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| **SEXUAL ASSAULT SURVIVOR TRANSFER PLAN** |
| [Facility(ies) Name(s)] |
| Eff. Date: | Rev. Date: |  |
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**PURPOSE**

This Sexual Assault Survivor Transfer Plan (the “Plan”) is adopted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Transfer Hospital”) and applies to every patient of the Transfer Hospital who presents with injuries or trauma resulting from sexual assault or discloses or is known or is suspected to be a victim of sexual assault (“Patient”) and any Treatment Hospital that has agreed to accept transfer of Patients (“Treatment Hospital”).

The Transfer Hospital has entered into a Sexual Assault Survivor Transfer Agreement (“Transfer Agreement” Exhibit A) with one or more Treatment Hospitals and each such Treatment Hospital recognizes the specialty services that a person who presents with injuries or trauma resulting from sexual assault requires and agrees to accept the transfer of all Patients, limited only by capacity, from Transfer Hospital and provide sexual assault survivor treatment services in accordance with the Plan.

**SAS TRANSFER PLAN AND PROCEDURE**

1. **Medical Screening Examination and Necessary Stabilizing Treatment**

Transfer Hospital will ensure that a qualified medical professional provides an appropriate medical screening examination of Patient [in accordance with the Emergency Medical Treatment and Active Labor Act (42 USC § 1395dd et seq.) (EMTALA)].

[Describe any qualifications of responsible personnel and any basic procedures for initiating and completing the medical screening examination]

The purpose of the medical screening examination and stabilizing treatment, if any, is to identify any injuries or emergency medical conditions that require stabilizing treatment, address Patient’s immediate health care needs, and help to preserve evidence for potential use in the criminal justice system.

Transfer Hospital will also provide any necessary stabilizing treatment to Patient [in accordance with the Emergency Medical Treatment and Active Labor Act (42 USC § 1395dd et seq.) (EMTALA)] prior to transfer to Treatment Hospital.

The medical screening examination and any stabilizing treatment provided to a Patient will be informed by the clinical and social considerations described in Exhibit B.

1. **Information Regarding Emergency Contraception**

Transfer Hospital will provide to Patient medically and factually accurate written and oral information about:

* Emergency contraception;
* The indications, contraindications, and potential risks associated with the risk of emergency contraception; and
* The availability of emergency contraception and where it can be obtained.

[Describe any basic instructions regarding provision of initial doses if applicable, and any information to be provided to Patients about how to obtain emergency contraception, including information about meeting transportation needs and other resources needed to assist them in obtaining emergency contraception, including alternatives if the Treatment Facility does not provide on religious grounds.]

The written information that will be provided to Patients is attached in Exhibit C.

[Attach all emergency contraception information and consent documents at Exhibit C.]

1. **Patient Transfer**

Transfer Hospital will ensure a prompt transfer of the Patient to Treatment Hospital in accordance with the Transfer Agreement (see Exhibit A).

Transfer Hospital:

[Name]

[Address]

[Designated Representative]

Prior to transfer, Transfer Facility will communicate with the receiving Treatment Hospital to confirm the availability to accept transfer.

Transfer Facility will also ensure that the transfer can be completed without undue burden to the Patient.

 [Describe any minimum precautions]

[Transfer Facility will comply with EMTALA in coordinating transfer with Treatment Hospital.]

[Reference corresponding policy and procedure for EMTALA and coordination with transfer facilities]

Transfer Facility will provide a copy of or access to the Patient’s records, including reports of any treatment administered or testing performed, to the Treatment Hospital.

1. **Mandatory Reporting Requirements**

Transfer Facility will ensure compliance with mandatory reporting requirements pursuant to § 63.2-1509 (*Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report*) of the Code of Virginia.

[Specify responsible personnel and any basic procedures for initiating and completing mandatory reporting or reference corresponding policy and procedure for mandatory reporting requirements]

**REFERENCE:**

Va. Code § 32.1-162.15:2 et seq.

**EXHIBIT A**

**SAS TRANSFER AGREEMENT**

**[To be Attached]**

**EXHIBIT B**

**CLINICAL AND SOCIAL CONSIDERATIONS**

**I. SOCIAL/PSYCHOLOGICAL**

1. Respond to the Patient’s immediate emotional needs and concerns, assess safety, and assist with intervention.
2. Develop culturally responsive care and be aware of issues commonly faced by Patients from specific populations.
3. Provide information that is easy for the Patient to understand, in the Patient’s language, and that can be reviewed at their convenience.

**II. TRIAGE**

1. Telephone Triage
	1. If a Patient or their caregiver calls before arrival, discuss with the Patient what to expect and that a medical forensic examination will not be performed at your health care facility so the Patient will either have to be transferred to a treatment hospital or travel directly to the treatment hospital if they wish to receive a medical forensic examination, including a physical evidence recovery kit. All Patients seen at a transfer health care facility with an emergency department must be stabilized and treated, as required by EMTALA.
	2. Advise the Patient and/or their caregiver with the following but not limited to:
		1. Do not bathe before examination
		2. About the medical forensic examination
		3. Bring a support person (family, friend, etc.) if possible
2. Medical and Legal
	1. Assent should be sought from Patients who are too young to grant informed consent for care, but old enough and/or developmentally able to understand and agree to participate in that care.
	2. Provide immediate medical care as indicated to include a medical screening exam prior to transfer. Obtain minimal history as needed for treatment purposes.
	3. Sexual assault Patients should be prioritized as emergency cases.
	4. Accommodate Patients’ requests for responders of a specific gender throughout the exam as much as possible.
	5. Address physical comfort needs of Patients prior to transfer that do not compromise forensic evidence collection. Provide the necessary means to ensure Patient privacy.

**III. LIMITED ENGLISH PROFICIENCY**

A medical interpreter must be accessed for limited English proficiency Patients and their caregivers for evaluation. Family members are not appropriate interpreters. Follow hospital policies and protocols for appropriate interpretation services.

**IV. CONSENT FOR CARE**

Identify who needs to provide consent for care for Patient. Patients are generally below the age to consent to their own care in a jurisdiction, so health care providers need to identify the person(s) responsible for providing permission for the child’s care (e.g., the parent/guardian). It is important to know the policies in place at your facility to obtain consent for care. Consent may be withdrawn at any time during the exam process, even if consent forms have been signed.

In addition to seeking consent, seek Patient’s assent for care throughout the exam process. Assent should be sought from children who are too young to grant informed consent for care, but old enough and/or developmentally able to understand and agree to participate in that care. Patients aged five years of age or younger are generally not capable of informed assent, but health care providers should consider each Patient’s developmental capacity. Do not proceed with an examination without the assent/cooperation of the Patient, even if their caregiver gives consent, with exceptions in instances of serious medical injury, pain, or trauma to be evaluated/treated.

Make sure that consent and assent are informed. To obtain permission to proceed with an exam procedure, health care providers should explain its full nature to the Patient and their caregiver (e.g., what it entails, the rationale, possible side effects, and the potential impact of declining). Patients and their caregivers should be told their options and encouraged to ask questions about the process, and to apprise health care providers if they wish to decline a particular exam procedure. Information provided should be complete, clear, and concise, and accommodate the communication skill level/modality and language of the Patient and their caregiver.

**V. MANDATED REPORTING REQUIREMENTS**

The transferring facility maintains responsibility to report to Child Protective Services (CPS) or Adult Protective Services (APS) and maintain documentation of the report number provided by the hotline or online.

Pursuant to Va. Code § 63.2-1509, certain persons are required to report suspected child abuse and neglect to an appropriate agency or agencies, such as Child Protective Services, a law enforcement agency, and/or a state toll-free child abuse reporting hotline (800-552-7096#1)

Mandatory reporters include:

* Any person licensed to practice medicine or any of the healing arts;
* Any hospital resident or intern, and any person employed in the nursing profession;
* Any person employed as a social worker or family-services specialist;
* Any mental health professional;
* Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;
* Any person 18 years of age or older associated with or employed by any public or private organization responsible for the care, custody, or control of children;
* Any person 18 years of age or older who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;
* Any emergency medical services provider certified by the Board of Health pursuant to Va. Code § 32.1-111.5, unless such provider immediately reports the matter directly to the attending physician at the hospital to which the Patient is transported, who shall make such report forthwith; and
* Any minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church, unless the information supporting the suspicion of child abuse or neglect (i) is required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) would be subject to Va. Code § 8.01-400 or 19.2-271.3 if offered as evidence in court.

Or § 63.2-1603 *(Requirement that certain injuries to incapacitated or elderly adults be reported by physicians, nurses, etc.)* of the Code of Virginia. The APS hotline for the state (866) 832-3858 or the local jurisdiction in which the abuse occurred should be contacted.

**VI. AUTHORIZTION TO RELEASE PROTECTED HEALTH INFORMATION**

Information obtained by medical personnel cannot be shared with anyone, including law enforcement, except as authorized by law.

This authorization may be by:

* The Patient, if they have consented to their own treatment pursuant to Va. Code § 54.1-2969
* The Patient’s custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to Va. Code § 54.1-2969
* Court order or warrant

Without this consent, health care providers may release information only as authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Va. Code § 32.1-127.1:03.

If there are concerns about authorization for release, health care facility risk management and legal counsel should be involved.

**VII. UNIQUE POPULATIONS**

1. Cultural Groups
	1. Culture can influence beliefs about sexual assault, its survivors, and offenders as well as health care practitioners. It can affect health care beliefs and practices related to the assault and medical treatment outcomes, and to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of survivors to be involved in the system.
	2. Some survivors may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
	3. Be aware that cultural beliefs may preclude a member of the opposite sex from being present when survivors disrobe.
	4. Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among survivors of different cultural backgrounds. Also, understand that what helps one survivor deal with a traumatic situation like sexual assault may not be the same for another survivor.
	5. Help survivors obtain culturally specific assistance where they exist.
2. Persons with Disabilities
	1. Understand that Patients with disabilities may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities. Make every effort to recognize issues that arise for survivors with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.
	2. People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault.
	3. Speak directly to survivors with disabilities, even when interpreters, intermediaries, or guardians are present.
	4. Recognize that individuals may have some degree of cognitive disability: intellectual disability, traumatic brain injury, or neurodegenerative conditions, or stroke.
	5. Assess a survivor's level of ability and need for assistance during the medical examination and stabilizing treatment. Ask for permission before proceeding in an exam (or touch them, handle a mobility or communication device, or touch a service animal).
	6. Keep in mind that survivors with disabilities may be reluctant to report the crime for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.
	7. Recognize that the medical examination and stabilizing treatment may take longer to perform with survivors with disabilities. Avoid rushing through — such action not only may distress survivors, it can lead to missed evidence and information.
3. Incarcerated Juvenile Offenders
	1. Health care providers should understand that prison culture is a very unique culture that is influenced by inmate characteristics, prison as a segregated society, as well as policies and practices of the prison itself. Prison culture is based on assumptions about a person’s physical and mental weakness. Prisoners most likely to be victimized are those who are young, smaller in stature or less experienced in prison culture, physically or developmentally disabled prisoners and young inmates who identify as LGBTQIA+.
	2. Sexual assault experiences of male and female prisoners differ. Male inmates were most likely assaulted by other inmates, more likely to be threatened with harm, have greater use of physical force, or have a weapon used in the assault. They are likely to have more physical injuries and to experience more sexual acts. Female inmates were as likely to be assaulted by other inmates as by prison staff.
	3. Under-reporting is common due to poor handling of complaints, lack of criminal charging of offenders, fear of retaliation. Inmates who reported sexual violence were often subjected to more violence. When prison staff members are the assailants, survivors are even less likely to report as they have no escape from the assailant. They often have even more to fear as the assailant who is a staff member has absolute power over the survivors.
4. Male Survivors
	1. Men and adolescent boys can be survivors of sexual assault by women or by men.
	2. Help male survivors understand that male sexual assault is not uncommon and that the assault is not their fault. Many male survivors focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may reduce their self-blame.
	3. Because some male survivors may fear public disclosure of the assault and the stigma associated with being a male survivor of sexual assault, emphasis may need to be placed on the scope of confidentiality of Patient information during the exam process.
	4. Offer male survivors assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
	5. Male survivors may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services.
5. Military
	1. Survivors of sexual assault who are family members of active-duty military should be referred to the sexual assault advocacy services for their base or duty station to ensure comprehensive support.
	2. The military offers survivors the option of restricted reporting or unrestricted reporting. Restricted reporting allows a survivor of sexual assault to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling without triggering the official investigative process or command notification.
	3. Restricted reporting can be voided if the medical facility contacts law enforcement or other professionals other than advocates, chaplains, and military sexual assault response coordinators.
	4. Exam sites that provide exams for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of evidence.
6. Multiple Survivors
	1. Survivors may reside in group homes, assisted living, nursing homes, or be inpatient in hospitals. Reporting to Child Protective Services (CPS) is mandatory. Appropriate triage and planning is essential to a Patient-centered, coordinated response.
	2. Health care provider considerations should include:
		1. Multiple survivors needing transfer at the same time
		2. Need for multidisciplinary collaboration (health care, social work, CPS, facility staff)
		3. Ability to ensure no cross-contamination of evidence
		4. Inclusion of support person for medical exam
		5. Access to medical records from home or facility
		6. Past medical history including records from facility
		7. Survivors may experience humiliation, shock, disbelief, and denial. The full emotional impact of the assault may not be felt until the survivor is alone, after initial contact with Health Care Professionals, law enforcement, and legal advocates.
		8. Fear, anger, or depression can be common responses in these survivors. Fear of losing independence as a result of family members learning about the sexual assault can be a strong deterrent to reporting.
	3. Recognition by health care providers that the offender may be a family member, friend or caregiver is important.
7. Indigenous Populations
	1. Survivors from indigenous populations may have unique cultural or language needs, whether they are assaulted on tribal lands or in an urban area.
	2. Recognize that indigenous populations may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault.
	3. As in many cultures, indigenous women are of central and primary importance to the family and the community. Be mindful that sexual violence against an indigenous woman may be seen as an assault on both the individual and her community.
	4. Be mindful of historical trauma. Some survivors may be slow to engage with non-natives.
8. Sex Trafficked/Commercial Sexually Exploited Survivors
	1. Human trafficking is considered an especially egregious form of exploitation of vulnerable persons and an emerging health care priority. Sex trafficked persons can come from all countries and walks of life, though the majority of trafficked persons are women and girls.
	2. Key factors for sex trafficking include young age, history of abuse, poverty, lack of education, conflict with family of origin, lack of economic opportunity.
	3. Traffickers may include females who are respected in communities, males who present as “boyfriends” or family members.
	4. It is important for providers to recognize the varied experiences and reactions of sex trafficked persons and to demonstrate consistent, culturally aware trauma-informed care when working with sex trafficked persons.
	5. Disclosures can be both emotionally difficult and potentially dangerous for the sex trafficked persons, who may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.
	6. Identifiers for possible trafficking include:
		1. Recurrent sexually transmitted infections or diseases
		2. Multiple or frequent pregnancies
		3. Frequent or forced abortions
		4. Delayed presentation for medical care
		5. Companion who speaks for the Patient and controls the encounter and refuses to leave
		6. Discrepancy between stated history and clinical presentation or pattern of injury
		7. Tattoos or other marks that may indicate “ownership” by another person
		8. Presentation to health care with non-guardian or unrelated adults
		9. Access to material possessions outside their financial means
		10. Over-familiarity with sexual terms and practices
		11. Excessive number of sexual partners
		12. School truancy
		13. Fearful attachment to cell phone (as a monitoring/tracking device)
	7. Health care providers should:
		1. Provide culturally sensitive, resilience-oriented trauma informed care to all Patients
		2. Partner with advocates, social service providers and case managers to ensure all needs are met
		3. Educate self on dynamics of trafficking and resources within each community
9. LGBTQIA+
	1. Always refer to survivors by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
	2. Treat the knowledge that the person is LGBTQIA+ as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBTQIA+ survivors may not know their gender identity or sexual orientation.
10. Transgender or Gender Non-Conforming Survivors
	1. Understand that transgender people have typically been subject to others’ curiosity, prejudice, and violence. Transgender survivors may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the survivor does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
	2. Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
	3. A vagina that has been exposed to testosterone or created surgically may sustain more damage in an assault.
	4. Transgender male individuals who still have ovaries and a uterus can become pregnant even when they are using testosterone and/or had not been menstruating.
	5. Per the “Sexually Transmitted Infections Treatment Guidelines, 2021” released by the Centers for Disease Control and Prevention, the following are screening recommendations for transgender and gender diverse persons:
		1. Because of the diversity of transgender persons regarding surgical gender-affirming procedures, hormone use, and their patterns of sexual behavior, providers should remain aware of symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the Patient’s sexual practices and anatomy.
		2. Gender-based screening recommendations should be adapted on the basis of anatomy (e.g., routine screening for trachomatis and N. gonorrhoeae) as recommended for all sexually active females aged <25 years on an annual basis and should be extended to transgender men and nonbinary persons with a cervix among this age group.
		3. HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.
		4. For transgender persons with HIV infection who have sex with cisgender men and transgender women, STI screening should be conducted at least annually, including syphilis serology, HCV testing, and urogenital and extragenital NAAT for gonorrhea and chlamydia.
		5. Transgender women who have had vaginoplasty surgery should undergo routine STI screening for all exposed sites (e.g., oral, anal, or vaginal). No data are available regarding the optimal screening method (urine or vaginal swab) for bacterial STIs of the neovagina. The usual techniques for creating a neovagina do not result in a cervix; therefore, no rationale exists for cervical cancer screening.
		6. If transgender men have undergone metoidioplasty surgery with urethral lengthening and have not had a vaginectomy, assessment of genital bacterial STIs should include a cervical swab because a urine specimen will be inadequate for detecting cervical infections.
		7. Cervical cancer screening for transgender men and nonbinary persons with a cervix should follow current screening guidelines (see Human Papillomavirus Infections).

**EXHIBIT C**

**PATIENT INFORMATION ABOUT EMERGENCY CONTRACEPTION**

**[To be Attached]**