Original Article

Using Telehealth Technology to Serve Patients Reporting Sexual Assault: An Evaluation of Key TeleSANE Program Features

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ABSTRACT

Many communities across the country are developing, implementing, or already operating programs that provide patients with access to sexual assault nurse examiner (SANE) expertise and care through telehealth technology (e.g., teleSANE or teleSAFE). The speed at which teleSANE programs are proliferating is outpacing the available research and evaluation to inform key decisions on program development and implementation. During the height of the COVID-19 pandemic, the Massachusetts Department of Public Health SANE Program and its National TeleNursing Center decided to rapidly and temporarily convert a set of hospitals from providing in-person SANE care to remote teleSANE care. Several specific changes were made to this program's established teleSANE model for the rapid, temporary conversion. This article reports on findings from an evaluation of the temporary TeleSANE model that provide insight into key decisions that must be made in the development and implementation of teleSANE program features. Communities considering developing or already operating a teleSANE program should be intentional in making program goals, purposes, and values explicit as well as develop their program accordingly.

KEY WORDS:

FNE; forensic nurse examiner; forensic nursing; SANE; sexual assault; sexual assault nurse examiner; telehealth; telemedicine; telenursing; teleSAFE; teleSANE

Sexual assault nurse examiners (SANEs) have been documented to provide a substantially improved medical forensic response to sexual assault patients as compared with the traditional emergency department (ED) response across a number of domains (i.e., patient experience, medical service provision, forensic outcomes, legal outcomes, and community impact; see Shaw et al., 2017). Unfortunately, as reported in recent press (e.g., Lavoie, 2020; Ruiz, 2020), in-person SANE care is not available in many communities across the country. Telehealth technology offers an opportunity to provide SANE expertise to patients and communities that would otherwise go unserved. Since 2012, the U.S. Department of Justice, Office for Victims of Crime has funded a series of pilots and demonstration projects to test the use of telehealth technology in this domain (i.e., teleSANE; see Walsh et al., 2019). Communities considering teleSANE care must make myriad decisions, from who will provide care, to what technology will be employed, to the specific physical location in which services are provided. The speed at which communities are considering, developing, and implementing

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teleSANE services is outpacing the available research and evaluation to inform these key decisions. In 2020, the Massachusetts Department of Public Health (MDPH) SANE Program and its National TeleNursing Center (NTC) elected for a rapid and temporary conversion to teleSANE at a subset of hospitals in which they typically provide an in-person SANE response. To allow for the rapid conversion of a subset of hospitals from in-person SANE care to teleSANE care, and in light of the COVID-19 pandemic, the MDPH SANE Program and NTC made several specific changes to their typical teleSANE protocol related to who provided care, how they were prepared to provide care, with what technology, and where it was provided. These changes were not made with the explicit intention of comparing and evaluating different choice points in the provision of teleSANE care; however, the approach allowed us to gain insight into several of the key decisions that must be made when considering, developing, and implementing teleSANE. This article details five specific changes that were made to the MDPH NTC Model for implementation of the temporary TeleSANE model and presents evaluation findings that can inform decision making related to teleSANE care. Before detailing these changes and what we learned in evaluating them, we briefly discuss the well-established NTC Model for reference.

The MDPH NTC Model

MDPH provides an in-person response for 30 SANE sites in Massachusetts. The NTC provides a teleSANE response for an additional 10 hospitals across the state from a brick-and-mortar center on a community hospital's campus outside Boston (see Meunier-Sham et al., 2019). When a patient arrives at one of the 10 teleSANE sites after a sexual assault, the hospital site calls the NTC's call center, which notifies the on-call teleSANE. TeleSANEs have 60 minutes to travel to the NTC to provide teleSANE services via secure, encrypted telehealth equipment. The non-SANE trained on-site medical providers, referred to as remote site clinicians (RSCs), obtain patient consent for teleSANE services and a medical forensic examination. The RSCs complete the patient's medical forensic examination and all patient documentation with real-time guidance from the expert teleSANE clinician via telehealth technology. This includes collecting patients' accounts of their assaults and all other forms contained within the state's Sexual Assault Evidence Collection Kit (SAECK). The teleSANEs also make recommendations regarding postassault medications per Centers for Disease Control and Prevention guidance and assist in developing a follow-up plan for the patient.

The Temporary TeleSANE Model

Massachusetts was one of the first states in the country to experience a COVID-19 surge (Solis, 2020), resulting in an overwhelming impact on hospitals statewide. Because of a shortage of personal protective equipment and an attempt to minimize exposure for patients, hospital staff, and SANE personnel, the SANE program leveraged its expertise with a teleSANE delivery model by temporarily converting five in-person SANE sites to teleSANE sites from May 27 to July 13, 2020. These sites were selected as they served a geographic region that routinely had a sizable caseload that could benefit from the temporary model but where COVID-19 cases were not surging as high. SANEs who typically provided in-person care to these sites had also expressed concerns about being able to safely serve patients and have consistent access to personal protective equipment. Several specific modifications were made to the MDPH NTC Model for the temporary model.

Working From Home

In the MDPH NTC Model, teleSANEs are on call (i.e., "take call") and provide care from a central brick-and-mortar location. For the temporary TeleSANE model, 10 NTC teleSANEs who are state employees (as opposed to contracted teleSANEs) took call and provided care from a secure, private, approved location in their homes. This change allowed teleSANEs to work safely from home, reducing potential exposure to the virus. It also allowed additional SANEs to serve in this role as they did not have to travel to the center, increasing capacity and immediacy to respond to these additional sites. Because these teleSANEs did not have to travel to the central brick-and-mortar location, teleSANEs were expected to be immediately available. All 10 teleSANEs who provided care during the temporary model were intimately familiar with the MDPH NTC Model and had extensive experience providing and supervising SANE care.

Technology

In the NTC Model, teleSANE sites are outfitted with a mobile cart equipped with a computer, a pan–tilt–zoom camera, and external speaker and microphone, whereas the central brick-and-mortar MDPH NTC relies on desktop computers and cameras. For the temporary model, teleSANE sites and teleSANEs used iPads. This change was made because iPads were able to be secured and supplied to sites quickly; there was not enough time to equip sites and teleSANEs working from home with the typical teleSANE equipment.

Selection and Preparation of RSCs

In the NTC Model, a subset of medical providers at each hospital site are selected to act as RSCs in providing teleSANE care, complete a 6-hour training, and receive ongoing training and consultation. In the temporary model, all ED medical providers were eligible to act as RSCs and RSCs were not required to complete training before or during the temporary model implementation, although some received a limited orientation to the process via a short webinar that was offered several times over a 2-week period. The rapid

implementation did not allow for a subset of providers to receive extensive training before initiation of the temporary model.

Patient History and Documentation

In the NTC Model, RSCs often take the patient history and complete documentation, with the support of the teleSANE. For the temporary model, teleSANEs took the patient history and completed SAECK forms on the specifics of the examination and the patient narrative as well as any required mandatory reporting. TeleSANEs used secure, encrypted email to send documentation to RSCs. Any ED provider could serve as the RSC and had not received specific training on how to take the patient history or complete documentation. Having teleSANEs collect the patient history and complete part of the documentation would reduce the burden on the RSCs who were used to in-person SANEs completing the entire examination and documentation and who were working in an overwhelmed ED with a high volume of patients with COVID-19.

Leaving the Room

In the NTC Model, RSCs remain in the room for the entire examination as the teleSANE guides them through the process. In the temporary model, RSCs were offered the opportunity to leave the room while the teleSANE collected the patient history to reduce COVID-19 exposure for the patient and the RSC, allow the RSC the opportunity to tend to other responsibilities, and reduce the number of people with whom the patient had to share their account of the sexual assault.

The Current Study

In rapidly converting a subset of hospitals from in-person SANE to teleSANE care, the MDPH SANE Program and NTC wanted to learn if their plan for and implementation of the temporary model was a success. The SANE program partnered with a team of two external evaluators (first and second authors of this article) to evaluate the temporary model, with a particular focus on the five specific changes made to the NTC Model. Given the rapid implementation and planned termination of the temporary model, the external evaluators had to collect data quickly. This precluded data collection with patient survivors as the rapid nature of the evaluation would not allow for the design and implementation of trauma-informed, survivor-centered data collection strategies. The evaluators focused their efforts on learning directly from the teleSANEs and RSCs who provided care during implementation of the temporary model, as well as leadership at the five selected hospitals and in the SANE program. These individuals provided nuanced insight into high-level decisions made throughout the process, as well as the experience of providing on-the-ground care. In this article, we detail evaluation findings related to the five specific program features altered for the temporary model. These findings can inform communities' decisions as to how best to structure their program models and provide teleSANE care. Evaluation findings on the preparation and rollout of the temporary model, the patient and provider experiences in implementing the temporary model, and broader implications for the future care of patients reporting sexual assault are presented in a separate article (Shaw et al., 2022).

Methods

The evaluation team conducted qualitative interviews with key stakeholders involved in developing and implementing the temporary model: the teleSANEs providing care, the RSCs who treated sexual assault patients at the hospital sites, hospital leadership, and MDPH SANE Program and NTC leadership. Interviews were conducted by Zoom and were audio recorded with the participant's permission. After obtaining informed consent to participate from each participant, interviewers asked about participants' (a) background and experience; (b) hopes, concerns, and expectations for the temporary model before it began; (c) experiences with the temporary model; (d) reflections on their entire experience with the temporary model; (e) recommendations for the future of teleSANE care; and (f) basic demographics (i.e., race and gender). Participants were interviewed one time, and each interview lasted 45–90 minutes. All interviews took place between July 30 and September 9, 2020. All methods were reviewed and approved exempt by the University of Illinois at Chicago Institutional Review Board.

The evaluation team recruited participants by sending individual emails to those involved in the development or implementation of the temporary model. This included all RSCs and teleSANEs who treated a patient at any of the five hospitals during implementation of the temporary model; all SANE and NTC leadership; and hospital ED nurse educators, nurse managers, and SANE liaisons. Forty-eight individuals were invited to participate in an interview. Twenty-eight people replied to the recruitment email to express interest in participating or ask questions about participating (e.g., confirming they were eligible to participate). The evaluation team was unable to schedule interviews with five of these individuals because of nonresponses from the potential participants during the scheduling process, resulting in $n = 23$ interviews. Several interview participants held multiple roles during the implementation of the temporary model and thus could discuss their experiences with the temporary model from multiple perspectives. For example, almost all teleSANEs served in SANE/NTC leadership in some capacity, and some SANE leaders and hospital leaders also treated patients in the ED as an RSC. Ultimately, the evaluation team interviewed 10 teleSANEs, six members of hospital leadership (one of whom was also trained as a SANE), four members of NTC/SANE leadership (who also sometimes

served as an RSC), and three individuals who exclusively served as RSCs. Importantly, although the evaluation team only interviewed three individuals who served exclusively as RSCs, evaluation findings reflect the perspective of five individuals who served in this capacity. TeleSANEs had, on average, 16.6 years of experience as a trained SANE (range: 6–24 years). The large majority had provided teleSANE care in some capacity before the onset of the temporary model. The RSCs had an average of 6.8 years of nursing experience, with all having worked in an ED for at least 4 years (range: 4–8.5 years). All interview participants identified as White women.

Given how quickly the evaluation needed to be developed and implemented, the evaluation team employed rapid evaluation and assessment methods (REAM; McNall & Foster-Fishman, 2007). REAM is a set of techniques used to quickly produce trustworthy, actionable information that can inform decision making in critical moments. Using REAM requires targeted evaluation questions and that data collection and analysis happen simultaneously (McNall & Foster-Fishman, 2007). The evaluation team was able to move quickly through analysis because they had already identified the five specific changes to examine (i.e., targeted evaluation questions). In line with REAM, the evaluation team did not transcribe verbatim the full interviews (McNall & Foster-Fishman, 2007). Instead, evaluation team members analyzed the digital audio recordings directly, recording all information relevant to the five changes of interest. To do this, the evaluation team employed Miles et al.'s (2020) matrices approach. Specifically, the evaluation team created tables that listed participants in rows and each of the five program features in columns. After conducting an interview, the evaluation team member would listen to the audio recording of the interview and record relevant verbatim quotes that pertained to any of the five changes of interest in their corresponding cell in the table. Participants' overall valences toward each program feature were also recorded (i.e., they liked/were satisfied with the program feature; they disliked/were unsatisfied with the program feature; they were indifferent, were unsure, or had mixed feelings). These matrices allowed the evaluation team to review one another's work to ensure assigned valences aligned with the data and to identify patterns across the participants and their specific roles.

Results

Working From Home

More than half (65%) of the participants felt positively about teleSANEs taking call from home, with the remaining having mixed feelings (22%) or no opinion (13%). No participants disliked having the teleSANEs taking call from their homes. Whereas two RSCs did not comment on the topic at all, another noted that she thought this aspect of the model was fine, as she did not even realize that the teleSANE with whom she connected was working from home. Whereas one member of the hospital leadership did not comment on the topic, the remaining five noted that they saw no issues as the experience seemed to be private and professional. One member of hospital leadership explained, "She had a white coat on. She had a banner. There would have been no way the patient would have thought anything other than, 'I have someone 100% focused on me right now. It was very, very professional'" (Participant 142).

SANE leadership and the teleSANEs had a more nuanced response to teleSANEs taking call from home. They spoke highly of eliminating long commutes to the MDPH NTC. TeleSANEs specifically enjoyed being able to just walk to the other room in their home to take a call and reported no challenges or distractions that resulted from working from home. SANE leadership and the teleSANEs also appreciated the opportunity to reduce delays in patient care, as the teleSANE could be available immediately. Unexpectedly, this sometimes meant the teleSANE was the one waiting for the hospital to be ready for the encounter; there were several instances when the teleSANE was ready but the hospital staff were not. SANE leadership and the teleSANEs also detailed the effort required to implement this aspect of the model. One member of SANE leadership noted that the temporary model went so well because they had a lot of control over the process (e.g., each home space was individually vetted by SANE leadership to ensure the space was professional, private, and free from any potential distractions). This might not have been such a success, or even feasible at all, had there been fewer checkpoints or more teleSANEs taking call from home.

Technology

Participants described initially being nervous about implementing the technology for the temporary model, as it was a new setup for both the teleSANEs and the hospital sites. Once underway, some participants thought, "it worked flawlessly" (Participant 102), whereas others felt some frustration with this aspect of the experience. TeleSANEs described instances of the iPads falling over or not being charged properly at the hospital sites. Some also noted issues with the camera being placed in suboptimal positions for viewing examination activities or some stress logging into the iPad as, sometimes, password changes or other troubleshooting approaches were necessary to get the tech up and running. One member of SANE leadership described these challenges as "the bumps that come with having a new program," suggesting that all technological issues could be overcome with time and experience (Participant 135).

Indeed, once the technology was working, it worked well. TeleSANEs shared that the picture on the iPads were clear and, when positioned in the right place, the video quality was sometimes better than that provided with the typical equipment at the NTC. TeleSANEs felt properly trained to

use the technology with one teleSANE stating, "Nothing could have been done to better prepare us…it was pretty simply actually. It was pretty fail safe" (Participant 106). RSCs also liked the technology, with one RSC stating, "I really liked it. I was not expecting it, but I liked it. It was nice to have a live resource" (Participant 114). Importantly, all participants believed that the patient experience with the technology was positive. One member of hospital leadership stated, "It's 2020. It's tele-everything" (Participant 141), to suggest that patients would not be put off by interacting with a provider on-screen.

Selection and Preparation of RSCs

All ED providers were eligible to serve as RSCs in the temporary model. ED staff were notified by email that their hospital would be temporarily converted from an in-person SANE site to a teleSANE site. The MDPH SANE and NTC leadership also offered a series of webinars for staff at each hospital site to attend to learn more about the temporary model. Even with these efforts, many ED personnel who went on to serve as RSCs were not aware of the conversion from in-person SANE to teleSANE care until they were assigned a case. One teleSANE described a case in which the RSC did not realize the role they would play in the examination, "I don't think people were really aware of the pilot of what was happening. I think she was taken by surprise. She was like, I'm going to do what?" (Participant 104). Another teleSANE explained how there were so many changes happening in the ED because of COVID-19, that ED staff may have been told but simply forgot about this change. This teleSANE explained that RSCs adapted quickly:

> These nurses had a lot on their plates at the time, so maybe they knew and they forgot. I'm not sure, or maybe they got an email that says, "SANE," and they think that doesn't apply to me because we have SANE nurses that come in…. It wasn't a big deal. It wasn't a panic thing. I just said, this is what we're doing, with the COVID-19 crisis, we're going to minimize the time you need to be in the room with the patient, minimize the time I'm going to be in the room with the patient. I'm going to do the paperwork for you, then you'll collect the swabs that need to be collected. I let them know we're working as a team, it's almost like team nursing…. Everyone was adaptable and we made it work. (Participant 109)

The five hospitals selected for the temporary model also responded differently to prepare their staff. At one hospital, nurse educators and SANE liaisons filled educational gaps by performing ad hoc trainings for as many ED staff as possible. As one member of hospital leadership explained, "The more education the better for a process like this. It's paramount" (Participant 149). One RSC attended a hospital-hosted training and reported feeling more confident in taking a case as a result, stating, "Just knowing what the kit is, and what's inside of it, and the timeframe it would take was helpful" (Participant 126). Some hospitals also limited who on their staff would take these cases. The temporary model was designed to have any ED clinician serve as the RSC, but some hospitals chose to rely only on their most experienced or SANE-trained nurses or staff to take these cases. This meant experienced nurses were sometimes called in early or patient care was delayed until a shift change when the designated nurse was available. Although well intentioned, this practice resulted in delays in patient care. Many participants reported the RSCs being hesitant about taking on patients seeking emergency care postassault, even with the assistance of a teleSANE. Potential RSCs feared what the examination would entail or being called into court later. As one teleSANE explained, this resulted in a game of "hot potato" to find RSCs willing to treat these patients (Participant 108). This teleSANE explained that if the RSCs realized how straightforward the cases would be, they would be more willing to take on these patients, "[What you need is] someone that is compassionate, and caring, and kind. And if you're those things, you can do this kit…with expert help, you can do anything" (Participant 108). Still, some teleSANEs described how the lack of training ahead of time meant that some RSCs required a significant degree of hand-holding, causing patients to sit through instructional periods.

Although most participants agreed that some training would have been preferred, ED nurses were described as well equipped to handle this type of situation and learn from the teleSANE providers in real time. As one hospital staff member stated, "I think they figured it out. They got enough. They got what they needed to go forward and make it work" (Participant 151). The RSCs who did take on cases also reflected this point—once in the examination room, they felt as though the guidebook, the equipment, and the support of the expert teleSANE made the experience seamless and positive even without training. One RSC even noted that she would have been unlikely to attend an optional training if offered, for fear that her department would then prioritize her for teleSANE cases.

Patient History and Documentation

All participants agreed that having the teleSANE take the patient history was preferred. Participants reported that this reduced the burden on the RSCs, allowed for trauma-informed engagement with the patient when taking their history, and resulted in high-quality, appropriate, and streamlined documentation. RSCs emphasized how it felt like a lot was taken off their plate with this process, with one RSC stating, "I think I could have done it. It's just more lessening the load that was helpful" (Participant 112).

Another said, "Not being trained in SANE, I'm not sure exactly what language to use, exactly how many details to collect…. I'm more comfortable with her [the teleSANE] taking the history than myself, just to make sure that every base is covered" (Participant 126). One member of hospital leadership suggested that this approach reduced anxiety for RSCs. SANE leadership also discussed how this practice had the potential to reduce RSC exposure to sexual trauma, in addition to the stress and trauma they may be experiencing because of working in an ED during the COVID-19 pandemic. Reducing this exposure may be particularly beneficial for those who are not trained in the field as "some of the stories are brutal to hear, so [it's good] if you're minimizing a clinician's exposure to that" (Participant 133). TeleSANEs shared how they preferred the process of taking the patient history and completing documentation themselves, as it provided the opportunity to connect with the patient directly, to have complete control over completing a component of the examination their way, and to speed up the examination. One teleSANE preferred this change to the NTC Model and thought, "It is something I think we should consider for the [NTC] because I think it adds value to your service" (Participant 104).

The transmission of completed documentation is where participants reported room for improvement. Many teleSANEs and RSCs noted instances of not being able to open the files correctly or needing multiple attempts to retrieve the documentation successfully. However, one teleSANE described how this likely would have become easier with more experience.

Leaving the Room

The RSCs interviewed for this evaluation chose to stay in the room for the patient history. RSCs reported how their ED staff made sure to cover their other cases so they could devote their attention to the sexual assault patient. Some members of hospital leadership recommended RSCs stay in the room with their patients. As one member of hospital leadership explained, "They're the one that has to build the rapport with that patient…it's horrible enough to have to say it once, but to have to say it to the SANE and then repeat it to the nurse [is worse]" (Participant 146). One RSC interviewed by the evaluation team expressed how their presence in the room was important to provide hands-on care, "You want to just be a constant for that patient. I'm here. I have tissues. I have water…and I'm your person while you're here" (Participant 114). One teleSANE agreed, "Thinking of the trauma-informed piece, [let's say the patient] has a bruise on her right hip, [and the RSC asks,] 'want me to write that in?' 'Yes, that was part of the assault.' If [the RSC] was in the room, she'd know that and we wouldn't have to reiterate it again and say it out loud" (Participant 106). Other teleSANEs discussed how having an RSC leave the room wouldn't "work for every patient" (Participant 110). If a patient had anxiety, was in acute distress, or had any other challenge that would make leaving them in a room alone difficult, it would be important to keep the RSC in the room. However, most teleSANEs preferred to have time alone with the patient. One teleSANE explained that in being alone with the patient, "I didn't have to model trauma-informed care. I could just be trauma-informed care" (Participant 105). An additional unintended benefit of RSCs leaving the room was that the patients were able to remove their face masks. One member of SANE leadership noted that the patient was "really relieved about being able to take off their own mask and see [the teleSANE's] face" (Participant 135). Notably, this evaluation only captures the perspective of RSCs who chose to stay in the room.

Discussion

Communities across the country are considering, developing, or they have already implemented teleSANE programs. Although not designed for the explicit purpose of examining key decision points in teleSANE program development, the rapid conversion of five hospitals from providing in-person SANE to teleSANE care allowed us to examine five specific features of teleSANE programs. Of course, it is important to note that the evaluation team had to act quickly to collect data to learn from this experience and that individuals who chose to participate in the interviews may have had systematically different experiences from those who chose not to participate. Still, these findings include the perspectives of the teleSANEs providing care across all five selected hospital sites, hospital leadership and the RSCs who treated sexual assault patients from four of the five selected hospitals, and MDPH SANE and NTC leadership. Together, these findings provide insight into how teleSANE programs may choose to provide care. We discuss implications for clinical practice specific to each of the five unique program features of the temporary model.

Working From Home

Allowing teleSANEs to take call from home may be a viable option for providing teleSANE care. However, it is critical that there is a high degree of oversight to ensure home work spaces meet set criteria before and throughout service provision. At a minimum, home work spaces should be completely private (e.g., a room that is used only for taking call and has a door that can close, use of headphones, access to encrypted networks that are necessary for the provision of care), quiet (e.g., adequate soundproofing to reduce sounds that might intrude from other parts of the home or outside), reliably connected (e.g., reliable, consistent high-speed Internet), and professional (e.g., neutral background, appropriate signage and branding to identify the teleSANE, and the teleSANE donning a laboratory coat). Before any teleSANE taking call in the temporary model, all home work spaces were vetted by MDPH SANE and NTC leadership. For programs that

choose to allow teleSANEs to take call from home, work spaces should be reviewed on a regular basis to ensure they continue to meet specific standards. TeleSANEs should be required to report any interruptions or issues that occured while taking call from home so a plan to prevent them in the future can be developed.

Technology

Computers equipped with cameras and mounted on a mobile cart (i.e., at hospital sites) or desk (i.e., at a central brick-and-mortar teleSANE location) provide a consistent view of the hospital examination room, patient, and the teleSANE. However, iPads may be more feasible in specific circumstances, for example, if teleSANEs are taking call from home. Evaluation findings indicated that iPads provided high-quality pictures and were easy to use at a reasonable price point, but some teleSANEs reported difficulty seeing the patient or the examination because of iPad positioning. Therefore, if iPads are used, it is important to develop protocols regarding positioning during encounters, particularly if the RSC steps out of the room. Any site equipped with an iPad should be supplied with long charging cables and ways to connect the iPad to a mobile stand or an intravenous pole so the iPad can be moved around the room to increase the teleSANE's range of vision. Ideally, the configuration of the iPad mount should allow the patient to hold the iPad while communicating with the teleSANE one-on-one, if desired.

Selection and Preparation of RSCs

Ideally, all medical providers at a remote site that uses teleSANE services would be trained and ready to serve as an RSC. In circumstances where this is not feasible, communities should concretize via memoranda of understanding, or through other written agreements, who will serve as an RSC and what training or preparation is required to serve in this role. Routinizing and institutionalizing these standards provides a means of accountability for the teleSANE program to ensure RSCs are adequately trained and prepared to treat patients. At a minimum, all RSCs should receive regular training that provides information on the SAECK with the intention of demystifying the process of kit collection, trauma-informed care, and what providers can expect should a criminal case progress to prosecution for a patient they treat.

Patient History and Documentation

Communities developing teleSANE programs should consider the purpose of the teleSANE program. All teleSANE programs aim to provide SANE care and expertise to patients and communities that would otherwise not receive it. Some teleSANEs may have a secondary aim to improve RSCs' independent skillset in responding to this patient population. This may particularly be the case in settings where RSCs can self-select to serve as an RSC. In the temporary model, RSCs did not self-select to serve in this capacity and oftentimes were unwilling or hesitant to take these cases. In such circumstances, the protocol should focus on providing quality care for the patient while reducing the burden on the RSC. This would mean that the teleSANE should collect the patient history and complete as much documentation as possible for the RSC. In circumstances in which the RSC self-selects to serve this patient population, the RSC may be invested in learning more about how to interact and care for sexual assault patients, and the teleSANE program may see this as an important aim of the program. In such circumstances, it may be more appropriate for the teleSANE to assist the RSC in collecting the history and completing the relevant documentation. Communities developing their own teleSANE programs should consider the exact purposes of their program and how RSCs will be selected when deciding who should collect the patient history and complete the documentation. If it is determined that the teleSANE will complete documentation, teleSANE programs will need to work with their information technology professionals to ensure a secure method of documentation transmission.

Leaving the Room

As with collecting the patient history and completing documentation, communities should consider the exact goals of their teleSANE program when deciding whether the RSC is required to remain in the room for the entire encounter. If the teleSANE program aims to provide SANE expert care and an educational opportunity for the RSC, the teleSANE program may require that the RSC stays in the room. This may be the most appropriate approach when RSCs choose to serve as RSCs. If participation as an RSC is required, rather than optional, the teleSANE program could identify times throughout the encounter when the RSC may be offered the opportunity to leave the room. This provides the teleSANE an opportunity to connect with the patient one-on-one and may reduce the traumatic load that ED staff have to carry by limiting their exposure to stories of sexual violence. It is critical that the decision for the RSC to leave the room is patient directed and assessed on a case-by-case basis. Much like how patients are offered the opportunity for a rape crisis advocate to stay in the room or leave, patients should be able to decide if they would like the RSC there or not. If the RSC and patient agree to have the RSC stay in the room, the primary focus should remain on serving the patient. Although the RSC may learn from observing how the teleSANE interacts with the patient, the educational opportunity should continue to come second to meeting the needs of the patient.

Conclusions

In providing care to sexual assault patients, what you do matters—precisely *how* you do it is just as important. The

series of decisions made in the development and implementation of a teleSANE program can have significant impacts on the experiences of the teleSANE, RSC, and—most importantly—the patient. Communities should consider and make explicit the goals, purposes, and values of their teleSANE program so that they may guide all decision making throughout the development and implementation of their program model. The specific program elements discussed herein are a starting point for communities who want to be more intentional in building out their teleSANE programs.

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