

## Effective Medical Advocacy

MV: Male Voice  
FV: Female Voice  
(IB) = Inaudible  
(PH) = Phonetic  
(SL) = Speaker Low  
(AC) = Accent  
(OV) = Overlapping Voices  
(BN) = Background Noise  
(CH) = Cough Interference  
(LH) = Laugh  
(MC) = Music

-Transcript begins-

### **Dusty Olson**

My name is Dusty Olson. And I work for Providence Intervention Center for Assault and Abuse, which is the CSAP located in Everett, Washington. And for those of you from the other side of the state, that's about 30 miles north of Seattle. I've been here in this position for about six years now, but have worked in several bill (PH) programs before that. Both in Montana and California.

So, I've been doing this for quite a while. But really didn't have a good concept of Medical Advocacy, what that meant and what that was, until I came here to my program. And the reason for that is that we are part of a hospital. All of our Advocates are part of the hospital and I got a crash course in what it was like to fully connected to the medical system. So, hopefully I'll be able to bring you some of that information today.

So, our objectives today are, first of all, to have an increased understanding of the CSAP service standards for Medical Advocacy. There is some real general things in the standards, but what does that actually mean as far as specific activities, things that you should and shouldn't be talking about, information that you do and don't want to provide to your, to your client, increased knowledge of medical models and service settings.

One of the things that I have found in recruiting and training our staff and volunteers here for our agency is that a lot of people are really excited to work for us until we talk about how much we're spending time in the ER. The medical systems and settings can be a little overwhelming for people, sometimes. And so the more information and knowledge that you have about

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how they work and who to talk to, and best ways to cooperate with them, can be very helpful in this process.

We're going to talk a little bit about if you don't have a real positive relationship with the hospital in your area who can you contact, how can you present your program, to increase the likelihood that they're going to contact you to work effectively with your program.

And then at the end, we'll talk a little bit about some problems and pitfalls that may come up periodically, so that you can be prepared to address those.

I just want to tell you briefly a little bit about the model that we work under, so that you can understand a little bit about the background that I come from. Providence Intervention Center has provided victim advocacy services for about 28 years now as a part of their hospital program. In 1997, we added a SANE (PH) Team as part of our department and combined it with our existing advocates.

That was done because the people at the hospital went well, that makes sense. We already have a sexual assault program; let's put the same program in there, not really realizing how unusual that was. That the SANE Team and the Victim Advocacy Program would come from the same location in the same department. And was particularly unusual because we were, we were, it was unusual for the Victim Advocates to have come from the hospital to begin with.

So, we provided full comprehensive medical services as well our full CSAP services to victims of sexual assault. The interesting thing about trying to make this work is that the advocacy philosophy and the medical philosophy are very different. And that as we talk about this process, one of the things that we will talk through is how those difference in philosophies sort of lend itself to some of the difficulty that we have as advocates working in a medical setting.

Advocacy is very much about empowerment of our clients. We want victims to have all of the information that they need and make their own choices and work really hard to ensure that they are the ones making the choices about the outcomes. The medical model is very patriarchal which is I am an expert and here's what I think you should do. And if you care about yourself and you want to take good care of yourself, you'll follow the instructions that I give you. And so, as you can see, those are really different perspectives.

And you will run into times, as we all do, where those don't agree. Where the victim doesn't want to do what is medically

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maybe the best option. And how do you help the provider understand that they're not making a bad choice, they're making their personal choice?

The nice thing about our model, and I think that it's really effective in having a good relationship with a medical provider who provides these services in your community, is that victims sometimes identify different things as what's important to them. So, one victim may say I'm really worried about my physical health. I'm really worried I have an STD. I want to make sure I'm not pregnant. And they will access a medical service. If you have a quality relationship with a medical provider, they will then help that person access advocacy services.

Or another person may be really worried about the emotional response and think to call the crisis line and not think to go to the hospital. But as an advocate, if you're really comfortable with the medical advocacy, you then have the ability to help them access all of the comprehensive medical services that they may need.

Why is Medical Advocacy so important? Other than the fact that the service standards say that we have to do it. The, in the Statutory Victims Rights, it indicates that a victim of sexual assault has a right to a support person available to them at a medical exam. And I'll actually cite that statute in just a little bit. But, they have a right to have somebody. And most victims are not aware of that unless somebody tells them. So, either as an advocate to them or to establish such a positive relationship with your local providers that the provider tells them.

But we really want victims to know that they have that right available to them. And then as I mentioned, obviously, the core services, the CSAPs that we're supposed to be providing.

But I think the main reason is that oftentimes the medical exam is a barrier to, fear of the medical exam is a barrier to them accessing services. It can be very intimidating. They're very nervous. They're really overwhelmed about what that's going to be like. And positive participation in that and really having a positive experience with their medical exam not only ensures that they are able to access the service, but it's an important part of their recovery process, to begin with a positive experience. So, as advocates, we can help to ensure that outcome if we have the proper training and education.

I think one of the things that it's important to remember about Medical Advocacy is that it's an active process. I sent out the survey, or had you Yaway (PH) send out the survey, to the programs about their Medical Advocacy activities prior to this

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webinar. And there were a couple of people in the comments who mentioned things like I, I feel like I'm just standing there observing this medical exam. And I'm just watching and that seems like an invasion of privacy.

And one of the things that I want people to understand is that Medical Advocacy is a really dynamic activity. It's something that is very involved on the advocate's part if they have a real comprehensive understanding of the examination, the environment, being comfortable and confident in answering questions or knowing when those questions are outside of their bounds of things that they should answer. And so I think that feeling of I'm just, I'm just there to observe can certainly decrease the more confident an advocate becomes with the medical process.

The important thing to remember about Medical Advocacy is it's not about the location. I was doing technical assistance for a community, a crime, a crime victim service center in our State who was trying to add Medical Advocacy. And as I was talking to the provider, she was saying well, I can certainly be available to go to the hospital to support a victim of an assault. And I asked her, well, what kind of things would you talk about while you were there. And she said, well, I would talk about what the investigation would be like and I would talk about what they can expect when they meet with the detective and what kind of trial things are.

And it dawned on me that her concept of Medical Advocacy was that she was providing advocacy at the hospital. And I think that's a common misconception. Medical Advocacy is not about where you're at; it's about what you're talking about. So, information is the important part, not the location. There's a lot of different locations in which Medical Advocacy can happen.

What Medical Advocacy is is providing comprehensive information about the services, options and procedures that a victim can have available to them or expect to experience in a medical setting. So, talking about the investigation, which is something that we do all the time while we're at the hospital, is Legal Advocacy that we're providing at the hospital. It's not Medical Advocacy. So, we've got to be careful to make sure that we're spending time meeting all of the victim's advocacy needs. Not just that we're at the hospital talking with them.

One of the things that I think is a big barrier to Medical Advocacy Services is similar to Legal Advocacy Services is what is that line. What is the line where I'm giving medical advice? And that's not always really clear, but you do want to be careful. What you're doing as an advocate is giving information about expectations and procedures and options, but not about

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what to do or what, what type of treatment, those kind of things.

I always tell one of the advocates here that the first time that you're giving medical advice is any time that you're talking about what you would do, any time you're talking about things that have worked for other people in the past, those types of things. So, you want to be careful. One of the things that we've done in our program to remedy that situation somewhat is that our medical provider did basically a frequently asked questions list for adults, for kids, for teenagers. And really if we're getting into medical specifics beyond that, then that's something that the medical provider should be asking. So, that's something that can be helpful if you have a good relationship with someone in your medical community to sort of give you guidelines around what is and what isn't medical services.

And then, like I said, you want to know when to refer to other resources. So, if you get beyond the scope of what Medical Advocacy is, so when people are talking about, you know, I'm having this kind of pain, I'm having that kind of pain. We get people who call our crisis line all the time and say, you know, I, I was raped a couple of days ago or I had a sexual assault exam a couple of days ago, and this pain hasn't gone away and that pain hasn't gone away. It's real tempting to, you know, kind of give them options about what's available, but as soon as you get into talking about going, addressing pain or addressing discharge or some of the other things that come up, you're getting into medical diagnosis over the phone. And so that's when you want to be able to refer to a medical provider.

One of the questions that I asked in the survey was where do you provide your Medical Advocacy primarily. Not surprisingly, most people put that that was the hospital. But there are certainly other options for where you're providing Medical Advocacy. One being the crisis line. If somebody calls on the crisis line and they have just been assaulted, and you've worked through the crisis intervention, and you're talking to them about what their options are, and you talk to them about the option of a sexual assault exam or forensic evidence collection, those types of things, then that's what you're doing is Medical Advocacy. And you're doing that on your crisis line.

Same thing if you have a walk-in client who comes into the office who indicates that they have been assaulted, even, you know, not in the last couple of days, but in the last few weeks and months, you know, what options are available to them. That is Medical Advocacy as well.

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So, anytime you're talking to somebody about what their medical choices and the things available or, unfortunately, in some communities, not available to them, are, you're doing Medical Advocacy. So, that can also be occurring on your crisis line in the office.

There are a few other places that it makes sense in your community or if you have them. We have a, we work closely with a lot of our outpatient clinics here in our community. We give them brochures, we talk to them about, you know, for example, we go out and give information to Planned Parenthood about what constitutes sexual assault around age differences and those things. So, we get calls periodically from those types of providers with clients that are in their office, that, or there are questions, those types of things. So, those are also good providers to facilitate relationships with.

If you have a jail or prison, their PRIA (PH) Program, working with them about understanding that may occur. And then schools. Lots of school nurses, school counselors, will contact us about how to arrange for an examination for a child or a teenager, where can they go. We go out to schools a lot of times and talk to the kids at the school about what an exam may be, because they're too nervous to go directly to the emergency room.

One of the questions that I asked in the survey was how often are people going to the hospital. It was really interesting to me because I really had no idea what, what this would break down as. And it was a pretty even split. Some programs are going a couple of times a year. Sometimes a couple times a month. Sometimes a couple times a week.

That one person that says almost every day, that's us. We, we went to the hospital 768 times last year. So, that's pretty much every day, a couple times a day. But one of the things that was very apparent to me is that as we work with advocates here, it often takes a number of hospital visits, a number of times working with somebody during a sexual exam, sexual assault exam, before they feel comfortable. Because they're different, providers are different, there's different styles.

So, the thing that was very striking to me is that going a couple of times a year, somebody in your entire agency is going a couple of times a year. That developing that comfort level is, is going to be particularly difficult compared to somebody who can go really routinely. So, it will be even more important in programs where you're not going very often, to have a real strong sense of what that will be like and have a really quality relationship with your provider so that you're able to maintain a quality skill set and, and good comfort level only attending a couple of times a year.

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The other thing that I asked about in the, in the survey was what do you think the barriers are. And the number one answer to that was not having a good relationship with a medical provider so that the victim knows that they can have an advocate present during the exam. So, one of the things that we'll talk about later is how to outreach to your providers and what kind of things that medical people are interested in knowing about, so that hopefully we can increase that to more than a few times a year, if that's appropriate for your community.

There are a couple of victim's rights that specifically apply to medical services here in Washington. And the first thing RCW759.30 which indicates that access to immediate medical assistance without unreasonable delay is a right that a victim has. One of the things that I think it's important to remember as advocates about that, is that that is a victim's desire to access medical assistance. It's not necessarily need.

So, we will have police officers, for example, sometimes that will tell victims, you know, you, you really don't need an exam based on the history that you're telling me. And that's not the law enforcement decision. That's the victim's decision. And if they, for any reason, feel like they want to have an examination, they have a right to have that without unreasonable delay. So, if they ask for that, that needs to be made arranged to them.

Law enforcement can't, for example, say well, I would really prefer that we wait and we do you interview first. That we get this statement written before you have your exam. They have a right to have that without delay. And it's not the medical diagnosis of the police officer is not what determines that. It's their desire.

So, advocating strongly for the victim's that you work with that if they want that service, that it's available to them as soon as they want it. There's often cases, in fact most cases, it's not going to be medically or forensically detrimental to wait until after, for example, a statement's given or the officer's finished. But if the victim desires to have that immediately, they have the right to have that.

The other RCW 7125.50 (PH) indicates that a personal representative of the victim's choice may accompany the victim to the hospital or other healthcare facility. And RCW indicates that the victim has a right to have somebody with them at the hospital or healthcare facility while they have their examination. As you can see, personal representative may mean a friend, a relative, a lot of people, but it also means an advocate. So, if they want the advocate to be present, they

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have the right to have that. And that's during the entire examination.

So, the medical provider cannot insist that you leave, cannot insist that it's not appropriate for them to have somebody with them. Our medical provider here routinely indicates to me that some of the other medical providers that she consults with around the State are outraged that she allows victim advocates to be in the room during their medical exam. That that's a violation of their patient privilege and their, their relationship with the patient.

And, you know, she's brought up this law to them a number of times and kind of gets met with resistance. So, I'm not used to that resistance because of the program that I work with, but I am aware that it does occur in different places throughout the State. That the medical providers, whether they're doctors or SANE nurses, are really adamant that it's a violation on their part to have an advocate present. However, the law in this particular situation is on our side, meaning that if the victim wants you to be there, you have a statutory right to be there just like we do with the police or any other situation.

Okay. We're going to spend a little time talking about the service standards for the next few minutes. So, the activities that are bulleted right up here (Indicating) are the, the general service standards for CSAPs in the State of Washington. So, the first activity is assistance in making informed decisions including referral for forensic exams.

So, in order to help victims make informed decision, as an advocate you need to be able to answer their questions, to explain the exam process, to explain what will happen if they choose to go to the hospital. Those types of things. So, that they are informed in making that choice. So, it's really important to be knowledgeable about that from your perspective.

The second one is provide information about medical care and concerns and assistance with needed follow-up. I think the important thing to know about that, because like I said, you don't want to be giving medical advice about when they do and don't need to go to the doctor for follow-up, but you want to be familiar with the procedures that your provider uses. So, for example, in our program, universally we indicate that it would be appropriate for follow-up testing for certain STDs and HIV in three months.

And there's arrangements with the health district to do that. So, the advocates all know if somebody calls and wants to know about follow-up STD testing, that that's what was provided to them.

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The other thing I think it's really important to know about being able to provide follow-up information is where on the patient's discharge paperwork did the nurses put that. So, we have a specific discharge form and any time somebody's in the emergency room, they're going to get discharge instructions. It's the law. So, where on the discharge instructions does it indicate what they're follow-up can be. So, to say, you know, on the paper they gave you from the emergency room, usually down towards the bottom it will say what they want you to follow-up with. Can you find that paper, do you have it still, those types of things so that you can help them access the follow-ups that the medical provider felt was appropriate.

Support at medical exams and appointments. Obviously that's the, I'm standing there observing part. And you just really want to be comfortable with that and we'll talk a little bit about developing some more comfort in the emergency room in a few minutes.

Last activity listed specifically under Medical Advocacy is information and assistance with Crime Victims Compensation Applications. In the State of Washington, Crime Victims Compensation is the only insurance provider or payer that a, an initial forensic evaluation for a sexual assault can be billed to. So, their single largest expenditure is sexual assault exams. That can be billed without filling out a Crime Victims Compensation claim by the victim, but it's only going to cover, without an additional claim and application, it's only going to cover the forensic exam.

It may not include certain types of testing, even STD testing. It may not include certain types of treatment, even antibiotics for STDs or emergency contraception without filling out the claim form. So, helping people understand what is and isn't covered is a very big part of Medical Advocacy. And that changes routinely, so you want to be up on that, because it may be that if they have money, CVC will cover things like STD testing and prophylactic antibiotics to prevent disease for certain times of the year. But if they're, if they're lacking, they may not cover that.

And since one of the big barriers that a lot of people that we work with feel around going to the emergency room is financial. We want to have a real good understanding of how things can get paid for, which actually leads right to a question that I was just asked via chat which has to do with the HIV prophylactics in the ER, and the, the barrier, the cost being a barrier to that. That the first prescription, the first dose is given in the hospital and the rest is a prescription and that prescription can run five, six, seven hundred dollars sometimes.

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The Crime Victims Compensation has been hit or miss about how they feel about reimbursement for that, for the prophylactic HIV. They will not reimburse in every case. There has to be a specific, it has to be specifically medically indicated. And as much as I think being sexually assaulted by anybody would be a specific medical indication, there has to be some element of the history for the offender to indicate that that's medically indicated. And that's a really horrible sort of line of questioning to put victims through, but if there can some sort of indication in, by the medical provider who's conducting the SANE exam, that there is a specific reason that the HIV prophylactics is necessary, above and beyond the fact that they were sexually assaulted, it's usually helpful, more helpful.

The other, other part of this question is any thoughts or suggestions about other ways to get people to pay for that. I know that we have been successful in the charity care department of our hospital in helping people get that. So, most hospitals have funds for charity care and it's an application process that the, the patient goes through to apply. And then they receive information about whether or not the hospital will provide them that prescription or that coverage at no charge. So, hopefully that answers your question there, Sarah.

Who receives Medical Advocacy? These are the standard service recipients for all of our, of our core services. Child sexual abuse and assault victims. With kids, you want to be careful that if you're seeing a child in the emergency room for a sexual assault evaluation, and I know not all programs do that, the advocates role in that particular situation is really about helping the child be comfortable. Comfortable in the environment, distracting them or helping them focus, depending on what's necessary. Sometimes during an exam, distraction is what's necessary and sometimes helping them focus, particularly with older kids where the, the SANE may have some questions for them. Or for older children, about, above 10, you know, they may have their own questions about why they're having an exam and what that means.

For adults and adolescents, explaining the exam to them, what they can expect, what they have a right to have, how they can stop the examine if they need to. One of the things that's really helpful is helping them develop, with the provider, what they can say, assuring them that they can stop at any point if they want to, those types of things.

With non-offending parents, the primary reason to provide medical advocacy to non-offending parents, in my opinion, is that they have an unrealistic idea of what a child sexual abuse exam is like. Most moms think we're going to be doing full pelvic exams on their kid, they're worried that it's very

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traumatic, those types of things. So, helping them understand that there's not insertion of, you know, speculums in little kids and that it's very quick and those types of things.

Now, if your SANE team doesn't provide services to kids, which a lot of them don't, you know, hopefully you have a relationship with whatever provider in your community does that. And I recognize that there are not a lot of them in the State. Because at our program here, we see kids from all over this whole region of Washington, because there's not providers that are providing medical exams to children in most places.

The qualification standards, obviously core training. The advocates have to have core training. Four hours of Medical Advocacy specific training as part of that core, which if you're core certified, that's already taken care of. Understanding of medical services and how to respond to victims of sexual assault and then 12 hours of ongoing training. Same type of requirements that are universal for most of our service standards.

One of the things that it's particularly important to think about when we're talking about Medical Advocacy is there is not a uniform service provider for this. In, different people in different communities do this and sometimes different people in the same community. So, I was interested in seeing who provides the forensic examinations, the sexual assault exams, in your community. In the survey I lumped SANE nurses and forensic nurses together, so that came out to 63%. So, that's most people have the availability of a SANE nurse. SANE stands for Sexual Assault Nurse Examiner.

Sometimes that title has been changed to a forensic nurse examiner. That's what our nurses are called. That really is a semantic thing, because in a lot of communities, SANE nurses are providing forensic examinations for other types of crime victims as well. Our respond to domestic violence, they respond to other types of criminal assault, so they're not necessarily doing only sexual assault victims. So, training wise there's not a big difference between a SANE nurse and a forensic nurse examiner around sexual assault. Then a forensic nurse examiner has additional training in other types of forensic crimes.

Twenty-seven percent of respondents said that the nurses in the emergency room conduct the medical exams, which is what happened in our emergency room before we had a SANE team. 22% said their doctors, ER doctors, were doing it. And then I did not list physician's assistant or nurse practitioner in the survey, but the important part of understanding this is that there are lots of different types of providers that are doing this. So, what

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one provider does, another provider may not do. And we'll talk a little bit about variations in practice in just a few minutes.

Where are exams happening? The most common place, universally around the State, is emergency rooms. You'll see that I put emergency department up there. That's the best indicator of knowing whether or not somebody is from a hospital or not. Everybody in the world calls them emergency rooms. Hospital people call them emergency departments, because it's more than just a room. So, I still get it wrong and get glared at here, but it is actually the emergency department, not the emergency room.

Specialized clinics, so for example, in our program here, we have a clinic specifically for our medical services that don't happen in the emergency room. So, follow-up services are scheduled appointments. Other, there are a few other places that have that. Often those are around children's services, but not always.

Some general clinics may perform sexual assault exams. I know that there is a couple of Planned Parenthoods in the State that have, that do that. Our Planned Parenthood, for example, send everybody to the emergency room to be seen by the SANE nurses. But I know in some communities where there's not an active SANE team, they will perform those exams and have somebody trained to do that.

And then there are other, there's a couple of places in the State where it's not school nurses like high school nurses, but there are some colleges and universities that have trained SANE nurses at them. And then some of the correctional facilities as well.

I'm going to talk for a few minutes about the emergency room department and kind of what that's like. The emergency department is incredibly overwhelming if it's not a place that you're used to being. There's a lot of people there doing a lot of different things and it's sort of really unorganized chaos. And what that looks like to an outsider is sometimes difficult. So, one of the things that's really helpful is to understand who all the different people and different staff and their roles in the emergency room are.

So, for example, there's a HUC (PH) which is not something I knew what it was before I came to a hospital. It stands for Health Unit Coordinator. That's the person who knows where all the patients are, knows where the labs are at, knows, you know, where the doctors are. Their, they keep track of everything. That's the person who's going to know what room you need to go to. So, usually they're sitting in the emergency room behind

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the desk by a computer, but not always. So, the HUC is a good person to know because they're usually the ones that can get you people or things or services that you need.

The other person to make yourself familiar with is the charge nurse. The charge nurse is the head nurse in the emergency room for that particular shift. And they're the ones that often have to approve, for example, if a social worker needs to come in. Or in our hospital, they're the ones that have to approve taxis, for example, or interpreters. So, they're often the ones that you can use to access additional resources.

Most emergency rooms have social workers, if not there, on call. So, that if you have a client who is suicidal or homeless or needing some additional resources, that's a good option. The doctors, obviously. It is, if somebody comes into the emergency room, they are required to be seen by a doctor. So, even if a SANE nurse provides the forensic examination, a doctor will come and screen them at some point. So, being prepared that there's another person who may come in. And sometimes that's a little disconcerting to victims. There's techs and they do lab work and things like that.

So, usually the person who has the first contact with the patient where they're getting any sort of detailed information is the triage nurse. So, if you're working with an emergency room and wanting them to contact you as an advocate, that's often the person who's responsibility that would be. To explain to the victim that there is a service that's available to them if they want it. In our hospitals that we work with, the triage nurse is always who contacts the SANE nurse and the advocate to come in and see the patient. So, when you're looking at who in the emergency room is a likely person to do that, who to get information from, and what relationship to cultivate so that you get called, the triage nurses are often the best place to go for that.

As I mentioned a doctor's screening is required. So, even if there is another provider such as a SANE nurse that does all the examination and gets the full history, a doctor has to see somebody in the emergency room before they leave. So, hopefully those doctors are really well trained to not ask a lot of questions and to rely on the SANE nurse to provide that kind of care, but that's not always the case. So, helping a victim understand that it's necessary for the doctor to screen them is part of the process. Not that we're just adding additional questions or adding additional burden, it's the law.

Emergency rooms are run on policies and procedures. And I'll get a little further into why that's helpful for you to know in just a few minutes. The other thing about the emergency room is

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it's crowded. You have to wait a long time. There's no space available. So, you want to make sure that you're trying really hard to be an advocate for your patient without being a pest. And, and make sure that they're getting their needs met given the environment that they're in.

I think a really good example that I have of this is that I was in the emergency room once and they wanted the SANE nurse to do the examination in the room, this was a, this was a child, but they wanted the SANE nurse to do the examination in the room where we were sitting on the couches and chairs waiting for our room. Not in the waiting area, but like in a little separate secluded room that they called the quiet room. They, they kept telling the nurse to just do the exam in their. Well, part of my role as an advocate is to know that that's not appropriate for a victim's, you know, positive experience to have to do their examination in, you know, a little tiny room outside of the hall where anybody can walk in, that's not an exam room. And so being able to go out and find the person, the charge nurse or the HUC who's responsible for, for coordinating the rooms and explaining why it is that we need a room or working with the SANE nurse to do that. The SANE nurse wasn't there at that point, but that would be a good thing to work together on.

One of the cardinal rules about the emergency room is don't feed people. People are not allowed to eat. Now, they bring in their own food and that's fine, but they can't be offered food in the hospital. And one of the things that we often do as advocates, because we're trying to make people comfortable, is do things like offer to get water and offer to get juice or those kind of things, because we're trying to comfort somebody and, and meet their needs. Big no, no in the emergency room and sure fire way for medical providers to not want you to be there.

If she, at any point, the victim, at any point, says you know, my abdomen hurts and there's a determination that as part of the assault she was kicked in the abdomen and may need surgery and, you know, we gave her a glass of water because she was thirsty, that could delay the surgery. So, one of the things to be really conscientious about as an advocate is that you want to follow the policies and procedures of the place that you're at. And in the emergency room, it is don't give them food or drink until they have been screened. So, if they're really hungry or really thirsty, you know, when the SANE nurse is there, you know, letting them know that so that that process, the screening process can happen as quick as possible so that they can have something to eat or drink. One of the things that can really sort of ruin the relationship between medical providers and other people in the emergency room, like advocates, is to do things like give them food or drink without permission.

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The other thing to be prepared for in the emergency room is role confusion. Victims get us all mixed up and they don't know who's the nurse and who's the advocate. And you'll walk through the hospital emergency room and people will stop you and, and things. And it's just because it's a busy environment and our victim is in crisis and they, they have a hard time keeping it straight. So, you want to be really clear about who you are and what you're there to do.

One of the things that's important to remember, I talked about all the different people who can do sexual assault exams. So, what you're going to have then is a variation in practice and so helping a victim be prepared for what they're going to experience is a little different depending on who you are looking at. So, some providers are very holistic and some are very focused. So, one of the things that our advocates struggles with sometimes is why is this, why is this provider also talking to them about their, you know, sore nasal passages and the goop in their eye and it's because as long as they're there, they're going to provide care for all of the things that are necessary for that person, whether they're related to their sexual assault or not. If the victim doesn't want to do that, then we need to speak up and say, you know, she's really not here to deal with that.

The other thing is that we want to make sure that, you know, all the needs that they want met are met. So, if they have other questions (IB), that's a good opportunity to do that. A SANE nurse is going to know about forensics and, and an RN is not. The ER nurses are not trained in forensics, how to, how to keep them, how to collect them, any of that thing. So, they're going to have a little bit of a different experience depending on what it is that, who it is that's providing that.

Some SANE nurses come from hospitals. SART, which stands for Sexual Assault Response Team, may be employees of the prosecutor's office or the police department. That's not a real common model in our State, but it is in a lot of other states. And so they don't have some of the same privileges for working in the emergency room that a nurse from the hospital does. So, like for example, if a SART nurse comes and, comes to the hospital, the MD screening that the doctor has to do may be more comprehensive than if it's a SANE nurse who's employed by the hospital. So, understanding those variation is helpful and can give you an idea of what victims that you're working with can expect. So, really knowing your own providers.

And I see your question, Cindy, and I'm, was going to point that out in the other slide, but Cindy typed in that the other thing about not wanting them to eat or drink anything is that there may be evidence in their, in their mouth. And that's absolutely

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important forensic concern as well. That's less likely to upset the hospital with you, unless you're dealing with a SANE nurse, but it's certainly likely to upset the SANE nurse.

Why do an examination? Why go to the ER? So, helping victims understand what the benefits of going to the emergency room are. The, the history as reported by the victim to the SANE nurse, history reported to a victim, to a medical provider becomes evidence in the case similar to a statement to law enforcement. So, it's an additional opportunity that, for them to provide evidence in their, in their law enforcement investigation if that's what they're doing. It's also a way to document that history as evidence if they're not sure whether or not they want to report to law enforcement, to have that documented in a way that would be evidence in a case even if they report in three weeks or a year. That they have a documentation that can be used as evidence at the time or as immediately post assault as they choose to go in to do that, without necessarily having to report to the police at that time.

Examinations are the purposes are to locate and document injuries. Injuries, some injuries go away very quickly. Vaginal injuries can heal in a matter of days. Some, like, the ligature marks or redness or abrasions can heal very quickly, so if somebody is not sure what they want to do, having that documented early on is important. The provider can also assess medical risk, things like STDs, pregnancy, those kind of things. They can educate on medical concerns. The protect (IB) I already talked about, because they had hold that documentation in a formal way until a victim decides whether or not they want to report.

Another really positive benefit of medical exam is that medical providers enjoy exception to hearsay. So, if somebody is providing information to a medical provider for the purposes of medical treatment, a medical provider can go on the stand and testify to that statement as if the victim was on the stand saying it themselves. So, they have some exceptions to hearsay that are very positive for cases.

They also can be reassured that they're healthy and that things are okay, which is often a very big concern for victims. And we know that statistically having a medical exam does increase the likelihood that somebody will report an assault.

Sexual assault exams could be, what an exam is can be in a training (PH) all on its own, certainly. But, the history drives the exam and the forensic decisions. For most forensic nurses, or sexual assault nurses, they, it's not the same; the exam's not exactly the same for every person. What the victim describes as the history is what determines how that examine and

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forensic collection looks. But what it often includes is some type of physical exam, which is different for different people. But, usually there's a pelvic exam associated with that if there's any sort of medical reason to do that. Collection of forensic evidence, which I'll talk about in the next slide; collection and forensic documentation of clothing; adjunct treatment meaning other types of treatment that they may need.

So, our nurses will make sure that the ER is aware of any other medical condition, sore throat, earaches, anything like that that's occurring. So they can get treatment as long as they're there. And obviously treatment for their sexual assault, so emergency contraception, prophylactic antibiotics, those types of things. And then their discharge instructions and their referral.

So, I just received a question about how long can the kit be stored and how is the chain of custody monitored. The kit can be stored indefinitely depending on who's storing it. So, some of that depends on the procedures in your community. We store ours here are our program; our SANE nurses store them, until law enforcement picks them up. If somebody's chosen not to report, we hold them for six months. We just have somebody from the crime lab come and present to us and who said that they can easily be stored for several years with very minimal deterioration of the evidence.

And how is chain of custody monitored? In our program, the SANE nurse does a chain of custody form which is then transferred to; we have a forensic person who's responsible for our forensics in our office as part of her job. She is then the next chain of custody and that's who stores it until law enforcement picks it up. That's pretty unusual I think for most programs. We have that because, like I said, we're responding to the emergency room 700 times a year, so we need somebody who's dedicated to that. But usually the, the SANE nurse has chain of custody that goes to whoever is the next storage person, which more often than not is law enforcement. I know in some of the other programs, the ER stores the kits until the police officers pick them up directly from the ER, but some of that is specific to what the policies are in your community.

Forensics, the forensic examination collection is really variable because it depends on the history and what the patient prefers. If, if they do not want swabs, you know, anally for example, which is something that a lot of victims that I've worked with are resistant to. That's not something that's going to be collected. So, they need to, with your help, have the voice for that. And it also depends on who's doing, the provider. We have a couple of SANE nurses on our program, for example, that collect just about everything. And then we have

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others that are more experienced that collect really based on the history. So, how much and what's collected is really variable.

But often, there's some sort of clothing collection. That may be a debate about what is collected, because inevitably victims don't want to give up, sometimes, their clothing. And so what's the most useful piece of information. I know our forensic nurses will try really hard to get underwear almost always if they can. The Woods Lamp (PH) is the, used to look for biological swabs. We don't use it a whole lot here, but other programs are very dedicated to it. Biological samples, skin and hair, trace and debris, so things like that would be scrapings under the fingernails, those types of things.

What's important for us to know as advocates about forensics is that there really isn't an effect of things like Law & Order and CSI. That people have an expectation that there's this full kit that gets done, that it takes 45 minutes to find out the answer to what's in it and that that's always really useful information. And so, helping victims understand that that is not in fact the case. That many kits do not get run. It's usually the choice of the investigator or the prosecutor's office whether or not to run a kit. But, at our laboratories here on this side of the State, six months is a fast run for a kit. So, it certainly is not going to be information that they're going to have shortly, which is often a misconception that victims have when they come into the emergency room.

Emergency contraception is often a hot button topic when people are calling and they want to find out on the crisis line or they want to find out when they come into the emergency room, about emergency contraception. Pregnancy is often one of the biggest concerns that victims have, understandably so. In the State of Washington, the, the law requires that unless there's a medical reason not to do it, so for example, they're already pregnant or they're allergic to some sort of medication that would interact with the emergency contraception, but unless there's a medical reason not to do, hospitals are required to provide emergency contraception to sexual assault victims if they request it.

It is not, there's lots of clauses now about like the pharmacists that can opt out of providing it for moral reasons. That is not the case in the emergency room. So, it, for a sexual assault victim, it must be provided to them. One of the things that, as part of the hospital that we have to do, is a monitoring from the Department of Health and all the people that certify hospitals. And the only reason they ever want to come to the sexual assault center to talk to us is to make sure that the hospital is doing this. So, they really do check and it is, in fact, a very important thing.

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If you have a Catholic Hospital in your community that says that they don't provide contraception, there are Catholic health directives that specifically indicate that sexual assault victims can have emergency contraception. So, there is zero standing for a hospital not to provide emergency contraception to a victim of sexual assault. Okay. And so knowing that as an advocate is really important, because if you ever run into the situation where somebody doesn't want to provide that, that's not an option. The hospital has to provide it.

One of the things that's very helpful to understand as an advocate so that you can work on the best behalf of your client is why it is that the nurses are making the decisions. If you don't understand why something is happening, the victim probably doesn't understand it either. So, you want to know why they're asking types of questions. So, for example, one of the questions that the SANE nurses often ask is when was your last period or when was your last consensual sex. Those are kind of personal questions and sometimes people are uncomfortable asking them, but there's medical reasons to do that.

When the period was, for example, is important about how, how much at risk they are for pregnancy and how much the nurse will try to talk them into, or not, into emergency contraception. How worried they are about that concern. When their last consensual sex was has to do with when they're looking for injuries or their documenting collection of semen, for example, and the forensics being able to have that. So, understanding why they make, they're asking questions.

And it's completely acceptable if you don't understand why they're asking a question to; to say can you explain why that's important. Our, one of our medical providers tells a story about the first time she worked with an advocate and she asked about when her period was. The advocate jumped in front of the client and said you don't have to answer that. Well, she doesn't have to answer it, but a better way would be to explain, to ask why it is that that's important. Because if you don't know, the victim probably doesn't understand either.

You want to, you want to be careful to remember that if you don't, if you don't hear something that you always hear, you don't want to assume that they forgot it or that they did or didn't think about it. It's okay to ask. I mean, if you're working with providers that are really different and really variable and have lots of different skill sets and how they're used to doing this, it's completely appropriate to say, you know, in my experience this is something that's been talked about. Such as emergency contraception or antibiotics to prevent STDs and I just wanted to make sure that we have the opportunity to talk about that.

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You can step out of the room and talk to the provider about that outside of the (IB) if that's appropriate. Or if it's, if it's something real benign like that, it's completely appropriate to do that.

Okay. When you look at how can you develop a more positive relationship with the medical providers in your community so that they contact you and provide information about your services to clients, first of all, you want to know who's available in your community and what they are. Know whether or not SANE nurses are conducting the exams or whether or not emergency room nurses are conducting the exams. Does the SANE team belong to one hospital, do they go to all the hospitals, those types of things, which I'm guessing most people are real familiar with that.

But then what you need to be able to do is sell your services to that person. Whoever it is that is the provider, the SANE team or the hospital or whatever that is. You know why you're valuable. You want them to know why you're valuable. The same way that we do with law enforcement, for example, in explaining to them that if you work effectively with a victim advocate, maybe the person won't call you three times a day and they're like oh, cool. Knowing what can be helpful with medical providers and selling yourself to them is very helpful as well.

They need to know that they need you. That victims of sexual assault are more likely to fully participate in a sexual assault exam. It's faster and more efficient if they have a good understanding of the sexual assault exam up front and an advocate can do that. And then you want to inform victims in your community or people in your community in general, that they have a right to have an advocate with them during medical procedures, because one of the best ways to sell your services to a hospital is to have patients ask for it.

So, if people are asking for it in the emergency room, they will know that they need to make sure to establish that relationship. So, you want to, you want to work on being proactive in both ways, with the community members so that they ask when they go into the hospital, and with the hospital so that they know to call you when people come in.

So, when you're looking at establishing a relationship with a hospital, there's a couple of obvious places to start. The first is the emergency room. You don't want to start with doctors in the emergency room. You want to start with nurses. One thing that working here has taught me is that nurses are really sort of in charge of lots of things and so the emergency room nurses is a good place to start. So, every hospital has like a Director of Nursing or a Director of Emergency Nursing if

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it's a large depart, large hospital. They may have a director of, of emergency nursing. And so being able to meet with that person and find out about the SANE, the sexual assault exams in the hospital.

One of the other places to work with is the Women and Children Services. Most providers have, most hospital have Women and Children specific services. A lot of that's child birth, midwifery, those types of things, but those providers are good ins to getting, to starting to establish the relationship with the hospital. Another really good in place and person to call you is the social workers. So, if you've not gotten to the point where the emergency room staff is willing to call you, but they may call a social worker. Any time somebody's really distressed in the ER around emotional things, optimally the social worker gets called, so having a good relationship with the hospital social worker.

Remember a little while ago I said policies and procedures are really important? Hospitals run on policies and procedures and that is the way that they like things done. It's incredibly frustrating sometimes to be somebody who doesn't come from that background and try to work in that world. But if you want to outreach to a medical provider, you want to know what you want to have happen. You want to go in with essentially a business plan. So, you want to come prepared for what you think this will look like.

You want to be able to talk about who will call the advocate, will it be the triage nurse, will it be the nurse that's providing care. Who will the advocate contact when they come to the hospital? How long will it take somebody to get there? Emergency rooms are timed on the fact, like every patient, what time they got there and what time they leave. And that's something that's studied across the State. So, things like how long is this going to delay care is an important thing for them. So, how long can, how long will it take somebody to be there.

What kind of things will you document? What's your, come prepared with copies of all of your client forms that they sign and fill out. Not filled out ones, but blank ones. So they can see what you're documenting. What kind of information you're taking out.

What kind of things you'll be providing. What sort of educational resources will you give? We give a packet of educational stuff to every client we see in the ER. What kind of information will you be providing, what kind of services will you be providing? How will you train your staff? How will you train them to work in the emergency room? What kind of training

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are you willing to provide to their staff, which is always a good, a good way to develop that relationship.

What kind of things do you want them to train you on? What, what are you hoping for? What are your expectations? And then because hospitals are business, even the non-profit ones, there will be a discuss, I guarantee it upfront, about reimbursement. Obviously we don't charge for advocacy services, but that's not something that they're used to. So, that, that discussion.

One of the things that comes up with working in a medical setting is HIPPA (PH), which stands for Health Information Protection and Privacy Act, I think, which has to do with protected health information. So, that's identifiable information about a patient. So, name, birth date, address, phone number, all that sort of stuff. And it's protected and covered by law and hospitals are really protective of that, because it's a liability to them if that gets out.

So, one of the things that will happen if you're working on a relationship with a hospital is that they will want to have formal procedures in place so that they are compliant with their HIPPA information. So what does that mean to you? The interesting thing about HIPPA is that it's a personal liability law. So, if you have access to protected health information and you release it, you can be held personally liable. In fact, one of the people here at our office who just came to us from another medical setting, just had to go to court on a, on a lawsuit around release of personal information. So, they can sue like individual people.

The other thing is, is that there's some professional liability associated with that. And if you want to have a positive relationship with the medical providers, they have to be very confident in your protecting their confidential information. And while we as advocates completely understand the concept of confidentiality, that's not going to be good enough for them. So, they will require things like a release of information so that they can call you, those types of things.

So, you want to be prepared for understanding that their confidentially laws have some legal parameters in place that are nothing like what ours are. So, they're going to be very conscientious about making sure that those procedures are in place. So you want to be prepared for that.

And nothing like ending on a negative note here, but we're going to talk for just a few minutes about some things to be prepared for as possible challenges. Medical providers and advocates, as I said way back at the beginning, come from very different philosophies. To the point even that we don't share a common

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language. So, as advocates we talk about enabling somebody as a negative thing. You know, I don't want to enable them. And that's, that's sort of the opposite of an empowerment concept.

In the medical world, enabling is a positive thing, meaning that you are doing for somebody until they're capable of doing for themselves, which is sort of the basis of a lot of nursing philosophy. So, we have different ideas about things. We have different things, ideas around consent and what consent means. Informed consent to us is really different than consent for medical staff. So, informed consent for an advocate means that they have been given all of the information, they understand their options, and they're making a choice based on that.

Consent in the medical world means that you can pass a mini mental exam, meaning I know who I am, I know where I am, I know what day it is. And so, if somebody is really intoxicated, you know, they're not going to maybe be able to pass an informed consent concept like we would have, but they certainly may be able to pass a medical consent. So, understanding that there are times when those standards are really different.

So, we may have cases, for example, where our SANE nurse and our advocate go out and the SANE nurse does an exam, but the advocate does not feel that the, the client is consent able for advocacy services because she can't stay awake, because she's intoxicated and she keeps falling asleep on the bed. We're obviously not going to feel like that person is making informed consent for advocacy services, but there may be a medical reason that it's necessary to do an examination and the SANE nurse goes ahead.

That creates a conundrum if you're working really closely together. So, you want to be prepared for the fact that you have different levels of consent and different understandings about what consent rights are.

One of the other pitfalls is that, you know, the advocate is impeding the care of the patient by, you know, standing up for them, by inserting the, asserting that the client doesn't want this particular procedure or to answer this question. And one of the things that has happened I think in advocacy over the years as we have developed more and more cooperative relationships with our specialized providers, is that we've lost some of the edge sometimes about being able to, to stand up and have good professional confrontations. So, but that is something that you need to be able to do even if with somebody that you have this type of relationship with. And theoretically, it should be easier, but it's now always.

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So, you want to be sure that you're understanding where you're at and what your role is. And doing that, whether or not the medical provider feels like that's potentially interference. You need to be prepared for that. You, it doesn't change what you're doing in your job. You just want to be prepared for that as a possibility and be able to talk that through with the provider.

Stepping on each other's toes is a pretty common one. A great example of this is, is suicide. You know, the advocates have questions that they ask about the intent to injure themselves or harm themselves and the medical providers are going to have those questions. And sometimes we have the same opinion about our level of concern about somebody, and sometimes we don't. So, sometimes things are going to get covered twice.

You know, sometimes you want to make sure that if it's an important thing and it gets covered twice, it gets covered twice. We know that people in crisis don't retain a large portion of what we said, so it's probably a good thing that the really important stuff gets covered twice. You just want to make sure that you have negotiated some of that.

I already talked about the food thing, so I won't talk about that. We don't need to talk about that again. The, the medical advice and advocates giving medical advice. And that is something is, is a potential concern and so as I addressed it at the beginning, you want to make sure that the medical provider that you work the closest with could help the advocates through training and through policies around what is and what isn't appropriate to talk about.

And then, as an advocate, if you see something that you think is up to standard with the services that are being provided medically, being able to know how to handle that. Who do you report to if a SANE nurse has engaged in inappropriate behavior? You know, what are, or inappropriate medical care or if an emergency room doctor is inappropriate. Not, not professionally inappropriate, but just, you know, a jerk or, you know, is asking undue questions, those kind of things. So, you want to be able to address those concerns.

So, that's my portion. I know that the, the slides came out to you available prior to the sign up, so they have the Power Point. If you have any questions, you're welcome to email me or give me a call.

-Transcript ends-