Care
- **West Virginia:** West Virginia Foundation for Rape Information & Services – West Virginia Rape Crisis Centers
- **Wisconsin:** International Association of Forensic Nurses – Wisconsin SANE Programs (not associated with the State Government)
 - Wisconsin Department of Justice – Medical Forensics Programs by County
- **Wyoming:** Wyoming Attorney General – Victim Services Providers (Not all SANE Programs)
 - Wyoming Coalition Against Domestic Violence and Sexual Assault
 - List of advocacy programs