COMMONWEALTH of VIRGINIA

Department of Health

Karen Shelton, MD
State Health Commissioner

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January 15, 2025

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor, Commonwealth of Virginia

The Honorable L. Louise Lucas
President Pro Tempore, Senate of Virginia

The Honorable Don Scott
Speaker, Virginia House of Delegates

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: Services for Survivors of Sexual Assault Task Force

This report is submitted in compliance with the Code of Virginia § 32.1-162.15:11, which states:

> *The Task Force shall… Report to the Governor and the General Assembly by December 1 of each year regarding its activities and the status of implementation of the provisions of this article.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/AJ
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

SERVICES FOR SURVIVORS OF SEXUAL ASSAULT

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

2023

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The Code of Virginia § 32.1-162.15:11 mandated the establishment of the Task Force on Services for Survivors of Sexual Assault (Task Force) and instructed the Task Force to assist with the implementation of the treatment and transfer requirements placed on hospitals and pediatric health care facilities for adult and pediatric survivors of sexual assault. The code requires that the Task Force produce an annual report to the Governor and the General Assembly by December 1 of each year regarding its activities and the status of implementation of the provisions the code. The code tasks the Virginia Department of Health (VDH) with providing staff support to the Task Force. VDH assisted the Task Force with preparing this document, which serves as the Task Force's 2023 report.

TASK FORCE MEMBERS

Virginia House of Delegates
The Honorable Kelly K. Convirs-Fowler, Delegate
The Honorable Karrie K. Delaney, Delegate

Senate of Virginia
The Honorable Jennifer B. Boysko, Senator

Office of the Attorney General
The Honorable Alyson Tysinger, Attorney General

Virginia Department of Health
Maria Altonen, Chair, Commissioner Designee, Office of Family Health Services

Virginia Department of Social Services
Danny Avula MD, Commissioner

Virginia State Police
Caren Sterling, Deputy Director Bureau of Criminal Investigation

Representatives of a Licensed Hospital
Robin Foster, MD
Dawn Scaff, MSN, RN, SANE-P

Licensed Physician and Practitioner of Emergency Medicine
Linsey N. Caley, MD
Scott E Sparks, MD, MS, RDMS, RDCS, FACEP

Sexual Assault Nurse Examiner
Bonnie Price, DNP, RN, ASNE-A, SANE-P, AFN-BC
Melissa Ratcliff Harper MSN, APRN, SANE-A, SANE-P
Sara Jennings, DNP, RN, SANE-A, ASNE-P, AFN-BC

Member of Sexual Assault Survivor Advocacy Organization
Patricia McComas Hall
Chatonia "Toni" Zollicoffer, LPC

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EXECUTIVE SUMMARY

Chapter 725 of the 2020 Acts of Assembly amended the Code of Virginia to include § 32.1-162.15:11, which established the Task Force on Services for Survivors of Sexual Assault (Task Force) to assist with the implementation of the treatment and transfer requirements placed on hospitals and pediatric health care facilities for adult and pediatric survivors of sexual assault. The code also mandates that the Task Force submit a report to the Governor and the General Assembly by December 1 of each year regarding its activities and the status of implementation. The code tasks the Virginia Department of Health (VDH) with providing staff support to the Task Force. VDH assisted the Task Force with preparing this report.

From December 2022 to September 2023, the Task Force convened five times to advance its work. A summary of the status of the Task Force's work is outlined below.

2023 STATUS UPDATE

In 2023, the Task Force continued to prioritize work on the development of model treatment and transfer plans and transfer agreements for adult and pediatric survivors of sexual assault. The composition of the Task Force allowed for input from hospitals, pediatric health care facilities, and subject matter experts to inform the development of these model documents. At the time of this report, the Task Force approved a model pediatric transfer agreement, pediatric transfer plan, pediatric full treatment plan, and pediatric partial treatment plan. The Task Force anticipates finalizing the adult model treatment and transfer plans and transfer agreements by the end of 2023.

In 2024, the Task Force plans to focus efforts on the remaining requirements identified in Code of Virginia § 32.1-162.15:11:

- Develop model written agreements for use by treatment hospitals and approved pediatric health care facilities required to enter into agreements with rape crisis centers;
- Work with treatment hospitals and approved pediatric health care facilities to develop plans to employ or contract with sexual assault forensic examiners for treatment services to survivors of sexual assault by sexual assault forensic examiners, including plans for implementation of on-call systems to ensure availability of sexual assault forensic examiners;
- Work with treatment hospitals and approved pediatric health care facilities to identify and recommend processes to ensure compliance related to creation, storage, and retention of photographic and other documentation and evidence;
- Develop and distribute educational materials regarding implementation to hospitals, health care providers, rape crisis centers, children's advocacy centers, and others; and
- Study and provide recommendations to the Virginia Department of Health for the use of telemedicine in meeting the requirements of Article 8 (§ 32.1-162.15:2 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia.

INTRODUCTION

TASK FORCE MANDATE

As outlined in the Code of Virginia § 32.1-162.15:11, the primary responsibilities of the Task Force are to develop model documents, plans, and processes for hospitals and pediatric health care facilities; educate facilities on their obligations in treating or transferring survivors of sexual assault; and provide recommendations to VDH to help increase the use of telemedicine in providing services to survivors of sexual assault. The code also mandates that the Task Force work with designated stakeholders, such as treatment hospitals, transfer hospitals, and pediatric health care facilities, to accomplish this work (Appendix A).

TASK FORCE ACTIVITIES

The activities of the 2023 task force can be summarized as follows:

- Voted to approve the pediatric full treatment plan, partial treatment plan, transfer plan, and transfer agreements, after incorporating feedback from the OLC and VHHA.
- Reviewed adult best practice and algorithm guidance:
    - Examined how a temporary detention order (TDO) would change the process TDO
    - Received feedback from OLC and VHHA

The pediatric model documents contain a transfer agreement, transfer plan, full treatment plan, and partial treatment plan, and can be summarized as follows:

- The transfer agreement outlines the criteria and responsibilities for transferring a pediatric patient to another hospital.
- The transfer plan outlines procedures for stabilizing treatment, patient transfer, mandatory reporting, and clinical considerations.
- The full treatment plan consists of procedures for stabilizing treatment, forensic exams, sexually transmitted disease evaluation, medication treatment and follow-up care, advocacy services, and sexual assault training.
- The partial treatment plan consists of procedures for stabilizing treatment, forensic exams, sexually transmitted disease evaluation, medication treatment and follow-up care, advocacy services, sexual assault training, and 24/7 coverage.

In 2024, the Task Force plans to complete the remaining requirements.

- Develop model written agreements for use by treatment hospitals and approved pediatric health care facilities required to enter into agreements with rape crisis centers;
- Work with treatment hospitals and approved pediatric health care facilities to develop plans to employ or contract with sexual assault forensic examiners for treatment services to survivors of sexual assault by sexual assault forensic examiners, including plans for implementation of on-call systems to ensure availability of sexual assault forensic examiners;
- Work with treatment hospitals and approved pediatric health care facilities to identify and recommend processes to ensure compliance related to creation, storage, and retention of

photographic and other documentation and evidence;
- Develop and distribute educational materials regarding implementation to hospitals, health care providers, rape crisis centers, children's advocacy centers, and others; and
- Study and provide recommendations to VDH for the use of telemedicine in meeting the requirements of Article 8 (§ 32.1-162.15:2 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia.

As of this report, the Task Force has 16 active members and three vacancies. In 2023, the Task Force prioritized work on the development of model treatment and transfer plans and transfer agreements for adult and pediatric survivors of sexual assault. The Task Force approved pediatric model plans and agreements and anticipates finalizing the adult model plans and agreements by the end of 2023. As mandated by § 32.1-162.15:11, VDH provided support staff to the Task Force to help carry out its work and produce this report. The Task Force met five times during this reporting period to move its work forward:

DECEMBER 12, 2022: FULL TASK FORCE HYBRID MEETING

Members of the Task Force discussed objectives and timelines for the Task Force. The Task Force decided that once they had completed and approved the pediatric transfer and treatment plans and transfer agreement model documents, they would complete the corresponding adult model documents, and then focus on developing the workforce and education plan activities. The Task Force requested more information from VDH on external deadlines for activity completion and the Chair stated that they would follow up about this during the next meeting. A Task Force member led a discussion on two draft documents that the Task Force had put together prior to the meeting, entitled the Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients document and the Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients Algorithm. The purpose of these documents was to outline best practices for the treatment and transfer of pediatric sexual assault patients for health systems. The Task Force made additional changes to both documents during the meeting.

JANUARY 9, 2023: FULL TASK FORCE VIRTUAL MEETING

Members reviewed a revised version of the Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients document, which incorporated the Task Force's edits from the December 12, 2022 meeting. The Task Force did not make any additional changes to this document during the meeting. Having met quorum, the Task Force voted to approve the Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients document. One member of the public joined the meeting and provided public comment. Following up on a question from the previous meeting, the Chair clarified that the Task Force's authorizing code did not mandate any specific external deadlines for the Task Force to complete its activities. Members of the Task Force suggested that the Task Force set its own deadlines for its deliverables to facilitate workflow. The Chair confirmed that they would bring this topic to the next meeting for discussion. A guest presenter from a forensic nurse examiners workgroup joined the meeting and shared updates about an upcoming training for forensic nurse examiners and the awardees of the Victim Fund Grant Solicitation. The Task Force reviewed the Model Transfer Quick Reference Guide for Pediatric Sexual Abuse Patients Algorithm and voted to approve the document.

MARCH 20, 2023: FULL TASK FORCE HYBRID MEETING

The primary agenda item for this meeting was to work on the adult model documents. Members of the Task Force read over the previously approved Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients document and Model Transfer Quick Reference Guide for Pediatric Sexual Abuse Patients Algorithm, to help inform the development of the adult model documents. A Task Force member led a review of a draft version of the Adult Algorithm and Best Practices Guide. The Task Force provided input on the document, and VDH staff recorded the proposed edits. The Task Force requested feedback from the VDH Office of Licensure and Certification (OLC) on processes regarding if a patient cannot be transferred to another facility for sexual assault due to a temporary detention order (TDO) and processes for transferring patient from trauma center to lower care center for sexual assault and back to trauma center.

JULY 17, 2023: FULL TASK FORCE VIRTUAL MEETING

In June 2023, prior to the Task Force meeting the VDH OLC emailed health systems and the Task Force requirements for the pediatric and adult treatment plans, transfer plans, and transfer agreements, including deadlines for health systems and a checklist of components that the plans and agreements must include. The Task Force Chair cross-checked the Task Force's approved pediatric documents with the OLC checklist and found gaps within the approved pediatric documents. The Chair arranged the July meeting with the Task Force to revise the previously approved pediatric documents to align with OLC's checklist and address health systems' concerns over deadlines.

During the Task Force meeting, the VDH Office of Family Health Services (OFHS) Director addressed timelines for hospitals to turn in their pediatric and adult plans without having to write and re-write their original plans. A representative from OLC provided context for how OLC developed the checklist and answered questions regarding regulatory language. The OLC representative reported that OLC has an internal deadline of October to draft its required report to the General Assembly to comply with the December 1st annual report submission deadline. The report must include a list of hospitals that have and have not submitted their plans, and OLC has 30 days to review and respond to hospital plans.

The Chair proposed that the Task Force use the meeting to begin to iterate on new pediatric treatment and transfer plans and a transfer agreement prepared by VDH in alignment with OLC guidance and integrating components from the previously approved pediatric documents. Members of the Task Force decided instead to review and provide feedback on the new draft pediatric model documents outside of the Task Force meeting, in a manner that complied with Virginia Freedom of Information Act (FOIA) requirements for gubernatorial Task Force operations.

The OLC representative answered remaining questions from the Task Force members, including questions related to how to address code that conflicts with best practice, education for emergency department nurses or forensic staff, annual training requirements, how the Emergency Medical Treatment and Active Labor Act (EMTALA) covers transfers, and how to verify oral information.

SEPTEMBER 22, 2023: FULL TASK FORCE HYBRID MEETING

A Virginia Hospital and Healthcare Association (VHHA) representative joined the Task Force meeting to support the Task Force in developing new pediatric model documents. The VHHA representative led the Task Force members in review of new proposed pediatric model documents, including a full treatment plan, partial treatment plan, transfer plan, and transfer agreement. The Task Force did not make any additional changes to the proposed documents. The Task Force voted to approve the pediatric full treatment plan, partial treatment plan, transfer plan, and transfer agreement, which are included as Appendix C, Appendix D, Appendix E, and Appendix F (respectively) of this annual report. These approved documents replaced the originally approved pediatric documents entitled, "Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients" and "Model Transfer Quick Reference Guide for Pediatric Sexual Abuse Patients Algorithm."

Next, the VHHA representative reviewed a new proposed adult treatment plan, transfer plan, and transfer agreement, modeled after the corresponding pediatric documents. The Task Force requested time to review the adult model documents outside of the Task Force meeting, in preparation to vote on the documents at the next Task Force meeting. Lastly, the VHHA representative provided an update on the drafted Memorandum of Understanding (MOU) model documents with rape crisis centers. The Task Force determined it would review the drafted MOU model documents for rape crisis centers and child advocacy centers at the following Task Force meeting.

REPORT OUTLINE

The remainder of this report summarizes the activities of the Task Force. The approved pediatric model documents are included in the report appendix.

TASK FORCE ON SERVICES FOR SURVIVIORS OF SEXUAL ASSAULT

During the reporting period, the Task Force focused on the first two responsibilities required by the Code of Virginia § 32.1-162.15:11:

- Develop model treatment and transfer plans and work with hospitals and pediatric health care facilities to facilitate the development of treatment and transfer plans; and
- Develop model written transfer agreements and work with treatment hospitals, transfer hospitals, and pediatric health care facilities to facilitate the development of transfer agreements.

The composition of the Task Force allowed for input from hospitals, pediatric health care facilities, and subject matter experts to inform the development of draft model treatment and transfer plans and transfer agreements. Initially, the Task Force drafted and approved the Model Transfer Plan Quick Reference Guide for Pediatric Sexual Abuse Patients document and algorithm in January 2023. However, in June 2023, OLC emailed a checklist of requirements for model documents to be in line with proposed regulations and deadlines for hospitals to submit their plans. The Task Force therefore subsequently replaced the originally approved pediatric model documents with updated versions of the documents that aligned with OLC requirements. At the time of this annual report, the Task Force has approved a pediatric full treatment plan, partial treatment plan, transfer plan, and transfer agreement. The Task force anticipates finalizing the adult treatment plan, transfer plan, and transfer agreement by the end of 2023.

In 2024, the Task Force plans to complete the remaining requirements.

- Develop model written agreements for use by treatment hospitals and approved pediatric health care facilities required to enter into agreements with rape crisis centers;
- Work with treatment hospitals and approved pediatric health care facilities to develop plans to employ or contract with sexual assault forensic examiners for treatment services to survivors of sexual assault by sexual assault forensic examiners, including plans for implementation of on-call systems to ensure availability of sexual assault forensic examiners;
- Work with treatment hospitals and approved pediatric health care facilities to identify and recommend processes to ensure compliance related to creation, storage, and retention of photographic and other documentation and evidence;
- Develop and distribute educational materials regarding implementation to hospitals, health care providers, rape crisis centers, children's advocacy centers, and others; and
- Study and provide recommendations to VDH for the use of telemedicine in meeting the requirements of Article 8 (§ 32.1-162.15:2 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia.

APPENDIX A – CODE OF VIRGINIA §32.1-162.15:11

Be it enacted by the General Assembly of Virginia:

§ 32.1-162.15:11. Task Force on Services for Survivors of Sexual Assault.

A. There is hereby created the Task Force on Services for Survivors of Sexual Assault (the Task Force), which shall consist of (i) two members of the House of Delegates appointed by the Speaker of the House of Delegates; (ii) one member of the Senate appointed by the Senate Committee on Rules; (iii) the Attorney General, or his designee; (iv) the Commissioners of Health and Social Services, or their designees; (v) the Director of the Department of State Police; (vi) two representatives of hospitals licensed by the Department of Health appointed by the Governor; (vii) three physicians licensed by the Board of Medicine to practice medicine or osteopathy appointed by the Governor, each of whom is a practitioner of emergency medicine and at least one of whom is a pediatrician; (viii) three nurses licensed to practice in the Commonwealth appointed by the Governor, each of whom is a sexual assault nurse examiner; (ix) two representatives of organizations providing advocacy on behalf of survivors of sexual assault appointed by the Governor; and (x) one representative of an organization providing advocacy on behalf of children appointed by the Governor; and (xi) one representative of a forensic clinic appointed by the Governor. The Commissioner of Health or his designee shall serve as chairman of the Task Force. Staff support for the Task Force shall be provided by the Department of Health.

B. The Task Force shall:

1. Develop model treatment and transfer plans for use by transfer hospitals, treatment hospitals, and pediatric health care facilities and work with hospitals and pediatric health care facilities to facilitate the development of treatment and transfer plans in accordance with the requirements of this article;

2. Develop model written transfer agreements for use by treatment hospitals, transfer hospitals, and pediatric health care facilities and work with treatment hospitals, transfer hospitals, and pediatric health care facilities to facilitate the development of transfer agreements in accordance with the requirements of this article;

3. Develop model written agreements for use by treatment hospitals and approved pediatric health care facilities required to enter into agreements with rape crisis centers pursuant to subsection D of § 32.1-162.15:4;

4. Work with treatment hospitals and approved pediatric health care facilities to develop plans to employ or contract with sexual assault forensic examiners to ensure the provision of treatment services to survivors of sexual assault by sexual assault forensic examiners, including plans for implementation of on-call systems to ensure availability of sexual assault forensic examiners;

5. Work with treatment hospitals and approved pediatric health care facilities to identify and recommend processes to ensure compliance with the provisions of this article related to creation, storage, and retention of photographic and other documentation and evidence;

6. Develop and distribute educational materials regarding implementation of the provisions of this article to hospitals, health care providers, rape crisis centers, children's advocacy centers, and others;

7. Study and provide recommendations to the Department for the use of telemedicine in meeting the requirements of this article; and

8. Report to the Governor and the General Assembly by December 1 of each year regarding its activities and the status of implementation of the provisions of this article.

APPENDIX B – ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

CPS – Child Protective Services

EMTALA – Emergency Medical Treatment and Active Labor Act

FOIA – Freedom of Information Act

HCV – Hepatitis C Virus

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIV – Human Immunodeficiency Virus

LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and other orientations and identities

MOU – Memorandum of Understanding

NAAT – Nucleic Acid Amplification Test

OFHS – Office of Family Health Services

OLC – Office of Licensure and Certification

PSAS – Pediatric Sexual Assault Survivor

STI – Sexually Transmitted Infections

STD – Sexually Transmitted Disease

TDO – Temporary Detention Order

VDH – Virginia Department of Health

VHHA – Virginia Hopital and Healthcare Association

PEDIATRIC SEXUAL ASSAULT SURVIVOR TRANSFER AGREEMENT

THIS PEDIATRIC SEXUAL ASSAULT SURVIVOR TRANSFER AGREEMENT ("Agreement") is made by and between **[Hospital Name] (the "Treatment Hospital")**, and **[Hospital Name]** (**the "Pediatric Transfer Hospital"**) (individual and/or collectively, the "Party(ies)"). This Agreement is effective as of the date of the last signature below (the "Effective Date").

A. The Parties recognize the specialty and medically necessary sexual assault survivor treatment services (the "Services," as further defined in Article 8 (§ 32.1-162.15:2 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia) required to treat a person aged younger than 18 years of age who presents with injuries or trauma resulting from sexual assault.

B. The Parties desire to enter into this Agreement governing the transfer of pediatric sexual assault survivor patients (the "Patient(s)") from Pediatric Transfer Hospital to Treatment Hospital for Services available at Treatment Hospital but not at Pediatric Transfer Hospital.

C. Treatment Hospital agrees to accept from Pediatric Transfer Hospital Patients requiring such medically necessary Services available at Treatment Hospital but not at Facility, subject to the availability of an appropriate bed and the capacity to provide the Services required.

D. The Parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of Patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of Patients and records between the facilities, the parties hereto agree as follows:

1. **TRANSFER OF PATIENTS.** In the event any Patient of the Pediatric Transfer Hospital is deemed by the Pediatric Transfer Hospital to require the Services of the Treatment Hospital, and the transfer is deemed medically appropriate, the Pediatric Transfer Hospital shall arrange for the transfer of the Patient to the Treatment Hospital as set forth herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, including, but not limited to the *Emergency Medical Treatment and Active Labor Act* ("EMTALA") and its implementing regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. The Treatment Hospital's responsibility for the Patient's care shall commence upon the Patient's admission to the Treatment Hospital, unless the Treatment Hospital provides, or arranges for, the Patient's transportation from the

Pediatric Transfer Hospital, in which case the Treatment Hospital shall become responsible for the Patient's care upon the Patient's discharge from the Pediatric Transfer Hospital.

2. TRANSFER CRITERIA. The Pediatric Transfer Hospital shall transfer Patients, who may require further evaluation of sexual abuse, to Treatment Hospital for provision of Services. For purposes of this Agreement, "pediatric" means a sexual assault survivor who is under the age of 18 years old, and the presence of a developmental delay does not impact the applicability of this definition. The Pediatric Transfer Hospital may transfer Patients who may require Services if the Patient presents with physical findings concerning acute sexual abuse or assault, including signs of genital trauma or bleeding, or a disclosure of sexual assault or abuse.

3. RESPONSIBILITIES OF THE PEDIATRIC TRANSFER HOSPITAL. The Pediatric Transfer Hospital shall be responsible for performing, or ensuring the performance of, the following:

3.1. Provide, within its capacity and capabilities, an appropriate medical screening examination and stabilizing treatment of the Patient prior to transfer.

3.2. Designate an individual with the authority to represent the Pediatric Transfer Hospital and to coordinate the transfer of the Patient from the Pediatric Transfer Hospital ("Designated Representative").

3.3. Arrange for appropriate and safe transportation and care of the Patient during transfer.

3.4. Contact the Designated Representative of the Treatment Hospital prior to transfer to receive confirmation regarding appropriate Services and staff necessary to provide the Patient's care.

3.5. Provide the Patient's family with an appropriate explanation of the reason for the transfer to another hospital for treatment.

3.6. Report to Child Protective Services ("CPS"), as required pursuant Va. Code § 63.2-1509, and maintain documentation of the report number provided by CPS.

3.7. Ensure the medical record does not reflect conclusions regarding whether a crime (e.g., criminal sexual assault, criminal sexual abuse) occurred.

3.8. Notify the Designated Representative of the Treatment Hospital of the estimated time of the Patient's arrival.

3.9. Establish policies for (a) maintaining the confidentiality of the Patient's medical records in accordance with applicable state and federal law, (b) maintaining the chain of custody for handing the Patient and clothing, and (c) the inventory and

safekeeping of any Patient valuables sent with the Patient to the Treatment Hospital.

3.10. Recognize the right of a Patient to request transfer into the care of a physician and Treatment Hospital of the Patient's choosing.

4. RESPONSIBILITIES OF THE TREATMENT HOSPITAL. The Treatment Hospital shall be responsible for performing, or ensuring the performance of, the following:

4.1. Promptly provide confirmation to the Designated Representative of the Pediatric Transfer Hospital regarding the availability of appropriate Services and staff necessary to treat the Patient and confirmation that the Treatment Hospital agrees to accept transfer of the Patient.

4.2. Provide, within its capabilities, appropriate personnel, equipment, and Services to assist the receiving healthcare team with the receipt and treatment of transferred Patient.

4.3. Designate a Designated Representative to represent the Treatment Hospital and to coordinate the transfer of the Patient to the Treatment Hospital.

4.4. When appropriate and within its capabilities, assist with the medically appropriate transportation of the Patient.

4.5. Accept, within its capacity and capabilities, the transfer of the Patient and provide appropriate forensic medical examination as indicated.

4.6. Provide Services to the Patient, in accordance with its Pediatric Sexual Assault Survivor Treatment Plan approved by the Virginia Department of Health ("VDH").

4.7. Upon discharge of the Patient back to the Pediatric Transfer Hospital, provide the Pediatric Transfer Hospital with a copy of the Patient's clinical or medical records.

4.8. Establish policies for (a) maintaining the confidentiality of the Patient's medical records in accordance with applicable state and federal law, (b) maintaining the chain of custody for handing the Patient and clothing, and (c) the inventory and safekeeping of any Patient valuables sent with the Patient to the Treatment Hospital.

4.9. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a Patient and a designated provider.

5. IMPLEMENTATION; REVIEW. If either Party changes its respective Designated Representative or its capabilities to provide Services to Patients, the Party making

such change shall promptly notify the other Party. Designated Representatives shall review the Agreement once every twelve (12) months and make any necessary amendments to the Services provided or the terms and conditions of the Agreement. The Pediatric Transfer Hospital shall resubmit the Agreement to VDH for approval thirty (30) calendar days prior to the effective date of any change to the Agreement.

6. TERM & TERMINATION.

6.1. The initial term of this Agreement shall be for a twelve (12) month period commencing on the Effective Date, unless terminated earlier by either party as provided in this Agreement. This Agreement shall renew automatically for additional twelve (12) month periods, unless written notice is given thirty (30) days before the end of any contract year during the extension period or the Agreement is terminated as provided in this Agreement.

6.2. This Agreement may be terminated by either Party at any time, without cause or penalty, upon thirty (30) days' prior written notice.

7. NOTICES. All notices, requests, demands, and other communication required or permitted under this Agreement shall be in writing and shall be deemed as having been duly given, made and received when personally delivered or upon actual receipt of electronic mail, registered or certified mail, postage prepaid, return receipt requested, addressed as set forth below. Either Party may change the address to which communications are to be sent by giving written notice of such change of address in conforming with the provisions of this paragraph and the giving of notice.

If to Transfer Hospital: Name
Title
Transfer Hospital
Postal Address
Electronic Mail Address

If to Treatment Hospital: Name
Title
Treatment Hospital
Postal Address
Electronic Mail Address

8. [Insert Additional Boilerplate Provisions from Exhibit A as agreed to by the parties.]

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective representatives.

_____

PEDIATRIC TRANSFER HOSPITAL

By:_____

Printed Name:_____

Title:_____

Date:_____

_____

TREATMENT HOSPITAL

By: _____

Printed Name:_____

Title:_____

Date:_____

EXHIBIT A

BOILERPLATE PROVISIONS FOR CONSIDERATION

1. **TERM AND TERMINATION.** This Agreement shall automatically and immediately terminate in the event that either Party loses its accreditation from the Joint Commission on Accreditation of Healthcare Organizations or any other applicable accrediting bodies, loses its license, and/or loses it certification to participate in or is subjected to sanctions under the Medicare/Medicaid Programs.

2. **RIGHT TO CONTRACT.** Nothing in this Agreement shall be construed as limiting the right of either Party to affiliate or contract with any other hospital while this Agreement is in effect.

3. **INDEPENDENT CONTRACTORS.** Each Party, its employees, agents or subcontractors, shall be and at all times act as independent contractors in performing Services in connection with this Agreement. No term of this Agreement shall be construed so as to render any Party an employee, or agent of any other, nor shall this Agreement be construed as a contract for employment. Neither Party shall have nor exercise control over the manner in which the Services set out in this Agreement are rendered by the other Party, its agents, employees or independent contractors except to be sure that the other Party in rendering such Services is in compliance with the terms and obligations of this Agreement.

4. **WAIVER.** Neither the failure nor any delay on the part of any Party to exercise any right, remedy, power or privilege under this Agreement shall operate as a waiver thereof. No waiver shall be effective unless it is in writing and is signed by the Party asserted to have granted such waiver.

5. **GOVERNING LAW.** This Agreement shall be construed in accordance with the laws of the Commonwealth of Virginia. The provisions of this Section shall survive expiration or other termination of this Agreement regardless of the cause of such termination.

6. **ENTIRE AGREEMENT; AMENDMENT; COUNTERPARTS.** This Agreement constitutes the entire agreement of the parties hereto and supersedes all earlier oral or written agreements between the parties. This Agreement shall not be modified except in writing signed by the parties hereto. This Agreement may each be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

7. **BILLING.** Each Party shall only be responsible for collecting its own bill for Services rendered to the Patient. Except by operation of a separate written agreement between the parties or except to the extent that the Treatment Hospital incurs additional costs as a result of the Transfer Hospital's failure to accept the return of a transferred Patient as required by this Agreement, no part of this Agreement shall be

interpreted to authorize either Party to look to the other Party for payment for Services rendered to a Patient transferred by virtue of this Agreement.

8. **DEBTS & OBLIGATIONS.** Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Party to this Agreement. Each Party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Party.

9. **RESPONSIBILITY; INSURANCE.** The Facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder and the acts and omissions of their own employees and agents. In addition, each Party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage, with the professional liability insurance coverage being equal to or greater than the per occurrence limits established from time to by the Virginia Medical Malpractice Act and an aggregate amount equal to three (3) times such per occurrence limits.

10. **ASSIGNMENT.** This Agreement may not be assigned by either Party without the prior written consent of the other Party.

11. **COMPLIANCE WITH LAWS.** Each Party shall comply with all applicable federal and state laws, rules, and regulations, including without limitation those laws and regulations governing the maintenance of medical records and confidentiality of Patient information as well as with all standards promulgated by any relevant accrediting agency.

12. **CHANGE IN LAW.** Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payor, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes or otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within thirty (30) days after said notice was given, this Agreement shall automatically terminate.

PEDIATRIC SEXUAL ASSAULT SURVIVOR TRANSFER PLAN

[Facility(ies) Name(s)]

Eff. Date: Rev. Date:

PURPOSE

This Pediatric Sexual Assault Survivor Transfer Plan (the "Plan") is adopted by _____ ("Pediatric Transfer Hospital") and applies to every patient of the Pediatric Transfer Hospital that is a person aged younger than 18 years of age who presents with injuries or trauma resulting from sexual assault or discloses or is known or is suspected to be a victim of sexual assault ("Patient") and any Pediatric Treatment Hospital that has agreed to accept transfer of Patients ("Treatment Hospital").

The Pediatric Transfer Hospital has entered into a Pediatric Sexual Assault Survivor Transfer Agreement ("Transfer Agreement" Exhibit A) with one or more Treatment Hospitals and each such Treatment Hospital recognizes the specialty services that a person aged younger than 18 years of age who presents with injuries or trauma resulting from sexual assault requires and agrees to accept the transfer of all Patients, limited only by capacity, from Pediatric Transfer Hospital and provide sexual assault survivor treatment services in accordance with the Plan.

PSAS TRANSFER PLAN AND PROCEDURE

1. Medical Screening Examination and Necessary Stabilizing Treatment

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

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

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

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

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

2. Information Regarding Emergency Contraception

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

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

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

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

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

3. Patient Transfer

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

Transfer Hospital:
[Name]
[Address]
[Designated Representative]

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

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

[Describe any minimum precautions]

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

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

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

4. Mandatory Reporting Requirements

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

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

REFERENCE:

Va. Code § 32.1-162.15:2 et seq.

EXHIBIT A

PSAS TRANSFER AGREEMENT

[To be Attached]

EXHIBIT B

CLINICAL AND SOCIAL CONSIDERATIONS

I. SOCIAL/PSYCHOLOGICAL

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

II. TRIAGE

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

III. LIMITED ENGLISH PROFICIENCY

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

IV. CONSENT FOR CARE

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

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

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

V. MANDATED REPORTING REQUIREMENTS

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

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

- Any person licensed to practice medicine or any of the healing arts;
- Any hospital resident or intern, and any person employed in the nursing profession;
- Any person employed as a social worker or family-services specialist;
- Any mental health professional;

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

VI. AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

This authorization may be by:

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

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

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

VII. UNIQUE POPULATIONS

A. Cultural Groups
   a. Culture can influence beliefs about sexual assault, its survivors, and offenders as well as health care practitioners. It can affect health care beliefs and practices related to the assault and medical treatment outcomes, and to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in

the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of survivors to be involved in the system.

b. Some survivors may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
c. Be aware that cultural beliefs may preclude a member of the opposite sex from being present when survivors disrobe.
d. Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among survivors of different cultural backgrounds. Also, understand that what helps one survivor deal with a traumatic situation like sexual assault may not be the same for another survivor.
e. Help survivors obtain culturally specific assistance where they exist.

B. Persons with Disabilities

a. Understand that Patients with disabilities may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities. Make every effort to recognize issues that arise for survivors with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.
b. People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault.
c. Speak directly to survivors with disabilities, even when interpreters, intermediaries, or guardians are present.
d. Recognize that individuals may have some degree of cognitive disability: intellectual disability, traumatic brain injury, or neurodegenerative conditions, or stroke.
e. Assess a survivor's level of ability and need for assistance during the medical examination and stabilizing treatment. Ask for permission before proceeding in an exam (or touch them, handle a mobility or communication device, or touch a service animal).
f. Keep in mind that survivors with disabilities may be reluctant to report the crime for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.
g. Recognize that the medical examination and stabilizing treatment may take longer to perform with survivors with disabilities. Avoid rushing through — such action not only may distress survivors, it can lead to missed evidence and information.

C. Incarcerated Juvenile Offenders

a. Health care providers should understand that prison culture is a very unique culture that is influenced by inmate characteristics, prison as a segregated society, as well as policies and practices of the prison itself. Prison culture is based on assumptions about a person’s physical and mental weakness. Prisoners most likely to be victimized are those who are young, smaller in stature or less

experienced in prison culture, physically or developmentally disabled prisoners and young inmates who identify as LGBTQIA+.

b. Sexual assault experiences of male and female prisoners differ. Male inmates were most likely assaulted by other inmates, more likely to be threatened with harm, have greater use of physical force, or have a weapon used in the assault. They are likely to have more physical injuries and to experience more sexual acts. Female inmates were as likely to be assaulted by other inmates as by prison staff.
c. Under-reporting is common due to poor handling of complaints, lack of criminal charging of offenders, fear of retaliation. Inmates who reported sexual violence were often subjected to more violence. When prison staff members are the assailants, survivors are even less likely to report as they have no escape from the assailant. They often have even more to fear as the assailant who is a staff member has absolute power over the survivors.

D. Male Survivors
    a. Men and adolescent boys can be survivors of sexual assault by women or by men.
    b. Help male survivors understand that male sexual assault is not uncommon and that the assault is not their fault. Many male survivors focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may reduce their self-blame.
    c. Because some male survivors may fear public disclosure of the assault and the stigma associated with being a male survivor of sexual assault, emphasis may need to be placed on the scope of confidentiality of Patient information during the exam process.
    d. Offer male survivors assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
    e. Male survivors may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services.

E. Military
    a. Survivors of sexual assault who are family members of active-duty military should be referred to the sexual assault advocacy services for their base or duty station to ensure comprehensive support.
    b. The military offers survivors the option of restricted reporting or unrestricted reporting. Restricted reporting allows a survivor of sexual assault to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling without triggering the official investigative process or command notification.
    c. Restricted reporting can be voided if the medical facility contacts law enforcement or other professionals other than advocates, chaplains, and military sexual assault response coordinators.

d. Exam sites that provide exams for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of evidence.

F. Multiple Survivors
   a. Survivors may reside in group homes, assisted living, nursing homes, or be inpatient in hospitals. Reporting to Child Protective Services (CPS) is mandatory. Appropriate triage and planning is essential to a Patient-centered, coordinated response.
   b. Health care provider considerations should include:
      i. Multiple survivors needing transfer at the same time
      ii. Need for multidisciplinary collaboration (health care, social work, CPS, facility staff)
      iii. Ability to ensure no cross-contamination of evidence
      iv. Inclusion of support person for medical exam
      v. Access to medical records from home or facility
      vi. Past medical history including records from facility
      vii. Survivors may experience humiliation, shock, disbelief, and denial. The full emotional impact of the assault may not be felt until the survivor is alone, after initial contact with Health Care Professionals, law enforcement, and legal advocates.
      viii. Fear, anger, or depression can be common responses in these survivors. Fear of losing independence as a result of family members learning about the sexual assault can be a strong deterrent to reporting.
   c. Recognition by health care providers that the offender may be a family member, friend or caregiver is important.

G. Indigenous Populations
   a. Survivors from indigenous populations may have unique cultural or language needs, whether they are assaulted on tribal lands or in an urban area.
   b. Recognize that indigenous populations may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault.
   c. As in many cultures, indigenous women are of central and primary importance to the family and the community. Be mindful that sexual violence against an indigenous woman may be seen as an assault on both the individual and her community.
   d. Be mindful of historical trauma. Some survivors may be slow to engage with non-natives.

H. Sex Trafficked/Commercial Sexually Exploited Survivors
   a. Human trafficking is considered an especially egregious form of exploitation of vulnerable persons and an emerging health care priority. Sex trafficked persons

can come from all countries and walks of life, though the majority of trafficked persons are women and girls.

b. Key factors for sex trafficking include young age, history of abuse, poverty, lack of education, conflict with family of origin, lack of economic opportunity.
c. Traffickers may include females who are respected in communities, males who present as “boyfriends” or family members.
d. It is important for providers to recognize the varied experiences and reactions of sex trafficked persons and to demonstrate consistent, culturally aware trauma-informed care when working with sex trafficked persons.
e. Disclosures can be both emotionally difficult and potentially dangerous for the sex trafficked persons, who may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.
f. Identifiers for possible trafficking include:
    i. Recurrent sexually transmitted infections or diseases
    ii. Multiple or frequent pregnancies
    iii. Frequent or forced abortions
    iv. Delayed presentation for medical care
    v. Companion who speaks for the Patient and controls the encounter and refuses to leave
    vi. Discrepancy between stated history and clinical presentation or pattern of injury
    vii. Tattoos or other marks that may indicate “ownership” by another person
    viii. Presentation to health care with non-guardian or unrelated adults
    ix. Access to material possessions outside their financial means
    x. Over-familiarity with sexual terms and practices
    xi. Excessive number of sexual partners
    xii. School truancy
    xiii. Fearful attachment to cell phone (as a monitoring/tracking device)
g. Health care providers should:
    i. Provide culturally sensitive, resilience-oriented trauma informed care to all Patients
    ii. Partner with advocates, social service providers and case managers to ensure all needs are met
    iii. Educate self on dynamics of trafficking and resources within each community

I. LGBTQIA+

a. Always refer to survivors by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
b. Treat the knowledge that the person is LGBTQIA+ as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBTQIA+ survivors may not know their gender identity or sexual orientation.

J. Transgender or Gender Non-Conforming Survivors
    a. Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Transgender survivors may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the survivor does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
    b. Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
    c. A vagina that has been exposed to testosterone or created surgically may sustain more damage in an assault.
    d. Transgender male individuals who still have ovaries and a uterus can become pregnant even when they are using testosterone and/or had not been menstruating.
    e. Per the "Sexually Transmitted Infections Treatment Guidelines, 2021" released by the Centers for Disease Control and Prevention, the following are screening recommendations for transgender and gender diverse persons:
        i. Because of the diversity of transgender persons regarding surgical gender-affirming procedures, hormone use, and their patterns of sexual behavior, providers should remain aware of symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the Patient's sexual practices and anatomy.
        ii. Gender-based screening recommendations should be adapted on the basis of anatomy (e.g., routine screening for C. trachomatis and N. gonorrhoeae) as recommended for all sexually active females aged <25 years on an annual basis and should be extended to transgender men and nonbinary persons with a cervix among this age group.
        iii. HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.
        iv. For transgender persons with HIV infection who have sex with cisgender men and transgender women, STI screening should be conducted at least annually, including syphilis serology, HCV testing, and urogenital and extragenital NAAT for gonorrhea and chlamydia.
        v. Transgender women who have had vaginoplasty surgery should undergo routine STI screening for all exposed sites (e.g., oral, anal, or vaginal). No data are available regarding the optimal screening method (urine or vaginal swab) for bacterial STIs of the neovagina. The usual techniques for creating a neovagina do not result in a cervix; therefore, no rationale exists for cervical cancer screening.
        vi. If transgender men have undergone metoidioplasty surgery with urethral lengthening and have not had a vaginectomy, assessment of genital

bacterial STIs should include a cervical swab because a urine specimen will be inadequate for detecting cervical infections.

vii. Cervical cancer screening for transgender men and nonbinary persons with a cervix should follow current screening guidelines (see Human Papillomavirus Infections).

EXHIBIT C

PATIENT INFORMATION ABOUT EMERGENCY CONTRACEPTION

[To be Attached]

APPENDIX E – PEDIATRIC SEXUAL ASSAULT SURVIVOR TREATMENT PLAN – FULL TREATMENT SERVICES

PEDIATRIC SEXUAL ASSAULT SURVIVOR TREATMENT PLAN

[Facility(ies) Name(s)]

Eff. Date: Rev. Date:

PURPOSE

This Pediatric Sexual Assault Survivor Treatment Plan (the "Plan") is adopted by _____ ("Pediatric Treatment Facility") and applies to every patient of the Pediatric Treatment Facility that is a person aged younger than 18 years of age who presents with injuries or trauma resulting from sexual assault or discloses or is known or is suspected to be a victim of sexual assault ("Patient") and any Patient of a Pediatric Transfer Hospital that Pediatric Treatment Facility has agreed to accept transfer of Patients ("Pediatric Transfer Hospital").

Pediatric Treatment Facility has entered into a Pediatric Sexual Assault Survivor Transfer Agreement ("Transfer Agreement" see Model Transfer Agreement in Exhibit A) with one or more Pediatric Transfer Hospitals and each such Pediatric Transfer Hospital and Pediatric Treatment Facility agrees to accept the transfer of all Patients, limited only by capacity, from Pediatric Transfer Facility and provide sexual assault survivor treatment services in accordance with the Plan.

PSAS TREATMENT PLAN AND PROCEDURE

5. Medical Forensic Examination

Pediatric Treatment Hospital will provide an appropriate medical forensic examination.

> [Describe any basic procedures for initiating and completing the medical forensic examination]

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

6. Sexually Transmitted Disease Evaluations

Pediatric Treatment Hospital will provide appropriate evaluations to determine a Patient's risk of infection or sexually transmitted disease, including HIV, resulting from the sexual assault.

[Describe any basic procedures for initiating and completing the STD evaluations]

7. Information Regarding Sexually Transmitted Diseases and Pregnancy

Pediatric Treatment Facility will provide to Patient medically and factually accurate written and oral information about:

- The possibility of infection from sexually transmitted disease, including HIV, resulting from the sexual assault;
- Accepted medical procedures and medications for the prevention or treatment of infection or sexually transmitted disease, including HIV, resulting from the sexual assault;
- The indications, contraindications, and potential risks of treatments or medications for the prevention or treatment of infection or sexually transmitted disease, including HIV, resulting from the sexual assault; and
- The possibility of pregnancy resulting from the sexual assault.

8. Information Regarding Emergency Contraception

Pediatric Treatment Facility will provide to Patient medically and factually accurate written and oral information about:

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

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

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

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

9. Prescriptions of Appropriate Medications for Treatment

Pediatric Treatment Facility will ensure that the Patient receives prescriptions for appropriate medications for treatment both during treatment at the Pediatric Treatment Facility and upon discharge, including, in cases in which prophylactic treatment for infection with HIV is deemed appropriate, an initial dose or all required doses of HIV prophylaxis.

[Describe any basic procedures for prescribing]

10. Follow-Up Care

Pediatric Treatment Facility will provide to Patient written and oral information regarding the need for follow-up care, including examinations and laboratory tests to determine the presence or absence of sexually transmitted infection or disease and follow-up care related to HIV prophylaxis.

[Describe any basic procedures for providing information about follow-up care]

11. Advocacy Services and Counselling and Support Services

Pediatric Treatment Facility will provide to Patient information about advocacy services provided by [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU]. Pediatric Treatment Facility has entered into a Memorandum of Understanding (MOU) with [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU]. Under the MOU, [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU] has agreed to arrange for crisis services to be provided to Patients.

[Describe any basic procedures for providing information to patients about Child Advocacy Center or Rape Crisis Center or arranging for support services from Child Adovocacy Center or Rape Crisis Center.]

Pediatric Treatment Facility will ensure that appropriate referrals are made to counselling and other support services for Patient. This could include referrals to the following support services:

[Describe other support services for which referrals may be appropriate to Patients.]

12. Sexual Assault Training

Emergency Department and other appropriate personnel will complete annual training regarding this Plan and other policies and procedures regarding examination and treatment of Patients following sexual assault.

[Describe training programs and personnel for which it is required.]

REFERENCE :

Va. Code § 32.1-162.15:2 et seq.

EXHIBIT A

MODEL PSAS TRANSFER AGREEMENT

[To be Attached]

EXHIBIT B

CLINICAL AND SOCIAL CONSIDERATIONS

I. SOCIAL/PSYCHOLOGICAL

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

II. TRIAGE

A. Telephone Triage
    1. If a Patient or their caregiver calls before arrival, discuss with the Patient what to expect and that a medical forensic examination will not be performed at your health care facility so the Patient will either have to be transferred to a treatment hospital or travel directly to the treatment hospital if they wish to receive a medical forensic examination, including a physical evidence recovery kit. All Patients seen at a transfer health care facility with an emergency department must be stabilized and treated, as required by EMTALA.
    2. Advise the Patient and/or their caregiver with the following but not limited to:
        a. Do not bathe before examination
        b. About the medical forensic examination
        c. Bring a support person (family, friend, etc.) if possible
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    1. Assent should be sought from Patients who are too young to grant informed consent for care, but old enough and/or developmentally able to understand and agree to participate in that care.
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A medical interpreter must be accessed for limited English proficiency Patients and their caregivers for evaluation. Family members are not appropriate interpreters. Follow hospital policies and protocols for appropriate interpretation services.

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

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- Any person licensed to practice medicine or any of the healing arts;
- Any hospital resident or intern, and any person employed in the nursing profession;
- Any person employed as a social worker or family-services specialist;
- Any mental health professional;

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

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the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of survivors to be involved in the system.

b. Some survivors may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
c. Be aware that cultural beliefs may preclude a member of the opposite sex from being present when survivors disrobe.
d. Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among survivors of different cultural backgrounds. Also, understand that what helps one survivor deal with a traumatic situation like sexual assault may not be the same for another survivor.
e. Help survivors obtain culturally specific assistance where they exist.

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      iii. Ability to ensure no cross-contamination of evidence
      iv. Inclusion of support person for medical exam
      v. Access to medical records from home or facility
      vi. Past medical history including records from facility
      vii. Survivors may experience humiliation, shock, disbelief, and denial. The full emotional impact of the assault may not be felt until the survivor is alone, after initial contact with Health Care Professionals, law enforcement, and legal advocates.
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   c. Recognition by health care providers that the offender may be a family member, friend or caregiver is important.

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   a. Survivors from indigenous populations may have unique cultural or language needs, whether they are assaulted on tribal lands or in an urban area.
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   c. As in many cultures, indigenous women are of central and primary importance to the family and the community. Be mindful that sexual violence against an indigenous woman may be seen as an assault on both the individual and her community.
   d. Be mindful of historical trauma. Some survivors may be slow to engage with non-natives.

H. Sex Trafficked/Commercial Sexually Exploited Survivors
   a. Human trafficking is considered an especially egregious form of exploitation of vulnerable persons and an emerging health care priority. Sex trafficked persons

can come from all countries and walks of life, though the majority of trafficked persons are women and girls.

b. Key factors for sex trafficking include young age, history of abuse, poverty, lack of education, conflict with family of origin, lack of economic opportunity.
c. Traffickers may include females who are respected in communities, males who present as “boyfriends” or family members.
d. It is important for providers to recognize the varied experiences and reactions of sex trafficked persons and to demonstrate consistent, culturally aware trauma-informed care when working with sex trafficked persons.
e. Disclosures can be both emotionally difficult and potentially dangerous for the sex trafficked persons, who may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.
f. Identifiers for possible trafficking include:
    i. Recurrent sexually transmitted infections or diseases
    ii. Multiple or frequent pregnancies
    iii. Frequent or forced abortions
    iv. Delayed presentation for medical care
    v. Companion who speaks for the Patient and controls the encounter and refuses to leave
    vi. Discrepancy between stated history and clinical presentation or pattern of injury
    vii. Tattoos or other marks that may indicate “ownership” by another person
    viii. Presentation to health care with non-guardian or unrelated adults
    ix. Access to material possessions outside their financial means
    x. Over-familiarity with sexual terms and practices
    xi. Excessive number of sexual partners
    xii. School truancy
    xiii. Fearful attachment to cell phone (as a monitoring/tracking device)
g. Health care providers should:
    i. Provide culturally sensitive, resilience-oriented trauma informed care to all Patients
    ii. Partner with advocates, social service providers and case managers to ensure all needs are met
    iii. Educate self on dynamics of trafficking and resources within each community

I. LGBTQIA+

a. Always refer to survivors by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
b. Treat the knowledge that the person is LGBTQIA+ as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBTQIA+ survivors may not know their gender identity or sexual orientation.

J. Transgender or Gender Non-Conforming Survivors
    a. Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Transgender survivors may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the survivor does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
    b. Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
    c. A vagina that has been exposed to testosterone or created surgically may sustain more damage in an assault.
    d. Transgender male individuals who still have ovaries and a uterus can become pregnant even when they are using testosterone and/or had not been menstruating.
    e. Per the "Sexually Transmitted Infections Treatment Guidelines, 2021" released by the Centers for Disease Control and Prevention, the following are screening recommendations for transgender and gender diverse persons:
        i. Because of the diversity of transgender persons regarding surgical gender-affirming procedures, hormone use, and their patterns of sexual behavior, providers should remain aware of symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the Patient's sexual practices and anatomy.
        ii. Gender-based screening recommendations should be adapted on the basis of anatomy (e.g., routine screening for C. trachomatis and N. gonorrhoeae) as recommended for all sexually active females aged <25 years on an annual basis and should be extended to transgender men and nonbinary persons with a cervix among this age group.
        iii. HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.
        iv. For transgender persons with HIV infection who have sex with cisgender men and transgender women, STI screening should be conducted at least annually, including syphilis serology, HCV testing, and urogenital and extragenital NAAT for gonorrhea and chlamydia.
        v. Transgender women who have had vaginoplasty surgery should undergo routine STI screening for all exposed sites (e.g., oral, anal, or vaginal). No data are available regarding the optimal screening method (urine or vaginal swab) for bacterial STIs of the neovagina. The usual techniques for creating a neovagina do not result in a cervix; therefore, no rationale exists for cervical cancer screening.
        vi. If transgender men have undergone metoidioplasty surgery with urethral lengthening and have not had a vaginectomy, assessment of genital

bacterial STIs should include a cervical swab because a urine specimen will be inadequate for detecting cervical infections.

vii. Cervical cancer screening for transgender men and nonbinary persons with a cervix should follow current screening guidelines (see Human Papillomavirus Infections).

EXHIBIT C

PATIENT INFORMATION ABOUT EMERGENCY CONTRACEPTION

[To be Attached]

APPENDIX F – PEDIATRIC SEXUAL ASSAULT SURVIVOR TREATMENT PLAN – PARTIAL TREATMENT SERVICES

PEDIATRIC SEXUAL ASSAULT SURVIVOR TREATMENT PLAN
PARTIAL TREATMENT SERVICES

[Facility(ies) Name(s)]

Eff. Date: Rev. Date:

PURPOSE

This Pediatric Sexual Assault Survivor Treatment Plan (the "Plan") is adopted by _____ ("Pediatric Treatment Facility") and applies to every patient of the Pediatric Treatment Facility that is a person aged younger than 18 years of age who presents with injuries or trauma resulting from sexual assault or discloses or is known or is suspected to be a victim of sexual assault ("Patient") and any Patient of a Pediatric Transfer Hospital that Pediatric Treatment Facility has agreed to accept transfer of Patients ("Pediatric Transfer Hospital"). This Partial Pediatric Treatment Facility is only capable of providing a certain range of treatment services as outlined below. This plan describes the process of transferring Patients to a Full Pediatric Treatment Facility for further treatment services.

Pediatric Treatment Facility has entered into a Pediatric Sexual Assault Survivor Transfer Agreement ("Transfer Agreement" see Model Transfer Agreement in Exhibit A, Part 1) with a Full Pediatric Treatment Facility and such Full Pediatric Treatment Facility agrees to accept the transfer of all Patients, limited only by capacity, from Pediatric Treatment Facility and provide sexual assault survivor treatment services in accordance with the Plan.

PSAS TREATMENT PLAN AND PROCEDURE

13. Medical Forensic Examination

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will provide an appropriate medical forensic examination.

> [Describe any basic procedures for initiating and completing the medical forensic examination; As a Partial Pediatric Treatment Facility, describe the partial range of treatment services the Pediatric Treatment Facility is capable of providing.]

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

14. Sexually Transmitted Disease Evaluations

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will provide appropriate evaluations to determine a Patient's risk of infection or sexually transmitted disease, including HIV, resulting from the sexual assault.

[Describe any basic procedures for initiating and completing the STD evaluations; As a Partial Pediatric Treatment Facility, describe the appropriate evaluations the Pediatric Treatment Facility is capable of providing.]

15. Information Regarding Sexually Transmitted Diseases and Pregnancy

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will provide to Patient medically and factually accurate written and oral information about:

- The possibility of infection from sexually transmitted disease, including HIV, resulting from the sexual assault;
- Accepted medical procedures and medications for the prevention or treatment of infection or sexually transmitted disease, including HIV, resulting from the sexual assault;
- The indications, contraindications, and potential risks of treatments or medications for the prevention or treatment of infection or sexually transmitted disease, including HIV, resulting from the sexual assault; and
- The possibility of pregnancy resulting from the sexual assault.

16. Information Regarding Emergency Contraception

Pediatric Treatment Facility will provide to Patient medically and factually accurate written and oral information about:

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

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

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

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

17. Prescriptions of Appropriate Medications for Treatment

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will ensure that the Patient receives prescriptions for appropriate medications for treatment both during treatment at the [Pediatric Treatment Facility] [Full Pediatric Treatment Facility] and upon discharge, including, in cases in which prophylactic treatment for infection with HIV is deemed appropriate, an initial dose or all required doses of HIV prophylaxis.

[Describe any basic procedures for prescribing]

18. Follow-Up Care

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will provide to Patient written and oral information regarding the need for follow-up care, including examinations and laboratory tests to determine the presence or absence of sexually transmitted infection or disease and follow-up care related to HIV prophylaxis.

[Describe any basic procedures for providing information about follow-up care]

19. Advocacy Services and Counselling and Support Services

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will provide to Patient information about advocacy services provided by [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU]. [Pediatric Treatment Facility] [Full Pediatric Treatment Facility] has entered into a Memorandum of Understanding (MOU) with [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU]. Under the MOU, [Child Advocacy Center or Rape Crisis Center with which Pediatric Treatment Facility has an MOU] has agreed to arrange for crisis services to be provided to Patients.

[Describe any basic procedures for providing information to patients about Child Advocacy Center or Rape Crisis Center or arranging for support services from Child Adovocacy Center or Rape Crisis Center.]

[Pediatric Treatment Facility] [Full Pediatric Treatment Facility] will ensure that appropriate referrals are made to counselling and other support services for Patient. This could include referrals to the following support services:

[Describe other support services for which referrals may be appropriate to Patients.]

20. Sexual Assault Training

Emergency Department and other appropriate personnel will complete annual training regarding this Plan and other policies and procedures regarding examination and treatment of Patients following sexual assault.

[Describe training programs and personnel for which it is required.]

21. Transfer Services

Pediatric Treatment Facility will provide for transfer services for a Patient to a Full Pediatric Treatment Facility if the treatment services required are beyond those provided by the Partial Pediatric Treatment Facility.

[Describe transfer services for Patients who require an appropriate level of Treatment Services beyond capabilities of Partial Pediatric Treatment Facility.]

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

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

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

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

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

Partial Pediatric Treatment Facility will ensure a prompt transfer of the Patient to Full Pediatric Treatment Facility in accordance with the Transfer Agreement (see Exhibit A, Part 2).

Transfer Hospital:
[Name]
[Address]
[Designated Representative]

Prior to transfer, Partial Pediatric Treatment Facility will communicate with the receiving Full Pediatric Treatment Facility to confirm the availability to accept transfer.

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

[Describe any minimum precautions]

[Partial Pediatric Treatment Facility will comply with EMTALA in coordinating transfer with Full Pediatric Treatment Facility.]

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

Partial Pediatric Treatment Facility will provide a copy of or access to the Patient's records, including reports of any treatment administered or testing performed, to Full Pediatric Treatment Facility.

The Transfer Agreement between Partial Pediatric Treatment Facility and Full Pediatric Treatment Facility is attached in Exhibit A, Part 2.

22. 24/7 Coverage

If Partial Pediatric Treatment Facility does not provide services 24/7, it will inform the public that Patients need to seek treatment, including emergency medical services, elsewhere. It will post clear and visible signage, accessible to the public from the exterior of the premises, that it does not provide 24/7 treatment services.

REFERENCE :

Va. Code § 32.1-162.15:2 et seq.

EXHIBIT A

MODEL PSAS TRANSFER AGREEMENT

Part 1

[To be Attached]

EXHIBIT A

MODEL PSAS TRANSFER AGREEMENT

Part 2

[To be Attached]

EXHIBIT B

CLINICAL AND SOCIAL CONSIDERATIONS

I. SOCIAL/PSYCHOLOGICAL

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

II. TRIAGE

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

III. LIMITED ENGLISH PROFICIENCY

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

IV. CONSENT FOR CARE

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

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

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

V. MANDATED REPORTING REQUIREMENTS

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

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

- Any person licensed to practice medicine or any of the healing arts;
- Any hospital resident or intern, and any person employed in the nursing profession;
- Any person employed as a social worker or family-services specialist;
- Any mental health professional;

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

VI. AUTHORIZTION TO RELEASE PROTECTED HEALTH INFORMATION

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

This authorization may be by:

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

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

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

VII. UNIQUE POPULATIONS

A. Cultural Groups
    a. Culture can influence beliefs about sexual assault, its survivors, and offenders as well as health care practitioners. It can affect health care beliefs and practices related to the assault and medical treatment outcomes, and to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in

the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of survivors to be involved in the system.

b. Some survivors may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
c. Be aware that cultural beliefs may preclude a member of the opposite sex from being present when survivors disrobe.
d. Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among survivors of different cultural backgrounds. Also, understand that what helps one survivor deal with a traumatic situation like sexual assault may not be the same for another survivor.
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    c. Because some male survivors may fear public disclosure of the assault and the stigma associated with being a male survivor of sexual assault, emphasis may need to be placed on the scope of confidentiality of Patient information during the exam process.
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E. Military
    a. Survivors of sexual assault who are family members of active-duty military should be referred to the sexual assault advocacy services for their base or duty station to ensure comprehensive support.
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   c. As in many cultures, indigenous women are of central and primary importance to the family and the community. Be mindful that sexual violence against an indigenous woman may be seen as an assault on both the individual and her community.
   d. Be mindful of historical trauma. Some survivors may be slow to engage with non-natives.

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c. Traffickers may include females who are respected in communities, males who present as “boyfriends” or family members.
d. It is important for providers to recognize the varied experiences and reactions of sex trafficked persons and to demonstrate consistent, culturally aware trauma-informed care when working with sex trafficked persons.
e. Disclosures can be both emotionally difficult and potentially dangerous for the sex trafficked persons, who may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.
f. Identifiers for possible trafficking include:
    i. Recurrent sexually transmitted infections or diseases
    ii. Multiple or frequent pregnancies
    iii. Frequent or forced abortions
    iv. Delayed presentation for medical care
    v. Companion who speaks for the Patient and controls the encounter and refuses to leave
    vi. Discrepancy between stated history and clinical presentation or pattern of injury
    vii. Tattoos or other marks that may indicate “ownership” by another person
    viii. Presentation to health care with non-guardian or unrelated adults
    ix. Access to material possessions outside their financial means
    x. Over-familiarity with sexual terms and practices
    xi. Excessive number of sexual partners
    xii. School truancy
    xiii. Fearful attachment to cell phone (as a monitoring/tracking device)
g. Health care providers should:
    i. Provide culturally sensitive, resilience-oriented trauma informed care to all Patients
    ii. Partner with advocates, social service providers and case managers to ensure all needs are met
    iii. Educate self on dynamics of trafficking and resources within each community

I. LGBTQIA+

a. Always refer to survivors by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
b. Treat the knowledge that the person is LGBTQIA+ as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBTQIA+ survivors may not know their gender identity or sexual orientation.

J. Transgender or Gender Non-Conforming Survivors
    a. Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Transgender survivors may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the survivor does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
    b. Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
    c. A vagina that has been exposed to testosterone or created surgically may sustain more damage in an assault.
    d. Transgender male individuals who still have ovaries and a uterus can become pregnant even when they are using testosterone and/or had not been menstruating.
    e. Per the "Sexually Transmitted Infections Treatment Guidelines, 2021" released by the Centers for Disease Control and Prevention, the following are screening recommendations for transgender and gender diverse persons:
        i. Because of the diversity of transgender persons regarding surgical gender-affirming procedures, hormone use, and their patterns of sexual behavior, providers should remain aware of symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the Patient's sexual practices and anatomy.
        ii. Gender-based screening recommendations should be adapted on the basis of anatomy (e.g., routine screening for C. trachomatis and N. gonorrhoeae) as recommended for all sexually active females aged <25 years on an annual basis and should be extended to transgender men and nonbinary persons with a cervix among this age group.
        iii. HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.
        iv. For transgender persons with HIV infection who have sex with cisgender men and transgender women, STI screening should be conducted at least annually, including syphilis serology, HCV testing, and urogenital and extragenital NAAT for gonorrhea and chlamydia.
        v. Transgender women who have had vaginoplasty surgery should undergo routine STI screening for all exposed sites (e.g., oral, anal, or vaginal). No data are available regarding the optimal screening method (urine or vaginal swab) for bacterial STIs of the neovagina. The usual techniques for creating a neovagina do not result in a cervix; therefore, no rationale exists for cervical cancer screening.
        vi. If transgender men have undergone metoidioplasty surgery with urethral lengthening and have not had a vaginectomy, assessment of genital

bacterial STIs should include a cervical swab because a urine specimen will be inadequate for detecting cervical infections.

vii. Cervical cancer screening for transgender men and nonbinary persons with a cervix should follow current screening guidelines (see Human Papillomavirus Infections).

EXHIBIT C

PATIENT INFORMATION ABOUT EMERGENCY CONTRACEPTION

[To be Attached]