West Virginia
MOBILE SANE PROJECT
FINAL REPORT

Project Period 10/2002 – 9/2005

Index

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Overall Project Performance Measures.

a. The number of sexual assault victims provided with SANE services and sexual assault advocacy services: 107 (September 2004 – September 2005)

b. Determine the number of professionals served:
1. SANEs - 13 SANEs are trained and participating in the project
2. Advocates – 51 advocates are trained and participating in the project

c. The number of sites reporting policy/practice changes: All four participating hospitals and 2 rape crisis centers made policy and practice changes to participate in this project. During this grant period the hospitals instituted a pediatric protocol and medical history form because the one that was being utilized focused only on adult victims. The new form provides better guidelines for the nurses since the kit itself is geared toward adults. We also added new information on the data collection form that will accompany the kit. Statewide we are in the process of implementing a sexual assault kit tracking application, SAKiTA, which will provide evaluation feedback to nurses regarding evidence collection quality.

d. The number of sites reporting an increase in collaborative partners: All four counties increased their collaborative efforts, both locally and regionally.

Background of Project

West Virginia was experiencing what many communities across the country also have learned: there are not enough SANEs (sexual assault nurse examiners) in rural hospitals to staff 24/7 SANE programs. Many times only one or two nurses are trained at a time to be a SANE. The limited number of available SANEs results in the same nurses always being on-call, causing high burn out and a high turnover rate. Too often there is only one nurse in a rural hospital who is a trained SANE, thus when she leaves the hospital the program ends. Many rural hospitals lack the number of sexual assault victims seeking treatment for the hospital administration to justify the financial cost of maintaining a 24/7 program (although arguably the moral aspect carries no price tag), and often SANEs in those hospitals feel that the limited number of exams they perform each year are inadequate to enable them to maintain their skill level.

At a statewide SANE training the concept of a mobile SANE project kept surfacing, and the state sexual assault coalition, the West Virginia Foundation for Rape Information and Services (FRIS), decided to explore that possibility. Through a feasibility study grant in 2002 from the Office for Victims of Crime, FRIS began the process of determining if a mobile SANE project

was feasible in West Virginia. Two additional components of the study were to ascertain the s*ustainability* of the program, and determine the *replicability* of the program. It was important to us to create a project that had the potential to be financially self-sufficient if were going to have longevity in a rural area with limited resources. Of equal importance was to create a solution that could be utilized by other areas of the state and country.

Our plan was to conduct the study, convene focus groups in two regions of the state where the data indicated were the most feasible for the SANE mobile project project, and finally select one site where the project could be piloted

Our vision when the project idea was submitted to the Office for Victims of Crime was that of a mobile unit that would allow for a timely response to a sexual assault victim. The mobile unit would contain the equipment necessary for a SANE to conduct the exam in the actual vehicle, thus creating a system where the participating hospitals would not each have to purchase costly equipment (i.e. colposcopes). The concept of a mobile unit would allow for a more timely response as well as the sharing of SANEs throughout a region.

This vision changed dramatically as a result of the information gleaned from the feasibility study. Although we cannot say that our initial concept would not work somewhere else, we unquestionably believe that our final project is the most cost effective and practical solution to addressing the issue of SANEs in rural areas.

The following report is divided into two sections: The Feasibility Study and The Implementation Phase. The report details our processes, obstacles and the results in each phase.

THE FEASIBILITY STUDY

When FRIS first began a SANE/SART initiative in the state in June of 2000, there were only two functioning SANE programs in West Virginia with a only a handful of trained nurses. By 2002 the number of SANEs had increased but the concept of a SANE was not widely recognized throughout the medical, prosecutorial, and law enforcement disciplines in the state. For the project to be successful, we knew that a study needed to be conducted to determine which areas of the state had a significant enough number of reported sexual assaults to warrant local interest in a mobile SANE project and to sustain it.

FRIS hired a consulting firm to conduct a feasibility study under the supervision of the coalition's SANE coordinator. We initially thought it would be best to have a SANE coordinate this aspect of the project, but quickly learned that the research component was best left to someone with research experience – just as the actual coordination of the SANE project itself needed a nurse to administer it.

In October 2002 we began by identifying our basic assumptions about a mobile unit shared among licensed medical facilities over a large geographical area:

- A larger geographical area allows for an increased number of potential SANEs, creating a larger pool of on-call SANEs. This would be a primary benefit to rural hospitals.
- The "sharing" of SANEs should reduce burnout, increase flexibility, and increase experience/competency skills for the nurses.
- The sharing of SANEs would also create the sharing of on-call costs, making the project attractive to rural hospitals.
- A mobile SANE program would create more consistent and compassionate victim services.

We identified three sources of data regarding the number of sexual assault exams performed at medical facilities. Those three sources were:

- West Virginia Prosecuting Attorneys Institute
  (which is the entity designated by our state legislature to provide reimbursement for forensic sexual assault exams)
- West Virginia State Police Crime Lab
  (which is the entity in the state that processes all of the sex crimes kits submitted by law enforcement for testing)
- The state's licensed medical facilities
  (which would allow for self-reporting by the hospitals of the number of exams conducted, since not all exams result in sex crimes kits being collected)

We rather quickly learned the value in using multiple sources for data, since our survey of the three sources provided differing results. In some cases, the data was not even comparable. From all three sources, it was impossible to distinguish the actual county of the assault vs. where the victim chose to seek medical treatment. This is a factor to consider when trying to identify where most assaults occur. We were reminded that victims in rural areas often choose not to present at their local hospital due to the lack of anonymity.

In the case of gleaning data from forensic exam fund records, it was impossible to determine if hospitals with no reimbursements had no sexual assaults or simply were not requesting reimbursements from the Forensic Exam Fund. The data from the Crime Lab was identified by county, but again, it was impossible to verify the actual county of the assault. And the data collected from the hospital survey – well, that generated a whole new source of data! One tiny rural hospital self-reported treating several hundred rape victims annually, while other larger ones minimized the need for forensic exams. The hospital telephone survey (**attached as Appendix A**) enabled us to clarify and verify information in many instances and also brought to light issues we had not considered.

One such issue was the fact that many West Virginia hospitals contract with out of state companies for their Emergency Department physicians. This fact countered one of the common 'selling points' of a SANE program to hospital administrators: that it costs the hospital increased dollars for a doctor to conduct the exam – and even more dollars if she is subpoenaed and has to testify. With a SANE program the SANE would be testifying, not the doctor. But in contracted

emergency physician services, the hospitals don't pay any increased dollars when a doctor testifies so initiating a SANE program because it saves physician time and expense is not an enticement.

We also learned that in West Virginia there is a severe nursing shortage. This placed the on-call SANE project in competition with all other hospital on-call departments and had a direct impact on the on-call pay for our nurses.

Our third discovery was that several of the hospitals are networked, but not locally. This made hospital decision making much more challenging in terms of participation in the project.

The goal of this phase of our project was to identify two areas of the state with two or more adjacent counties that could be potential sites for the mobile project.

Criteria for Selecting Pilot Region for the Project.

FRIS wanted the site selection to be as objective as possible. A primary factor was that there needed to be a history of enough reported sexual assaults in the region to warrant the project and create the possibility for sustainability. But other issues were factors in the selection process as well. Prior to collecting all of the data, we identified the following additional criteria to be used in the site selection:

- # of Licensed Medical Facilities
- # SANEs
- Existing SANE Programs
- Strong Rape Crisis Centers
- Geographic Area / Transportation
- Active SARTs

We felt it was imperative that the selection criteria be established as early as possible. We did not want to be biased in the site selection. We knew that, particularly for a pilot project, support for a mobile SANE project would be greater in areas where SANE programs – however skeleton – existed. Building from a base of existing SANEs and active SARTs in a region would garner initial support for the project. We also had to be cognizant of the geographical challenges in the region, with a primary concern for response time and our snowy winter weather conditions.

When we analyzed the data from this portion of our study, the data results clearly identified one region of the state where the project would be most feasible: the north central portion. (Ironically, prior to the study, this was not an area that we had even considered as a potential site. This again substantiates the importance of research!) **Appendix B** shows a map of the state with the number of SANEs per county indicated. Other dynamics eliminated some of the counties in the state from consideration for this project, so we decided to turn our efforts to conducting a focus group in the region and researching mobile units.

Researching Mobile Units

While we were preparing for the regional focus group, we studied mobile units to begin to assess the equipment needs and costs. Through Internet searches and phone contacts we began piecing

together a prototype, since we could find no existing mobile unit for sexual assault exams. We studied mobile units for other medical procedures – such as x-rays and dialysis – as well as those for nonmedical purposes such as libraries. The more in-depth we studied these units, the more necessary components we identified for the purpose of conducting a forensic medical exam. Some of the necessary components and challenges we identified included:

- Bathroom facilities
- Handicapped accessibility
- Security
- Space for victim advocate
- Vehicle maneuverability
- Confidentiality
- Lack of Nursing / Medical support
- Costs: Purchase and operating
- Liability/insurance

We began to conclude that a self-contained exam unit would be too large, be too difficult to maneuver for SANEs, and create major confidentiality issues in a rural area. As we grappled with some of the previously listed major issues, we struggled with some of the practicality issues as well, such as how we would keep the supplies stocked, how records would be maintained with a mobile unit, and where we could inconspicuously park such a conspicuous vehicle in a rural area and still maintain confidentiality.

We began visualizing a lone SANE nurse with a rape victim in a large, isolated mobile SANE unit. All of the aforementioned issues created obstacles, but the two that to us were insurmountable and had the potential of creating a risk for both the victim and the nurse were the lack of medical back-up and the lack of security. We had to remember that a SANE conducts a forensic exam, not a medical exam. So if the victim were in need of medical treatment, a mobile unit could actually isolate her from the medical care she needed. And although most rapes occur between acquaintances, we could not ignore that rape is a violent crime and a mobile unit would not be secure. By March 2003 we felt, for us, those two issues were deal breakers. We knew we would need to create a 'Plan B' for our project.

Mobile Unit – Adapted

Our 'Plan B' was to forego conducting the exam in the vehicle but instead move the SANEs and the equipment among the different hospitals. This would still allow for the sharing of SANEs and equipment among hospitals (which would save in both labor and equipment costs) and would allow for a smaller, more manageable and less conspicuous vehicle. It would address many of the obstacles identified with the self-contained unit, particularly the medical support and security concerns.

Through our research we found that there was a project in Houston that actually was in the final stages of creating a mobile unit – not one in which the exam would be conducted (as we had envisioned) – but one that would move the exam equipment from hospital to hospital.

The prototype was at Memorial Hermann Hospital (MHH) in Houston, Texas. After numerous phone calls and exchanges, we decided in April 2003 to go to Houston to see the unit and meet with the coordinator of the project, Rusty Rooms.

That visit was extremely helpful to us in formulating the plans for our project and allowed us to begin considering an adaptation of a self-contained unit. Memorial Hermann Hospital's vehicle was a Chevy Blazer, which was donated by the MHH Volunteer Association. What was unique to their project was that it only included hospitals that were part of their seven hospital system. Therefore many issues that we would have to resolve were non-issues for their project. The vehicle was owned by the hospital system, covered by the system's insurance, and a gas card was just kept in the vehicle so the SANEs could charge gas to the hospital. Where the vehicle was parked was not an issue since all of the SANEs were employed by the system. They could take the vehicle home or leave it at one of the hospitals and pick it up if they were called out. Dispatching the SANEs was easy: they planned to utilize the hospitals' existing Lifeflight dispatchers. With all of the SANEs already employed at one of the system's hospitals, payroll and liability insurance coverage were not factors. Training also was not a consideration, since the hospital already offered SANE trainings.

When asked the three largest obstacles for their program, Rusty listed: the cost of the equipment, getting enough nurses trained, and the red tape among the hospitals. He was hired 20 hours per week to monitor and coordinate the services and had an assistant at 8 hours per week. He was projecting a six month turnaround time from the time nurses were recruited to when they were trained and had completed the clinical requirements. When we visited the project in April 2003, the vehicle was ready and fully equipped. The other issues were delaying the start of the project.

We left that visit with many ideas for our own mobile unit after seeing the equipment and their generous sharing of forms and policies. But we also left with a new list of issues that would need to be resolved for our project. They included:

- Different Hospital Systems
  - Turf issues
  - Varying number of SANEs per hospital
  - Logistics: Payroll / shared medical records
- Geography
  - Larger geographical area
  - Response time / logistics: Shared vehicle
- Recruitment and Training
- Equipment Purchase
- Liability: SANEs and mobile vehicle
- Project coordination with multiple hospitals and no single system
- Mobile Unit Logistics
- Dispatch system / procedures
- Maintenance of the vehicle
- Adequacy of one vehicle
- Location of vehicle
- Exam/program logistics
- Medical Record Retention: Who? / Where?

- Medication Dispensing: (varying procedures; emergency contraception issues)
- Who would actually hire the nurses?
- Creating a financially self-sustaining program

This new list of concerns and obstacles would have to be addressed with the focus group. It underscored the importance of thinking through how a project fits each unique community and set of circumstances. We knew that we wanted to have a very open and frank discussion of the project with our potential partners at the focus group meeting. We wanted all potential participants to clearly understand all of the issues involved before they made a decision whether or not to participate.

Regional Focus Group Meeting

After we identified a potential six county region in north central West Virginia as the site of the project, we turned our attention to coordinating an all-day meeting of key decision makers in that region. First we identified the critical decision makers and partners. The list included the rape crisis center directors, hospital administrators, prosecuting attorneys, law enforcement, SANEs, emergency medical services, and representatives from the local colleges.

Although we had no intention that the project would be so vast that it would cover six counties, we wanted the counties that would participate to 'self-identify.' We did not want to make that decision for them. In hindsight, we were lucky that two of the counties opted out of the project during the focus group meeting, because if all six counties would have decided to participate, it would have created a geographical nightmare in terms of the response time. So our efforts to be inclusive could have created major obstacles in the end.

We began preparing for the focus group meeting by meeting with the rape crisis center directors serving those six counties. We compiled a list of names and contact persons, since it is common that the best contact in an organization is not always the name at the top of the organizational chart. We knew that the local connections of the rape crisis centers would maximize the chances of good representation at the focus group meeting.

We selected a date in late April 2003 for the meeting and chose a conference room at a local hotel as the site. We wanted a central location and needed to be able to provide lunch for the group. We offered a $100 stipend for participants (although only two participants – a nurse and an EMS worker- requested the stipends).

We sent out an overview of the project to the targeted focus group participants, giving them the background on the project as well as the date of the focus group meeting. We had the rape crisis centers assist in the recruitment process and sent a followup letter as well.

For the focus group meeting itself we contracted with an outside facilitator. In hindsight, this was a necessary, critical part of the process. Knowing now how much competition and mistrust there is among the different hospitals, we recognize how the use of an outside facilitator allowed for a more open dialogue at the meeting.

We had an excellent response to our selected 22 invitations to participate in the meeting. Again, the recruitment help of the local rape crisis centers was critical in the process. The focus group meeting agenda (**Appendix C)** was established to first identify our potential partners in the room, create a general base of knowledge of SANEs and SARTs, and then provide an understanding of the project itself. We felt it was important for the participants to understand what had occurred prior to the meeting, what data had been collected that resulted in our selection of their region for the pilot site, and what we had learned from our Houston visit.

We then had a brainstorming type of session on the logistics of the project. Our purpose was not to necessarily resolve the issues but to identify them. The facilitator gave participants post-it notes to identify (one issue per note) some of the main obstacles and issues they would need to have addressed in order to participate in the project.

At the lunch break the post-it notes were collected. During lunch the coalition staff and facilitator grouped the post-it notes into categories (such as the advocates, the exam, payment of nurses.) Although we had not planned it, lunch provided a wonderful opportunity for the representatives from each county to 'caucus' and discuss the project and the implications for their community. During lunch representatives from two of the counties met and decided to opt out of the project. Both were from the northern end of the six county area and they recognized that they did not have the number of SANEs nor the strong SARTs that the remaining four counties did.

We reconvened and began addressing the obstacles and challenges to creating the project. As we talked, it became clearer that the issue of sharing a vehicle over such a large geographical area was going to be a major obstacle, and we began to discuss the possibility of sharing only the SANEs. This would allow the victim to remain at the hospital where she presented for treatment. It would reduce the response time of the nurse, who could go directly to that hospital without first having to go pick up a mobile unit.

The last part of the meeting was intentionally spent on a positive note, focusing on the benefits of the project and ways we could make the project work. Participants were then asked if they wanted to continue exploring the feasibility of the project. The remaining representatives of the four counties all agreed to continue. We formed committees from the county representatives to explore the different issues over the next few months, with the coalition staff and the consulting firm facilitating those committees meetings.

Critical Committees

At this part of the process it was through committees that we were able to work through the details of implementing the project. The larger group was too cumbersome for decision-making, and usually the key decision-makers were not all present. We had to have all four hospitals from the region agree on each issue and it was nearly impossible to have key decision-makers from each hospital present at each meeting, which forced a delay on every issue. We had two meetings where this occurred before we decided to work through smaller committees. We lost momentum during that time, since it is frustrating to those who attend meetings where issues cannot be resolved. Since we could only meet once a month, the process slowed considerably.

But collectively we established a goal of implementing the project in July of 2004 and worked to establish a timeline, identify issues that needed to be resolved, and assigned the issues to committees.

The advocate component was the easiest to create. The rape crisis centers already utilized volunteers in other areas of their services and worked with us to establish the necessary advocate job descriptions. They were eager to expand into hospital advocacy and willing to take the lead on the project.

The committee that was the most critical to the direction of the project in the initial stages was that of the SANEs. In June 2003 we met with the existing small number of SANEs from the four counties to discuss some of the basic issues of recruitment, training, and payment. In the area of recruitment, they felt we needed to look outside of the emergency department and include ob/gyn nurses, public health and midwives. They assisted in developing a screening process (which will be discussed later) and recommended that training be offered at no cost in return for a signed contract to participate in the project. The issue of payment was resolved through this committee. Through our research we had learned that on-call payment varied widely throughout the country for SANEs - from no payment unless a nurse is called in to conduct an exam to about $2.00 per hour utilized by the Houston model to $3.00 in some other areas. Because we have such a nursing shortage in West Virginia, the nurses felt that $3.00 per hour on-call pay would be necessary. Having the nurses' input into setting the pay scale was an important strategic decision. Although it didn't seem that we should pay a higher on-call rate in West Virginia than they do in urban areas, and although a $1 per hour pay differential from $2 per hour to $3 per hour raised the fixed cost of the project by 1/2, we felt that a rate that was approved by the nurses was critical to the survival of the project. The SANEs decided that a flat fee of $200 would be appropriate for when a nurse was called out to conduct the exam. The flat fee eliminated the issue of travel reimbursement. The $200 rate was higher than in some areas of the country ($150 was a common amount), but it also would cover any time involved to testify in court. The nurses suggested a 12 hour on-call shift would be best to fit their normal work schedules. They felt that a maximum of on-call time should be twice per week. This then identified the need for 12 SANEs to accommodate an on-call schedule. We also learned from the nurses that although they had been trained in working with adult victims, most had not completed a pediatric SANE course.

Working with the hospitals was the most challenging piece, since we never in the planning process had all four key hospital representatives in the same room. We also had folks who were designated representatives but really did not have the final say – that was left to the CEOs. This was the group that almost prevented the implementation of the project – on several occasions. It is critical to be able to discuss the project with the administrator or their designee who can make financial decisions for the hospital.

THE IMPLEMENTATION PHASE

We began the implementation phase by creating a strategic plan **(Appendix D)** for the year to keep us on task. There were still many details to be resolved. Our goal was to have a signed

contract with the hospitals within the first quarter of the grant (October 2003), hire a SANE to be the Project Administrator (10 hours per week) in the second quarter (January – March 2004) and resolve the policy/procedural issues, get the advocates and nurses recruited and trained in the third quarter (April – June 2004), and be up and running by the beginning of the 4th quarter (July 2004). We met most of those deadlines, but it was a very bumpy road in the beginning. It is important to note that until the hospitals committed to the project, the actual service area could not be defined. Therefore all of the next steps (e.g. hiring a local coordinator, recruiting SANEs, etc.) were dependent upon the hospitals signing an agreement.

Getting the Hospitals on Board

Early in the process we recognized that one entity would need to 'umbrella' or 'host' the project to provide the payroll department to pay the SANEs and to cover the liability issue. As the state sexual assault coalition we did not want to move into the business of providing forensic medical exams, so it was imperative that one of the hospitals assume that role. This issue was by far our greatest concern, probably because we had the least control over the outcome. Fortunately, the largest hospital of the four agreed to do so. We were actually surprised at how easily that piece of the puzzle was resolved and very appreciative of their generosity in doing so. At times their flexibility during the process was limited, but the project is indebted to their willingness to host the project.

In hindsight, if we had worked out more of the agreements and logistics prior to one hospital assuming the lead role, the process may have been smoother – although we will never know that for certain. What we do know is that there was extensive resistance, mistrust, and actual animosity at times within the group of hospital representatives. This made it extremely time intensive on our part to move forward. Prior to actually writing the contracts, one day we might agree on an issue, and the next day that agreement would be changed. To help with the logistics of the committees and the hospital negotiations we had hired a part-time community liaison (10 hours per week). Also during this process, the consulting firm (that worked on the initial feasibility study) worked with our coalition staff and the committees on many of the procedural details, such as compiling and reviewing each hospital's current protocol, establishing a recommended protocol, writing job descriptions and contracts for the SANEs and advocates, and arranging for trainings for the SANEs and the advocates as well as finalizing the strategic plan.

The Agreement

The hospital representatives eventually agreed that each hospital would 'contribute' 3 SANEs from their areas to the project. They did not necessarily have to be employed by that hospital but had to be from the area. The theory was that the program would function well with 12 SANEs, and each hospital would be responsible for recruiting three. The SARTs in some of the areas were very helpful in this process.

The hospitals and the SANEs agreed that the SANEs would be hired by the host hospital on a prn (per need)– or temporary part-time status. The host hospital required that each of the nurses complete its own training program, complete with a physical and background check. This added an extra layer of 'to do's' for the project and delayed the starting time by about a month. The

host hospital insisted that the nurses be paid on the scale for its own nurses during the two day training.

At one point in the long negotiation process with the hospitals, one of the hospitals decided it was not going to participate. We believe that it was only because of our face-to-face meeting with the hospital administrator that the CEO changed his mind. We enlisted the support of a key member of the SART there, the local sheriff, who went with us to ask the CEO to reconsider and explained how important the project was to the community. When we finally had his commitment, we were ready to move forward. This underscored the importance of input from the local communities. We had involved the SARTs from the beginning of the process, and they were critical in garnering the hospitals' involvement. Although all acknowledged it would be a good program, for the hospitals the bottom line was really all about the cost.

The issue of liability was a major hurdle. Although our research indicated that no SANE had ever been the defendant in a civil action as a result of conducting a forensic exam, liability was of paramount concern to the hospitals. We emphasized that the SANEs were collecting evidence, not performing a medical exam. We also asked them to assess their liability without a SANE collecting the evidence. Ironically, it just became a 'non-issue' at one meeting. Some level of trust either developed or the hospital representatives became weary of belaboring the issue!

The negotiations with the hospitals stalled for over two months. The issues of liability, one hospital hiring all of the nurses (which was a potentially threatening concept for the smaller hospitals who do not pay as competitively), the agreement that the hospitals would equally contribute $4000 to the project (which was a concession by the smaller hospitals in light of the fact that they treat fewer sexual assault victims than the larger, regional hospital), and a general mistrust among the competing hospitals were all obstacles we overcame in the beginning of the implementation phase. But a new hurdle appeared when the contracts were written.

Originally, it was the general understanding that the hospitals would pay to train their own nurses, but when the final contract was distributed, the host hospital first included a clause that our sexual assault coalition would pay the nurses to be trained, and then changed it that the hospitals would equally share in that cost. That item was a deal breaker for the smaller hospitals, who had already made numerous concessions. Although we had job descriptions in place for the project administrator and the volunteer advocate coordinators and had recruited and interviewed for those positions, we could not move forward until we could determine which hospitals would actually be participating in the project. The SANE training (adult), volunteer training, and pediatric SANE training were all scheduled. All other components of the contract had received verbal agreement by the four hospitals.

In the end the hospitals agreed to share in the training costs, with our grant covering the cost of the SANE and initial volunteer trainings. The contract, signed by all four hospitals and our sexual assault coalition, would be for a one year period. It was very helpful, again, that our coalition participated in all aspects of the negotiating process. We served as a buffer and we were able to work out compromises and encourage participation.

In the end, the hospitals agreed to:

- Pay $1000 per quarter to the host hospital for the 24/7 SANE service
- Bill the state forensic exam fund for all forensic exams conducted and submit the reimbursements they received to the project
- Arrange for 3 nurses from their county to participate
- Provide a designated space in their hospital for the exams
- Provide supplies for the exams
- Sign a one year contract to participate in the project

The Budget

The project had two fixed costs: the cost of training the nurses at the host hospital and the on-call pay for the project. (Our grant was paying for the SANE project administrator position.)
The on-call pay ($3 per hour) was the largest expense:

$3 x 24 hours x 365 days = **$26,280**

The second projected fixed cost was the hospital training of the nurses to be employed on prn status. We projected the following for that expense:

12 nurses x 16 hours training x $30 per hour = **$5760**

Our total unreimbursed expenses were projected to be:

$26280 + $5760 = **$32,040**

We felt at times there were inequities in some aspects of the budget, and this at times seemingly created animosity among the facilities. Yet the participating hospitals chose to move past the hurdles. It is extremely important to note that we took the role of the negotiator in this process. We did advocate behind the scenes for certain issues, but tried not to intervene unless the negotiations totally broke down – which they did on several occasions. There were times when we would make suggestions/requests in the process on behalf of the smaller hospitals that were initially denied but later incorporated into the project. We believe that the fact that we avoided major confrontations enabled this method of diplomacy to work. The turf issues were so entrenched that avoiding face to face disagreements (and thus alienating the smaller hospitals) was the only way for an eventual agreement. It cannot be emphasized enough how time consuming this process was, and how critical the importance of flexibility was on the part of all of the participating hospitals.
The payment to a SANE for conducting the forensic exam was set at $200. Our state Forensic Exam Fund reimburses hospitals $350 for each approved exam conducted. Each hospital agreed to bill the fund for all exams conducted and turn the monies over to the host hospital for the project. Therefore, if a SANE conducted an exam, the project would receive $350. $200 of the $350 would be used to pay the SANE, and the remaining $150 would be revenue to the project.

This is where our research again became a major factor. Based on the statistics we had gathered from the Forensic Exam Fund, we projected that the number of forensic exams that would be reimbursed by the fund to the project through the 4 participating hospitals in the project year would be 104.

The 104 exams multiplied by the $150 that would be income to the project provided:

104 x $150 = **$15,600 Project Revenue**

Total projected expenses: $32,060
Total projected Forensic
Exam Fund income: $15,600

Balance: ($16,460)
The balance divided among 4 hospitals was rounded off to $4000 per year per hospital.

Each hospital agreed to provide $1000 per quarter (or $4000 for the year) to the host hospital. For their $4000 they would receive:

- 24/7 SANE coverage
- 24/7 advocate coverage
- Free adult and pediatric SANE training of their nurses in the project
- Polaroid Macro 5 camera and storage cart for kits and supplies

All for only $4000 per year!!!

We mentioned earlier about the inequity of the training costs. It must be pointed out the host hospital was taking a risk by agreeing to absorb the costs based on this projected budget. If there were less than the projected 104 exams conducted, the cost to the host hospital would increase. (Conversely, they could actually profit if more than 104 exams were conducted.) They also provided the in-kind service of their payroll department. Although they had the required 'deep pockets' to host the project, they also were paying much less for the service ($4000) than when they had a stand-alone SANE program and were paying all of the on-call costs. We hoped this would be a 'win-win' situation for them, but there was no guarantee that the projected number of exams needed for the project to operate in the black would actually be performed. They generously were taking that risk on behalf of the project.

The Start-up

Two months prior to the start-up of the actual mobile SANE project, we hired (through grant funds) the part-time SANE project administrator. **(job description and contract in Appendix E)** We filled the position with a SANE nurse, who had a solid belief that the project was a necessary one. She approached the task with skill, humor and diligence – all of which were tested in the process.

We purchased medical storage carts for each of the facilities, stocked them with the supplies necessary for the forensic exams as well as a Macro 5 camera. The same keys fit all of the carts, so SANEs would have easy access to the carts at each site. Each nurse was provided with a map and protocol for each location as well as an identification badge. Our SANE project administrator worked with us to get all of those pieces in place.

The SANE project administrator was in charge of scheduling and providing each emergency department with the on-call schedule. If a victim presented at a hospital, the hospital emergency

room director was to contact the SANE on-call. The SANE project administrator served as the back-up.

The SANE project administrator also was in charge of the payroll component. She handled the submission of time cards and payment for the SANEs with the host hospital. She also compiled quarterly reports (statistical and financial) and made sure the hospitals were invoiced.

Recruitment and Trainings

Publicity was conducted on the project to recruit both nurses and advocates. The SARTs in each county were extremely helpful in the recruitment process. Because of the cost invested in the trainings, both SANEs and advocates were asked to sign a one year commitment agreement to be able to attend the trainings at no cost. **(Appendix F – Application for SANE, Appendix G – SANE Contract/Commitment Agreement, Appendix H – Application for Volunteer Advocate and Appendix I – Volunteer Advocate Contract)** The SANE agreement notes that if they do not fulfill the commitment, they would be asked to reimburse the project for the training expenses. Our goal was to have a pool of 12 SANEs (15 would be ideal) and at least 25 trained advocates – the latter of which would vary per site.

The grant allowed for the coalition to contract with each of the two rape crisis centers in the region to hire a part-time advocate coordinator. Each of the centers served two counties in the four county project area. The advocate coordinators recruited, scheduled and trained the volunteers and worked with the hospitals to develop an on-call protocol. They also transitioned their agencies into absorbing this service for sustainability purposes. A training was held for the newly recruited advocates, followed by a 'train the trainer' training for the advocate coordinators and other rape crisis center staff. The advocate coordinators subsequently conducted additional trainings with new volunteers during the project period and held regular volunteer meetings. It was important that we created a volunteer component to the project that could be sustained by the centers.

An adult SANE training was held for the newly recruited SANEs as well as a pediatric SANE training two months later. Both trainings were repeated near the end of the project year. The SANE project administrator and coalition staff assisted the nurses in arranging opportunities to complete the clinical component of the training. They also worked out the logistics of the training and paperwork required by the host hospital. (This aspect may seem minor, but it was the final step in implementing the project. Because the hospital's in-house training was only held semi-monthly and because all of the SANEs were already working other jobs, this was a logistical challenge to complete.)

Publicity

In addition to the publicity involved in recruiting SANEs and volunteer advocates, we felt it was important to publicize the project itself. Because of its uniqueness, we had no difficulty generating television and newspaper coverage. We were careful to encourage local articles featuring the local hospitals and rape crisis centers as well as members of the original focus group.

One month after we actually started the project we held a celebratory meeting and invited the press as well as everyone who had participated in the development and implementation of the project. Several advocates and nurses were able to give testimonials regarding their actual experiences to date, and the meeting was quite uplifting for all who attended.

The Results

Once we actually started the project, it immediately began functioning as we had envisioned. The host hospital wanted to begin a month earlier than our revised October start-up date, so we unofficially began the program in September 2004 (two months after our original starting date and one month early of our rescheduled target date). All components of the project were not fully in place – not all of the nurses had completed the necessary clinicals for the pediatric SANE competency. Consequently, on September 1st, the first day of the project, a child victim presented at a hospital and the nurse on call was one who needed further pediatric clinical experience. Although the hospitals could not complain because they were not paying for that month of service, this is a good example as to why we should not have begun the project until we were 100% ready.

After that glitch, there really were no major problems. We did have some turnover in nurses, but we recruited and trained new nurses to take their places. We did not have significant problems in recruiting nurses. The screening process we used initially was that each nurse applied to be part of the team, each hospital recommended their own nurses for the project, additional references were required by nurses who applied who were not currently employed by one of the participating hospitals, and all of the nurses were interviewed by the nurse manager at the host hospital.

The hospitals began looking at the project as a collaborative effort. The nurses functioned very well as a team. Our concerns about traveling in bad weather were unfounded – the nurses worked the issues out among themselves. One way that we helped develop camaraderie and a sense of teamwork among the nurses was through quarterly meetings. Most utilized the opportunity to share experiences and best practices and they were paid to attend by their individual hospitals. We did host an advanced pediatric training for the nurses to address some of their training concerns. Four members of the team attended a training in a neighboring state in September, prior to taking the national SANE certification test. The trainer asked the entire audience numerous questions, which evidently our nurses were eagerly answering. This prompted a question from the trainer, asking who had trained them since they were so well prepared. These experiences substantiate the benefits of training nurses as a team.

The advocate component has been equally successful, with 51 volunteers trained and participating on some level.

Replicability

One of our goals was to create a project that could be replicated. We unquestionably believe we have done that and have documented details of the planning and implementation process to assist other geographical areas in the process. We have presented this project at three national conferences: the national SART conference in May 2003, the national SART conference in June 2005, and the international End Violence Against Women Conference in October 2005. We

have provided technical assistance to numerous programs across the country and have responded to two international inquiries. But more importantly to us, we have several regions in our state considering replicating the project.

For states where the Forensic Exam Fund (and each state has one in some format) reimburses more than $350 per exam, the cost to individual hospitals for implementing this project should be significantly less. Other suggestions we have for creating a cost efficient program include:

- Seek funding for the SANE training component from hospital associations (state and local), statewide ob/gyn and emergency room physician associations, and through the attorney general's office
- Seek funding for the SANE project administrator's salary through local United Way funds, child advocacy center grants, and victim of crime act funds
- Recognize that many hospitals are multi-million dollar organizations. If the rape crisis centers can provide their service at no cost to the hospital, the hospitals should be able to invest some funds into the SANE program.

Additional Background information on the areas/medical facilities

Immediately prior to the implementation of the mobile SANE project, none of the four hospitals had an actual 24/7 SANE program. The largest hospital had previously sponsored one, but it ended because there were not enough SANEs willing to be on-call. The other three hospitals all had 1-4 SANEs on staff, but no on-call program. It is important to note the difference in sizes among the hospitals; the largest is 3-4 times the size of each of the other 3 hospitals.

Also, the project covered a very large geographical area. One of the counties alone is almost the size of the state of Rhode Island (1045.0 sq. miles).

County	Population	Square Miles	Hospital Beds
A	68,652	416.0	286
B	16,919	388.8	70
C	28,262	1039.8	90
D	23,404	354.8	95

Staff and staff time involved in the project

We will preface this section by saying that we were starting this project from scratch. We had no preconceived idea as to whether or not the project would work or where it would be located if we determined it was even feasible. To establish a project in an area that already has interested participants should require fewer staff than this project required, which included a research component. We also had to spend considerable time developing protocols, job descriptions, contracts, and a structure for the project. Much of that information is shared in the Appendices and should require only adaptations for areas interested in replicating the project. Additionally,

we had the parameters of a grant to follow, which created a very stringent timeline that at times was totally out of our control. (For example, the contract among the four hospitals and our coalition had to go through four legal departments. One change by one department started the process over again.)

The staff we had for the project included:
-Coalition staff – we planned for 2 hours per week and in reality was almost ten times that amount to try to deliver the project within the grant time period
-Project Coordinator – we contracted with a consulting firm at the onset of the project (December 2002 – September 2004) to assist us with the study, research mobile projects, and work with us in the second year on much of the planning of the implementation stage. As noted earlier in this report, we initially had planned to hire a SANE, but later concluded that a different skill set was needed for this phase of the project. (A SANE is best, we believe, for the SANE Project Administrator position.) We budgeted 10 hours per week for the Project Coordinator position.
-Community Coordinator – we hired someone for approximately 6 months (April 2003 – November 2003) for about 10 hours per week. This position helped us through the intense period of identifying the focus group region and decision-makers, holding the focus group meeting, and the committee work necessary in the planning process.
-SANE Project Administrator – We did not hire the SANE for this position until July 2004 – less than two months before the project actually began. This position was a contracted position and was projected to work 10 hours per week. Her duties, (after the initial flurry of getting the nurses through the host hospital's mandatory orientation and the protocols and exam rooms were established), included scheduling the nurses, providing the hospitals with the on-call schedule each month, collecting and coordinating the nurses' time sheets with the host hospital's payroll department, and providing quarterly reports and invoices to the hospitals and state sexual assault coalition. She had numerous situations when she provided back-up to the project, including times when more than one victim presented at a hospital at the same time. It was invaluable to the project that the position was filled by a SANE.

Additionally, through the grant we provided each of the two rape crisis centers with funds for a part-time advocate coordinator to develop the volunteer components at two hospitals each. They worked with the hospitals to establish protocols and recruited volunteers, coordinated trainings, maintained the on-call schedule, and held regular meetings with the volunteers.

Current Project Status

Although the grant officially ended September 30, 2005, the hospitals have met about the possibility of extending the project. They currently are in contract negotiations for the project to continue!

The mobile SANE concept is a cost-efficient way to provide a valuable service to victims of sexual violence. It worked very well in our pilot area and we believe that it is a viable solution to developing SANE programs in rural areas.

APPENDIX A
HOSPITAL SURVEY

BACKGROUND INFORMATION NEEDED FROM HOSPITALS

Name of Hospital_____

Address _____

Phone Number_____

Contact Person _____ Date_____

Hi. This is_____, and our Firm has been contracted by the West Virginia Foundation for Rape Information and Services, Inc. to perform a study to assess the feasibility of establishing a regional mobile Sexual Assault Nurse Examiner (SANE) unit in West Virginia. The federal Office of Victims of Crime is looking to pilot the development of this regional mobile unit in West Virginia which will work towards improving the quality of care for sexual assault victims in our State. The development of this mobile SANE unit will also be a unique concept that will then be able to be replicated in other areas across the county.

The purpose of our conversation today is to gain some background information on your hospital and some of the emergency department procedures regarding sexual assault victims and the services provided to them. We have a brief questionnaire that we would like to ask you. Is now a good time?

1. Does your emergency department perform forensic medical exams on sexual assault victims?

1a. If yes, who performs these exams?

1b. If exams are currently being conducted by SANEs (Sexual Assault Nurse Examiners)*, how may SANE trained nurses are actively conducting the exams?

*** A SANE is a registered nurse who has completed specialized classroom training and clinical exams to become eligible for certification to conduct forensic examination of sexual assault victims.**

1c. If your emergency department does have SANE trained nurses, what is the protocol the hospital uses for calling them when a victim is present in the Emergency Department? or example, is the SANE trained nurse on-call or is there a SANE scheduled for each shift, etc.)

1d. Since January 1st of this year, approximately how many sexual assault kits have been used by your hospital's emergency department?

1e. When working with sexual assault victims, does your emergency department follow the WV Protocol for working with sexual assault victims?

1f. If your emergency department does not follow the WV Protocol, why not? (i.e.: are you unaware of it, is it too time consuming, etc.)

2. Do you have any SANE nurses in your hospital that are trained but currently are not actively conducting exams? If so, how many nurses?

3. Do you have any nurses at your hospital who are interested in being trained as a SANE Nurse? If so, approximately how many?

4. What is the service area of your hospital?

5. Do you provide any services to other areas? If so, what are these services and to which areas are they provided?

6. Does your hospital do any other regional networking or credentialing on other healthcare issues?

7. Would you do credentialing with properly trained SANE nurses?

8. Who would I need to talk with about the credentialing process at your hospital?
What is the process which must be undertaken to achieve credentialing?

9. If a SANE mobile unit were set-up on a regional basis, would your hospital be able to provide any nurses to become trained SANE nurses and participate with this program? If so, approximately how many nurses?

9a. If your hospital is not interested in participating, what are the specific reasons? (i.e.: no available funds for training, no nurses available to participate in SANE training, no SANE trained nurses, etc.)

10. Is your hospital organized as a for-profit or not-for-profit organization?

11. Who provides the medical emergency department services in your hospital? Are the doctors employed by your hospital or is it a contracted service? Are the nurses employed by your hospital or is it a contracted service?

<u>If it is a contracted service, then ask questions 11a -11c. If not a contracted service, proceed to question 12.</u>

11a. If services are contracted, name and location of company providing these services?

<u>Physicians</u>:

Nurses:

11b. How long have they been providing these services to your hospital, and when does their contract expire?

Physicians:

Nurses:

11c. Do their contracts automatically renew or does the hospital have to solicit propo-sals each time?

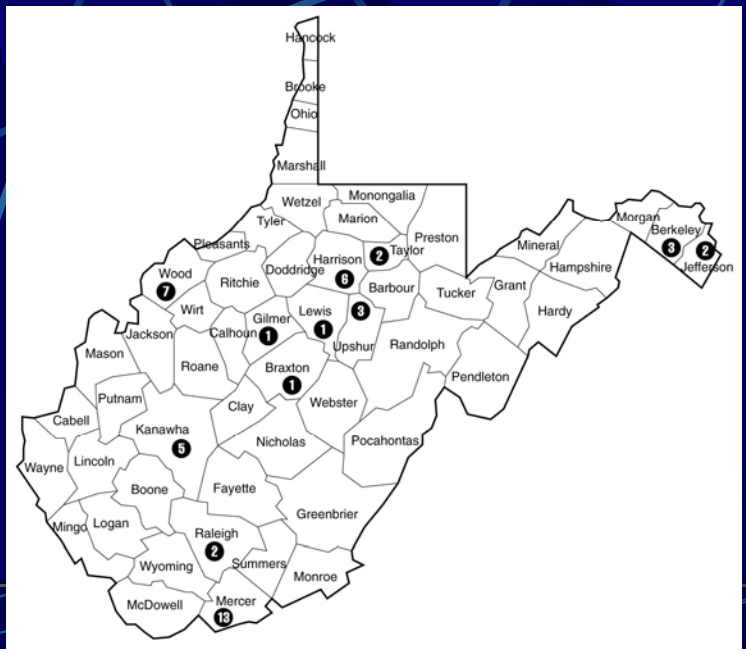
3. How much turnover does your hospital have with regards to emergency depart-ment nurses?

4. Any other comments. (Use back of page if necessary.)

We appreciate you taking the time to answer our questions. Thank you!

APPENDIX B
MAP IDENTIFYING SANE IN WV 2002

WV SANEs - 2002



APPENDIX C

ENDA

REGIONAL SANE MOBILE UNIT
FOCUS GROUP MEETING

Linda E. Ledray, PhD, RN, FAAN, Facilitator

April 23, 2003

9:00a.m.-10:00a.m.	**Welcome/Introductions** **Overview of local SANE/SART Program** **Video: SANE-SART Overview**
10:00a.m.-10:30a.m.	**SANE Mobile Unit Project**
10:30a.m.-10:45a.m.	**BREAK**
10:45a.m.-12:00p.m.	**Feasibility of a SANE Mobile Unit in WV**
12:00p.m.- 1:00p.m.	**LUNCH**
1:00p.m. - 2:15p.m.	**Issues to be Addressed** **Obstacles to the Process**
2:15p.m. – 2:30p.m.	**BREAK**
2:30p.m. - 4:00p.m.	**Advantages with the Program** **How To Make It Work**

APPENDIX D
STRATEGIC PLAN

WEST VIRGINIA FOUNDATION
FOR RAPE INFORMATION AND SERVICES
REGIONAL MOBILE SANE PROJECT
STRATEGIC PLAN

Introduction

The West Virginia Foundation for Rape Information and Services (FRIS) was organized in 1982 to act as the statewide sexual assault coalition for the State of West Virginia. Operating in this capacity, FRIS coordinates the development of a multi-disciplinary protocol for working with sexual assault victims. In addition, the organization has coordinated numerous state-level projects that range from state-wide training sessions to the creation of a 320 page sexual assault prevention curriculum for middle school students. FRIS has been the recipient of federal grants that have been directed at activities and projects such as covering the cost of providing Sexual Assault Nurse Examiner (SANE) training for nurses through out the state. A SANE is a nurse who has completed specialized training classroom training and clinical exams to become eligible for certification to conduct forensic exams of sexual assault victims. This project was directed at a problem facing many assault victims in West Virginia and those in other rural areas of the nation: unequal access to adequate medical care and proper forensic examinations.

The Problem

Sexual assault victims in West Virginia have limited and unequal access to medical care resources and facilities and as a result unequal access to proper forensic examinations which are necessary to prosecute successfully rapists

and perpetrators of sexual assaults. There are a total of 69 licensed medical facilities within the state's 55counties and many counties lack any such facility. This means that in many situations sexual assault victims are forced to travel long distances to the nearest hospital or clinic and upon arrival, they are forced to wait for an oby/gyn to arrive and conduct an examination. This lack of access and medical resources represents a major obstacle to victims who will often leave in frustration and as a result, they do not receive the medical care that they need and they never report the crime. Other obstacles include matters such as: medical personnel who are untrained in forensic evidence collection procedures, staff who are insensitive to the trauma suffered by a sexual assault victim, and medical staff who view the medical needs of an assault victim as much less urgent than that of other injured or ill patients in the emergency room. This is often the case if no physical injuries are visible.

The SANE Solution

FRIS identified the development of a SANE program as a way to ameliorate this deficiency. In 2000-2001, the organization created a statewide advisory board to assist in solving this problem by assisting hospitals in the creation of SANE programs. While SANE programs have been in existence since the late 1970's, they have experienced a strong increase during the 1990's as hospitals across the nation have implemented these programs to improve the level and quality of care provided to sexual assault victims. This expansion has been accompanied by an increase in the level of reporting and an improvement in the quality of forensic evidence collected in support of prosecution efforts.

This effort on the part of FRIS and its SANE Advisory Board enabled these programs to grow from one facility to their location in 9 hospitals with SANEs by the mid-year of 2002. While this represented an incredible success and improvement in the situation facing most sexual assault victims, the majority of these facilities and their respective SANEs were located in the more urban and populated areas of the state. Also, there were fewer SANEs associated with

hospitals in the more rural areas of the state that increases the potential stress levels and the opportunity for burnout and discourages other nurses in their community or local area from becoming a SANE.

Regional Mobile SANE Project

After learning of the existence of regional, mobile SANE units, FRIS believed that this concept represented a very viable alternative that could be implemented in the more rural areas of the state to enhance the development and operation of SANE programs. Regional, mobile units could work to alleviate the deficiencies which are associated with rural health care systems and facilities and which pose significant barriers to the delivery of needed services to victims of sexual assault.

Upon receipt of the grant award, FRIS began the project by searching for a part-time project coordinator with the necessary skills in conducting feasibility studies, needs assessments and coordinating grant-funded activities. This role was filled by the consulting firm of Tiano-Knopp Associates (TKA) of Parkersburg, West Virginia, a private consulting firm with a strong background in conducting feasibility studies, needs assessments, grant writing and administration and related activities.

A telephone survey instrument was developed to collect data and information from the vast majority of all hospitals and licensed medical facilities in the state. This effort identified some additional issues and differences that proved to be quite relevant to the proposed SANE program. Many of the hospitals secured emergency room physicians through external contracts, instead of hiring their own doctors. Professional credentialing of nurses who practice their profession at a specific hospital, but may visit another non-associated facility to provide a professional service, such as conducting a forensic examination, may be a very practical way of enabling SANEs to work on a “regional” basis. There was a gulf between the institution’s understanding of the SANE program and the willingness of many nurses to participate. In some

situations, the hospital expressed a reluctance about the program even though their nurses were willing to become trained and participate in the program. Also, the research associated with this aspect of the project enabled the development of some very sound criteria which were used to identify potential areas of the state where a regional mobile SANE could best operate. This process identified a six county region where a focus group of potential participants was held. The focus group meeting provided critical insights into the development of the project by creating a better understanding of the SANE program on the part of the potential partners in the project and other potential participants. They believed that it was the "right thing to do". Most of the participants stepped up to the challenge and took ownership of the problem. In fact, two of the counties recognized that they were not in a position to proceed this time and opted out of the project. This left four counties with a combined population of approximately 137,237 people which represents slightly more than 7.5 percent of the state's entire population of 1,809,344 persons.

Geography represents a significant challenge in the operation of a regional mobile SANE project. While the region has the population of a metropolitan area, it is spread over a large area where one of the counties has a larger landmass than the State of Rhode Island. This coupled with the terrain of the region makes travel and travel time a challenge in operating the project for the long-term.

However, the final conclusion of the focus group and the follow-up working committee meetings which have been conducted afterwards is that it is not realistic for a rural hospital to meet all of the needs of a sexual assault victim, and in particular the need for a comprehensive, forensic examination and therefore demonstrates the urgent need for a mobile regional SANE project.

Regional Mobile SANE Project: Planning and Implementation

FRIS secured an additional grant to complete the necessary planning and training activities required to implement a regional mobile SANE project in a

rural, four county region of West Virginia. During the initial six months of the project, all of the proposed activities will be implemented by the SANE Coordinator, the Project Coordinator and the Community Coordinator. To enable a seamless transition from this initial phase of the project to its long-term operation, a Regional Mobile SANE Project Administrator will be hired and involved in the project during the third quarter of the grant period. This event will be coupled with the hiring of two Advocate Coordinators who will work on a part-time basis (20 hours per week) in providing sexual assault advocacy services to the participating hospitals prior to the training of volunteer advocates, in assisting in the advocate recruiting and training and assisting in with local and regional SART planning and training activities.

Given the nature of the area and the design of the program, this project will be replicable in other rural areas of the nation. This request also includes funding for examination equipment required to complete a competent forensic examination. The training components include SANE training for nurses and sexual assault advocate training sessions along with a "train the trainer" advocate session. In addition a final SART training element is included as one of the project's final components.

SANE
Statement of Values

The fundamental value of a SANE program is the belief that sexual assault victims have the right to immediate, compassionate, and comprehensive medical-legal intervention and treatment by a specially trained professional who has the experience to anticipate their needs during this time of crisis.

All sexual assault victims have a right (and a responsibility) to report the crime of rape.

a. While a victim may not choose to report the crime to law enforcement, they do have a right to know all available options and what can be expected if they do or do not report the crime.
b. If the victim decides to report the crime, they have a right to sensitive, knowledgeable, and unbiased support during the often difficult criminal justice process.
c. Victims choosing not to report the crime of rape have a right to expert health care.

As health care providers, SANEs have an ethical responsibility to provide victims with complete information about choices so victims can make informed decisions about the care they desire.

The provision of a higher standard of evidence collection and care can speed the victim's recovery to a higher level of functioning, prevent secondary injury or illness, and ultimately increase the prosecution of sex offenders and reduce the incidence of rape.

SANE Mission Statement

The primary mission of a SANE program is to meet the needs of sexual assault victims through the provision of immediate, compassionate, culturally sensitive, and comprehensive forensic evaluation and treatment by trained, professional nurse experts within the bounds of the West Virginia Nurse Practice Act, the SANE standards of the International Association of Forensic Nurses (IAFN), and the policies of the WV FRIS.

National SANE Program Goals

1. To protect the sexual assault victim from further harm.
2. To provide crisis intervention.
3. To provide timely, thorough, and professional forensic evidence collection, documentation, and preservation of evidence.
4. To evaluate and treat prophylactically for sexually transmitted diseases (STDs).
5. To evaluate pregnancy risk and offer prevention.
6. To assess, document, and seek care for injuries.
7. To appropriately refer victims for immediate and follow-up medical care and follow-up counseling.

8. To enhance the ability of law enforcement agencies to obtain evidence and successfully prosecute sexual assault cases.

West Virginia Regional SANE Goals

1. To provide quality care and services to sexual assault victims in the four county region.

2. To decrease the number of sexual assaults in the four county region.

West Virginia Regional SANE Objectives

In order to achieve the above objectives of both the National SANE programs and the West Virginia Regional SANE project, as developed and implemented by FRIS, the following program objectives have been developed. These objectives, which should serve to operationalize the regional project as envisioned by the Regional SANE Advisory Board, are organized along functional categories and described in action or task oriented language.

1. <u>Program Development Objectives</u>

a. Develop Regional SANE Strategic Plan
b. Develop Memoranda of Understanding (MOUs) for all four participating medical facilities.
c. Develop MOUs for the two participating Rape Crisis Centers.
d. Execute MOUs with the four participating medical facilities.
e. Execute MOUs with the two participating rape crisis centers.

f. Identify the administrative party for the project.
    1. Develop and execute contract between FRIS and the administrating agency.
    2. Resolve administration/operation issues:
        a. Office/work space for the Project Administrator.
        b. Other.

g. Hire a Regional Mobile SANE Project Administrator.
    1. Develop a job description for the Project Administrator.
    2. Develop a job application for the Project Administrator.

2. <u>SANE Recruitment and Training Objectives</u>

a. Develop job descriptions for SANE nurses.
b. Develop Job applications for SANE nurses.
c. Develop SANE Commitment Agreements.
d. Recruit nurses for two adult SANE training sessions.
e. Conduct at least two adult SANE training sessions.
f. Train a minimum of 30 SANE nurses.
g. Secure Commitment Agreements from a minimum of 15 newly trained SANE nurses to participate in the regional project on an on-call basis.

3. <u>Sexual Assault Advocate Recruitment and Training Objectives</u>

a. Hire Advocate Coordinators in each of the two participating Rape Crisis Centers.

1. Develop a Job description for the Advocate Coordinator positions.
2. Develop a job application for the Advocate Coordinator positions.

b. Develop a recruitment brochure for the Sexual Assault Advocate Program.

c. Recruit volunteers for two Sexual Assault Response Team (SART) training sessions.

d. Conduct at least two SART training sessions.

e. Train a minimum of 25 volunteers to serve as Sexual Assault Advocates for the regional SANE program.

f. Train a minimum of 8 Sexual Assault Advocates who can provide ongoing training to future volunteers.

g. Secure commitment agreements from at least 10 newly trained Sexual Assault Advocates to participate in the regional SANE project.

4. Program Implementation Objectives

a. Identify and provide orientation to the SANEs who have agreed to take part in the regional project.

b. Identify and provide orientation to the volunteer Sexual Assault Advocates who have agreed to take part in the regional program.

c. Develop SANE examination/treatment protocols that are compatible with all of the four participating medical facilities.

d. Develop a “Completion Evaluation” Form to be used by the State Crime Lab to evaluate all sexual assault

evidence collection kits submitted for evidence processing.

e. Develop Sexual Assault Advocate protocols that are compatible with the two participating rape crisis centers.

f. Develop an on-call system for the SANEs that will be able to provide 24-hour coverage, 7 days per week at all four of the participating medical facilities.

g. Develop a back-up on-call system for the SANEs.

h. Develop an on-call system for the Sexual Assault Advocates that will be able to provide 24-hour coverage, 7 days per week at all four participating medical facilities.

i. Develop a back-up on-call system for the Sexual Assault Advocates.

j. Identify appropriate examination space in all four participating medical facilities where forensic examinations may be conducted by participating SANEs.

k. Develop specifications for all necessary forensic examination equipment that must be purchased.

l. Procure and provide necessary equipment and other matters, such as data collection forms, to the four participating medical facilities.

m. Assemble and distribute SANE notebooks to all participating SANEs that include site maps of each of the four participating medical facilities showing the location of forensic examination sites, equipment and related matters.

III. West Virginia Regional SANE Mobile Program Evaluation

In order to measure the impact of this project, certain evaluation measures have been developed based upon the larger nationwide experience with SANE programs. This experience has documented certain trends on the part of victims of sexual assault, service delivery agencies, and the criminal justice system once a SANE program is in operation. The following objectives will be measured and evaluated at the end of the project period (September, 2005) to indicate the impact of the project in the four county region where it is being implemented.

In addition, several comparison evaluations will be conducted to better assess the program's performance and include matters such as: the "completeness" of sexual assault evidence collection kits, the number of forensic examinations conducted by participating medical facilities, the number of sexual assault charges filed against perpetrators by prosecuting attorney's offices in the region and the disposition of those cases, and service delivery by the participating rape crisis centers.

Also, the overall impact of the project will be measured by collecting data regarding five distinct project concerns.

Finally, a follow-up telephone survey will be conducted to secure additional feedback on the project. This survey is driven by the anticipation of the projects impact on matters such as the streamlining of procedures of many of the agencies and organizations involved in the project, an increase in collaborative activities, an improvement in the support systems for sexual assault victims and additional impacts such as improvements in the reporting and collection of evidence.

1. <u>Program Evaluation Objectives</u>

a. A minimum of 80% of all sexual assault victims that present to participating regional medical facilities will consent to a forensic examination.

b. At least 95% of the sexual assault victims who present at participating regional medical facilities and who consent to a forensic examination will be examined by a SANE.

c. A minimum of 25 sexual assault victims who present at participating medical facilities, between September of 2004 through November of 2004 will be served by SANEs, based on a minimum of 100 victims during a 12-month period.

d. At least 95% of sexual assault victims who present at participating medical facilities will have access to a sexual assault advocate.

e. At least 98% of the sexual assault evidence collection kits submitted to the State Crime Lab from participating medical facilities will be complete.

f. Based upon previous reporting levels (see 3a and 3b, below), the regional SANE project will result in a 10% increase in victims reporting sexual assault.

g. Based upon previous reporting levels (see 3a and 3b, below) the regional mobile SANE project will result in a 15% increase in convictions of perpetrators of sexual assault crimes.

h. Based upon previous reporting levels (see 3a and 3b, below) the regional SANE project will result in a 20% increase in the number of sexual assault victims served by the participating rape crisis centers.

i. Based upon previous reporting levels (see 3a and 3b, below) the regional SANE project will result in a 25% increase in the provision of follow-up victim services.

j. The cost for each of the participating medical facilities will be less than $4,000 per facility after deducting the initial start-up costs of taking part in the regional SANE project.

2. Program Comparison Evaluation

a. **State Crime Lab**. An evaluation will be conducted to determine the completeness of sexual assault evidence collection kits provided by medical facilities with SANEs compared to those without SANEs.

b. **Participating Medical Facilities.** An analysis will be conducted to determine the change in the number of sexual assault forensic examinations completed utilizing data from three reporting periods: 9/1/02 to 8/31/03, 9/1/03 to 8/31/04, 9/1/04 to 8/31/05.

c. **Participating Medical Facilities**. Near the end of the project period (no later than 9/01/05), a cost analysis of the SANE component will be conducted to determine the estimated cost or savings to each of the participating medical facilities for participating in the regional SANE project.

d. **Prosecuting Attorney's Offices**. An analysis will be conducted to determine the change in the number of assault charges filed against perpetrators and the disposition of those cases based upon data from three reporting periods: 9/1/02 to 8/31/03, 9/1/03 to 8/31/04, 9/1/04 to 8/31/05.

e. **Rape Crisis Centers.** An analysis will be conducted to determine the change in the number of sexual assault

victims served and the number of follow-up victims served for the following reporting periods: 9/1/02 to 8/31/03, 9/1/03 to 8/31/04, 9/1/04 to 8/31/05.

3. Overall Project Performance Measures

a. The number of sexual assault victims provided with SANE services and sexual assault advocacy services.
b. The number of professionals served:
    1. SANEs.
    2. Advocates.
c. The number of sites reporting policy/practice changes.
d. The number of sites reporting an increase in collaborative partners.
e. The number of active investigations.

4. Telephone Survey

Many of the impacts of a project such as this one are either not measurable in ways which can be objectively quantifies and in some cases they can not be precisely predicted or even predicted at all. To better gage the real impact of this project, a follow-up telephone survey will be conducted near the end of the project period (no later than 9/15/05) and will target each of the participating medical facilities, the prosecuting attorney's offices, local and county law enforcement agencies, and the participating rape crisis centers. The purpose of the survey is to collect information and data not included in the evaluation process. This includes anecdotal information on their evaluation of the project.

APPENDIX E
SANE Project Administrator Job Description
SANE Project Administrator Contract

West Virginia
Foundation for Rape Information and Services
Regional SANE Project

SANE Project Administrator
Job Description

1. The Project Administrator must be a SANE who is able to complete the evidentiary/forensic examination and maintains their professional competency and license.

    a. Enables the Administrator to act as the primary/emergency backup.

    b. Provides depth of coverage.

    c. Provides enhanced program credibility.

2. The Project Administrator will act as the “keeper of the records” for the SANE project.

    a. Allows the Administrator to testify as to the facts contained in the records collected by the SANEs.

    b. The Administrator may be able to testify as an expert witness if he/she maintains their professional credentials.

3. The Project Administrator should have management skills and experience.

4. Project Administrator, Job Duties:

    a. Responsible for the overall vision and direction of the SANE project and its day-to-day operations.

    b. Responsible for developing an annual budget and identifying appropriate revenue sources.

    c. Responsible for coordinating the recruitment and hiring of the SANE staff.

d. Responsible for insuring that SANEs maintain their training requirements and assisting in securing training needs.

e. Assists in identifying methods to reduce staff turnover and burnout.

f. Acts as a liaison with other community groups and resources.

   i. Involved in local/regional SART activities.

   ii. Involved in community education about sexual assault issues and the role of the SANE project and its staff.

   iii. Develop an understanding of the range of available community resources.

   iv. Provide positive and effective information and presentations on the SANE project to the general public.

g. Assist in the ongoing efforts involved in project evaluation activities.

h. Responsible for scheduling and conducting staff meetings of the SANE team members.

i. Responsible for ensuring that all SANES (including the Project Administrator) secure clinical requirements.

SANE PROJECT ADMINISTRATOR CONTRACT

PERSONAL SERVICES CONTRACT AGREEMENT

This Agreement is made effective as of the 1st day of July,2004, by and between The West Virginia Foundation for Rape Information and Services, Inc.(FRIS), whose address is 112 Braddock Avenue, Fairmont, West Virginia 26554 and _____, whose address is _____.

In this Agreement, the party who is contracting to receive services shall be referred to as FRIS and the party who will be providing the services shall be referred to as XXXXXX.

The parties agree as follows:

1. Description of Services: Beginning on July 1, 2004, serving as the Project Administrator of the Regional Mobile SANE Project, XXXXXX will perform the following job duties and responsibilities:

g. Responsible for the implementation of the overall vision and direction of the SANE project and its day-to-day operations. This includes creating a monthly on-call schedule, developing and maintaining a record-keeping system to monitor the forensic exams conducted, and a payment system for the SANE project nurses.

h. Responsible for working within the established an annual budget for the project and identifying other potential revenue sources for the SANE project if they become available.

i. Responsible for coordinating the recruitment the SANE project nurses and assist Host Hospital (upon request) in issues related to the orientation and hiring of those nurses.

j. Responsible for insuring that the SANE project nurses meet and maintain any mandated training requirements (including clinical experiences) and assisting in meeting training needs when possible.

k. Secure commitments from at least 10 SANEs for the project.

l. Work with the Project Coordinator to develop an on-call system and back-up on-call system for 24 hour coverage for the four participating medical facilities.

m. Work with the Project Coordinator to identify the forensic examination space at all four medical facilities, establish protocols, and create informational notebooks for the SANE project nurses.

n. Act as a liaison with other community groups and resources, and in particular may become involved in the following activities:

i) Local/regional SART activities.

ii. Community education about sexual assault issues and the role of the SANE project and its staff.

iii. Develop an understanding of the range of available community resources.

iv. Provide positive and effective information and presentations on the SANE project to the general public.

i. Assist the Project Coordinator and FRIS SANE Coordinator in the ongoing efforts involved in project evaluation activities.

j. Responsible for scheduling and conducting periodic meetings of the SANE project nurses and, as needed, address any issues regarding participation, scheduling, turnover, and burnout.

k. Responsible for working out an invoicing/payment system for the hospitals and Host Hospital for the payment of $350 to the host hospital each time one of the medical facilities utilizes a SANE project nurse to conduct a forensic exam.

2. Reporting Requirements:

a. To all participating hospitals and FRIS, XXXXXX will monthly provide a copy of the on-call schedule.

b. To HOST HOSPITAL and FRIS, XXXXXX will quarterly provide a report that includes the dates of any uncovered shifts, a listing (by nurses) of the number of exams they conducted and their financial remuneration (including on-call hours), a listing of any invoices sent to participating medical facilities for any forensic exams conducted and listing of revenue received (by source) by HOST HOSPITAL from the participating medical facilities.

c. To FRIS, XXXXXX will provide a monthly written summary of activities conducted under this contract.

3. Performance of Services: The manner in which the Services are to be performed and the specific hours to be worked by XXXXXX shall be determined by XXXXXX and the nature of the work. FRIS will rely on XXXXXX to work as many hours as may reasonably be necessary to fulfill her obligations under this Agreement.

4. Payment: FRIS will pay XXXXXX a fee for services at a rate of $1600 per month for the initial two months (July 2004 and August 2004), and $800 per month for the remaining 13 months. Upon termination of this Agreement, payments under this paragraph shall cease; provided, however, that XXXXXX shall be entitled to payments for periods or partial periods that occurred prior to the date of termination and for which XXXXXX has not yet been paid.

4. Expense Reimbursement: XXXXXX shall pay all "out-of-pocket" expenses and shall not be entitled to reimbursement from FRIS.

6. Termination: This Agreement shall terminate automatically on 9/30/05, or upon 30 days written, prior notice by either of the parties.

7. Relationship of Parties: It is understood by the parties that XXXXXX is an independent contractor with respect to FRIS and not an employee of FRIS. FRIS will not provide fringe benefits, including health insurance benefits, paid vacation, or any other employee benefit, for the benefit of XXXXXX.

8. Injuries: XXXXXX acknowledges XXXXXX's obligation to obtain appropriate insurance coverage for the benefit of XXXXXX. XXXXXX waives any rights to recovery from FRIS for any injuries that XXXXXX may sustain while performing services under this Agreement and that are a result of the negligence of XXXXXX.

9. Indemnification: XXXXXX agrees to indemnify and hold FRIS harmless from all claims, losses, expenses, fees including attorney fees, costs, and judgments that may be asserted against FRIS that result from the acts or omissions of XXXXXX.

10. Assignment: XXXXXX's obligations under this Agreement may not be assigned or transferred to any other person, firm, or corporation without the prior written consent of FRIS.

11. Notices: All notices required or permitted under this Agreement shall be in writing and shall be deemed delivered in person or deposited in the United States mail, postage prepaid, addressed as follows:

$ *If for FRIS:*

5. West Virginia Foundation for Rape Information Services, Inc.
   112 Braddock Avenue
   Fairmont, West Virginia 26554

- *If for XXXXXX:*

XXXXXX
Address
City, State

The above addresses may be changed, by either party, by providing written notice to the other party in the manner set forth above.

12. Entire Agreement: This Agreement contains the entire agreement of the parties, and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.

13. Amendment: This Agreement may be modified or amended if the amendment is made in writing and is signed by both parties.

14. Severability: If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

15. Waiver of Contractual Right: The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's rights to subsequently enforce and compel strict compliance with every provision of this Agreement.

16. Acceptance. The Parties indicate their acceptance of this Agreement by signing below.

Party Receiving Services:

West Virginia Foundation for Rape Information Services, Inc.
112 Braddock Avenue
Fairmont, West Virginia 26554

By:_____

Nancy Hoffman, State Coordinator

Party Providing Services:
XXXXXX
Address
City, State

By:_____
XXXXXX, SANE Project Administrator

APPENDIX F
APPLICATION - SANE

SANE Mobile Regional Project
Application for SANE

Name:

Current Address:

City/State/Zip:

Phone:_____ Cell Phone:_____Pager:

E-Mail Address:

RN Education: (Include Graduate Hours)

Name of School_____ Mo./Yr. Graduated Degree

Name of School_____ Mo./Yr. Graduated Degree

RN Licensure: State_____ Number_____ Expires_____ State_____ Number Expires

Is your license current and unencumbered?

Certifications/CEs: Please enclose copies.

Name:_____ Date Taken:_____Expires:

Name:_____ Date Taken:_____Expires:

Have you ever had disciplinary action taken against any of your nursing licenses, or are you at this time the subject of a report or investigation? No Yes

(If the above answer is yes, please provide details on a *Privacy Page)

Have you ever been convicted of a felony or misdemeanor?

RN EMPLOYMENT HISTORY: List most recent employment first. You must account for all time from the present to month & year that you passed the State Boards and received your RN license. Use additional pages as necessary. Do not omit any RN position. If there was a problem, explain on a separate page. Please explain all breaks in employment and provide verification information. Please make sure that the contact information and phone numbers are current and accurate.

Current Employer:_____ Employer ID#:
Charge Nurse:_____ Supervisor:
City:_____ State:_____ Zip Code:

How long have you been employed in your current position?

I work primarily (shift)_____ # of Days per Week

I would be available for on-call SANE duties, primarily (days of week and times):

Previous Employer:_____From:_____ To:

(Mo./Date/Yr.) **(Mo./Date/Yr.)**

Charge Nurse:_____ Supervisor:
City:_____ State:_____ Zip Code:

What most interests you about this position? What would you like to see accomplished as a member of the SANE team? What skills and qualifications do you bring to the position?

Comments/Questions:

I hereby certify that all of the statements contained in this application are true and complete to the best of my knowledge. In the event that I am hired for the team, I understand that if any of the information that I provided is not true, or if I have given incomplete information, my employment as a SANE may be terminated.

By my signature below, I hereby authorize the Mobile SANE program, or its designee, to conduct an investigation of all statements contained in this application, including credit and criminal histories. I further authorize all educational institutions and employers listed in this application to release any and all non-medical records related to me and to speak with and provide truthful, non-medical information about me. I understand that neither educational institutions nor former employers have an obligation to provide the requested information. Thus, the consideration for any such institution or organization to provide the requested information is my agreement hereby to hold them harmless and release them from any and all liabilities for their doing so.

Signature of Applicant:_____ Date:

Please return completed application with resume and two (2) references by

To:

APPENDIX G
SANE CONTRACT/COMMITMENT AGREEMENT

SANE Commitment Agreement

The purpose of the following agreement is to assure an understanding between hospitals participating in the SANE Mobile Project and the individual Sexual Assault Nurse Examiners, (SANEs). This agreement outlines the expectations of the Project Administrator of the SANE mobile Project, the SANEs, and the participating hospitals.

The SANEs may expect:

1. To be compensated when a forensic exam is performed. Future compensation will be based on certification.

2. To be compensated while on call.

3. To work at least one shift per week.

4. To have a non-judgmental, open door policy to address personal and professional issues related to the SANE practice.

5. To be provided with educational offerings within the SANE program in areas of interest and need.

6. To have advocacy support at every forensic exam.

7. To have available post event counseling and debriefing.

8. To be oriented with each participating hospital.

9. To attend regularly scheduled staff meetings.

10. To have normal exam competencies waived for SANEs performing a minimum of five forensic exams per year.

The participating hospitals can expect:

1. The nurse to attend the 5-day (40 hours) SANE Adult Training and the 4-day (32 hours) Pediatric SANE Training and complete the necessary clinical training.

2. The SANE to take the minimum of one shift of on-call duty per week to maintain examiner privileges for a minimum of one year after completing their training.

3. The SANE to report as soon as possible, but no later than two hours from the time they are called to perform the examination.

4. The SANE to provide the medical/forensic examination as outlined by the SANE protocol and established procedures.

5. The SANE to maintain currency in practice by attending the educational offerings provide with the SANE Mobile Project.

In addition to the above the undersigned SANE understands that if they fail to fulfill their commitment of training, certification, and one year of practice in the SANE Mobile Project, the undersigned SANE will reimburse the appropriate party for their SANE training expenses.

_____

SANE Date

_____

SANE Project Administrator Date

APPENDIX H
APPLICATION FOR VOLUNTEER ADVOCATE

SANE Mobile Project Volunteer Advocate Application

Date _____

Name _____

First Middle Last

Address _____

_____

_____

Phone: Home _____ Work _____

DOB _____ SS# _____

How did you hear about our program?

Current Employer/School _____

Address_____

_____

_____

Phone _____

Emergency Contact _____

Address _____

_____

_____

Phone: Home _____ Work _____

References

We will use the employer listed above as a reference. Please list three additional references we may contact, giving COMPLETE and CURRENT addresses and phone numbers.

1) Name _____

Address _____

_____

_____

Phone: Home _____ Work _____

Relationship _____

2) Name _____

Address _____

_____

_____

Phone: Home _____ Work _____

Relationship _____

3) Name _____

Address _____

_____

_____

Phone: Home _____ Work _____

Relationship _____

Please answer the following questions as completely as possible. Feel free to include extra pages if you need additional space.

1. Briefly describe your employment background.

2. Please describe your educational background and training.

3. What are your reasons for wanting to volunteer as a Rape Crisis Advocate?

4. What do you think you can offer as an advocate?

5. Please describe your own history with sexual violence, harassment, or domestic violence, if any.

6. Working closely with issues of sexual abuse can be stressful. Describe the types of support available to you.

7. What, if any, foreign language do you speak, including sign language?

8. Are you able to commit to attend team and/or in-service meetings regularly?

9. Are you able to commit to this position for a minimum period of one year?

10. What do you hope to get for yourself from this experience?

11. Is there anything else you would like us to know about you?

12. How far do you live from the closest hospital?

APPENDIX I
VOLUNTEER ADVOCATE CONTRACT

VOLUNTEER ADVOCATE CONTRACT

Responsibilities of the Volunteer Advocate:

1. Maintaining strict confidentiality with each case so as to protect the privacy of all clients served.
2. Attending all parts of the initial advocacy training.
3. Attending a monthly advocate team meeting, including in-service presentations, and contacting team leader or program coordinator if unable to attend.
4. Making a minimum one-year commitment to the program.
5. Being on call, from home or by a pager, according to a monthly pre-arranged schedule.
6. Being completely drug- and alcohol-free while on shift or backing up a shift.
7. Calling the shelter at the beginning of your shift to verify your phone number and update it as needed.
8. Providing information, referrals or emotional support over the phone for hotline callers, and responding in person at the hospital to assist survivors of sexual assault.
9. Never entering into a professional relationship with a client (e.g., as a hair stylist, dog groomer, etc.)
10. Never going to a victim's home or the scene of the alleged crime without having a police escort and contacting your program supervisor.
11. Reporting a brief description of each case to the office staff at the beginning of the next working day.
12. Providing a written report with details of each case within 48 hours of the call.
13. Reporting any incident of child sexual abuse (age 17 or under) or alleged/suspected child abuse to Child Protective Services and Law Enforcement immediately after receiving a disclosure. You are required by law to file this report.
14. Consulting with office staff before maintaining ongoing involvement in any case.
15. Doing follow-up on cases when appropriate, and providing information regarding that follow-up to the program supervisor.

Responsibilities of the Rape Crisis Center Staff:

1. Providing an initial 2-day training for Volunteer Advocates as well as follow-up training and supervision in specific areas to enhance their job performance, as appropriate.
2. Providing debriefing and supervision to advocates in the office and via phone during and after the immediate crisis in which they are involved, as appropriate.
3. Providing support services to advocates in the areas of information, referral, backup advocacy, and short-term personal counseling pertaining to their role as an advocate.

4. Providing evaluations pertaining to an advocate's performance at the request of the advocate, or the supervisor.
5. Other responsibilities as agreed upon:

_____

_____

I understand and agree to accept the responsibilities outlined above. I understand that CONFIDENTIALITY is the primary task of all advocates; therefore, I will use only the office staff for consultation on cases. I understand that if I break any part of this contract, my services with the _____ will be terminated.

_____
Date

_____
Volunteer Advocate

_____
Volunteer Supervisor