DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

MAR 22 2013

Dear Tribal Leader:

I am writing to request your comments on the draft revised Indian Health Service (IHS) policy on Sexual Assault, Part 3 - Chapter 29 of the IHS *Indian Health Manual*.

The IHS established its first policy Sexual Assault in March 2011. This policy seeks to establish a uniform standard of care for sexual assault victims (adults and adolescents) seeking clinical services at an IHS operated hospital, to ensure their care is culturally sensitive, patient-centered, their needs are addressed, and the community response is coordinated.

I have enclosed a copy of the revised policy on Sexual Assault that incorporates feedback from American Indian and Alaska Native Tribes, Tribal Organizations, Urban Indian Health programs and other federal entities. I invite your comments on the revised policy. Please e-mail your feedback by June 14, 2013, to consultation@ihs.gov, or send your comments by postal mail to: Yvette Roubideaux, M.D., M.P.H., Director, IHS, 801 Thompson Avenue, Suite 440, Rockville, Maryland 20852.

Thank you for your input and I look forward to your additional comments on the revised IHS policy on Sexual Assault.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure

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SEXUAL ASSAULT

3–29.1 INTRODUCTION

A. Purpose. This chapter establishes uniform clinical care guidelines for health care providers conducting sexual assault medical forensic examinations on all patients 18 and older at Indian Health Service (IHS) hospitals, health centers, and health stations (hereafter referred to as facilities). Appropriate training is needed to ensure that sexual assault services are consistent and result in complete medical forensic examinations and appropriate documentation. This chapter aims to ensure that sexual assault services are patient centered, culturally sensitive, and part of a coordinated community response.

NOTE: For children aged 17 and under who present with concerns of sexual abuse, refer to the IHS child abuse policies and procedures for treatment. (See the Indian Health Manual, Part 3, Chapter 13, Section 8, “Sexual Abuse.”)

B. Background. In 2008, the Centers for Disease Control and Prevention reported that 39 out of 100 American Indian/Alaska Native (AI/AN) women and 19 out of 100 AI/AN men have been victims of intimate partner violence at some point in their lives—the highest rates for both women and men in the United States.

In general, gender stereotypes and social stigmas associated with sexual assault contribute to the underreporting of rape—particularly by males; therefore, rates may be much higher. Morbidity and mortality outcomes for sexual assault victims can include depression, substance abuse and addictions, posttraumatic stress disorder, suicide, chronic pain, and other conditions.

Sexual assault can co-occur with domestic violence. A response to sexual assault occurring within a domestic violence context requires understanding: the overlapping dynamics of sexual assault and domestic violence; the complex needs and safety of victims; the potential dangerousness of offenders; and resources available for victims. The response requires adherence to jurisdictional policies on response to domestic violence.

It is important to be aware that victims may be both male and female and may also be transgender. Transgender victims may have unique issues, including: gendered histories that encompass more than one gender; pervasive experience with discrimination, violence, prejudice, and invasive curiosity; identity documents or other paperwork that do not match their current identity; or bodily configurations that do not align with society's (and medical

personnel's) expectations. Health care providers should be aware of these differences to ensure the appropriate response to transgender victims.

C. Authorities.

(1) Indian Law Enforcement Reform Act, 25 United States Code (U.S.C.) § 2801 et seq, as amended

(2) Indian Health Care Improvement Act, 25 U.S.C. § 1601 et seq, as amended

(3) Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. § 3201 et seq.

(4) Snyder Act, 25 U.S.C. § 13

D. Policy. It is the policy of the IHS that:

(1) All IHS-operated facilities shall provide patients 18 and older who present for a sexual assault examination with access to a medical forensic

examination. Medical forensic examinations may be provided onsite and/or by referral.

(2) If patients are transferred offsite for services, all transfers must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).

(3) Every facility shall develop local policies and procedures for responding to sexual assault. (See 3–29.4 of the Indian Health Manual (IHM).)

E. Definitions.

(1) Adolescent. For the purposes of this policy, “adolescent” refers to an individual who is 13 to 17 years of age. For individuals aged 17 and under who present with concerns of sexual abuse or sexual assault, refer to the IHS child abuse policies and procedures for treatment. (See 3–13.8 of the IHM.)

(2) Anonymous Sexual Assault Evidence Collection Kit. An Anonymous Sexual Assault Evidence Collection Kit (anonymous evidence kit) is a kit

that is used in the event that the sexual assault victim either declines to report to law enforcement or is undecided about reporting at the time of exam and chooses to remain anonymous. A unique identifier must be created for each kit. The Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC § 201 et seq., prohibits the use of any other existing identifier, including the medical record number or the patient account number.

(3) Behavioral Health Providers. Behavioral health providers include psychiatric mental health nurse practitioners, licensed clinical social workers; marriage and family counselors; licensed professional counselors; certified addictions counselors; psychologists; and psychiatrists (medical doctor and doctor of osteopathy).

(4) Chain of Custody. “Chain of custody” refers to the preservation of physical evidence from the time of its collection until the time that it is presented in evidence at trial. Chain of custody requires that the evidence be maintained either by packaging and/or custody in a manner that ensures that the evidence has been neither tampered with nor contaminated between collection and admission. The chain of custody also requires that,

from the moment the evidence is collected, every transfer of evidence from person to person be documented. It must be provable that no unauthorized individual had access to the evidence. The transfer of evidence must be kept to a minimum. Contact the regional Office of General Counsel (OGC) for guidance on chain of custody procedures.

(5) Child Sexual Abuse. Child sexual abuse occurs when a child is engaged in sexual activities that: (a) he or she cannot comprehend; (b) he or she is developmentally unprepared and cannot give consent for; or (c) violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.

(6) Coordinated Community Response. This term refers to the community response to sexual assault that is coordinated among involved agencies, organizations, and staff. While IHS provides medical forensic examination services and interventions according to IHS-specific policies, IHS also works with Tribal, State, and Federal agencies (such as, law enforcement, prosecution, etc.) and various professionals to ensure a coordinated

response. The desired result is a collective response to victims that is appropriate, streamlined, and as comprehensive as possible. This may be called a sexual assault response team (SART), but may also have other names.

(7) Confidentiality. Medical records of IHS program patients, including records contained in the IHS Privacy Act System of Records Notice 09–17–0001 Medical, Health, and Billing Records, are subject to the following laws: the Privacy Act, 5 U.S.C. § 552a; the Freedom of Information Act, 5 U.S.C. § 552; the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 21 U.S.C. § 1101; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, 42 U.S.C. § 4541; the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Confidentiality of Medical Quality Assurance Records, 25 U.S.C. § 1675; the Patient Safety and Quality Improvement Act of 2005; and Federal regulations promulgated to implement those acts, including the HIPAA Privacy Rule (45 Code of Federal Regulations (CFR) Parts 160 and 164).

Note: State laws requiring disclosure of protected health information

(PHI) generally do not apply to the IHS.

When medical records and other PHI are needed for use or disclosure not authorized by Federal law, the written authorization or consent of the patient and/or a valid court order or subpoena may be required. Consultation with the regional OGC is encouraged to ensure that all uses and disclosures of medical information under this policy are compliant with the law.

(8) Consent for Sexual Contact. Consent for sexual contact is defined by law, and it varies by age, marital status, and other factors, such as mental status and level of consciousness. Individuals below the age of 18 or with certain disabilities may or may not be able to consent for sexual contact. Facilities must consult their regional OGC for further guidance.

(9) Disability. For the purpose of this policy, the term "disability" means (with respect to an individual):

a. A physical or mental impairment that substantially limits one or more of the major life activities of an individual;

b. A record of such impairment; or

c. Being regarded as having such an impairment.

This term includes physical, sensory, or mental disabilities, or a combination of disabilities. Physical disabilities may result from injury (e.g., spinal cord injury and amputation), chronic disease (e.g., multiple sclerosis, rheumatoid arthritis, and diabetes), or congenital impairments (e.g., developmental conditions, such as cerebral palsy and muscular dystrophy). Sensory disabilities include hearing or visual impairments. Mental disabilities include developmental conditions (e.g., intellectual disabilities), cognitive impairment (e.g., traumatic brain injury), or mental illness.

(10) Domestic Violence. Domestic violence is abusive behavior involving intimate partners, family members, or household members that is used to gain or maintain power and control over another intimate partner, family member, or household member. Some examples of tactics employed by abusers include: the use of coercion, threats, humiliation, intimidation,

manipulation; emotional, physical, and sexual abuse; economic manipulation; restricting reproductive choices; the use of privilege; the use of children and pets; isolation of victims; minimization and denial of violence; blaming victims for the violence; and other actions that frighten, control, or terrorize the victim. An episode of domestic violence often includes multiple actions, and the violence typically escalates over time.

(11) Drug-Facilitated Sexual Assault. A drug-facilitated sexual assault is when drugs or alcohol are intentionally given by a perpetrator to compromise an individual's ability to consent to sexual activity, and/or minimize the resistance and memory of the victim of a sexual assault.

(12) Incapacitated Sexual Assault. An incapacitated sexual assault is when the victim consumes the drug or alcohol, and the perpetrator takes advantage of the incapacitation caused by those drugs or alcohol in order to have illegal sexual contact with the victim.

(13) Indian Country. "Indian Country" is:

a. All lands within the limits of any Indian reservation under the

jurisdiction of the U.S. Government, notwithstanding the issuance of any patent and including rights-of-way through the reservation;

b. All dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof and whether within or without the limits of a State;

c. All Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same; and

d. Other lands determined to be Indian Country by other provisions of Federal law.

(14) Informed Consent. Informed consent is the process by which a fully informed patient can participate in choices about his or her health care. The patient must be given all relevant information prior to the medical procedure. This includes information about the impact of declining a procedure, which may negatively affect the quality of care and the

thoroughness or usefulness of evidence collection. In order for the patient's consent to be valid, he or she must be considered competent to make the decision at hand and the consent must be voluntary. Informed consent includes a discussion of the following elements:

a. The nature of the decision or procedure;

b. Reasonable alternatives to the proposed intervention;

c. The relevant risks, benefits, and uncertainties related to each alternative;

d. Assessment of patient understanding; and

e. The acceptance of the intervention by the patient.

NOTE: The age of informed consent for the sexual assault medical forensic examination is governed by the law of the State where the IHS facility is located. (Refer to 3–13.8 of the IHM.)

(15) Jurisdiction. The term "jurisdiction" is defined as: the power, right, or authority to interpret and apply the law; the authority of a sovereign power to govern or legislate; the power or right to exercise authority; or the limits or territory within which authority may be exercised.

(16) Priority Treatment. "Priority treatment" refers to immediate and more private care for victims of sexual assault. Priority treatment is implemented by bringing the patient into a private exam room or private waiting area away from main waiting areas and other patients. The patient's privacy and safety must be ensured. Visitors shall be screened in coordination with facility security and not permitted access to the patient without his or her consent.

(17) Sexual Assault. "Sexual assault" refers to all forms of sexual contact that are nonconsensual, forced, surrendered, threatened, coerced, or committed while the victim is (a) drugged, inebriated, or unconscious, (b) has certain disabilities, or (c) is a minor.

(18) Sexual Assault Victim Advocate. Sexual assault victim advocates support victims by providing crisis intervention services, including emotional

support, information, and counseling. Sexual assault victim advocates support victims before, during, and after sexual assault examinations. If the victim chooses to report the sexual assault to law enforcement, the advocate may support and guide the victim throughout the victim's involvement with the criminal justice system. Sexual assault victim advocates may work in the criminal justice system (including Tribal, State, or Federal law enforcement or prosecution) or for private advocacy groups (such as domestic violence or sexual assault organizations). The IHS does not employ sexual assault victim advocates.

(19) Sexual Assault Evidence Collection Kit. The sexual assault evidence collection kit includes materials used to collect forensic evidence during the sexual assault medical forensic examination and after the exam. The kit is used to contain the forensic evidence.

(20) Sexual Assault Examiner. A sexual assault examiner (SAE) is a registered nurse, advanced practice nurse, physician, or physician assistant specially trained to provide care to sexual assault patients. SAEs are health care providers who conduct sexual assault medical forensic examinations. They are also referred to as sexual assault nurse examiners (SANEs) and sexual

assault forensic examiners (SAFEs).

(21) Sexual Assault Forensic Evidence. Sexual assault forensic evidence collected as a part of the sexual assault medical forensic examination may include (but is not limited to); the patient's clothing and underwear; foreign material dislodged from clothing; foreign material on the patient's body, including blood, dried secretions, fibers, vegetation, soil, or debris; fingernail scrapings and/or cuttings; material dislodged from the mouth; swabs of suspected semen and saliva; vaginal/cervical swabs and smears; penile swabs and smears; anal/perianal swabs and smears; oral swabs and smears; body swabs; and buccal swabs.

(22) Sexual Assault Medical Forensic Examination. This is an examination of a victim of sexual assault for both medical and evidentiary purposes. It includes: the medical history; physical examination; assessment and treatment of injuries; documentation of biological and physical findings; collection of evidence from the patient; providing care for sexually transmitted infections and human immunodeficiency virus (HIV) postexposure prophylaxis; assessing pregnancy risk and discussing treatment options, including reproductive health services; providing

emergency contraception; providing instructions and referrals for followup medical and behavioral health care; and any needed followup care to document additional evidence.

(23) Sexual Assault Forensic Examiner. A SAFE may include a physician, physician assistant, registered nurse, or advanced practice nurse who is specially trained to conduct sexual assault medical forensic examinations.

(24) Sexual Assault Nurse Examiner. A SANE is a registered nurse who is specially trained to conduct sexual assault medical forensic examinations.

(25) Sexual Assault Response Team. A SART is a multidisciplinary team that provides a coordinated response to victims of sexual assault.

NOTE: The IHS does not mandate and is not solely responsible for the development or implementation of a SART. However, IHS shall be an active participant of local Tribal SARTs or other coordinated community response to sexual assault.

(26) Victim-Centered Care. Victim-centered care is compassionate, preserves

patient dignity, and respects the patient's individuality and choices.

(27) Vulnerable Adult. A vulnerable adult is any person older than age 18 who has a substantial mental or functional impairment that renders him or her temporarily or permanently unable to provide consent.

3–29.2 RESPONSIBILITIES

A. IHS Director. The Director of the Indian Health Service is responsible for:

(1) Directing Area directors, Area chief medical officers, and Service Unit chief executive officers to identify and ensure that the resources are available to implement this policy; and

(2) Approving or denying an IHS employee's subpoena or request to testify in accordance with IHS policies for responding to such requests.

B. IHS Chief Medical Officer. The IHS Chief Medical Officer (CMO) is responsible for developing, publicizing, and assisting in the implementation and monitoring of this policy.

C. Area Director. The Area director is responsible for:

(1) Ensuring that administrative support and the necessary funds are made available at IHS-operated facilities in his or her Area to implement this policy; and

(2) Ensuring that every IHS facility in his or her Area has made available all other resources necessary to implement this policy.

D. Area Chief Medical Officer. The Area CMO must work with the IHS facility medical director or clinical director to ensure:

(1) The availability of physician consultation to the SAE, SART, where applicable, and physician supervision for registered nurses practicing as SAEs; and

(2) Monitoring for sexual assault policy compliance of IHS facilities.

E. Chief Executive Officer. The chief executive officer (CEO) is responsible for:

(1) Approving the facility's sexual assault response policy and ensuring the policy is: fully implemented; reviewed and updated annually; and submitted annually to the IHS Area chief medical officer and to IHS SANE-SART coordinators for monitoring purposes;

(2) Ensuring the facility's sexual assault policy addresses the practice of registered nurses as SAEs with physician collaboration and supervision;

(3) Ensuring the facility has a domestic violence response policy that:

a. Works in tandem with the sexual assault response policy;

b. Is fully implemented, reviewed, and updated annually; and

c. Is submitted annually to the IHS chief medical officer and to IHS SANE-SART Coordinators for monitoring purposes;

(4) Ensuring that once the patient identifies himself or herself as a victim of sexual assault, he or she must be immediately taken to a private

examination room or private waiting area and ensuring victims of sexual assault are triaged as priority treatment patients whether they present to either the emergency department or outpatient service;

(5) Ensuring that the facility has a policy for obtaining the patient's informed consent and that the policy follows applicable laws and policies for obtaining consent for treating all persons;

(6) Ensuring the facility has protocols in place for sexual assault services by onsite examinations, by referral, or by a combination of onsite and referral services;

(7) Ensuring the facility has the necessary equipment for conducting a sexual assault examination, such as, digital cameras, tape measures, evidence collection kit supplies, clothing, traditional healing items, etc.;

(8) Ensuring the facility has the required, secure (locked) storage capacity for biological evidence and forensic evidence;

(9) Identifying an SAE liaison within each facility who will collaborate with

the local coordinated community response to sexual assault, attend regular meetings (where scheduled), and obtain feedback from stakeholders on the facility's sexual assault response and forensic evidence collection policies and protocols;

(10) Ensuring the SAE liaison will identify community resources and referrals available for victims of sexual assault, including culturally appropriate resources, such as traditional healers and language interpreters to be made available to patients, when needed;

(11) Ensuring that all health care providers who are new to the specialized of conducting sexual assault medical forensic examinations attend a minimum of 40 hours of training and all health care providers receive 1 hour of required annual training on sexual violence awareness;

(12) Ensuring physicians and/or advanced practice nurses with prior experience or training to conduct sexual assault medial forensic examinations must be credentialed and privileged (see Credentialing and Privileging);

(13) Ensuring all employees and contractors working with children have been

cleared pursuant to IHS regulations at 42 CFR Part 136 Subpart K;

(14) Ensuring that all SAEs obtain a minimum 4 CEUs or CMEs directly related to sexual assault annually and ensuring records are kept as a part of the credentialing, privileging, and competency process in each facility;

(15) Providing secure (locked) storage and maintenance of hard copies or discs of digital photographic records of the sexual assault examination and ensuring that storage of digital photographic records is separate from the patient's main medical record;

(16) Providing secure (locked) storage and maintenance of all written and electronic medical record documentation of the sexual assault and ensuring that storage of the sexual assault medical forensic exam documentation is separate from the patient's main medical record;

(17) Ensuring local policies regarding payment of the examination must exist if examinations are provided by referral, ensuring patients shall not be required to pay out-of-pocket expenses for medical forensic examinations, and ensuring payments for the examination are covered by the IHS facility

if no other funding mechanism exists for billing;

(18) Addressing the procedures for conducting suspect examinations, ensuring the safety of the victim if the suspect presents to the facility while the victim is at the facility, and ensuring the safety of IHS personnel by coordinating with hospital security and law enforcement;

(19) Ensuring anonymous reporting and collection of anonymous forensic evidence kits shall be addressed in each facility's local sexual assault protocols; and

(20) Ensuring every facility develops local policies to make sure:

a. Trained registered nurses have protocols and procedures in place for practice as a sexual assault examiner;

b. Physicians provide supervision for registered nurses and standing orders for sexual assault medical forensic examinations;

c. The facility participates in a chart review process for continuous

quality improvement (see Continuous Quality Improvement);

d. Victims are treated with dignity and respect while they are patients in IHS facilities;

e. Sexual assault victim advocacy services, if available, are offered before, during, and after the sexual assault examination;

f. Referral and/or followup care are provided to victims for medical, social, and behavioral health services;

g. Chain of custody procedures are outlined for handling, storing, and documenting the transfer of forensic evidence according to jurisdictional crime lab policy. At a minimum, local procedures for chain of custody must state that sexual assault evidence collection kits are locked up immediately following collection, that access to the locked up evidence collection kit is limited, and that the process of releasing the evidence collection kit to law enforcement is documented; and

h. Coordination with and referral to behavioral health services are provided to patients.

F. Facility Medical Director or Clinical Director. The facility's medical director or clinical director is responsible for:

(1) Participating in establishing local policies and procedures;

(2) Establishing physician supervision and standing for registered nurses practicing as SAEs for chart review and standing orders;

(3) Ensuring that the medical staff receive required annual sexual violence training; and

(4) Establishing local credentialing and privileging processes for conducting sexual assault medical forensic examinations.

G. Facility Chief Nursing Officer. The facility chief nursing officer is responsible for:

(1) Developing the facility's sexual assault policy and procedures;

(2) Ensuring SAE coverage is available during operating hours if the facility provides onsite sexual assault medical forensic examinations or ensuring referral procedures are in place after hours or when an SAE is unavailable;

(3) Developing a process for continuous quality improvement review of all sexual assault medical forensic examinations in coordination with the facility medical director or clinical director;

(4) Assisting in the development of standing orders for registered nurses practicing as SAEs;

(5) Assisting in the development of local competencies for nursing staff for SAE practice;

(6) Ensuring approval for registered nurses to attend SAE and clinical skills training;

(7) Ensuring health care workers in the nursing department receive required

annual sexual violence training; and

(8) Ensuring records are kept for compliance in each facility and made available upon request from the Area chief medical officer or IHS SANE-SART coordinators.

H. Behavioral Health Provider. The behavioral health provider is responsible for:

(1) Evaluating the behavioral health needs of sexual assault victims and providing counseling, followup care, or referring for specialty care as needed; and

(2) Participating in the development of local facility policies and protocols and serving as a member of the community SART, where SARTs exist, or other coordinated community responses.

I. Sexual Assault Examiner. The SAE will gather the medical history from the patient for the purposes of medical diagnosis and treatment and to guide evidence collection. If the victim chooses to involve law enforcement, the SAE shall work in conjunction with law enforcement to coordinate and streamline the medical history to reduce repeated questioning. The medical history component shall be

gathered by the SAE, not law enforcement. The SAE is responsible for:

(1) Conducting the sexual assault examination and referring patients for additional followup care;

(2) Treating all victims of sexual assault and domestic violence with dignity and respect;

(3) Ensuring patient confidentiality;

(4) Coordinating with the sexual assault victim advocate, if available, to ensure that patients are offered crisis intervention, support, and advocacy before, during, and after the examination process, and offering the use of other victim services, such as spiritual or faith-based consultation;

(5) Coordinating with law enforcement as needed;

(6) Obtaining informed consent (For more information, please refer to 3–29.3 of the Indian Health Manual; see also 3–3.13 and 3–3.14 of the IHM, and Chapter 6 of the IHS Risk Management Manual, and the Service Unit's

informed consent policies.);

(7) Providing comfort and pain management measures per facility protocol;

(8) Providing information and prophylactic treatment for sexually transmitted infections, including HIV;

(9) Screening for pregnancy and providing emergency contraception for pregnancy prevention if the patient chooses;

(10) Maintaining the chain of custody according to local jurisdictional requirements;

(11) Releasing the sexual assault evidence collection kit, including clothing and other forensic evidence to law enforcement, in accordance with applicable laws, patient consent, and/or a valid court order;

(12) Providing information and followup referrals for medical, behavioral health, and forensic purposes; and

(13) Notifying his or her supervisor and/or the facility CEO that he or she has received a subpoena to testify.

J. Local Protocol Roles. The following roles shall be addressed in local protocols.

(1) Reception/Intake/Registration. Once the patient identifies himself or herself as a victim of sexual assault, the triage nurse shall be notified immediately. The patient shall immediately be taken to a private examination room or private waiting area.

(2) Triage Nurse. All victims of sexual assault shall be triaged as priority patients.

K. Chain of Custody. All staff involved in handling, documenting, transferring, and storing evidence must be trained in properly preserving evidence and maintaining the chain of custody.

(1) Handling Evidence. The SAE and all other staff who handle sexual assault forensic evidence (including the forensic evidence collection kit, the victim's clothing, photos, etc.) are responsible for securing the chain of

custody by documenting the collection, storage, transfer, and disposition of the forensic evidence.

(2) Evidence Integrity. The SAE shall protect the integrity of the evidence and guard the chain of custody by properly drying, packaging, labeling, and sealing all evidence collected, including clothing (particularly the clothing worn closest to the genitals).

3–29.3 INFORMED CONSENT

A. Informed Consent. An informed consent procedure shall be developed for each facility.

(1) Health care providers and other responders are required to seek the informed consent of patients as appropriate throughout the exam process. There are two consent processes: one for medical evaluation and treatment and one for the release of the forensic evidence to law enforcement.

(2) Informed consent for the sexual assault medical forensic examination and evidence collection is typically required for:

a. Photographs, including colposcopic images;

b. Notification to law enforcement or other authority, depending on reporting requirements;

c. The examination itself and evidence collection;

d. Toxicology screening, if indicated, in cases of suspected drug-facilitated sexual assault or incapacitated sexual assault;

e. Release of information and evidence to law enforcement; and

f. Permission to contact the patient after discharge.

B. Informed Consent—Minors. When an Indian child is alleged to have been subject to abuse in Indian Country, a sexual assault examination shall be allowed without parental consent if the local child protection services or law enforcement agency has reason to believe the child has been subject to abuse, pursuant to the Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. § 3201 et seq.

Age of informed consent for the sexual assault medical forensic examination is governed by the law of the State where the IHS facility is located. (Refer to 3–13.8 of the IHM.) When developing local policy and procedures, any questions regarding this provision must be directed to the OGC regional attorney.

C. Informed Consent—Patients Under the Influence of Alcohol or Drugs. A patient's consumption of alcohol or drugs does not necessarily mean that a patient cannot give informed consent. When intoxicated patients present and report a sexual assault, informed consent shall be obtained in accordance with the informed consent laws of the State. State law may require medical personnel to make a determination as to whether a patient is competent to provide consent. In the development of local policies and procedures, consult the regional OGC regarding applicable consent laws. For more information, please refer to Sections 3–3.13 to 3–3.14 IHM and the IHS Risk Management Manual, Chapter 6. Facility staff should also consult with their Service Unit or Area risk managers regarding local informed consent policies. Some Service Units have treatment-specific informed consent or general informed consent policies. When there are questions, facility staff should consult with the risk manager or the OGC regional attorney.

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3–29.4 UNIFORM CLINICAL CARE GUIDELINES

A. Patient Safety. Patient safety must be ensured by notifying security, limiting visitor's access to the patient without the patient's consent, and requesting law enforcement presence, if needed.

B. Patient-Centered Care. Each sexual assault patient shall be:

(1) Triaged as priority treatment patients;

(2) Provided a full explanation of the examination process, including the use of language interpreters when needed;

(3) Provided with a private examination room and/or private waiting area;

(4) Offered prophylactic medications against sexually treatment infection and immunizations for tetanus and hepatitis B, when appropriate;

(5) Offered HIV postexposure prophylaxis to the patient if the sexual assault was within the timeframe recommended for postexposure prophylaxis;

provided access to a 3-day supply of medication at the time of examination with provisions for the remaining course of medication, without cost to the patient; and provided coordination for referral and followup medical care;

(6) Offered emergency contraception to all females of reproductive ability and, if accepted, provided emergency contraception medication;

(7) Offered the services of a non-IHS-employed sexual assault victim advocate, where available, and persons of his or her choosing; informed, however, of the potential for personal support persons (other than advocates with privilege) to be subpoenaed if they are present during the medical forensic history; and given the right to accept or decline advocacy services at any time;

(8) Accommodated when the request for a health care provider of a specific gender to conduct the sexual assault examination is made; and

(9) Offered referral and followup medical, behavioral health, community, or other services, as needed.

C. Clinical Forensic Examination Services. Adult clinical forensic examination services are primarily the chief nursing officer's official area of responsibility; however, physicians and physician assistants may conduct sexual assault medical forensic examinations as part of their credentialing and privileging process. All health care providers shall meet minimum training standards set forth in Section 3–29.5.

D. Timing Considerations for Collecting Evidence. The DNA technology is extending the timing when evidence can be collected; however, jurisdictional policies still vary. All SAEs shall be familiar with local jurisdictional crime laboratory recommendations for timing of evidence collection. All patients should have a medical history gathered, medical examination, and medical documentation, where patients provide consent, whether or not evidence is gathered for the sexual assault evidence collection kit.

E. Access by Referral. All IHS-operated facilities that provide access to sexual assault examinations by referral:

(1) Shall have local policies, protocols, and procedures that outline the referral process, including the name and location of the offsite provider; and

(2) Shall refer to centers to provide a higher quality of care that employ trained SAEs and that have access to appropriate forensic equipment.

F. Transportation. All IHS-operated facilities shall have local policies, protocols, and procedures in place outlining transportation services to include: transportation when the patient requires or requests facility-funded transportation and transportation services when provided by a partner agency, organization, or service. Transportation shall require coordination for facility-funded transport of the patient to and from the referral provider in compliance with EMTALA, if applicable.

(1) Transportation to the referral provider shall be no more than 2 hours of travel time from the IHS facility.

(2) Transportation may be coordinated with victim advocacy, social services, or other service agency providing transportation for victims of sexual assault. However, if no other service is available or if requested by the

patient, the IHS shall provide facility-funded transportation to and from the referral facility.

G. Anonymous Evidence Collection Kits. Ensure policies and protocols are in place to address anonymous evidence collection kits, in conjunction with local law enforcement. If the patient is reluctant to report the assault to law enforcement, inform the patient of the option of conducting a sexual assault medical forensic examination, collecting the forensic evidence, and storing the evidence as an anonymous sexual assault evidence kit.

(1) Anonymous evidence collection kits shall be labeled with a unique alphanumeric identifier. Medical record and patient account numbers may not be used as a unique alphanumeric identifier if the kits are turned over to law enforcement.

(2) Ideally, local law enforcement have policies in place allowing the storage of anonymous evidence kits. If local law enforcement policies for anonymous evidence kits do not exist, the kit must be stored at the IHS facilities for no longer than 6 months. The patient

must be informed at the time of the examination that kits will be destroyed 6 months later.

3–29.5 NON-REPORTING

Sexual assault victims shall not be required to report the sexual assault to law enforcement in order to have access to a sexual assault medical forensic examination or to have evidence collected. NOTE: A victim's declination to report a sexual assault does not take precedence over a provider's mandatory reporting requirements.

3–29.6 MANDATORY REPORTING REQUIREMENTS

A. Federal Law. Three Federal laws require the reporting of sexual assaults of minors.

(1) Federal law requires persons engaged in a professional capacity or activity on Federal land or in a federally operated (or contracted) facility to report suspected abuse to the local law enforcement or child protective services agency if they learn of facts that give reason to suspect that a minor has

suffered an incident of child abuse, which includes sexual abuse or exploitation. 42 U.S.C. § 13031

(2) Federal law further provides that if a person who is engaged in such a capacity or activity and learns of facts that give reason to suspect that a child has suffered an incident of child abuse, but fails to make a timely report as required by the statute, such person shall be fined or imprisoned not more than 1 year or both. 18 U.S.C. § 2258

(3) Federal law imposes reporting requirements when child abuse is suspected in Indian Country. Federal law requires certain persons to report to child protective services or law enforcement if they have knowledge or reasonable suspicion that a minor was abused in Indian Country or actions are being taken, or are going to be taken, that would reasonably be expected to result in the abuse of a minor in Indian Country. “Abuse” includes any case in which a minor is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution. This requirement applies to nurses, physicians, surgeons, dentists, podiatrists, chiropractors, dental hygienists, optometrists, medical examiners, emergency medical technicians, paramedics or health care providers,

psychiatrists, psychologists or psychological assistants, and licensed or unlicensed counselors or persons employed in the mental health professions. Failure to make an immediate report to child protective services of law enforcement is punishable by a fine or imprisonment for not more than 6 months or both. 18 U.S.C. § 1169

3–29.7 MEDICAL RECORDS

A. Record Keeping. All the written medical records and digital photographic records of the sexual assault and the forensic evidence must be stored as follows.

(1) Digital photographic records that is separate from the patient's main medical records must be securely stored.

(2) All other documentation of the sexual assault that is separate from the patient's main medical record must be securely stored.

(3) Wet biological evidence (e.g., urine) must be stored in secure (locked), refrigerated storage according to jurisdictional policy.

(4) All forensic evidence must be in secure (locked) storage until it is transferred to law enforcement.

(5) Each facility shall develop and approve a policy for the maintenance, secure storage, and release of photographic images and of the sexual assault medical forensic examination record. The policy will include the requirement that all IHS staff (including medical records staff) shall comply with the release of medical records with proper patient consent and/or subpoena or valid court order, or other lawful authority.

B. Use of Medical Information. The sexual assault victim's medical information may be disclosed for law enforcement purposes to the extent permitted or otherwise required by Federal law. To the extent permitted by Federal law, the sexual assault victim's medical information may also be shared in private, interagency, interdisciplinary meetings whenever those meetings are not open to the general public and participants in the meeting are required to keep conference proceedings confidential. These private, interagency, interdisciplinary meetings are for the purposes of (a) establishing a diagnosis, (b) formulating a treatment plan, and (c) monitoring the plan.

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3–29.8 SUSPECT EXAMINATIONS

In the event that law enforcement requests an examination of an individual suspected of committing a sexual offense, health care professionals in IHS facilities may conduct suspect examinations with proper legal authorization (such as a court order or warrant) or with written consent from the suspected individual. Suspect examinations may be performed by physicians, physician assistants, advanced practice nurses, or SAEs. The same SAE staff shall not perform the exam on both the suspect and the victim.

3–29.9 SEXUAL ASSAULT EXAMINER TRAINING, COMPETENCIES, CREDENTIALING, AND PRIVILEGING

NOTE: SANE certification is not a requirement for practice at IHS-operated facilities.

A. Adult/Adolescent SAE Training. Forty hours of SAE training is required for all registered nurses, advanced practice nurses, physicians, and physician assistants new to the specialized area of caring for adult and adolescent sexual assault patients. All SAE training must yield 40 contact hours, academic credits, or national equivalents. All SAE training must conform to the Adult and Adolescent SANE educational requirements of the International Association of Forensic

Nurses and the U.S. Department of Justice's National Sexual Assault Forensic Medical Examination Training Standards.

(1) Clinical Skills Competency. Direct patient care clinical preceptorship is required for all registered nurses, advanced practice nurses, physicians, or physician assistants who are new to the field of clinical forensic services or need a refresher course for clinical skills. Clinical preceptorship shall be completed with the guidance of a physician, physician assistant, advanced practice nurse, or a forensically experienced registered nurse. Training may be completed through an IHS facility, a high-volume SAE program, or a simulation clinical skills laboratory setting. Clinical preceptorship content must meet the educational requirements of the International Association of Forensic Nurses and the Department of Justice's National Sexual Assault Forensic Medical Examination Training Standards.

NOTE: Competency is determined by the professional assessing the required clinical skills.

(2) Continuing Education. The continuing education requirement for SAEs is 4 hours of annual relevant sexual assault training. The training may be

completed by continuing education, webinars, peer review, repeat clinical skills training, or conference attendance.

B. Suspect Examinations. Health care professionals should also receive training on evidence collection for suspect examinations.

C. Credentialing and Privileging. The training specified in this policy shall be part of the Area and local facility credentialing and privileging policies for physicians, physician assistants, and advanced practice nurses conducting sexual assault medical forensic examinations.

D. Competencies. The training specified in this policy shall be part of the competencies for registered nurses to conduct sexual assault medical forensic examinations and shall be addressed in Area and local facility policies.

E. Minimum Number of Yearly Examinations. Maintenance of competencies to perform examinations shall be addressed in local credentialing and competency policies. If an SAE has conducted no sexual assault medical forensic examinations over a 1-year period, methods for competency assessments may include completing a virtual clinical practicum, repeating clinical skills training,

or completing a sexual assault medical forensic examination with case review by a forensically experienced SAE.

F. Continuous Quality Improvement. All facilities providing onsite sexual assault medical forensic examinations must have processes in place for continuous quality improvement review of all examinations conducted.

3–29.10 RESPONDING TO A SUBPOENA AND TESTIFYING IN COURT

When an IHS employee receives a subpoena in a matter in which the United States is a party to the litigation, that employee shall immediately notify his or her supervisor and/or the facility CEO; and the supervisor and/or the facility CEO shall immediately consult with OGC.