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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review to determine compliance with the Veterans Health Administration (VHA) policy on management of the emergent care needs of acute sexual assault victim-survivors.¹ Sexual assault is an invasive form of interpersonal violence that can have medical, psychological, and legal consequences, requiring a coordinated and compassionate response from medical providers and law enforcement officers when victim-survivors seek care. Victim-survivors who present for care related to acute sexual assault may need two types of healthcare services: (1) an evaluation and treatment of medical and mental health needs, and (2) a sexual assault forensic examination.²

Emergent care for acute sexual assault is a low frequency, but crucial, specialty care need in VHA. During the review period (July 1, 2020, through June 30, 2021), VHA emergency departments and urgent care centers generated more than 2.7 million encounters.³ Of these encounters, the OIG identified 100 VHA emergency department or urgent care center visits related to acute sexual assault.⁴

¹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. “Alleged acute sexual assault is defined as sexual contact with an alleged perpetrator within the last 72 hours.” This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023, and VHA Directive 1101.13, *VHA Urgent Care*, March 20, 2023. “Acute sexual assault is defined as an unwanted sexual contact by an alleged perpetrator.” Unless otherwise specified, the 2023 directives contain the same or similar language as the rescinded 2016 directive; Sexual Assault Kit Initiative, “Victim or Survivor: Terminology from Investigation Through Prosecution,” accessed March 29, 2022, <https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf>. For the purposes of this report, the term “victim-survivor” is used to describe individuals who experienced sexual assault. *Victim* is a term often used within the criminal justice system; *Survivor* is a term often used within healthcare and advocacy systems and may be preferred as denoting empowerment and conveying that a person has started the healing process.

² VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. A forensic examination should be offered after the victim-survivor is medically stable and is neither a mandatory examination nor an emergency procedure. The purpose of a sexual assault forensic examination is to collect and preserve forensic evidence for potential use during investigation and prosecution, as well as address the health care needs of the victim-survivor.

³ VA Office of Informatics and Information Governance, “Fact Sheet: Electronic Encounter Form Completion,” May 2017. “An encounter is a professional contact between a patient and a provider assigned with the responsibility of diagnosing, evaluating, and treating the patient’s condition.”

⁴ The OIG utilized data from the VHA Corporate Data Warehouse (CDW) to identify all VHA emergency department or urgent care center visits with diagnostic codes related to acute sexual assault or procedural codes related to forensic examination for sexual assault associated with an episode of care from July 1, 2020, through June 30, 2021. VHA Office of Clinical Services provided the OIG with a list of 140 facilities with emergency departments and urgent care centers. Of these facilities, the OIG identified 145 visits as related to sexual assault based on diagnostic or procedural coding. The OIG reviewed EHRs for those 145 visits and excluded 45 from further analysis because they were not related to acute sexual assault or were duplicates of patient encounters.

The OIG reviewed the electronic health records (EHRs) of the 100 patients who presented to a VHA emergency department or urgent care center for acute sexual assault during the review period. The OIG also requested facility policies and guidance from all VHA facilities with an emergency department or urgent care center, and reviewed all documents received. Additionally, the OIG disseminated questionnaires to facility emergency department or urgent care center chiefs and nurse managers (emergency department or urgent care center leaders) and chiefs of police covering the topics of policy, training, available resources, and coordination between clinical and law enforcement staff as relates to acute sexual assault.

Compliance with VHA Policy on Management of Acute Sexual Assault

The OIG found deficiencies in adherence to VHA policy on requirements to ensure the provision of sexually transmitted infection prophylaxis and pregnancy prophylaxis when clinically indicated, and to offer psychological counseling.⁵ Such deficiencies indicate that victim-survivors did not always receive adequate care when seeking emergency or urgent treatment. The OIG also noted deficiencies in required documentation of signature informed consent for the forensic examinations conducted by staff at VHA facilities.

The OIG's review found the majority of VHA emergency departments and urgent care centers utilize community Sexual Assault Forensic Examiner (SAFE) resources.⁶ Collaboration with community partners equipped to address the medical-forensic needs of acute sexual assault patients is key to meeting the care needs of the patients and VHA requirements.

The OIG was unable to fully assess whether VA police notifications were consistent with facility requirements due to insufficient detail regarding reporting procedures within facility policy or guidance. The OIG found that some facilities' policy or guidance documents lacked sufficient detail to fully advise staff on how to comply with VHA requirements for law enforcement notification in a manner consistent with the jurisdictions' law.

Clinical Management

VHA policy requires that “[a]ppropriate prophylaxis for sexually transmitted disease and pregnancy must be offered when clinically indicated” and that psychological counseling must be offered as part of the treatment and support services for acute sexual assault victim-survivors

⁵ Sexually transmitted infection prophylaxis refers to treatment with medications intended to prevent sexually transmitted infections, which may result from exposure during sexual contact. Pregnancy prophylaxis refers to emergency contraception measures (hormonal contraceptive pills or copper-containing intrauterine devices) utilized after sexual contact with the intent to prevent unintended pregnancy.

⁶ Within the report, community *SAFE resources* refers to community partners with healthcare professionals specially trained in the collection of evidence relating to sexual assault cases.

who present to emergency department or urgent care centers for treatment.⁷ VHA policy also states that a “separate signature informed consent is required to perform a forensic exam on a patient” and that providers document the informed consent process in the patient’s EHR.⁸

The OIG’s EHR review found that prophylaxis for sexually transmitted infections was not offered when clinically indicated for 15 percent of the victim-survivors. Of the 120 facilities that submitted clinical policy or guidance, 35 percent did not include guidance on sexually transmitted infection prophylaxis. Sexually transmitted infection is a risk associated with sexual assault. Ensuring that appropriate prophylaxis is offered as part of the medical care for victim-survivors is important to mitigate health risks associated with sexually transmitted infections.

The OIG’s EHR review found that pregnancy prophylaxis was not offered or provided when it was clinically indicated in 30 percent of the visits. Of the 120 facilities that submitted policy or guidance, 39 percent did not include guidance on pregnancy prophylaxis for acute sexual assault victim-survivors. Provision of emergency contraception for pregnancy prophylaxis should be considered as part of the treatment and support services offered if an assault could result in pregnancy.⁹ Furthermore, the OIG noted that in nearly half of the visits that staff failed to offer pregnancy prophylaxis when clinically indicated, pregnancy testing was documented.¹⁰ Failure to

⁷ VHA Directive 1101.05(2). VHA policy specifies that “[a] referral for psychological counseling. . . must be offered immediately. Initial contact from a mental health provider must occur within 24 hours.” VHA policy also specifies that “[f]or those patients who want to seek mental health care immediately, an initial appointment with the mental health clinic must be scheduled as soon as clinically indicated, but not later than 7 days.”; VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, language related to requirements on offering psychological counseling was revised. The new directives require VA emergency departments and urgent care centers to “have procedures in place to evaluate, support and treat patients of reported acute sexual assault” and specifies that “[f]ollow-up care may include. . . patient services such as a Rape Crisis Center based on regional availability and mental health services.”

⁸ VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended January 4, 2021.

⁹ US Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, Second Edition, NCJ 228119, April 2013. “The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent, similar to the risk of pregnancy from a one-time sexual encounter.”

¹⁰ A positive pregnancy test is used to determine if a victim-survivor was pregnant prior to the assault, and would be a contraindication for emergency contraception, as well as informing clinical decisions about other medications to be used in treatment. A negative pregnancy test result obtained during emergent care for acute sexual assault would not rule out the need to offer pregnancy prophylaxis. Human chorionic gonadotropin begins to build up in the body when a fertilized egg implants in the uterus and takes time to reach detectable levels in blood and urine. Around eight days after conception, pregnancy tests detect human chorionic gonadotropin in the urine or in low levels within the blood. Thus, a negative pregnancy test result within the time frame shortly following a sexual assault would not rule out the possibility of pregnancy resulting from assault.

offer emergency contraception for pregnancy prophylaxis when clinically indicated may increase the risk for the victim-survivor to face an unintended pregnancy because of the sexual assault.¹¹

The OIG's EHR review found no documentation of psychological counseling services offered or mental health referrals ordered in 53 percent of the emergency department and urgent care center visits for acute sexual assault.¹² Research has shown associations between sexual assault and a range of mental health concerns, including acute psychological distress, posttraumatic stress, depression, anxiety, substance misuse, and suicidality. Failure to offer psychological counseling may leave sexual assault victim-survivors without timely access to the mental health services needed to support their recovery from the trauma.

The OIG was also unable to locate required signature informed consent in the EHR for 9 of the 10 sexual assault forensic examinations performed at VHA facilities.¹³ Informed consent ensures that procedures are explained in an understandable manner and patients are aware they may accept or decline any or all parts of an examination.

The observed deficiencies in adherence to VHA policy on management of acute sexual assault suggests a need for additional guidance to ensure that appropriate prophylaxis for sexually transmitted infection and pregnancy are provided and psychological counseling is offered when patients present for treatment of acute sexual assault. For example, inclusion of supplemental information within facility policy or guidance to support evidence-based clinical care for sexually transmitted infection prophylaxis and pregnancy prophylaxis, such as resources for providers to access clinical practice guidelines or clinical order sets, may help address deficiencies observed in clinical practice.

¹¹ This review was completed prior to VA's September 2022 changes in abortion policy. VHA Directive 1330.01 (6), *Health Care Services for Women Veterans*, February 15, 2017, updated September 9, 2022; Under Secretary for Health Memorandum, *Provision of Abortion Counseling and Services*, September 14, 2022, provides for abortion counseling and abortions when pregnancy is the result of rape, incest, or in instances where the life or health of the pregnant veteran would be endangered if the pregnancy was carried to term.

¹² The OIG considered documentation within the EHR of an offer of psychological counseling services or a mental health referral order as meeting the VHA policy requirement. Of the 120 facilities that submitted clinical policy or guidance, 88 percent addressed psychological counseling.

¹³ Of the 10 examinations performed at VHA facilities, 8 were completed by VHA staff and 2 were completed by a community SAFE examiner. The OIG located the signature informed consent in the EHR for 1 examination performed by VHA staff. For the victim-survivors who were referred outside VHA to community facilities for forensic examination, informed consent would be documented by the community SAFE examiner and not be found in the patients' VHA EHRs.

Forensic Examinations

VHA policy requires emergency department and urgent care centers to have “plans in place” for collection of forensic evidence by appropriately trained staff.¹⁴ The OIG’s review found that the majority of VHA emergency departments and urgent care centers utilized community SAFE resources.¹⁵ National program office leaders identified utilization of community SAFE resources as a best practice for the majority of VHA facilities. Few VHA facilities have SAFE-certified staff, and the low frequency of patients utilizing this specialty care in VHA presents barriers for staff in accruing the relevant clinical practice hours to maintain certification and competency. For victim-survivors who consent to a forensic examination, collaboration with community partners equipped to address the medical-forensic needs of acute sexual assault victim-survivors is key. Facilities in localities that lack community resources may require additional support to develop alternative plans that ensure sexual assault forensic examination is available for victim-survivors when needed.

Reporting to Law Enforcement

Legal requirements for reporting of sexual assaults vary depending on jurisdiction. VHA policy specifies that “[r]eports of alleged sexual assault are made pursuant to valid state laws which provide for or require that such reports be made.”¹⁶ VHA policy directs that “VA Police must be notified to refer the report of the incident to law enforcement in the appropriate jurisdiction after consultation with Regional Counsel” when a victim-survivor consents to report a sexual assault to law enforcement.¹⁷ Alternatively, reporting may be required regardless of the victim-

¹⁴ VHA Directive 1101.05(2). The verbiage within VHA Directive 1101.14 and VHA Directive 1101.13 differs from the previous directive, specifying instead that facility emergency departments and urgent care clinics must “have procedures in place” for “performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

¹⁵ Facility-based SAFE resources were identified in 3 percent of the facilities’ guidance documents.

¹⁶ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, language related to requirements on reporting sexual assaults to law enforcement was revised. The new directives require VA emergency departments and urgent care centers to “have procedures in place to evaluate, support and treat patients of reported acute sexual assault” and specifies that “[f]ollow-up care may include. . . access to law enforcement.”

¹⁷ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. VHA policy also requires that “[t]he OIG must be notified of sexual assaults when the crime occurs on VA premises or by VA employees in connection with VA treatment or services.” Within the 2023 directives, language related to requirements on reporting sexual assaults to law enforcement was revised and refers staff to “See VHA Directive 5019.02(1) and VA Directive 0321, *Serious Incident Reports*, dated June 6, 2012, for requirements for reporting incidents of harassment or sexual assault”; VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA*, September 12, 2022, amended October 13, 2022. VHA has a standalone policy that establishes requirements for prevention and management of sexual assaults that occur in VHA facilities, including reporting requirements.

survivor's consent if the incident meets criteria for mandated reporting as defined by law in the jurisdiction where the facility is located.

The OIG reviewed EHRs for documentation of VA police notifications and compared the documentation to available facility policy or guidance on reporting sexual assaults to VA police.¹⁸ The OIG was unable to determine whether VA police notifications were consistent with facility requirements for 38 percent of the 100 visits due to insufficient detail on reporting procedures within facility policy or guidance. For the visits where facility policy or guidance on reporting requirements were sufficient, the documentation of VA police notification, or absence thereof, was inconsistent with the facility's guidance on reporting requirements for nearly 1 in 3 visits.

The majority of facilities' policies or guidance documents included references to law enforcement notification, with 94 percent referencing VA police and 89 percent referencing local law enforcement. However, the OIG found the degree of detail regarding reporting requirements and procedures varied. Some facilities' policy or guidance documents lacked sufficient detail to fully advise staff how to comply with VHA requirements for law enforcement notification in a manner consistent with the jurisdictions' laws.¹⁹ Responses to the OIG questionnaire from emergency department and urgent care center leaders and VA Police Chiefs revealed discrepancies in perspectives on reporting requirements; disagreements between clinical and law enforcement perspectives were more likely in scenarios where the victim-survivor did not consent for reporting. Given that law enforcement notification and associated limits of confidentiality vary based on jurisdictional reporting requirements, detailed facility policy or guidance is important to inform providers' practices and support patient care.

Challenges for VHA Facilities

The OIG found that the low frequency of patients seeking care related to an acute sexual assault contributed to challenges for VHA facilities in managing emergent care needs of these patients. These challenges included

¹⁸ It was beyond the scope of the OIG's review to fully ascertain all relevant factors to evaluate whether reporting actions documented for acute sexual assault visits were compliant with each facility's jurisdictional requirements. Additionally, the OIG noted that EHR documentation was unlikely to provide a reliable source to assess for local law enforcement notification, as VA police determinations regarding local law enforcement notifications may not be documented within patient's EHRs. The OIG review of facility policies and guidance did not necessarily correlate with the time frame of the OIG review of patients presenting for treatment care of alleged acute sexual assault.

¹⁹ The OIG considered policy or guidance as lacking sufficient detail if it did not contain information necessary to ascertain whether patient consent for reporting to law enforcement was required or whether facilities' jurisdictions had mandatory reporting requirements. For example, some facility policy and guidance documents only contained information for reporting events that occurred on VA property, and some addressed only mandated reporting for abuse or neglect of minors and vulnerable adults.

- maintenance of staffs' procedural knowledge and training;
- availability of facility resources, and knowledge of available community resources; and
- provision of detailed, facility-specific policy or guidance.²⁰

The OIG also found variability in the availability of facility policies or guidance on the management of acute sexual assault, the practices addressed, and the degree of detailed information on those practices for responding clinical staff and police officers.²¹

VHA policy requires that facility emergency departments and urgent care centers “have plans in place to appropriately manage the medical and psychological assessment, treatment, and collection of evidence from Veterans, male and female, who are victims of alleged acute sexual assault.”²² VHA policy specifies a requirement for 24/7 availability of sexual assault forensic examination via either appropriately trained VHA staff or via a local, non-VA facility SAFE resource.²³ Policy also requires emergency departments or urgent care centers to have a rape kit available if the victim-survivor is not medically stable for transfer and evidence collection needs to be completed on site.²⁴

Eighty-one percent of emergency department or urgent care center leaders who responded to the questionnaire cited the low frequency of patients presenting for acute sexual assault as a challenge for maintaining staff knowledge of procedures. Fourteen percent of emergency department or urgent care center leaders either indicated the facility did not have or were unsure of the availability of the resources to provide coverage for forensic examinations for acute sexual assault victim-survivors. Forty-two percent of emergency department or urgent care center leaders reported that their emergency department or urgent care clinic did not have a rape kit

²⁰ The OIG questionnaire responses from facility emergency department and urgent care center leaders and police chiefs highlighted the challenges associated with low frequency specialty care, maintenance of staff knowledge and training, and resource availability. The OIG interviews with subject matter experts from VHA national program offices similarly highlighted that the low frequency, specialized nature of comprehensive care for acute sexual assault presents challenges for maintaining staff knowledge and proficiency to address the complex, multifaceted needs of victim-survivors.

²¹ Out of 140 VHA facilities, 120 facilities (86 percent) provided facility policies or guidance related to the clinical management of acute sexual assault, and 49 (35 percent) provided facility policies or guidance for VA police responding to sexual assault allegations.

²² VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13.

²³ VHA Directive 1101.05(2); Local, non-VA facility acute sexual assault resources consist of rape crisis centers, Sexual Assault Nurse Examiner (SANE) units, or other appropriate organizations that have knowledge and experience with sexual assault forensic examinations; VHA Directive 1101.14; VHA Directive 1101.13. The 2023 policies no longer contain the language from the prior directive, and instead state that VA emergency departments and urgent care clinics must have procedures in place for “[p]erforming or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

²⁴ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, a requirement for rape kit availability is no longer referenced.

available for use, and an additional 11 percent were unsure of the kits' availability. While the 2016 Emergency Medicine directive required the availability of rape kits in VHA emergency departments and urgent care clinics, the 2023 Emergency Medicine and VHA Urgent Care directives do not; therefore, the OIG did not make a recommendation.²⁵

The challenges of maintaining staff knowledge of procedures for low frequency, specialty care, along with variability in resources and jurisdictional requirements across facilities, highlight the importance of clear, accessible facility-specific policy or guidance. VHA national program office leaders noted the importance of having VHA policy to ensure staff are aware of practice guidelines to support both recommended medical treatment and forensic examination protocols. They also stressed that national policy must provide flexibility and be supplemented by facility policy or guidance to align procedures with community resources and address jurisdictional requirements. However, the OIG found facility policies and guidance for the management of acute sexual assault varied in the utility of the guidance provided. The OIG determined that opportunities exist for many facilities to improve policy or guidance addressing the management of acute sexual assault patients. Improved facility policies or guidance would ensure implementation of VHA policy by providing frontline staff with relevant, accessible procedures; local community resources; and jurisdictional requirements to support clinical care and VA police response to patients presenting with acute sexual assault.

The OIG made eight recommendations to the Under Secretary for Health including provision of prophylaxis for sexually transmitted infection and pregnancy when indicated, offering psychological counseling, documenting signature informed consent for forensic examinations, updating VHA and VA police policy to include facility and jurisdiction-specific requirements that must be included in local policy or guidance, and ensuring the new requirements are implemented in facility policy or guidance as required.

²⁵ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13; VA Office of Security and Law Enforcement, "VA Police Standard Operating Procedure (SOP)," Chap. III, *Evidence/Property Collection, Documentation, and Processing Procedures*, revised September 30, 2021. VA Office of Security and Law Enforcement policy specifies requirements for facilities to have rape kits on site, including two kits to be stored in police operations and one to be kept with spare evidence supplies as determined by local VA police policy and procedures.

VA Comments

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix B). The OIG will follow up on the planned actions until they are completed.



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Contents

Executive Summary	i
Abbreviations	xi
Introduction.....	1
Scope and Methodology	3
Review Results.....	5
Compliance with VHA Policy on Management of Acute Sexual Assault.....	5
Challenges for VHA Facilities	19
Conclusion	25
Recommendations 1–8.....	26
Appendix A: Facility Policy Examples with Jurisdictional Reporting Requirements.....	28
Appendix B: Office of the Under Secretary for Health Memorandum	31
OIG Contact and Staff Acknowledgments	36
Report Distribution	37

Abbreviations

CDW	Corporate Data Warehouse
DNA	deoxyribonucleic acid
EHR	electronic health record
NIR	non-investigated report
OIG	Office of Inspector General
SAFE	Sexual Assault Forensic Examiner
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
VHA	Veterans Health Administration



Introduction

The VA Office of Inspector General (OIG) conducted a review to determine compliance with the Veterans Health Administration (VHA) policy on management of the emergent care needs of acute sexual assault victim-survivors.¹

Background

Sexual Assault

Sexual assault is defined by the US Department of Justice as “any nonconsensual sexual act proscribed by federal, tribal, or state law, including when the victim lacks capacity to consent.”² Sexual assault encompasses a range of unwanted sexual contact, such as rape, attempted rape, forcing a victim-survivor to perform sexual acts, and nonconsensual sexual touching.

Sexual assault affects people of all genders, races, ages, religions, and abilities. In the United States, 2015 research data estimates that more than 2 in 5 women and nearly 1 in 4 men experience some form of sexual violence in their lifetime. In addition, approximately 1 in 5 women and 1 in 38 men are victim-survivors of completed or attempted rape.³

Impact of Sexual Assault

Sexual assault is an invasive form of interpersonal violence that can have medical, psychological, and legal consequences, requiring an accurate, coordinated, and compassionate response from medical providers and law enforcement officers when victim-survivors seek care.

¹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. “Alleged acute sexual assault is defined as sexual contact with an alleged perpetrator within the last 72 hours.” This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023, and VHA Directive 1101.13, *VHA Urgent Care*, March 20, 2023. “Acute sexual assault is defined as an unwanted sexual contact by an alleged perpetrator.” Unless otherwise specified, the 2023 directives contain the same or similar language as the rescinded 2016 directive; Sexual Assault Kit Initiative, “Victim or Survivor: Terminology from Investigation Through Prosecution,” accessed March 29, 2022, <https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf>. For the purposes of this report, the term “victim-survivor” is used to describe individuals who experienced sexual assault. *Victim* is a term often used within the criminal justice system; *Survivor* is a term often used within healthcare and advocacy systems and may be preferred as denoting empowerment and conveying that a person has started the healing process.

² Department of Justice, Office on Violence Against Women, “Sexual Assault,” accessed March 1, 2022, <https://www.justice.gov/ovw/sexual-assault>.

³ Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Prevention, “National Intimate Partner and Sexual Violence Survey, 2015 Data Brief – Updated Release,” November 2018, accessed March 1, 2022, <https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf>.

Sexual assault may result in physical injuries, sexually transmitted infections, and unintended pregnancy, as well as acute and long-term psychological consequences for the victim-survivor. Victim-survivors who present for care related to acute sexual assault “may need two types of health care services; [(1)] an evaluation and treatment of medical and mental health needs, and [(2)] a forensic examination.”⁴

Sexual Assault Forensic Examination

The purpose of a sexual assault forensic examination is to collect and preserve forensic evidence for potential use during investigation and prosecution, as well as address the health care needs of the victim-survivor. Provision of a timely, high-quality forensic examination supports the victim-survivor by validating the patient’s concerns, minimizing their trauma, and promoting healing. A forensic examination can “increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable.”⁵

Collection of forensic evidence may include the history of the event, photographing injuries, taking samples of bodily fluids and hair, and collecting debris from fingernails and clothing. The samples may be used for toxicology tests or deoxyribonucleic acid (DNA) analysis.⁶ Forensic evidence deteriorates with time and should be collected as soon as possible.⁷ Legal requirements for evidence collection, storage and preservation, and incident reporting are significant considerations for the prosecution of alleged sexual assault cases and vary depending on jurisdiction. The US Department of Justice recommends forensic examinations “be performed by a health care professional specially trained in the collection of evidence relating to sexual assault cases such as a sexual assault nurse examiner [SANE] or other appropriately trained medical professional.”⁸

⁴ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

⁵ US Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, Second Edition, NCJ 228119, April 2013.

⁶ US Department of Justice, Office of Justice Programs, *National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach*, NCJ 250384, August 2017. “The type of evidence collected depends on what occurred during the assault.”

⁷ Sexual assault forensic examination time frames depend on state and local laws. For example, time frames may vary from 72 hours to seven days.

⁸ US Department of Justice, NCJ 250384.

A forensic examination should be offered after the victim-survivor is medically stable and is neither a mandatory examination nor an emergency procedure. Consenting to a forensic examination does not require the victim-survivor to report the incident to police or seek prosecution, ensuring that evidence may be collected during the allowable time frame while letting the victim-survivor decide whether to report the assault later.⁹

Scope and Methodology

The OIG initiated a national review in June 2021 to assess VHA’s management of emergent care needs for patients who present for care related to acute sexual assault.

The OIG reviewed VHA and VA policies for requirements related to management of sexual assault. The OIG utilized data from the VHA Corporate Data Warehouse (CDW) to identify all VHA emergency department or urgent care center visits with diagnostic codes related to acute sexual assault or procedural codes related to forensic examination for sexual assault associated with an episode of care from July 1, 2020, through June 30, 2021.¹⁰ During this time, VHA emergency departments and urgent care centers generated more than 2.7 million encounters. VHA Office of Clinical Services provided the OIG with a list of 140 facilities with emergency departments and urgent care centers; of these facilities, the OIG identified 145 visits related to sexual assault. The OIG reviewed electronic health records (EHRs) for those 145 visits and excluded 45 from further analysis because they were not related to acute sexual assault or were duplicates of patient encounters. Within the 140 VHA facilities with emergency departments or urgent care centers, the OIG identified a total of 100 visits related to acute sexual assault. Of the 100 visits related to acute sexual assault, 77 of the 100 victim-survivors were identified as female, and 23 were identified as male. Victim-survivor ages ranged from 18 to 89, with an average age of 36 (median age of 37). The OIG further reviewed EHRs for the 100 identified patient visits and evaluated aspects of clinical care against VHA policy requirements.

The OIG requested facility policies and guidance from VHA facilities with an emergency department or urgent care center. The OIG reviewed the policies and guidance provided for

⁹ US Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition*, NCJ 228119, April 2013. In some jurisdictions, health care workers are “bound by law to report some or all forms of sexual assault, regardless of patients’ wishes.”

¹⁰ VHA Corporate Data Warehouse, accessed March 21, 2022, <http://vaww.vhadataportal.med.va.gov/DataSources/CDW.aspx>. (This website is not publicly accessible.) VHA’s CDW is “a national repository comprising data from several VHA clinical and administrative systems, including the Electronic Health Record (EHR).” CDW refers to emergency department and urgent care center visits as encounters; VA Office of Informatics and Information Governance, “Fact Sheet: Electronic Encounter Form Completion,” May 2017. “An encounter is a professional contact between a patient and a provider assigned with the responsibility of diagnosing, evaluating, and treating the patient’s condition.”

inclusion of facility processes, local resources, and jurisdictional requirements.¹¹ Out of 140 VHA facilities, 120 facilities (86 percent) provided facility policies or guidance related to the clinical management of acute sexual assault, and 49 (35 percent) provided facility policies or guidance for VA police responding to sexual assault allegations.¹²

The OIG disseminated questionnaires to the emergency department or urgent care center chiefs and nurse managers (emergency department or urgent care center leaders), chiefs of police, and when available, sexual assault forensic examiners (SAFE) or equivalently certified examiners.¹³ The questionnaire covered the topics of policy, training, available resources, and coordination between clinical and law enforcement staff.¹⁴

The OIG team also interviewed subject matter experts from VHA's national program offices for emergency medicine, women's health, patient care services, military sexual trauma, and the Intimate Partner Violence Assistance Program. Additionally, the OIG interviewed the VHA senior security officer and VA Office of Security and Law Enforcement leader.

To inform an understanding of industry practices outside of VHA, the OIG reviewed US Department of Justice protocol, clinical research literature on clinical assessment and treatment, and Police Executive Research Forum guidance on law enforcement response to individuals who experience acute sexual assault.

The OIG did not independently verify VHA data for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous policy or guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

¹¹ VHA Directive 0999, *VHA Policy Management*, March 29, 2022, specifies that “[g]uidance provides supplemental information that establishes a course of action or procedures for a program from a SME [subject matter expert] or policy owner. Guidance documents are not policy and must be consistent with VHA national policy.” For the purposes of this report, the OIG uses the term “guidance” to refer to facility documents that detail facilities’ plans for the management of acute sexual assault, such as standard operating procedures.

¹² Facility-provided documents were considered relevant clinical policy or guidance if the document was (1) explicitly described as having a purpose related to management and treatment of sexual assaults, or (2) described as general emergency department or urgent care center policy or guidance and included a distinct section or appendix that provided guidance on management and treatment of sexual assault, or (3) described as policy or guidance on the reporting of patient abuse and neglect and included a distinct section or appendix about management and treatment of sexual assault, beyond reporting; Facility-provided documents were considered relevant police policy or guidance if the document was (1) explicitly described as providing policy or guidance to VA police for responding to sexual assault allegations, or (2) contained a section that provided policy or guidance to VA police for responding to sexual assault allegations.

¹³ Within this report, SAFE is used to indicate certified sexual assault forensic examiners and individuals with equivalent certifications in sexual assault forensic examination, such as sexual assault nurse examiners.

¹⁴ Questionnaires were completed by 134 of 140 (95.7 percent) emergency department or urgent care center chiefs, 131 of 140 (93.6 percent) emergency department or urgent care center nurse managers, 11 of 13 (84.6 percent) SAFE, and 137 of 140 (97.9 percent) police chiefs. Less than 10 percent of facilities employed SAFE staff and therefore, responses were not included.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

The OIG found varying levels of compliance amongst emergency department and urgent care centers, indicating that victim-survivors do not always receive needed care. Facilities face challenges in complying with acute sexual assault requirements due to the low frequency of individuals with this need presenting for care.

Compliance with VHA Policy on Management of Acute Sexual Assault

The OIG found deficiencies in adherence to VHA policy on management of acute sexual assault, including requirements to ensure the provision of sexually transmitted infection prophylaxis and pregnancy prophylaxis when clinically indicated, and to offer psychological counseling.¹⁵ The OIG noted deficiencies in required documentation of signature informed consent for the forensic examinations conducted by staff at VHA facilities. The OIG also found variability in the availability of facility policies or guidance on the management of acute sexual assault, the practices addressed, and the degree of detailed information on those practices for responding clinical staff and police officers.¹⁶

VHA policy requires that facility emergency departments and urgent care centers “have plans in place to appropriately manage the medical and psychological assessment, treatment, and collection of evidence from Veterans, male and female, who are victims of alleged acute sexual assault.”¹⁷

¹⁵ Sexually transmitted infection prophylaxis refers to treatment with medications intended to prevent sexually transmitted infections, which may result from exposure during sexual contact.

¹⁶ The OIG reviewed clinical policies and guidance received from 120 facilities and VA police policy and guidance received from 49 facilities, which the OIG determined were intended to provide specific guidance related to acute sexual assault.

¹⁷ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13.

The OIG reviewed facility policies and guidance and evaluated EHR documentation for the following VHA-required aspects of acute sexual assault clinical management:¹⁸

- Medical evaluation
- Sexually transmitted infection prophylaxis
- Pregnancy prophylaxis
- Psychological counseling
- Informed consent
- Coordination of patient transfers
- Forensic examination
- Reporting to law enforcement

Medical Evaluation

VHA policy requires provision of emergency treatment for victim-survivors of acute sexual assault, including “evaluation to stabilize and/or treat any acute medical or psychological problems.”¹⁹ Of the 120 facilities that submitted clinical policy or guidance, 93 percent addressed the victim-survivor’s medical evaluation.

The OIG’s review of patient EHRs found that emergency medical evaluation and treatment was documented in 99 of the 100 visits. The one remaining encounter included documentation that a medical evaluation was offered; however, the victim-survivor refused the examination.

Sexually Transmitted Infection Prophylaxis

VHA policy requires that “[a]ppropriate prophylaxis for sexually transmitted disease. . . must be offered when clinically indicated.”²⁰ Sexually transmitted infection is a risk associated with sexual assault and should be addressed as part of the medical care for victim-survivors.

For sexual assault victim-survivors who consent, evaluation and treatment for sexually transmitted infections should be addressed during the forensic examination.²¹ If the victim-

¹⁸ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13; VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended January 4, 2021; VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

¹⁹ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, language related to requirements for medical evaluation was revised and specified that VA emergency departments and urgent care centers conduct “screening for injuries requiring emergent treatment or stabilization.”

²⁰ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13.

²¹ US Department of Justice, Office on Violence Against Women, NCJ 228119.

survivor declines a forensic examination, evaluation and treatment for sexually transmitted infections should be addressed as part of the medical evaluation.

The OIG’s EHR review determined that sexually transmitted infection prophylaxis was clinically indicated in 97 of the 100 visits. However, prophylaxis for sexually transmitted infections was not offered to 15 percent of the victim-survivors with a clinical indication.²² See figure 1.

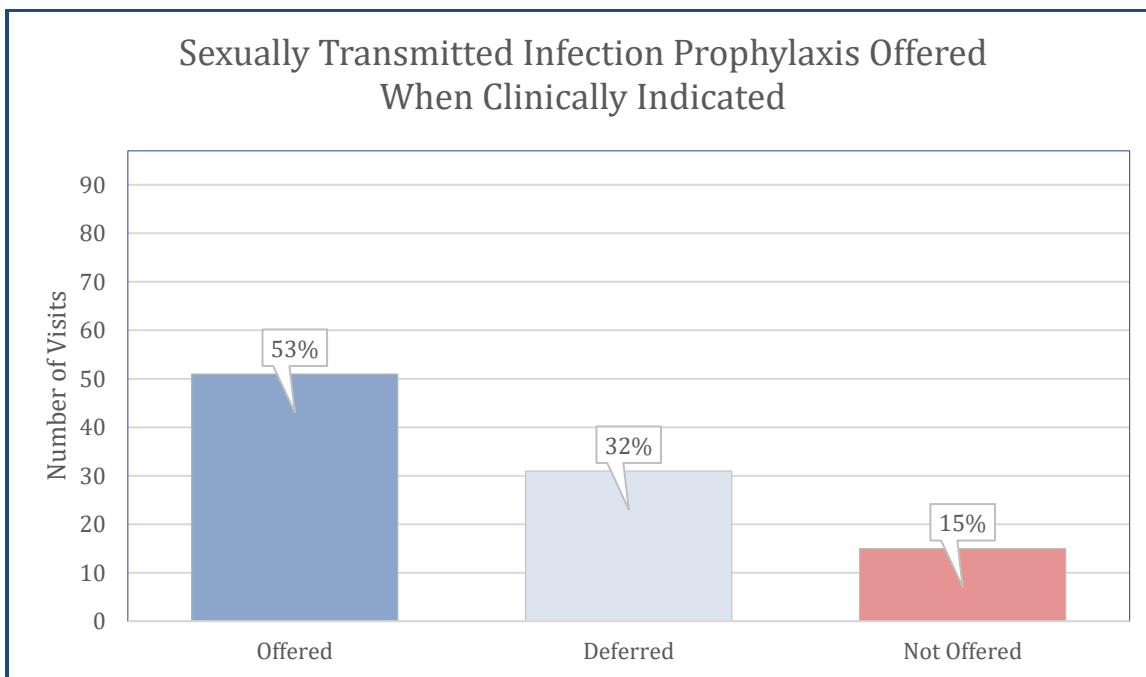


Figure 1. Emergency department and urgent care center visits for acute sexual assault during which sexually transmitted infections prophylaxis was offered when clinically indicated (July 1, 2020, through June 30, 2021).

Source: OIG review of patient EHRs.

Research suggests that many sexual assault victim-survivors do not complete recommended follow-up visits. Therefore, ensuring that appropriate prophylaxis is offered when victim-survivors seek care is important to mitigate health risks of sexually transmitted infections.²³

Of the 120 facilities that submitted clinical policy or guidance, more than 1 in 3 (35 percent) did not include any guidance on sexually transmitted infection prophylaxis. Inclusion of supplemental information within facility policy or guidance to support evidence-based clinical care for sexually transmitted infection prophylaxis, such as resources for providers to access

²² Patients referred to a community partner for a SAFE examination were not included within the cases identified as care not offered, as this aspect of care fell within the purview of the community SAFE examination.

²³ Centers for Disease Control and Prevention (CDC), Sexually Transmitted Infections Treatment Guidelines, 2021, “Sexual Assault and Abuse and STIs – Adolescents and Adults,” accessed October 6, 2022, <https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm>.

clinical practice guidelines or clinical order sets, may help address deficiencies observed in clinical practice.

Pregnancy Prophylaxis

VHA policy requires that “[a]ppropriate prophylaxis for. . . pregnancy must be offered when clinically indicated.”²⁴ Provision of emergency contraception for pregnancy prophylaxis should be considered as part of the treatment and support services offered if the assault could result in pregnancy.²⁵

Pregnancy tests detect human chorionic gonadotropin in the blood or urine. Around eight days after conception, human chorionic gonadotropin may be detected in the urine and may be detected in low levels in blood. Emergency contraception prevents pregnancy from occurring, and is recommended for use within five days of sexual intercourse.²⁶ For sexual assault victim-survivors who consent to a forensic examination, pregnancy testing and prophylaxis is addressed during that examination. If the victim-survivor declines a forensic examination, pregnancy testing and prophylaxis should be addressed as part of the medical evaluation.

The OIG’s EHR review determined that pregnancy prophylaxis was clinically indicated in 64 of the 100 visits. However, there was no documentation of pregnancy prophylaxis being offered or provided in 19 (30 percent) of those visits.²⁷ See figure 2.

²⁴ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13.

²⁵ US Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, Second Edition, NCJ 228119, April 2013. “The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent, similar to the risk of pregnancy from a one-time sexual encounter.” Pregnancy prophylaxis refers to emergency contraception measures (hormonal contraceptive pills or copper-containing intrauterine devices) utilized after sexual contact with the intent to prevent unintended pregnancy.

²⁶ World Health Organization, *Emergency Contraception*, November 9, 2021. Emergency contraceptive medications prevent pregnancy through delaying or preventing ovulation. Emergency contraceptive medications do not induce abortion and cannot interrupt an established pregnancy or harm a developing embryo.

²⁷ Patients referred to a community partner for a SAFE examination were not included within the cases identified as care not offered, as this aspect of care fell within the purview of the community SAFE examination.

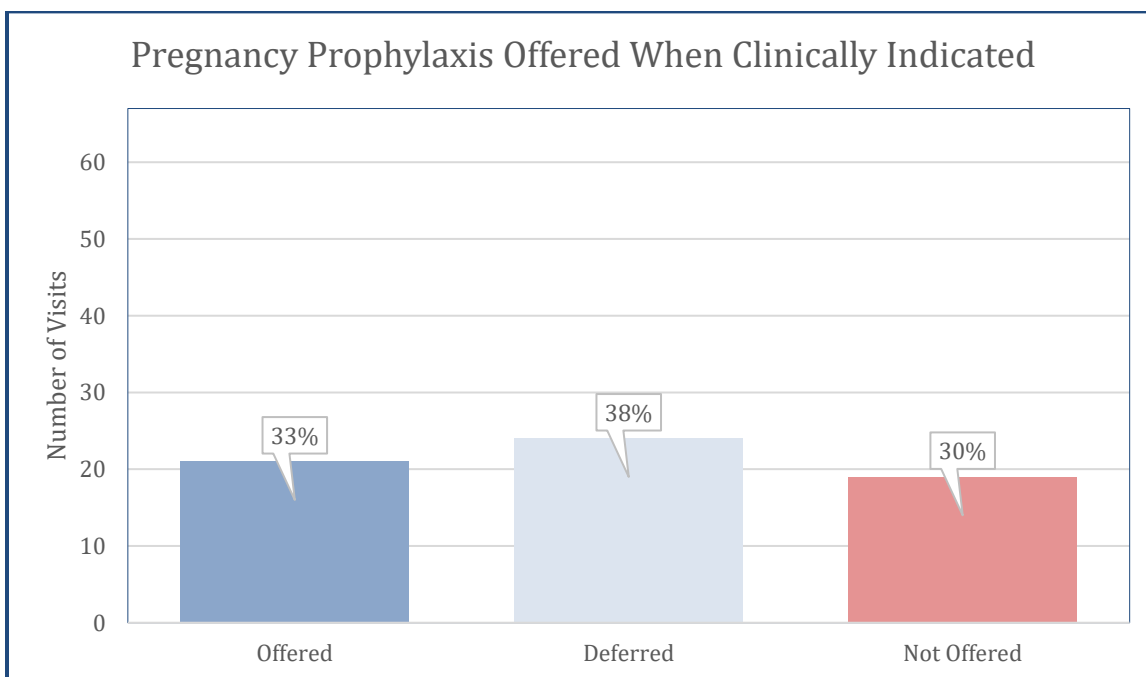


Figure 2. Emergency department and urgent care center visits for acute sexual assault during which pregnancy prophylaxis was offered when clinically indicated (July 1, 2020, through June 30, 2021).

Note: Total does not equal 100 percent because numbers were rounded to the nearest percent.

Source: OIG review of patient EHRs.

Furthermore, for 9 of the 20 visits in which providers failed to offer pregnancy prophylaxis, pregnancy testing was documented. A negative pregnancy test result during acute sexual assault emergent care would not rule out the need to offer pregnancy prophylaxis.²⁸

Failure to offer emergency contraception for pregnancy prophylaxis when clinically indicated may increase the risk for the victim-survivor of facing an unintended pregnancy because of the sexual assault.²⁹

Of the 120 facilities that submitted policy or guidance, more than 1 in 3 (39 percent) did not include pregnancy prophylaxis for acute sexual assault victim-survivors. Inclusion of

²⁸ A positive pregnancy test is used to determine if a victim-survivor was pregnant prior to the acute sexual assault and would be a contraindication for emergency contraception, as well as inform clinical decisions about other medications. Human chorionic gonadotropin begins to build up in the body when a fertilized egg implants in the uterus and takes time to reach detectable levels in blood and urine. Around eight days after conception, pregnancy tests detect human chorionic gonadotropin in the urine or in low levels within the blood. Thus, a negative pregnancy test result within the time frame shortly following a sexual assault would not rule out the possibility of pregnancy resulting from assault.

²⁹ This review was completed prior to VA's September 2022 changes in abortion policy VHA Directive 1330.01 (6), *Health Care Services for Women Veterans*, February 15, 2017, updated September 9, 2022; Under Secretary for Health Memorandum, *Provision of Abortion Counseling and Services*, September 14, 2022, provides for abortion counseling and abortions when the pregnancy is the result of rape, incest, or in instances where the life or health of the pregnant veteran would be endangered if the pregnancy was carried to term.

supplemental information within facility policy or guidance to support evidence-based clinical care for pregnancy prophylaxis after acute sexual assault, such as resources for providers to access clinical practice guidelines or clinical order sets, may help address deficiencies observed in clinical practice.

Psychological Counseling

Under VHA policy, a referral for psychological counseling must be offered when victim-survivors present for emergency care related to acute sexual assault. For patients who seek mental health care immediately, initial contact with a mental health provider must take place within 24 hours and an initial mental health appointment must be scheduled “as soon as clinically indicated, but not later than 7 days.”³⁰

The OIG considered documentation of an offer of psychological counseling services or a mental health referral order as meeting the VHA policy requirement. Through EHR review, the OIG found no documentation of psychological counseling services offered or mental health referrals ordered in just over half of the emergency department and urgent care center visits for acute sexual assault. See figure 3.

³⁰ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, language related to requirements on offering psychological counseling was revised. The new directives require VA emergency departments and urgent care centers to “have procedures in place to evaluate, support and treat patients of reported acute sexual assault” and specifies that “[f]ollow-up care may include. . . patient services such as a Rape Crisis Center based on regional availability and mental health services.”



Figure 3. Emergency department and urgent care center visits for acute sexual assault that documented offering psychological counseling (July 1, 2020, through June 30, 2021).

Source: *OIG review of patient EHRs.*

Research has shown associations between sexual assault and a range of mental health concerns, including acute psychological distress, posttraumatic stress, depression, anxiety, substance misuse, and suicidality.³¹ Failure to offer psychological counseling may leave sexual assault victim-survivors without timely access to the mental health services needed to support their recovery from the trauma.

Of the 120 facilities that submitted clinical policy or guidance, 88 percent addressed psychological counseling. However, the observed deficiencies in the EHR may indicate additional guidance is needed to ensure counseling is offered when patients present for treatment of acute sexual assault.

³¹ Anna Jaffe et. al., “Acute Stress Symptoms After Forcible and Substance-Involved Rapes,” *Psychology of Women Quarterly*, 43, No. 4, (2019): 485-493; Ruby Charak et. al., “Lifetime Interpersonal Victimization Profiles and Mental Health Problems in a Nationally Representative Panel of Trauma-Exposed Adults From the United Kingdom,” *Journal of Traumatic Stress*, 33, (2020): 654-664; Sharyn Potter et. al., “Long-term impacts of college sexual assaults on women survivors’ educational and career attainments,” *Journal of American College Health*, 66, No. 6, (2018): 496-507; Lance Brendan Young et. al., “Sexual Trauma and Addiction Severity in Military Veterans With Substance Use Disorder,” *Journal of Loss and Trauma*, 26, No. 2, (2021): 153-165; Emily R Dworkin et. al., “Associations Between Sexual Assault and Suicidal Thoughts and Behavior: A Meta-Analysis,” *Psychological Trauma: Theory, Research, Practice, and Policy*, 14, No. 7, (2022): 1208-1211.

Informed Consent

A patient has the “right to accept or refuse any aspect of the medical evaluation and treatment or forensic evidentiary examination.”³² VHA policy specifies a process for informed consent, which refers to the responsibility of healthcare providers to “[p]rovide information that a reasonable person in the patient’s situation would expect to receive in order to make an informed choice about whether or not to undergo the treatment or procedure” and obtain voluntary consent prior to treatment.³³ VHA policy also requires that providers document the informed consent process in the patient’s EHR and specifies a “separate signature informed consent is required to perform a forensic exam on a patient.”³⁴

The OIG was unable to locate the signature informed consent in the EHR for 9 of the 10 victim-survivors who received sexual assault forensic examinations at VHA facilities.³⁵ Of the 120 facilities that submitted clinical policy or guidance, 81 percent referenced informed consent. Informed consent is a patient’s right and an important part of patient-centered care. Informed consent ensures that procedures are explained in an understandable manner and the patient is aware of accepting or declining any or all parts of an examination. Informed consent reflects respect for a patient’s autonomy and empowers victim-survivors to make informed decisions about their care.

Patient Transfers

VHA policy stipulates that following emergency evaluation, “VA medical facilities are not required to provide complete care onsite” and specifies that VA facilities unable to provide full care must provide “transfer to an appropriate local, non-VA facility with trained and experienced providers in the examination, treatment and the collection of evidence of patients suffering from alleged acute sexual assault.”³⁶ VHA also sets requirements for coordination of patient transfers

³² VHA Directive 1101.05(2).

³³ VHA Handbook 1004.01(4).

³⁴ VHA Handbook 1004.01(4). The requirement for documentation of signature informed consent in the EHR applies to forensic evaluations performed at VHA facilities by VHA staff. “For the purposes of documenting informed consent for clinical treatments and procedures that require signature consent, the VA authorized consent form refers to the use of the iMedConsent™ software program to conduct the informed consent discussion, capture electronic signatures, and file the completed document electronically in the patient’s record.” VHA Emergency Medicine Program Office subject matter experts reported that in some circumstances, printed informed consent forms may be utilized instead of iMedConsent™ and scanned into the patient’s EHR.

³⁵ Of the 10 examinations performed at VHA facilities, 8 were completed by VHA staff and 2 were completed by a community SAFE examiner. The OIG located the signature informed consent in the EHR for 1 examination performed by VHA staff. For the victim-survivors who were referred outside VHA to community facilities for forensic examination, informed consent would be documented by the community SAFE examiner and not be found in the patient’s VHA EHR.

³⁶ VHA Directive 1101.05(2); VHA Directive 1101.14 and VHA Directive 1101.13 state VHA facilities must have a procedure in place for “performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

between facilities that include direct communication between the provider or designee at the referring and the accepting facility, and mode of transportation appropriate to the level of care required by the patient during the transfer.³⁷

Of the 120 facilities that submitted clinical policy or guidance, 86 percent addressed patient transfers and 5 percent specified standard procedures for completion of SAFE examinations at the facilities' locations. To evaluate the coordination of patient transfers to community facilities for forensic examinations, the OIG assessed whether facility staff documented contacting the community SAFE facility and whether the method of transport to the community SAFE facility was clinically appropriate for the patient.

The OIG determined that of the 34 patients who required transfer, staff coordinated transfer to community SAFE facilities for 31 (91 percent) patients. For 1 patient, transportation was coordinated, but the OIG was unable to confirm direct contact for coordination with the receiving facility due to insufficient documentation. For the 2 remaining patients, transportation to the community SAFE facility was not provided although transportation was indicated. In one case, EHR documentation specified that the victim-survivor was unable to drive to the community SAFE facility for the examination due to alcohol intoxication; however, the facility did not offer transportation and the victim-survivor arranged for a ride. In the second case, the VHA emergency department provider attempted to arrange transfer transportation to the community SAFE facility but documented delays and difficulty arranging transport due to internal policy changes; the victim-survivor was determined to be stable and opted for self-transport due to the delays.

Forensic Examinations

VHA policy requires emergency department and urgent care centers to have “plans in place” for collection of forensic evidence by appropriately trained staff, and specifies “consultation with Rape Crisis Centers, a SANE [Sexual Assault Nurse Examiner] unit, or other appropriate organizations having knowledge and experience in issues of sexual assault.”³⁸ Collection of sexual assault evidence is time sensitive. “Forensic DNA evidence deteriorates with time,” and evidence may be lost from the body or clothing if the victim washes or bathes, urinates, brushes

³⁷ VHA Directive 1094.

³⁸ VHA Directive 1101.05(2); The verbiage within VHA Directive 1101.14 and VHA Directive 1101.13 differs from the previous directive, specifying instead that facility emergency departments and urgent care clinics must “have procedures in place” for “performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

teeth, or changes clothes.³⁹ Time frames specified for collecting forensic evidence vary across jurisdictions, typically falling between 72 hours and one week following the sexual assault.⁴⁰

Of the 100 VHA emergency department or urgent care center visits for acute sexual assault, the majority of patients presented within a viable time frame for collection of forensic evidence (64 presented within 72 hours post- assault and 13 presented between 72 hours and 1-week post-assault).⁴¹ See figure 4.

³⁹ US Department of Justice, NCJ 250384.

⁴⁰ US Department of Justice, NCJ 228119.

⁴¹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. “VA medical facilities are not required to provide complete care onsite.” At facilities where complete care is not available onsite, “[a]n agreement with a local, non-VA facility needs to be arranged in advance and agreed to in a contract to provide this service 24 hours a day, 7 days a week at VA expense.” “Emergency evaluation to stabilize and/or treat any acute medical or psychological problems must be provided with subsequent transfer to an appropriate local, non-VA facility with trained and experienced providers in the examination, treatment and the collection of evidence of patients suffering from alleged acute sexual assault.” VHA policy requires that “VA medical facilities without a local, non-VA facility with staff providers experienced in the care of victims of alleged acute sexual assault must have appropriately trained staff available 24 hours a day, 7 days a week for the examination, treatment, and collection of evidence that fully meets patient needs.” The policy further specifies those services are “conducted in consultation with Rape Crisis Centers, a SANE unit, or other appropriate organizations having knowledge and experience in the issues of sexual assault.”; VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, the requirement for 24/7 availability of VHA staff trained for evidence collection in facilities without a local, non-VA resource for sexual assault forensic examinations is no longer specified. The 2023 directives specify a requirement that procedures are in place for “performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

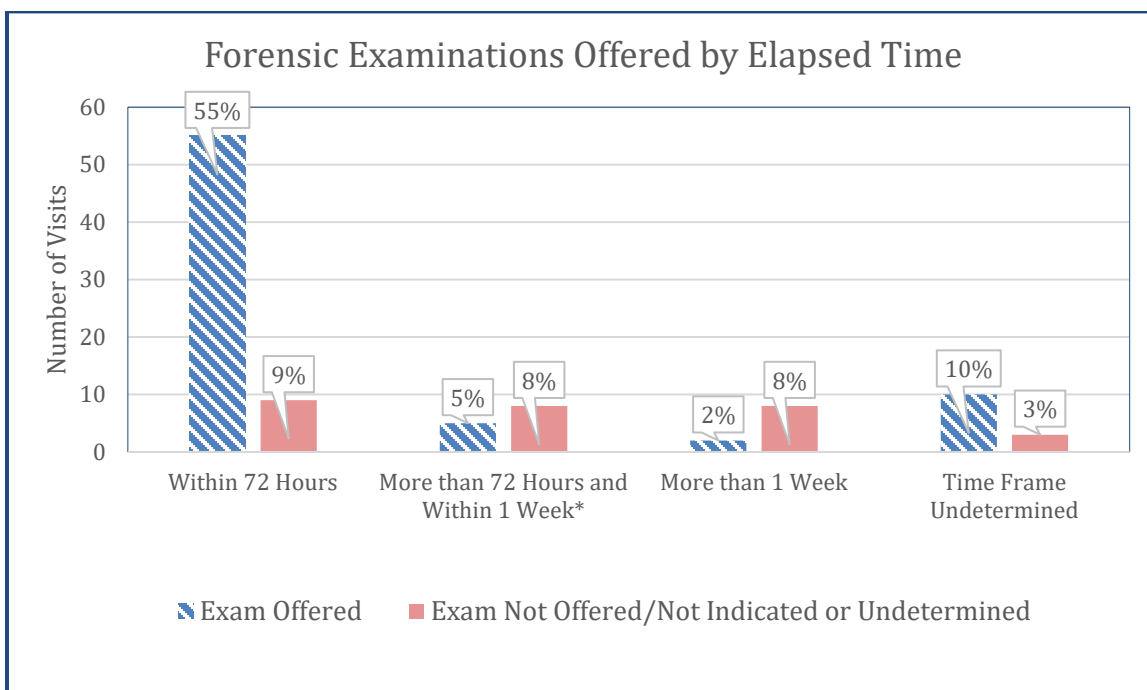


Figure 4. Emergency department and urgent care center visits for acute sexual assault during which forensic examinations were offered for patients who presented for acute sexual assault (July 1, 2020, through June 30, 2021).

Source: OIG review of EHR documentation.

Note: For those patients who presented within a viable time frame for collection of forensic evidence and whose EHR did not contain documentation of offering forensic examination, the OIG’s review determined that dispositions were consistent with relevant considerations documented within the EHR notes in 13 of 14 cases, with 1 case undetermined.

* One week is defined as equal to seven days.

Of the 72 total patients who were offered a forensic examination, nearly 2 in 3 consented (opted in) for the forensic examination. See figure 5.

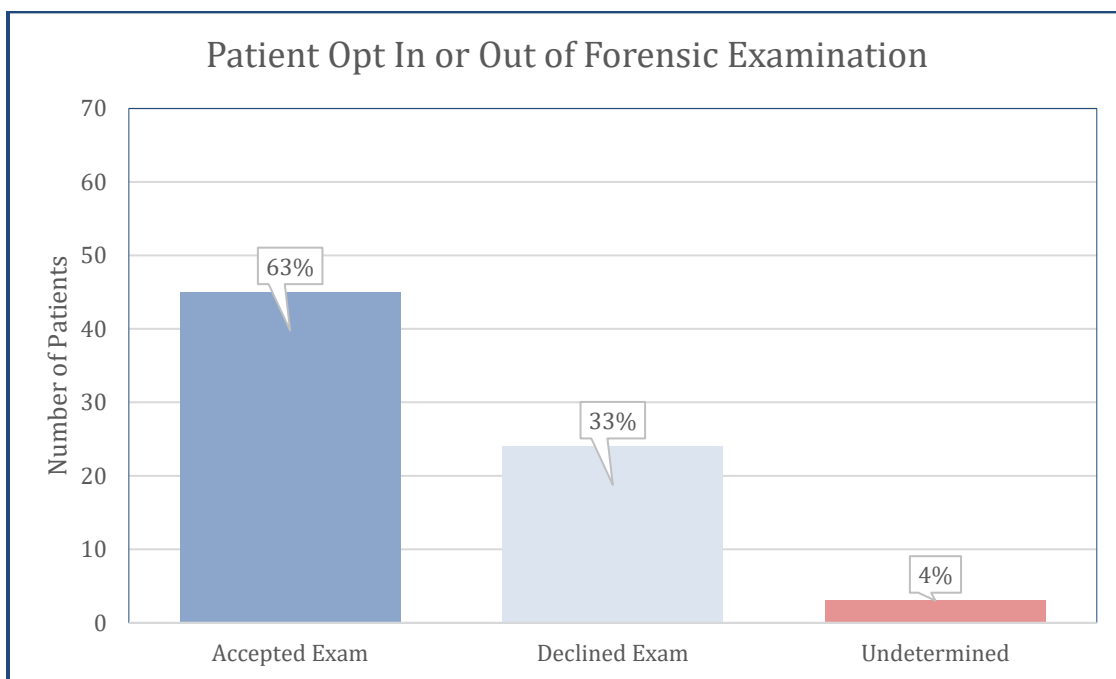


Figure 5. Patients opting in or out of forensic examinations for acute sexual assault (July 1, 2020, through June 30, 2021).

Source: OIG review of EHR documentation.

For the 45 patients who consented to a forensic examination, the majority were referred to a community facility with SAFE resources to complete the examination. See figure 6.

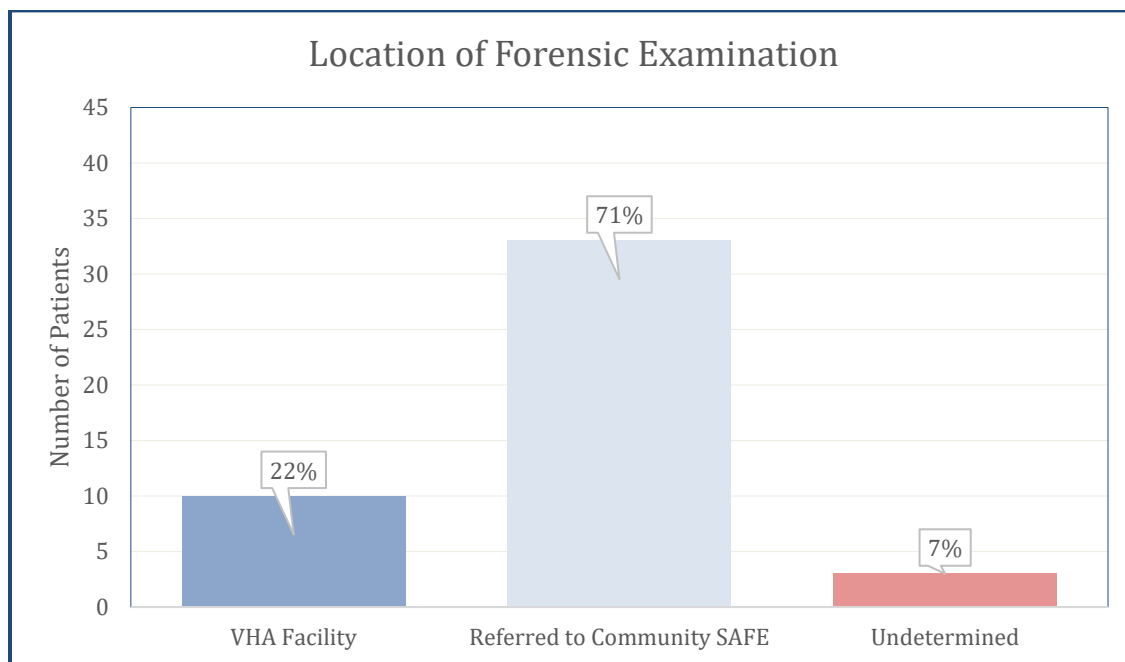


Figure 6. Location of forensic examinations (July 1, 2020, through June 30, 2021).

Source: OIG review of EHR documentation.

Of the 120 facilities that submitted clinical policy or guidance, 83 percent identified community SAFE resources for provision of forensic examinations.⁴² However, approximately 14 percent of the facilities failed to identify the SAFE community partners within the documents. Only 35 percent referenced procedures for evidence collection in the event a victim-survivor was too unstable for transfer to a community facility with SAFE resources.

Of the 10 forensic examinations that were completed at a VHA facility, 2 were completed at the facility by external staff from a community SAFE resource. SAFE-certified VHA staff completed 7 examinations; 1 was completed by a VHA provider without documentation to determine whether the provider was SAFE certified.⁴³

Responding to an OIG questionnaire, 84 percent of emergency department and urgent care center leaders reported that SAFE-certified staff at community facilities provided forensic examinations; 14 percent reported that community partner SAFE-certified staff performed examinations on site at the VHA facility. Six percent of emergency department and urgent care center leaders reported that forensic examinations could be performed on site by a SAFE-certified VHA staff member.

The OIG found the majority of VHA emergency departments and urgent care centers utilized community SAFE resources, and collaboration with community partners equipped to address the medical-forensic needs of acute sexual assault patients was key to meeting the care needs of the patients and VHA requirements.

Reporting to Law Enforcement

VHA policy specifies that when a victim-survivor consents to report a sexual assault to law enforcement, “VA Police must be notified to refer the report of the incident to law enforcement in the appropriate jurisdiction after consultation with Regional Counsel.”⁴⁴ VHA policy also provides that “[r]eports of alleged sexual assault are made pursuant to valid state laws which

⁴² Three percent of the facilities’ guidance documents identified facility-based SAFE resources.

⁴³ Two facilities accounted for the seven forensic examinations completed by SAFE VHA staff.

⁴⁴ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. VHA policy also requires that “[t]he OIG must be notified of sexual assaults when the crime occurs on VA premises or by VA employees in connection with VA treatment or services.” Within the 2023 directives, language related to requirements on reporting sexual assaults to law enforcement was revised and refers staff to “See VHA Directive 5019.02(1) and VA Directive 0321, *Serious Incident Reports*, dated June 6, 2012, for requirements for reporting incidents of harassment or sexual assault.”; VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA*, September 12, 2022, amended October 13, 2022. VHA has a standalone policy that establishes requirements for prevention and management of sexual assaults that occur in VHA facilities, including reporting requirements.

provide for or require that such reports be made.”⁴⁵ Alternatively, reporting may be required regardless of the victim-survivor’s consent if the incident meets criteria for mandated reporting as defined by law in the jurisdiction where the facility is located.⁴⁶ Additionally, some jurisdictions have implemented de-identified reporting options for mandated reporting, while others require inclusion of personally identifiable information.

The majority of facilities’ policies or guidance documents referenced law enforcement notification with 94 percent referencing VA police and 89 percent referencing local law enforcement notification. However, the OIG found the degree of detail regarding reporting requirements and procedures varied. Some facilities’ policy or guidance documents lacked sufficient detail to fully advise staff how to comply with VHA requirements for law enforcement notification in a manner consistent with the jurisdictions’ laws.⁴⁷

The OIG reviewed EHRs for documentation of VA police notifications and compared the documentation to available facility policy or guidance on reporting sexual assaults to VA police.⁴⁸ The OIG was unable to determine whether VA police notifications were consistent with facility requirements for 38 percent of the 100 visits, due to insufficient detail of reporting procedures within facility policy or guidance. For the visits where facility policy or guidance reporting requirements were sufficient, the documentation of VA police notification, or absence thereof, was inconsistent with the facility’s guidance on reporting requirements for nearly 1 in 3 visits. See figure 7.

⁴⁵ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, language related to requirements on reporting sexual assaults to law enforcement was revised. The new directives require VA emergency departments and urgent care centers to “have procedures in place to evaluate, support and treat patients of reported acute sexual assault” and specifies that “[f]ollow-up care may include. . . access to law enforcement.”

⁴⁶ State laws vary with regards mandates for medical personnel to make reports to law enforcement. States may have statutes that require reporting the treatment of a rape victim-survivor, reporting of treatment for injuries that may include sexual assault, or reporting of treatment relating to crimes or injuries that could impact sexual assault victim-survivors.

⁴⁷ The OIG considered policy or guidance as lacking sufficient detail if they did not contain information necessary to ascertain whether patient consent for reporting to law enforcement was required or whether facilities’ jurisdictions had mandatory reporting requirements. For example, some facility policy and guidance documents only contained information for reporting events that occurred on VA property, and some addressed only mandated reporting for abuse or neglect of minors and vulnerable adults. It was beyond the scope of the OIG’s review to fully ascertain all relevant factors to evaluate whether reporting actions documented for acute sexual assault visits were compliant with each facility’s jurisdictional requirements. Additionally, the OIG noted that EHR documentation was unlikely to provide a reliable source to assess for local law enforcement notification, as VA police determinations regarding local law enforcement notifications may not be documented within a patient’s EHR.

⁴⁸ The OIG review of facility policies and guidance did not necessarily correlate with the time frame of the OIG review of patients presenting for treatment of alleged acute sexual assault.

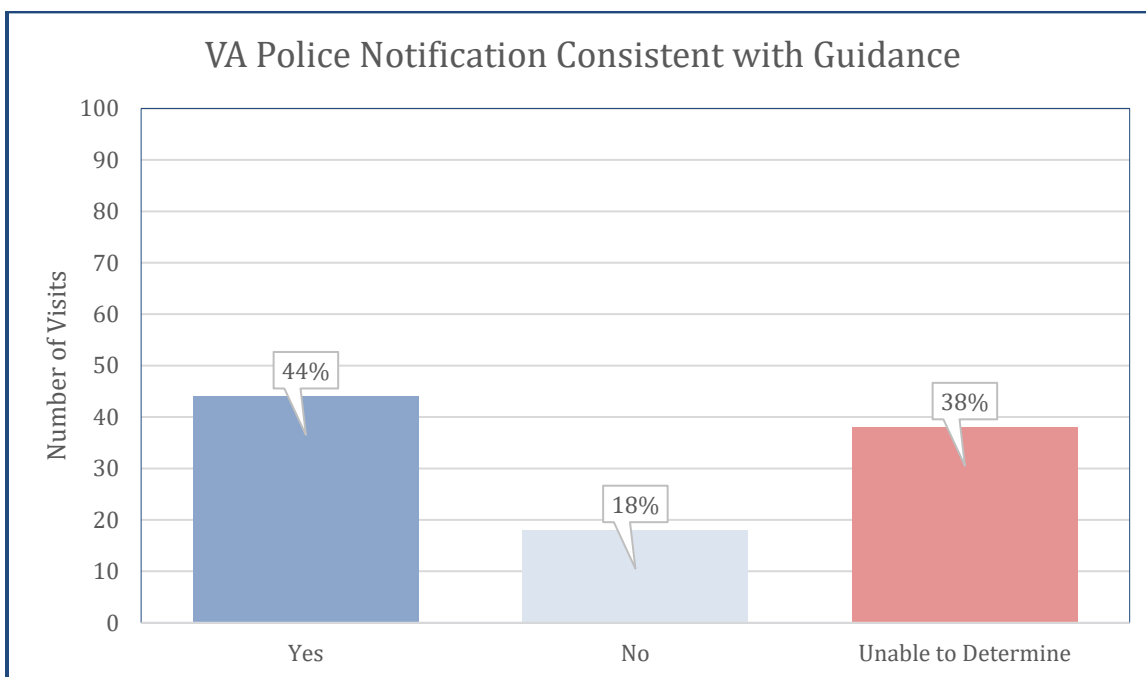


Figure 7. Number of emergency department and urgent care center visits for acute sexual assault during which documented VA police notifications were completed consistent with facility policy or guidance (July 1, 2020, through June 30, 2021).

Source: OIG review of EHR documentation and facility policy or guidance on reporting.

Given that law enforcement notification and associated limits of confidentiality vary based on jurisdictional reporting requirements, detailed facility policy or guidance is important to inform providers' practices and support patient care.

Challenges for VHA Facilities

The OIG found that the low frequency of patients seeking care related to an acute sexual assault contributed to challenges for VHA facilities in managing emergent care needs of these patients. These challenges included

- maintenance of staffs' procedural knowledge and training;
- availability of facility resources and knowledge of available community resources; and
- provision of detailed, facility-specific policy or guidance.

Care related to acute sexual assault is a low frequency, but crucial, occurrence in VHA, with 59 percent of VHA emergency department and urgent care centers having no identified visits from July 1, 2020, through June 30, 2021. See figure 8.

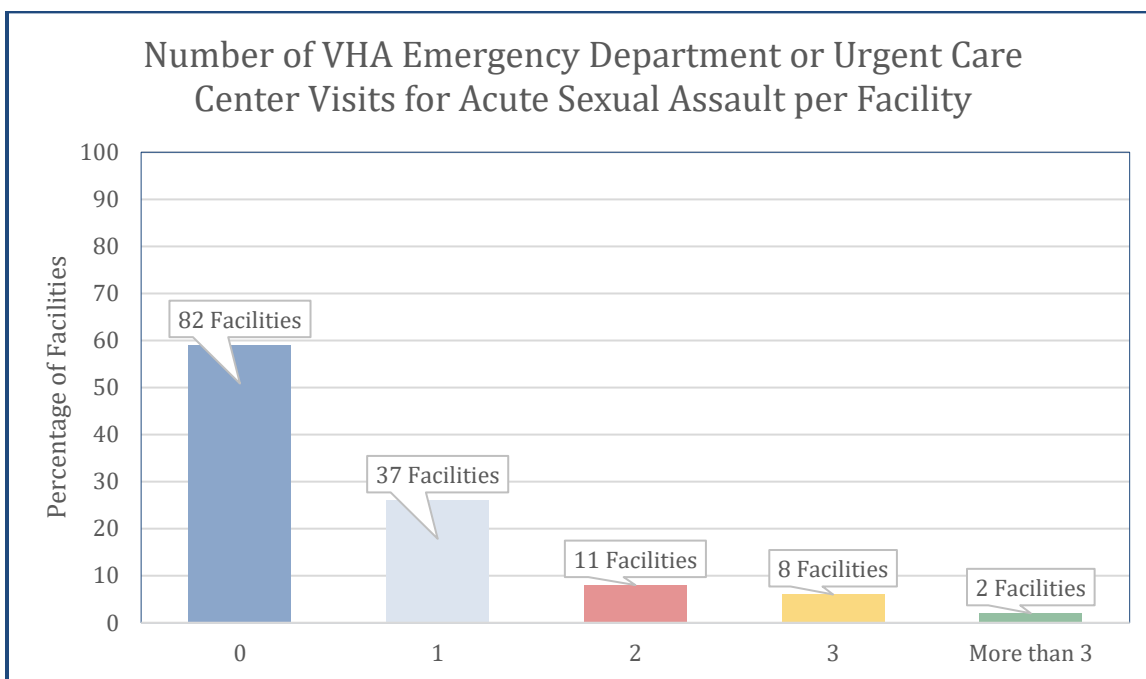


Figure 8. Emergency department or urgent care center visits for acute sexual assault per facility from July 1, 2020, through June 30, 2021.

Source: OIG analysis of data from VHA CDW.

The OIG questionnaire responses from facility emergency department and urgent care center leaders and police chiefs highlighted the challenges associated with low-frequency specialty care, maintenance of staff knowledge and training, and resource availability. The OIG interviews with subject matter experts from VHA national program offices similarly highlighted that the low frequency, specialized nature of comprehensive care for acute sexual assault presents challenges for maintaining staff knowledge and proficiency to address the complex, multifaceted needs of victim-survivors. VHA national program office leaders also confirmed that provision of care through partnerships with community SAFE programs was identified as a best practice for the majority of VHA facilities.

Maintenance of Procedural Knowledge and Training

VHA policy requires facilities to “develop plans for staff education that address the signs and symptoms of sexual assault, local reporting procedures, identification and treatment of sexual assault, institutional, local, state, and federal reporting mandates, and instruction on maintaining and safeguarding evidence of alleged sexual assault” as needed.⁴⁹

⁴⁹ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, training specific to sexual assault is no longer specified.

Eighty-one percent of emergency department or urgent care center leaders cited the low frequency of patients presenting for acute sexual assault as a challenge for maintaining staff knowledge of procedures. Twenty-nine percent of emergency department or urgent care center leaders identified staff training on the management of acute sexual assault as a challenge. Despite the VHA requirement, 37 percent of emergency department or urgent care center leaders reported their facility did not offer training for emergency department or urgent care center staff on responding to acute sexual assault patients. In addition, 28 percent reported that training was available, but optional, and only 35 percent reported mandatory training. Of the emergency department or urgent care centers that provided training, the most common education resources were computer-based virtual learning utilizing national training modules (72 percent), in person or virtual live in-service trainings (31 percent), and handout materials (16 percent).

Similar to the information provided by emergency department or urgent care leaders, 39 percent of police chiefs reported that VA police officers also did not receive training on responding to sexual assaults. The Director of the Law Enforcement Training Center reported to the OIG that sexual assault training for police officers was added to the mandatory VA Police Officer Standardized Training course for new officers in October 2017.⁵⁰ Along with the Law Enforcement Training Center course, police chiefs who reported sexual assault training identified computerized national training modules and facility-based trainings as the primary modalities. However, 15 percent of police chiefs responded that national and facility policies do not provide sufficient guidance for VA police officers to inform their roles and facilitate coordination with emergency department or urgent care center staff when responding to patients with acute sexual assault.

The low frequency of demand for acute sexual assault evaluation and management combined with limited training may leave some staff unprepared or in need of additional guidance to ensure care for these patients is appropriately addressed.

Facility and Community Resources

VHA policy requires facilities to have appropriately trained staff or have a local, non-VA facility resource available 24 hours a day, 7 days a week for sexual assault examination, treatment, and

⁵⁰ The Director of the Law Enforcement Training Center reported the VA Police Officer Standardized Training is a 400-hour, eight-week course that is offered at the Law Enforcement Training Center that is mandatory for all new VA police officers regardless of rank or experience. Training on sexual assault comprises a 3.5-hour block of instruction within the course. Additionally, the Director of the Law Enforcement Training Center reported that the police training on sexual assault was also assigned to active VA police officers in January 2017.

collection of evidence from victim-survivors.⁵¹ VHA policy also requires emergency departments or urgent care centers to have a rape kit available if a victim-survivor is not medically stable for transfer and evidence collection needs to be completed on site.⁵²

Fourteen percent of emergency department or urgent care center leaders either indicated the facility did not have, or were unsure of the availability of, the resources to provide coverage for forensic examinations for acute sexual assault victim-survivors.⁵³ Few VHA facilities reported having SAFE-certified staff. The low frequency of patients utilizing this specialty care in VHA presents challenges for staff accruing the relevant clinic practice hours to maintain certification and competency.⁵⁴ Most VHA facilities reported utilizing community partners to provide these services when needed; however, 12 percent of emergency department or urgent care center leaders identified lack of availability of certified SAFE examiners for referrals in the community as a barrier, and 5 percent identified distance to the nearest community facility with SAFE services as a challenge.

Forty-two percent of emergency department or urgent care center leaders reported that their emergency department or urgent care clinic did not have a rape kit available for use, and an additional 11 percent were unsure of the kits' availability. One leader explained that maintaining a rape kit was challenging due to the expiration of kits, and linked the concern to the low frequency of acute sexual assault evaluations in VHA. While the 2016 Emergency Medicine directive required the availability of rape kits in VHA emergency departments and urgent care clinics, the 2023 Emergency Medicine and VHA Urgent Care directives do not; therefore, the OIG did not make a recommendation.⁵⁵

⁵¹ VHA Directive 1101.05(2). Local, non-VA facility acute sexual assault resources consist of rape crisis centers, SANE units, or other appropriate organizations that have knowledge and experience with sexual assault forensic examinations; VHA Directive 1101.14; VHA Directive 1101.13. The 2023 policies no longer contain the language from the prior directive, and instead state that VA emergency departments and urgent care clinics must have procedures in place for “[p]erforming or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient.”

⁵² VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. Within the 2023 directives, a requirement for rape kit availability is no longer referenced.

⁵³ Two hundred sixty-five out of 280 (95 percent) emergency department or urgent care center leaders responded to the questionnaire, including 134 emergency department or urgent care center chiefs and 131 nurse managers.

⁵⁴ “Frequently Asked Questions (Certifications),” International Association of Forensic Nurses. accessed February 14, 2023, <https://forensicnurses.org/page/CertFAQs>. For example, one eligibility requirement for certification as a Sexual Assault Nurse Examiner (SANE) is the accrual of “a minimum of 300 hours of SANE-related practice within the past 3 years.”

⁵⁵ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13. VA Office of Security and Law Enforcement, “VA Police Standard Operating Procedure (SOP),” Chap. III, *Evidence/Property Collection, Documentation, and Processing Procedures*, revised September 30, 2021. VA Office of Security and Law Enforcement policy specifies requirements for facilities to have rape kits on site, including two kits to be stored in police operations and one to be kept with spare evidence supplies as determined by local VA police policy and procedures.

The OIG determined that community partnerships are key to ensuring that VHA acute sexual assault victim-survivors have timely access to providers with the specialized training to conduct forensic examinations. Ensuring access to facility and community resources to conduct forensic examinations is a challenge facing facilities. Facilities in localities where community resources are lacking may benefit from additional support to develop alternative plans that ensure sexual assault forensic examination is available for victim-survivors when needed.

Facility-Specific Guidance

VHA policy requires that facility emergency departments and urgent care centers “have plans in place to appropriately manage the medical and psychological assessment, treatment, and collection of evidence from Veterans, male and female, who are victims of alleged acute sexual assault.”⁵⁶ Facility and community resources, and jurisdictional requirements on reporting and evidence collection for acute sexual assault vary across facilities. These considerations, combined with the low frequency of occurrence and the specialized nature of this care, present a challenge for maintaining staffs' procedural knowledge. This challenge highlights the importance of clear, accessible facility-specific policy or guidance.

The need for facility-specific policy or guidance is further illustrated when considering law enforcement reporting practices. Reporting sexual assault to local law enforcement requires coordination between clinical staff and VA police as jurisdictions vary. Some jurisdictions mandate that healthcare providers notify local law enforcement of all sexual assaults; other jurisdictions require patient consent for notification.

The OIG questionnaire responses from emergency department and urgent care center leaders and VA Police Chiefs revealed discrepancies in their perspectives on reporting requirements. Discrepancies in perceptions of appropriate notification actions were more likely in scenarios where the victim-survivor did not consent to reporting to law enforcement.⁵⁷ See figure 9.

⁵⁶ VHA Directive 1101.05(2); VHA Directive 1101.14; VHA Directive 1101.13.

⁵⁷ VA police chiefs were more likely than emergency department and urgent care center leaders to respond affirmatively that VA police should be notified of patients presenting for care related to acute sexual assault.

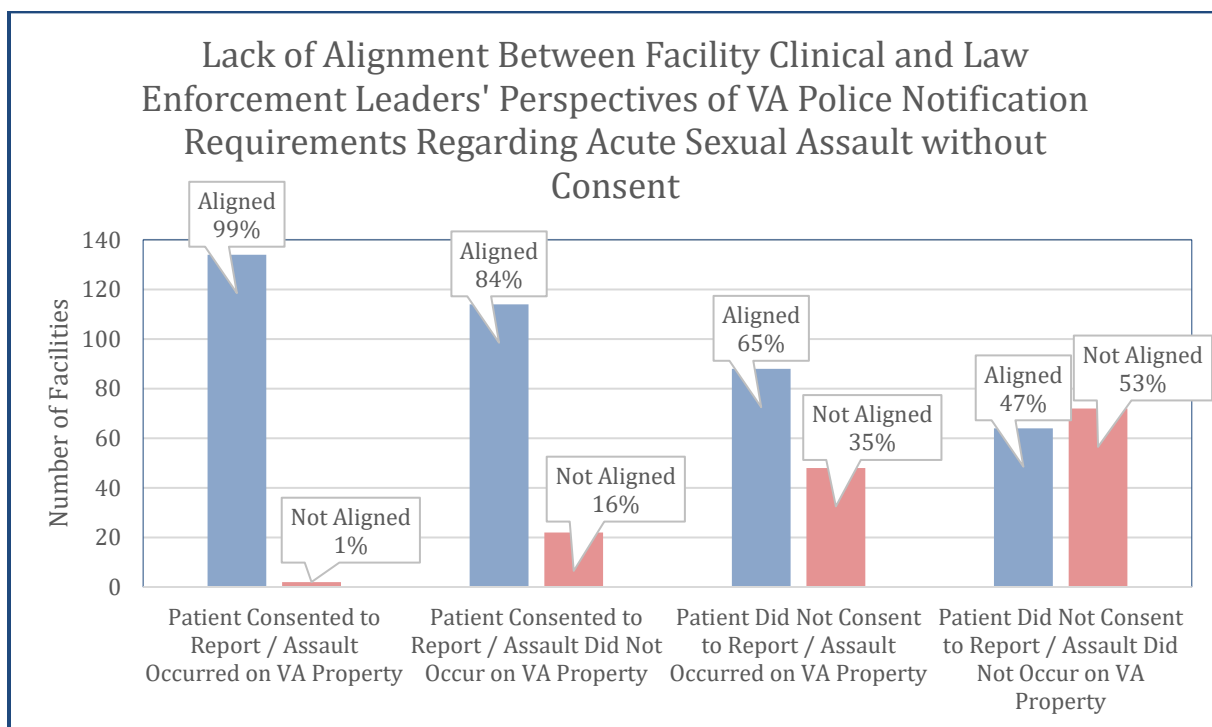


Figure 9. Alignment between facility emergency department and urgent care center leaders and VA Police Chiefs on VA police notifications of acute sexual assault patients.

Note: Concurrence between clinical leaders and police chiefs is reported for 136 of 140 facilities, due to missing questionnaire data. The OIG aggregated emergency department chief and nurse manager responses into one perspective.

Source: The OIG questionnaires disseminated to emergency department or urgent care center leaders and chiefs of police.

VHA national program office leaders noted the importance of having VHA policy to ensure staff are aware of practice guidelines to support both recommended medical treatment and forensic examination protocols. They also stressed that national policy must provide flexibility and be supplemented by facility policy or guidance to align procedures with community resources and address jurisdictional requirements. However, the OIG found facility emergency department and urgent care center policies and guidance for the management of acute sexual assault varied in the utility of the guidance provided.

VHA has established requirements for policy management that addresses national policy development and distribution, as well as details requirements for VA staff access to facility

policies and standard operating procedures.⁵⁸ VHA may consider opportunities to expand efforts to ensure consistency and accessibility when facility-level guidance is necessary. For example, an online national policy with an appendix containing each facility's supplemental information may offer advantages of having one policy for staff with facility-specific requirements made clear. Additionally, consolidating guidance in an accessible virtual location may facilitate VA leaders' ability to review supplemental policy elements and identify necessary changes or local accommodations.

The OIG determined that opportunities exist for many facilities to improve policy or guidance, addressing management of acute sexual assault patients. Improved facility policies or guidance would ensure implementation of VHA policy by providing frontline staff with relevant, accessible procedures; local community resources; and jurisdictional requirements to support clinical care and VA police response to patients presenting with acute sexual assault.

For example, clinical staff require facility-specific information to make reporting determinations when providing care for acute sexual assault victim-survivors to ensure compliance with VHA policy and local law. Appendix A provides excerpts from facility policies with examples of reporting requirements based on a facility's jurisdiction.

The accessibility of clear facility policy and guidance when a patient presents for treatment of acute sexual assault is critical, especially given the challenges of varying jurisdictions and low-frequency occurrence.

Conclusion

The OIG found deficiencies in adherence to VHA policy on management of acute sexual assault, including requirements to ensure the provision of sexually transmitted infection prophylaxis and pregnancy prophylaxis when clinically indicated, and to offer psychological counseling. As a result, sexual assault victim-survivors may experience increased risks for health consequences such as sexually transmitted infections and unintended pregnancy and may be left without timely access to the mental health services needed to support their trauma recovery. The OIG also noted deficiencies in required documentation of signature informed consent for the forensic examinations conducted at VHA facilities.

Care related to acute sexual assault is a low frequency, but crucial, occurrence in VHA, which presents challenges for maintaining staff knowledge and training. According to the national

⁵⁸ VHA Directive 0999, *VHA Policy Management*, March 29, 2022. Facility Directors are directed to ensure facility staff have "access to any VA website that hosts their MCPs [medical center policies]" and "access to all of their VA medical facility's SOPs [standard operating procedures] in a local SOP repository, with exceptions for specific services with separate SOP sites (for example, Sterile Processing and Pathology & Laboratory Medicine), for sensitive emergency response protocols (for example, SOPs overseen by the VA Police and Facilities Management) and by specific exemption by the VA medical facility Director."

program office leaders, utilization of community SAFE resources is a best practice for the majority of VHA facilities. Few VHA facilities have SAFE-certified staff, and the low frequency of this specialty care presents barriers for staff in accruing the relevant clinical practice hours to maintain certification and competency. For victim-survivors who consent to forensic examination, collaboration with community partners equipped to address the medical-forensic needs of acute sexual assault patients is key for patient care. Facilities in localities that lack community resources may require additional support to develop alternative plans that ensure sexual assault forensic examination is available for victim-survivors when needed.

VHA policy establishes requirements to ensure that veterans have access to safe, high-quality care, and provides system-wide direction for care.⁵⁹ Facility policy or guidance is needed to ensure that frontline staff have easy access to current clinical practices, local community resources, and jurisdictional requirements when responding to acute sexual assault. The OIG determined that opportunities exist for many facilities to improve policy or guidance addressing management of acute sexual assault patients.

Recommendations 1–8

1. The Under Secretary for Health makes certain the Veterans Health Administration complies with requirements that all acute sexual assault victim-survivors are offered prophylaxis for sexually transmitted infection when clinically indicated and monitors compliance.
2. The Under Secretary for Health verifies compliance with Veterans Health Administration requirements that all acute sexual assault victim-survivors are offered prophylaxis for pregnancy when clinically indicated and monitors compliance.
3. The Under Secretary for Health ensures all sexual assault victim-survivors are offered mental health resources, either directly through Veterans Health Administration or through the community and monitors compliance.⁶⁰
4. The Under Secretary for Health ensures compliance with Veterans Health Administration requirements for documentation of signature informed consent for forensic examinations conducted by staff at Veterans Health Administration facilities and monitors compliance.
5. The Under Secretary for Health coordinates with VA Office of Security and Law Enforcement to provide direction that facility policy or guidance include facility and jurisdiction-specific information necessary for frontline staff to act in accordance with jurisdiction and Veterans Health Administration requirements for VA police responding to sexual assaults.

⁵⁹ VHA Directive 1101.05(2).

⁶⁰ The OIG reviewed and considered the comments provided by the Office of the Under Secretary for Health. Based on the review, a change was made to the recommendation to ensure language is consistent with a new directive.

6. The Under Secretary for Health ensures Veterans Health Administration's policy specifies the required elements to include in Veterans Health Administration facilities' policies or guidance on acute sexual assault, including jurisdiction-specific requirements, and considers an online national policy with an appendix containing each facility's supplemental information.
7. The Under Secretary for Health makes certain that facility level management of acute sexual assault policy or guidance is updated to incorporate information on facility-specific resources and jurisdictional requirements as warranted, and educates staff as needed.
8. The Under Secretary for Health ensures that VA Police Chiefs review facility policy and guidance for police responding to sexual assaults and update to incorporate information on facility-specific resources and processes, including jurisdictional requirements, as warranted, and educates facility police officers as needed.

Appendix A: Facility Policy Examples with Jurisdictional Reporting Requirements

The following excerpts provide examples of facility guidance that supplements VHA policy to ensure providers have the detailed relevant information needed to support patient care and comply with VHA reporting requirements and applicable laws.

Excerpt 1—Facility in a Jurisdiction with Mandatory Reporting Requirements for Acute Sexual Assault

The ED [emergency department] physician asks if the patient wishes to obtain a forensic examination at a [Sexual Assault Response Team] SART facility and informs him/her that healthcare providers are mandated reporters and must notify law enforcement of the assault. If the patient wants to seek forensic examination, they are offered two options regarding how their case is handled. It may be classified as an investigated case or a non-investigated report (NIR) case.

- (1) With NIR cases, the mandated reporter cannot provide law enforcement identifying information concerning the victim.
- (2) An NIR allows the patient to receive a forensic exam without law enforcement giving identifying information. No arrests are made if an NIR is selected and the evidence is not examined by the crime lab.

The victim has up to 18 months to decide if he/she wishes to convert the case to an investigated case. Assaults are reported first to VA Police. They are further reported using the California Office of Emergency Services Mandated Suspicious Injury Report (OES 920). . . via fax to the law enforcement agency in the jurisdiction in which the crime occurred.

- (1) If the patient has selected the NIR option, ED staff may give the victims' gender, general location (major cross streets or city), date and time of assault, but not victims' name, birthdate, phone number or address. Instead in the patient information section write, 'Patient Selects NIR.'⁶¹

⁶¹ VA San Diego Healthcare System Memorandum 11-58, *Procedure for Caring for Acute Sexual Assault Victims*, October 18, 2017. The California Office of Emergency Services Mandated Suspicious Injury Report (OES 920), which was referenced, was also included for the provider as an attachment to the policy.

*Excerpt 2 – Facility in a Jurisdiction without Mandatory Reporting Requirements for
Acute Sexual Assault*

- (1) If the alleged sexual assault took place on VA property, the following must take place:
 - (a) The ED licensed treating provider or staff must notify VA Police, and so document in the patient’s chart.
 - (b) The VA Police will: take a “Uniform Offense Report” and after consultation with Veteran and Regional Counsel, notify local law enforcement and the Office of Inspector General (OIG).
 - (c) If the alleged sexual assault did NOT take place on VA property but was allegedly committed by a VA employee, in connection with VA treatment or services, the ED licensed treating provider or staff must notify VA Police, and so document in the patient’s chart.
 - (d) The VA Police will take a “Uniform Offense Report” and following consultation with the Veteran and Regional Counsel, OIG will always be notified.
- (2) If the alleged sexual assault did NOT take place on VA property, and was NOT by a VA employee in connection with VA treatment or services, the following must take place:
 - (a) The ED licensed treating provider will ask the patient if he/she wishes to report the sexual assault to the VA Police. To ensure that the patient is making an informed decision, the provider will inform the patient that, if the patient chooses to make a report to the VA Police, the VA Police are then bound to contact local law enforcement and, if the alleged sexual assault occurred on VA property or by a VA employee in connection with VA treatment or services, to the OIG.
 - (b) If the patient chooses not to make a report to the VA Police, the ED licensed treating Provider will NOT contact VA Police. The ED provider will document in the patient’s chart that the patient was offered the option of making a report to the VA Police, and declined.
 - (c) If the patient chooses to make a report to the VA Police, the ED licensed treating provider will contact the VA Police, and so document in the patient’s chart.
 - (d) The VA Police will take a Uniform Offense Report after consultation with Regional Counsel, contact local law enforcement and, as appropriate, will

immediately make a report to the Office of Security and Law Enforcement, OIG and Facility leadership.⁶²

The importance of accessible and detailed facility-specific policy or guidance for frontline staff is highlighted by these excerpts, which illustrate the variability in jurisdictional requirements and local processes that staff must follow to comply with VHA policy and respective state laws.

⁶² Cheyenne VA Health Care System, Medical Center Policy 11-20-04, *Management of the Acute Sexual Assault Victim*, September 4, 2020. This policy defines mandatory reporting within the state of Wyoming as “Although every sexual assault target has the right to report the crime, not all choose to do so. Patients 18 years of age and older, have the option of whether to report the assault or not. Regardless of whether they report the assault, all targets have the right to a medical forensic examination, crisis intervention, counseling, support groups and medical care.”

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 6, 2023

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Review of Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault (VIEWS 10807645)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report regarding the Veterans Health Administration's (VHA) Management of Emergent Care for Patients Presenting with Acute Sexual Assault. VHA concurs with all eight recommendations. More information is included in the attached action plan.
2. VHA appreciates the opportunity to review our policies and practices around the care of victim-survivors of acute sexual assault. VHA is committed to delivering high-quality, clinically effective and trauma-informed care to all Veterans. We are assured that in the vast majority of cases reviewed by the OIG, VHA met all required care elements and looks forward to implementing processes to improve and clarify care processes in the few areas identified by the OIG.
3. A large number of forensic exams are referred to community Sexual Assault Forensic Examiner programs. These community partners follow the Department of Justice National Protocol for Sexual Assault Medical Forensic Examinations and offer pregnancy risk evaluation and care, including emergency contraception, as well as sexually transmitted infection evaluation and care. Acute sexual assault patients require a holistic approach to evaluation and care that prioritizes building rapport with trained individuals and reducing re-traumatization.
4. Thank you again for partnering with VHA to ensure Veterans receive the high-quality health care they deserve. Comments regarding this memorandum may be directed to the GAO OIG Accountability Liaison Office at VACOVHA10BGOALOIG@va.gov.

Shereef Elnahal, M.D., MBA

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

**Review of Greater Compliance with Policies Needed Related to the Management
of Emergent Care for Patients Presenting with Acute Sexual Assault
(2021-01445-HI-1145)**

Recommendation 1. The Under Secretary for Health makes certain the Veterans Health Administration complies with requirements that all acute sexual assault victim-survivors are offered prophylaxis for sexually transmitted infection when clinically indicated and monitors compliance.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level guidance and procedures to ensure that all acute sexual assault victim-survivors are offered access to prophylaxis for sexually transmitted disease when clinically indicated, consistent with VHA Directives 1101.13, VHA Urgent Care and 1101.14, Emergency Medicine.

VHA will instruct all VHA medical facilities to conduct a clinical review of all available Emergency Department and Urgent Care cases of acute sexual assault 3 months from the date of the above memo to ensure that patients were offered access to prophylaxis for sexually transmitted infection when clinically indicated. Results of the review shall be presented to VA Medical Center and Veterans Integrated Service Network (VISN) Leadership no later than 6 months after issuance of the above memo, including action plan(s) for improvement if gaps from the review are identified.

In addition, VHA will hold educational sessions with VHA Emergency Department and Urgent Care field leaders to reinforce the need for all victim-survivors of acute sexual assault to be offered prophylaxis for sexually transmitted infection when clinically indicated.

Status: In progress

Target Completion Date: July 2024

Recommendation 2. The Under Secretary for Health verifies compliance with Veterans Health Administration requirements that all acute sexual assault victim-survivors are offered prophylaxis for pregnancy when clinically indicated and monitors compliance.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level guidance and procedures to ensure that all acute sexual assault victim-survivors are offered access to pregnancy prophylaxis when clinically indicated, consistent with VHA Directives 1101.13, VHA Urgent Care and 1101.14, Emergency Medicine.

VHA will instruct all medical facilities to conduct a clinical review of all available Emergency Department and Urgent Care cases of acute sexual assault 3 months from the date of the above memo to ensure that patients were offered access to pregnancy prophylaxis when clinically indicated. Results of the review shall be presented to VA

Medical Center and VISN leadership no later than 6 months after issuance of the above memo, including action plan(s) for improvement if gaps from the review are identified.

In addition, VHA will hold educational sessions with VHA Emergency Department and Urgent Care field leaders to reinforce the need for all victim-survivors of acute sexual assault to be offered prophylaxis for pregnancy when clinically appropriate.

Status: In progress

Target Completion Date: July 2024

Recommendation 3. The Under Secretary for Health ensures all sexual assault victim-survivors are offered mental health resources, either directly through Veterans Health Administration or through the community and monitors compliance.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level guidance and procedures to ensure that all acute sexual assault victim-survivors are offered mental health resources, either directly through VHA or through the community when clinically indicated consistent with VHA Directives 1101.13, VHA Urgent Care and 1101.14, Emergency Medicine.

VHA will instruct all VHA medical facilities to conduct a clinical review of all available Emergency Department and Urgent Care cases of acute sexual assault 3 months from the date of the above memo to ensure that patients were offered mental health resources when clinically indicated. Results of the review shall be presented to VA Medical Center and VISN leadership no later than 6 months after issuance of the above memo, including action plan(s) for improvement if gaps from the review are identified.

VHA will hold educational sessions with VHA Emergency Department and Urgent Care field leaders to reinforce the importance of offering victim-survivors of acute sexual assault mental health resources.

Status: In progress

Target Completion Date: July 2024

Recommendation 4. The Under Secretary for Health ensures compliance with Veterans Health Administration requirements for documentation of signature informed consent for forensic examinations conducted by staff at Veterans Health Administration facilities and monitors compliance.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level guidance and procedures to ensure that all acute sexual assault victim-survivors who have forensic examinations conducted by VHA staff must have documented signature informed consent for such examinations.

VHA will instruct all VHA medical facilities to conduct a review of all available Emergency Department and Urgent Care cases of acute sexual assault 3 months from the date of the above memo to ensure that patients who underwent forensic examination(s) conducted by VHA staff had documentation of informed consent signature for such exam(s). Results of the review shall be presented to VA Medical

Center and VISN leadership no later than 6 months after issuance of the above memo, including action plan(s) for improvement if gaps from the review are identified.

In addition, VHA will hold educational sessions with VHA Emergency Department and Urgent Care field leaders to highlight the need for informed consent signature for forensic examinations on victim-survivors of acute sexual assault performed by VHA staff.

Status: In progress

Target Completion Date: July 2024

Recommendation 5. The Under Secretary for Health coordinates with VA Office of Security and Law Enforcement to provide direction that facility policy or guidance include facility and jurisdiction-specific information necessary for frontline staff to act in accordance with jurisdiction and Veterans Health Administration requirements for VA police responding to sexual assaults.

VHA Comments: Concur

The VHA Office of Senior Security Officer will coordinate on behalf of the USH to provide direction that facility policy or guidance include facility and jurisdiction-specific information necessary for front-line staff to act in accordance with jurisdiction and VHA requirements for VA police responding to sexual assaults.

Status: In progress

Target Completion Date: December 2023

Recommendation 6. The Under Secretary for Health ensures Veterans Health Administration's policy specifies the required elements to include in Veterans Health Administration facilities' policies or guidance on acute sexual assault, including jurisdiction-specific requirements, and considers an online national policy with an appendix containing each facility's supplemental information.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level policies and procedures related to the care of victim-survivors of acute sexual assault to include applicable jurisdiction-specific reporting parameters and guidance with sufficient specificity to enable front-line staff to clearly understand their obligations with regard to permissible reporting as well as applicable restrictions on such reporting.

In addition, VHA will hold educational sessions with VHA Emergency Department and Urgent Care field leaders to emphasize the importance of including jurisdiction-specific guidance in local policies and procedures related to the care of acute sexual assault victim-survivors.

Status: In progress

Target Completion Date: January 2024

Recommendation 7. The Under Secretary for Health makes certain that facility level management of acute sexual assault policy or guidance is updated to incorporate information on facility-specific resources and jurisdictional requirements as warranted, and educates staff as needed.

VHA Comments: Concur

VHA will issue a memo to all facilities with an Emergency Department or Urgent Care to revise/update facility level policies and procedures related to the care of victim-survivors of acute sexual assault to include jurisdiction-specific requirements and guidance with sufficient specificity to enable front-line staff to clearly understand their legal reporting requirements. The memo will include instruction that all front-line Emergency Department and Urgent Care staff receive education on facility-specific policies and procedures for the care of victim-survivors of acute sexual assault.

Status: In progress

Target Completion Date: January 2024

Recommendation 8. The Under Secretary for Health ensures that VA Police Chiefs review facility policy and guidance for police responding to sexual assaults and update to incorporate information on facility-specific resources and processes, including jurisdictional requirements, as warranted, and educates facility police officers as needed.

VHA Comments: Concur

The VHA Office of the Senior Security Officer will coordinate with the Office of Security of Law Enforcement to establish guidance to all VA Police Chiefs to review facility policy and guidance for police responding to sexual assaults and update to incorporate information on facility-specific resources and processes, including jurisdictional requirements, as warranted, and educates facility police officers as needed.

Status: In progress

Target Completion Date: December 2023

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