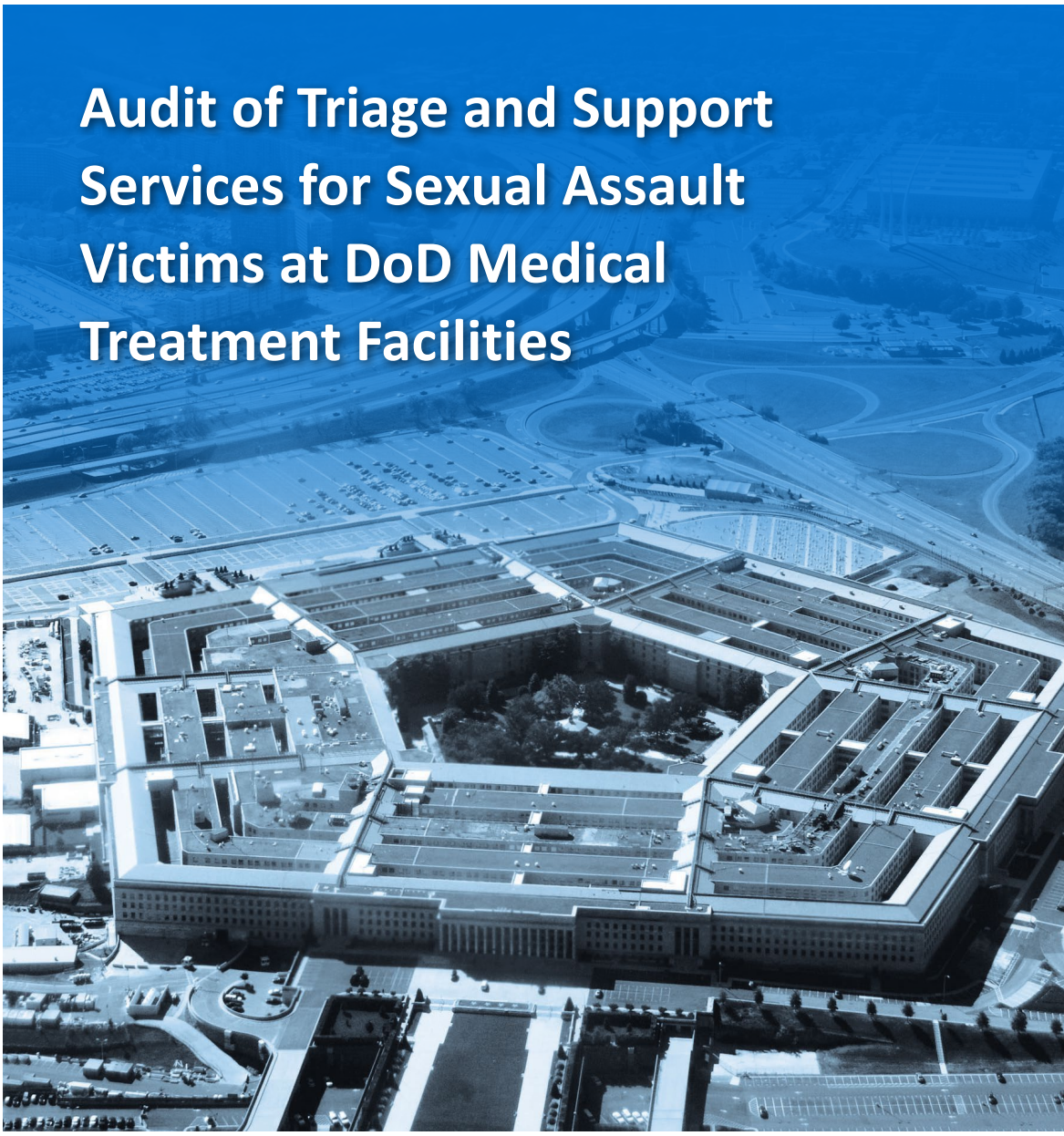
Report No. DODIG-2023-120

INSPECTOR GENERAL

U.S. Department of Defense

SEPTEMBER 7, 2023

Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities



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Results in Brief

Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities

September 7, 2023

Objective

The objective of this audit was to determine whether DoD medical treatment facilities triaged sexual assault victims with priority treatment as emergency cases, offered to perform Sexual Assault Forensic Examinations (SAFE), and notified support services, in accordance with Federal and DoD policies. In March 2021, the Acting Assistant Secretary of Defense (Health Affairs) (ASD[HA]) suggested that we review this topic.

Background

DoD guidance requires emergency department (ED) providers to:

- provide sexual assault victims with priority treatment as emergency cases;
- offer a SAFE to sexual assault victims; and
- immediately notify a Sexual Assault Response Coordinator (SARC), Sexual Assault Prevention and Response Victim Advocate (SAPR VA), or Family Advocacy Program (FAP) clinical provider when a victim discloses a sexual assault.

Findings

ED providers did not assign consistent triage levels for sexual assault victims who received care during FY 2021. Specifically, the DoD did not assign consistent triage levels for 43 out of the 209 sexual assault victims we reviewed. We project that the DoD did not assign consistent triage levels for 124 (20 percent) of the 630 sexual assault victims. See the Appendix for more details on the projections. The DoD did not assign consistent triage levels because DoD guidance does not prescribe a specific or minimum triage level for sexual assault victims. The assignment of inconsistent triage levels could result in sexual assault victims not receiving timely medical care and critical support services at DoD medical treatment facilities, which could prolong the physical and emotional harm experienced by those victims.

Findings (cont'd)

Also, ED providers did not consistently document triage levels, SAFE offers, or notification information for sexual assault victims who received emergency care at medical treatment facilities during FY 2021. Specifically, ED providers did not document triage levels for 25 victims; SAFE offers for 32 victims; and notification of SARC, SAPR VA, or FAP clinical providers for 34 out of 209 victims. We project that the DoD did not document triage levels for 82 victims (13 percent); SAFE offers for 96 victims (15 percent); and notification of SARC, SAPR VA, or FAP clinical providers for 108 victims (17 percent) of the 630 sexual assault victims.

The ED providers did not document care because the ASD(HA) did not require it. As a result, neither the ASD(HA) nor the SAPR Office can verify whether ED providers gave sexual assault victims access to needed care and services.

Recommendations

We recommend that the ASD(HA) conduct a study concerning triage levels for sexual assault victims, including a review of industry standards, and revise DoD guidance to prescribe a specific triage level for sexual assault victims or a minimum level that meets the requirements for priority and uniformity. We also recommend that the ASD(HA) revise guidance to require ED providers to document the triage level, SAFE offers, and notification information for sexual assault victims in the victim's medical record. The ASD(HA) should develop a process to review and ensure that ED providers implement and consistently apply the new guidance on assigning triage levels and documentation requirements for sexual assault victims.

Results in Brief

Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities

Management Comments and Our Response

The ASD(HA) agreed or partially agreed with the recommendations and described actions planned to resolve two of the five recommendations; therefore, two recommendations are open and resolved, and three recommendations remain unresolved.

We request that the ASD(HA) provide additional comments within 30 days in response to the final report. Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Assistant Secretary of Defense (Health Affairs)	A.1.a, A.1.b, B.1.c	B.1.a, B.1.b	None

Please provide Management Comments by October 10, 2023.

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – DoD OIG verified that the agreed upon corrective actions were implemented.


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September 7, 2023

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities (Report No. DODIG-2023-120)

This final report provides the results of the DoD Office of Inspector General's audit. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

This report contains three recommendations that are considered unresolved because management officials did not agree with or fully address the recommendations presented in the report. Therefore, as discussed in the Recommendations, Management Comments, and Our Response in Finding A and Finding B of this report, the recommendations will remain open. We will track these recommendations until management has agreed to take actions that we determine to be sufficient to meet the intent of the recommendations and management officials submit adequate documentation showing that all agreed-upon actions are completed.

This report contains two recommendations that are considered resolved. Therefore, as described in the Recommendations, Management Comments, and Our Response in Finding B of this report, we will close the recommendations when we receive adequate documentation showing that all agreed-upon actions to implement the recommendations are completed.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. For the unresolved recommendations, within 30 days please provide us your comments concerning specific actions in process or alternative corrective actions proposed on the recommendations to audityorktown@dodig.mil. For the resolved recommendations, within 90 days please provide us documentation showing you have completed the agreed-upon actions. Please send your documentation as a PDF to followup@dodig.mil if unclassified or rfunet@dodig.smil.mil if classified SECRET.

If you have any questions, please contact me at [redacted]

FOR THE INSPECTOR GENERAL:

Carol N. Gorman
Assistant Inspector General for Audit
Cyberspace Operations[1]

[1] The Assistant Inspector General for Audit, Cyberspace Operations, was the previous Acting Assistant Inspector General for Audit, Acquisition, Contracting, and Sustainment.

Contents

Introduction

Objective

The objective of this audit was to determine whether DoD medical treatment facilities (MTFs) triaged sexual assault victims with priority treatment as emergency cases, offered to perform Sexual Assault Forensic Examinations (SAFE), and notified support services, in accordance with Federal and DoD policies.[2] In March 2021, the Acting Assistant Secretary of Defense (Health Affairs) (ASD[HA]) suggested that we review this topic.[3] See the Appendix for the scope and methodology.

Background

DoD Instruction 6495.02 defines sexual assault as "intentional sexual contact characterized by the use of force, threats, intimidation, or abuse of authority or when the victim does not or cannot consent."[4] According to the Instruction, the term sexual assault includes "a broad category of sexual offenses," such as rape, aggravated or abusive sexual contact, forcible sodomy, or attempts to commit those offenses. DoD Directive 6495.01 defines a sexual assault victim as a "person who asserts direct physical, emotional, or [monetary] harm" resulting from a sexual assault.[5] The DoD's Annual Report on Sexual Assault in the Military for FY 2021 states that the DoD received 8,866 reports of sexual assault during FY 2021—7,916 initiated by Service members; 935 initiated by DoD civilians, DoD contractors, U.S. civilians, and foreign nationals; and 15 for which the initiator was undetermined.[6]

DoD Sexual Assault Prevention and Response Program

DoD Directive 6495.01 establishes policy for the DoD's Sexual Assault Prevention and Response (SAPR) Program and assigns the SAPR Office as the "DoD['s] single point of authority, accountability, and oversight for the SAPR Program."

[2] See the Appendix for a list of applicable laws and regulations.

[3] DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013 (Incorporating Change 1, August 10, 2017), states, "The ASD(HA) is the principal advisor to the Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) for all DoD health and force health protection policies, programs, and activities... ." "In carrying out these responsibilities, the ASD(HA) exercises authority, direction, and control over the DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the DoD, ..."

[4] Title 32 Code of Federal Regulations (CFR) section 103 implements DoD policy and responsibilities for the prevention, response, and oversight of sexual assaults according to policies and guidance, including DoD Instruction 6495.02. DoD Instruction 6495.02, "Sexual Assault Prevention and Response Program Procedures," March 28, 2013 (Incorporating Change 4, September 11, 2020).

[5] DoD Directive 6495.01, "Sexual Assault Prevention and Response (SAPR) Program," January 23, 2012 (Incorporating Change 4, September 11, 2020).

[6] DoD Sexual Assault Prevention and Response Office, "Department of Defense Annual Report on Sexual Assault in the Military–Fiscal Year 2021," August 29, 2022.

According to the Directive, the SAPR Program's objective is to establish "an environment and military community intolerant of sexual assault" that "[f]ocus[es] on the victim and on doing what is necessary and appropriate to support victim recovery… ." The Directive further states that the SAPR Program is responsible for ensuring that sexual assault victims receive "care that is gender-responsive, culturally competent, and recovery oriented… ." DoD Instruction 6495.02 requires standardized, timely, accessible, and comprehensive health care for sexual assault victims. The Instruction defines SAPR Program procedures and states that emergency department (ED) providers should provide sexual assault victims with priority treatment as emergency cases at MTFs, offer each sexual assault victim a SAFE, and notify a Sexual Assault Response Coordinator (SARC) or a SAPR Victim Advocate (VA) if a victim discloses a sexual assault.

Priority Treatment as Emergency Cases at MTFs

DoD Instruction 6495.02 states that the DoD will "[p]rovide sexual assault victims with priority treatment as emergency cases, regardless of evidence of physical injury," and recognize "that every minute a patient spends waiting to be examined may cause loss of evidence and undue trauma." According to the Instruction, "priority treatment as emergency cases includes activities relating to access to health care, coding, and medical transfer or evacuation, and complete physical assessment, examination, and treatment of injuries, including immediate emergency interventions." Furthermore, DoD Instruction 6310.09 states that sexual assault victims will be triaged by ED providers "in the category of life-threatening emergency responses [] when presenting to an ED for sexual assault, in accordance with DoD [] [Directive] 6495.01 and DoD [] [Instruction] 6495.02."[7]

The Department of Justice (DOJ) Office on Violence Against Women, in "A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents," (the DOJ Protocol) states that "[o]nce patients arrive at an exam site," ED providers "must evaluate, stabilize, and treat for life-threatening and serious injuries according to facility policy."[8] According to the DOJ Protocol, ED providers are "to facilitate triage and intake that addresses patients' needs [and] [c]onsider

[7] DoD Instruction 6310.09, "Health Care Management for Patients Associated With a Sexual Assault," May 7, 2019. According to Merriam-Webster dictionary, triage is "the sorting of patients (as in an emergency room) according to the urgency of their need for care."

[8] DOJ Office on Violence Against Women, "A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents," 2nd edition, April 2013. DoD Instruction 6495.02 requires that medical care be consistent with established community standards for the health care of sexual assault victims and the collection of forensic evidence from victims, in accordance with the DOJ Protocol.

sexual assault patients a priority." Defense Health Agency (DHA) Procedural Instruction 6025.03 states that if the MTFs have an ED, the MTFs will use the Emergency Severity Index (ESI) categories to triage and prioritize treatment for cases.[9] The ESI helps categorize patients by acuity and resource needs into five triage levels, from level 1 (most urgent) to level 5 (least urgent). ED providers first triage a patient for acuity, which is determined by the patient's stability of vital functions and the potential threat to life, limb, or organ.[10] Providers then determine the resources needed to admit, discharge, or transfer the patient. When two or more priority patients present at the same time, health care personnel must determine the amount of time the patients can safely wait. According to the "Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care," Version 4, Implementation Handbook 2020 Edition, triage levels are based on four key questions.

- "Does the patient require immediate lifesaving intervention?"
- "Is this a patient who should not wait?"
- "How many resources will this patient need?"
- "What are the patient's vital signs?"

Table 1 provides criteria for the triage levels with respect to acuity and resource needs.

Table 1. Criteria for Triage Levels

Acuity and Resource Needs	Triage Level 1	Triage Level 2	Triage Level 3	Triage Level 4	Triage Level 5
Vital functions and level of consciousness	Unstable or unresponsive	Threatened or severe pain/distress	Stable	Stable	Stable
Life threat or organ threat	Obvious	Reasonably likely	Unlikely (possible)	No	No
Requires resuscitation	Immediately	Sometimes	Seldom	No	No
Expected resource use–x-rays, labs, consultations, procedures	Maximum (≥2)	High (≥2)	Medium (≥2)	Low (1)	Low (none)
Response time	Immediate team effort	Minutes	Up to 1 hour	Can be delayed	Can be delayed

Source: Elshove-Bolk, Jolane et al. "Validation of the Emergency Severity Index (ESI) in self-referred patients in a European emergency department," *Emergency Medicine Journal*, Volume 24, Issue 3, March 2007.

[9] DHA Procedural Instruction 6025.03, "Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFs) to Support an Integrated Health Care System (IHCS)," January 30, 2018.

[10] Emergency Nurses Association, "ESI: A Triage Tool for Emergency Department Care Implementation Handbook 2020 Edition," Version 4, 2020. According to the ESI Handbook, "[a]cuity is determined by the stability of vital functions or, you culd put an asterisk after teand the potential threat to life, limb, or organ."

Offer of a Sexual Assault Forensic Examination

DoD Directive 6495.01 states that emergency care for sexual assault victims includes the offer of a SAFE and that if the SAFE is declined, "the victim is encouraged (but not mandated) to receive medical care, psychological care, and victim advocacy." DoD Instruction 6310.09 states, "the SAFE includes a medical-forensic history; physical examination; collection of evidence, documentation of biological and physical findings; and evaluation and treatment of sexually transmitted infections, pregnancy, suicidal ideation, substance abuse, and other non-acute medical concerns."

The Instruction further states that patients who disclose a sexual assault or are accused of committing a sexual assault, and children who the health care provider suspects have been sexually abused, are to be offered the services of a certified health care provider who has been appropriately trained to perform sexual assault forensic exams. However, according to DoD Instruction 6495.02, ED providers are not required to offer a SAFE to victims of sexual assault perpetrated by a spouse or intimate partner, or for military dependents under the age of 18 who are sexually assaulted. Instead, "in connection with an incident of domestic abuse, at the victim's discretion/request, [health care providers], if appropriately trained and/or supervised, shall conduct any forensic medical examination deemed appropriate," according to DoD Instruction 6400.06.[11]

Notification to a Sexual Assault Response Coordinator, Sexual Assault Prevention and Response Victim Advocate, or Family Advocacy Program Clinical Provider

DoD guidance requires DoD officials to notify a SARC, SAPR VA, or a Family Advocacy Program (FAP) clinical provider of a sexual assault. Figure 1 identifies the relevant information related to notifications of a SARC, SAPR VA, or FAP.

[11] DoD Instruction 6400.06, "Domestic Abuse Involving DoD Military and Certain Affiliated Personnel," August 21, 2007 (Incorporating Change 4, May 26, 2017).

Figure 1. Requirements for Notifications to a SARC, SAPR VA, or FAP

SARC	**DoD Directive 6495.01, DoD Instructions 6310.09 and 6495.02**
• A SARC is "[t]he single point of contact at an installation or within a geographic area who oversees sexual assault awareness, prevention, and response training; coordinates medical treatment, including emergency care, for victims of sexual assault; and tracks the services provided to a victim of sexual assault from the initial report through final disposition and resolution. This term and its definition are proposed for inclusion in the next edition of Reference (t)." • ED providers must notify a SARC or a SAPR VA immediately when a victim discloses a sexual assault. • The SARC shall inform the appropriate commanders of the sexual assault.	
SAPR VA	**DoD Directive 6495.01 and DoD Instruction 6310.09**
• A SAPR VA is "[a] person who ... provide[s] non-clinical crisis intervention, referral, and ongoing non-clinical support to adult sexual assault victims." • "The SAPR VA, on behalf of the sexual assault victim, provides liaison assistance with other organizations and agencies on victim care matters and reports directly to the SARC when performing victim advocacy duties." • ED providers must notify a SARC or a SAPR VA immediately when an active duty Service member, a member of the National Guard or Reserves, or a dependent 18 years or older of an active duty Service member was a victim of sexual assault, and the assault was not by an intimate partner.	
FAP	**DoD Instructions 6310.09 and 6400.06**
• The FAP is "designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up, and reporting of family violence." • The FAP "coordinate[s] efforts designed to prevent and intervene in cases" that impact military family readiness by promoting healthy relationships and families. • ED providers must notify FAP immediately when a child is suspected of being sexually abused or when a victim discloses a sexual assault by a spouse or initimate partner.	

Source: DoD Directive 6495.01 and DoD Instructions 6310.09, 6495.02, and 6400.06.

Review of Statistically Selected Medical Records

We statistically selected the medical records of 209 of 630 sexual assault victims who received care at MTF EDs from October 1, 2020, through September 30, 2021, for review.[12] We obtained the medical record data from the DoD Military Health System (MHS) Data Repository, which the DHA manages, and determined whether the ED providers:

- provided victims with priority treatment as emergency cases (triaged in the category of life-threatening emergency responses);
- offered victims a SAFE, if applicable; and
- notified the SARC, SAPR VA, or FAP clinical provider as applicable.[13]

We also reviewed the Defense Sexual Assault Incident Database (DSAID) to determine whether ED providers offered a SAFE to sexual assault victims and whether ED providers notified the SARC or SAPR VA.

[12] The statistical sample had a 95-percent confidence level and 5-percent precision.

[13] For 28 of the 209 victims, we did not determine whether a SAFE was offered because, according to DoD Instruction 6495.02, ED providers are not required to offer a SAFE to sexual assault victims if the assault was perpetrated by a spouse or intimate partner or if the victim is a military dependent under the age of 18. Instead, "in connection with an incident of domestic abuse, at the victim's discretion/request, [health care providers], if appropriately trained and/or supervised, shall conduct any forensic medical examination deemed appropriate," according to DoD Instruction 6400.06.

Finding A

DoD Providers Did Not Assign Consistent Triage Levels for Sexual Assault Victims

ED providers did not assign consistent triage levels for sexual assault victims who received care during FY 2021. Specifically, ED providers assigned triage level 2 for 138 victims, triage level 3 for 33 victims, and triage level 4 for 10 victims out of 209 sexual assault victims we reviewed. We project that ED providers assigned triage level 2 for 413 victims (66 percent), triage level 3 for 91 victims (15 percent), and triage level 4 for 33 victims (5 percent) of 630 sexual assault victims.[14] The DoD did not assign consistent triage levels because DoD guidance does not prescribe a specific or minimum triage level for sexual assault victims. The inconsistent assignment of triage levels could result in sexual assault victims not receiving timely medical care and critical support services at DoD MTF EDs, which could prolong the physical and emotional harm experienced by those victims.

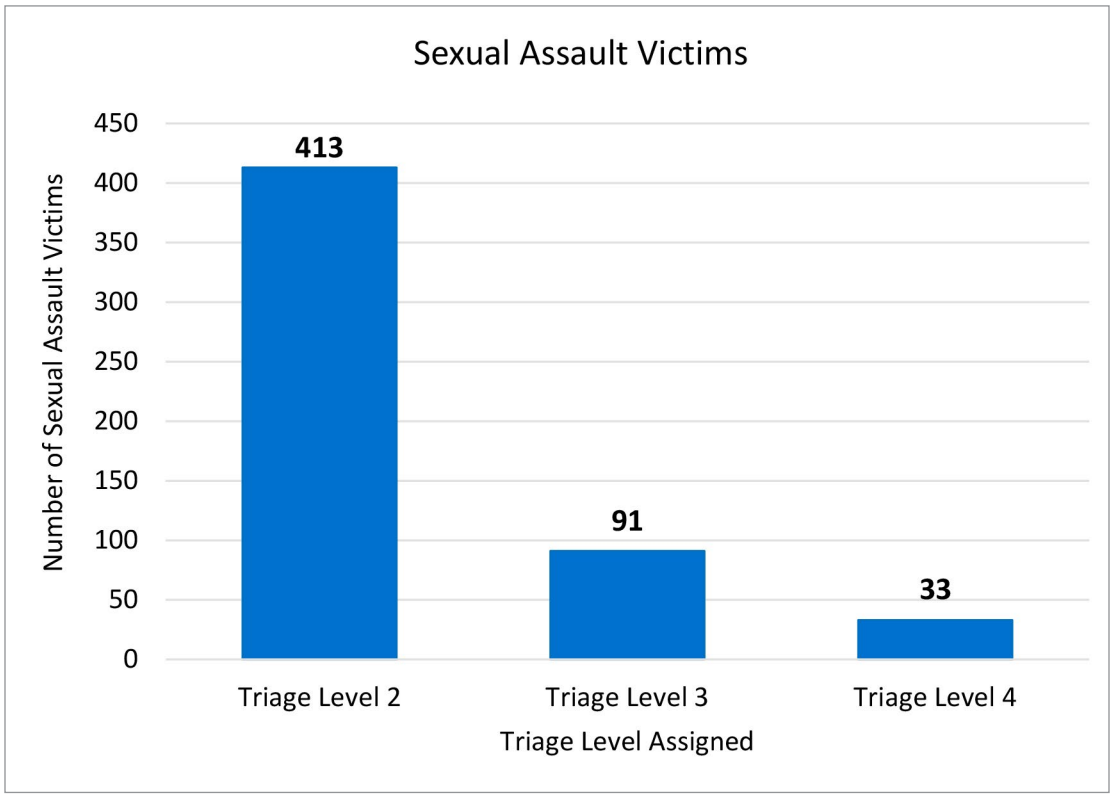
Triage Levels Were Not Consistently Assigned

ED providers did not assign consistent triage levels for sexual assault victims who received care during FY 2021. DoD Instruction 6310.09 states that sexual assault victims will be triaged by ED providers in the category of life-threatening emergency responses when presenting to an MTF ED for sexual assault, in accordance with DoD Directive 6495.01 and DoD Instruction 6495.02. DoD Directive 6495.01 and DoD Instruction 6495.02 state that ED providers must provide sexual assault victims with priority treatment as emergency cases. DoD Directive 6495.01 further states that sexual assault victims should be treated uniformly and consistent with the DOJ Protocol, which also states that sexual assault victims should be considered a priority.

ED providers assigned triage levels ranging from level 2 to level 4 for sexual assault victims who received care in FY 2021. See Figure 2 for our projections on the triage levels that ED providers assigned to sexual assault victims.

[14] The number of victims assigned triage levels does not represent the universe of 630 victims because the ED providers did not record the triage level in the medical records for 82 victims (13 percent) and we could not locate the medical records for another 11 victims (2 percent). See the Appendix for more details on the projections. The lack of documentation to support the triage level is discussed in Finding B of this report.

Figure 2. Triage Levels Assigned by ED Providers to Sexual Assault Victims



Source: The DoD OIG.

The inconsistent assignment of triage levels does not meet the DoD Directive 6495.01 requirement that ED providers treat sexual assault victims uniformly.

The inconsistent assignment of triage levels does not meet the DoD Directive 6495.01 requirement that ED providers treat sexual assault victims uniformly. Additionally, assigning triage level 3 may not align, and assigning level 4 does not align, with the DoD Instruction 6310.09 requirement that providers will triage sexual assault victims in the category of a life-threatening emergency. As shown in Table 1 in the Background section of this report, assigning triage level 3 indicates that there is a possible, but unlikely, life threat, and assigning triage level 4 indicates that there is no associated life threat, which would not meet a life-threatening emergency response, in accordance with DoD Directive 6495.01 and DoD Instruction 6495.02.

DoD Guidance Does Not Prescribe a Specific or Minimum Triage Level for Sexual Assault

Although DoD guidance states that providers will triage sexual assault victims in the category of a life-threatening emergency and treat victims with priority and uniformity, it does not prescribe a specific or minimum triage level for sexual assault victims. The DOJ Protocol also does not prescribe a specific or minimum triage level. However, the ESI Handbook included sexual assault victims who are distraught or under severe distress as an example of when to assign triage level 2. With respect to showing signs of severe distress, DoD Directive 6495.01 cautions that severely traumatized sexual assault victims "may appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help."

DoD guidance does not prescribe a specific or minimum triage level for sexual assault victims.

A requirement to assign a specific triage level, such as a level 2 for sexual assault victims, while meeting the uniformity requirement, might not always be appropriate as other factors could affect the needed triage level. However, the inconsistent assignment of triage levels that we identified, including the use of triage level 4, clearly does not meet the requirement to triage sexual assault victims in the category of a life-threatening emergency. Therefore, the ASD(HA) should conduct a study concerning triage levels for sexual assault victims, including a review of industry standards, and revise DoD guidance to prescribe a specific triage level for sexual assault victims or a minimum level that meets the requirements for priority and uniformity. Also, the ASD(HA) should develop a process to review and ensure that ED providers implement and consistently apply the new guidance for assigning a triage level for sexual assault victims.

Inconsistent Triage Levels Could Prolong Physical and Emotional Harm

The inconsistent assignment of triage levels could result in sexual assault victims not receiving timely medical care or critical support services.

The inconsistent assignment of triage levels could result in sexual assault victims not receiving timely medical care or critical support services at DoD MTF EDs, which could prolong the physical and emotional harm experienced by those victims. As stated in DoD Directive 6495.01, "[a] sexual assault victim needs immediate medical intervention to prevent loss of life or suffering resulting from physical

injuries (internal or external), sexually transmitted infections, pregnancy, and psychological distress." Giving access to comprehensive medical care in a timely manner is imperative to the SAPR Program's aim to focus on the victim and on doing what is necessary and appropriate to support victim recovery.

Recommendations, Management Comments, and Our Response

Recommendation A.1

We recommend that the Assistant Secretary of Defense (Health Affairs):

a. Conduct a study concerning triage levels for sexual assault victims, including a review of industry standards and revise DoD guidance to prescribe a specific triage level for sexual assault victims or a minimum level that meets the requirements for priority and uniformity.

Assistant Secretary of Defense (Health Affairs) Comments

The ASD(HA) partially agreed, stating that DoD Instruction 6310.09 already provides clear DoD guidance on the minimum level of triage for sexual assault victims. Additionally, the ASD(HA) acknowledged that the inconsistent priority triage of sexual assault victims identified in this audit is not in compliance with DoD guidance and reflects an implementation issue. The ASD(HA) recommended that the DHA update DHA Procedural Instruction 6025.03 or other procedural guidance to comply with the requirements outlined in DoD Instruction 6310.09.

Our Response

Although the ASD(HA) partially agreed, the recommendation is unresolved. We disagree that DoD guidance is clear on the minimum level of triage for sexual assault victims. DoD Instruction 6310.09 requires providers to give sexual assault victims priority as "an emergency case (triaged in the category of life-threatening emergency responses)," but does not define the triage level or minimum triage level that should be assigned for a life-threatening emergency. While the *Emergency Medicine Journal* is clear that a life-threatening emergency should not be assigned a triage level 4 or 5, it is not clear on the assignment of a triage level 2 or 3, stating that a triage level 2 assignment is "reasonably likely for a life threatening emergency" and "unlikely, but possible," for a triage level 3 assignment.[15] Furthermore, the ESI Handbook includes sexual assault victims

[15] Elshove-Bolk, Jolane et al. "Validation of the Emergency Severity Index (ESI) in Self-Referred Patients in a European Emergency Department," *Emergency Medicine Journal*, Volume 24, Issue 3, March 2007.

who are distraught or under severe distress as an example of when to assign triage level 2, and DoD Directive 6495.01 cautions that severely traumatized sexual assault victims "may appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help." Taken collectively, it is not clear from the guidance what the minimum triage level should be for a sexual assault victim. Therefore, we request that within 30 days of the final report, the ASD(HA) describe the specific actions they will take to conduct a study concerning triage levels for sexual assault victims and revise DoD guidance that meets the requirements for priority and uniformity.

b. Develop a process to review and ensure that emergency department providers implement and consistently apply the new guidance for assigning a triage level for sexual assault victims.

Assistant Secretary of Defense (Health Affairs) Comments

The ASD(HA) partially agreed, stating that they will work with the DHA to identify the appropriate mechanism to ensure uniform compliance with DoD Instruction 6310.09 and procedural guidance developed by the DHA.

Our Response

Although the ASD(HA) partially agreed, the recommendation is unresolved. This recommendation is contingent on the resolution of Recommendation 1.a. Therefore, we request that within 30 days of the final report, the ASD(HA) describes the specific actions they will take to develop a process to ensure the new guidance for assigning a triage level for sexual assault victims is implemented and consistently applied.

Finding B

DoD Providers Did Not Consistently Document Triage Levels, SAFE Offers, and Notification Information for Sexual Assault Victims

ED providers did not consistently document triage levels, SAFE offers, and notification information for sexual assault victims who received care at MTF EDs during FY 2021. Specifically, for the 209 sexual assault victims' medical records we reviewed, ED providers did not document triage levels for 25 victims; SAFE offers for 32 victims; and notification of a SARC, SAPR VA, or FAP clinical provider for 34 victims. We project that the DoD did not document triage levels for 82 victims (13 percent); SAFE offers for 96 victims (15 percent); and notification of a SARC, SAPR VA, or FAP clinical providers for 108 victims (17 percent) of the 630 sexual assault victims.[16] The ED providers did not document care because DoD guidance did not require ED providers to document in the victim's medical record the triage level assigned; whether they offered a SAFE; or whether they notified a SARC, SAPR VA, or FAP clinical provider. As a result, the ASD(HA) and the SAPR Office cannot verify whether ED providers gave sexual assault victims access to needed care and services, in accordance with DoD Instruction 6495.02.

Some Sexual Assault Notification Information Was Not Consistently Documented

ED providers did not consistently document triage levels, SAFE offers, and notification information for sexual assault victims who received care at MTF EDs during FY 2021. See Table 2 for the projected number of victims who had no evidence recorded in their medical records by ED providers for the assigned triage level, the offer of a SAFE, and the notification of a SARC, SAPR VA, or FAP clinical provider.

[16] For 11 of the 630 victims (2 percent), we were unable to determine whether DoD MTFs documented required care for sexual assault victims because we could not locate the victims' medical records.

Table 2. Documentation of Triage Levels, SAFE Offers, and Notification Information

Number of Sexual Assault Victims					
Area Reviewed	Evidence in Medical Record	No Evidence in Medical Record	SAFE Offer Not Required	Record Not Found	Total
Triage Level Assigned	537	82	N/A	11	630
SAFE Offered	438	96	86	11	630*
Victim Advocacy Notified	512	108	N/A	11	630*

* The total does not equal the sum of the individual categories because of rounding in the statistical projections.

Source: The DoD OIG.

DoD Guidance Does Not Require ED Providers to Document Assigned Triage Levels and Notification Information for Sexual Assault Victims

DoD guidance does not require ED providers to document in a sexual assault victim's medical record the assigned triage level; whether they offered a SAFE, if applicable; or whether they notified a SARC, SAPR VA, or FAP clinical provider. However, DoD Instruction 6040.45 requires that ED providers document clinically relevant care provided to sexual assault victims in the victim's medical record.[17] Specifically, DoD Instruction 6040.45 requires that ED providers ensure the patient's medical record contains:

- a patient identifier;
- support for the diagnosis and condition;
- justification for the care, treatment, and service rendered;
- accurate documentation of the results of care, treatment, and service rendered; and
- support for the continuity of care.

The ASD(HA) should revise guidance to require ED providers to document in a sexual assault victim's medical record: (1) the triage level of care assigned; (2) whether providers offered and documented a SAFE to the victim; and (3) whether providers notified a SARC, SAPR VA, or FAP clinical provider, and the details of the notification, including who was notified and when they were

[17] DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015 (Incorporating Change 1, Effective April 11, 2017).

notified. Also, the ASD(HA) should develop a process to review and ensure that ED providers implement and consistently apply the new guidance on documentation requirements for sexual assault victims.

In addition, the electronic health record systems did not have an automated control requiring that ED providers enter: (1) the triage level of care; (2) whether they offered a SAFE; and (3) whether they notified a SARC, SAPR VA, or FAP clinical provider for care provided at MTF EDs for sexual assault victims. The DoD uses electronic health records systems, including MHS GENESIS and the Armed Forces Health Longitudinal Technology Application (AHLTA), to provide electronic health records of services provided in the MHS. MHS GENESIS is the new DoD electronic health records system and replaces select DoD legacy health care systems, including AHLTA. However, the DoD is incrementally deploying MHS GENESIS, and some MTFs still rely on DoD legacy health care systems, including AHLTA, because these MTFs have not yet received MHS GENESIS. The ASD(HA) should update MHS GENESIS to add an automated control requiring ED providers to enter: (1) triage level of care assigned, (2) whether they offered a SAFE, and (3) whether they notified a SARC, SAPR VA, or FAP clinical provider for care provided at MTF EDs for sexual assault victims, and the details of the notification, including who was notified and when they were notified.

The DoD Could Not Verify Whether ED Providers Offered Victims Needed Care and Services

The ASD(HA) did not require ED providers to document in the victim's medical record the triage level assigned, whether they offered a SAFE, if applicable, or whether they notified the required sexual assault victim advocates. As a result, neither the ASD(HA) nor the SAPR Office could verify whether ED providers offered sexual assault victims access to needed care and services in accordance with DoD Instruction 6495.02. Additionally, the ASD(HA) and the SAPR Office would be able to better determine the success of the program if ED providers documented this information in the medical records.

Recommendations, Management Comments, and Our Response

Recommendation B.1

We recommend that the Assistant Secretary of Defense (Health Affairs):

a. Revise guidance to require emergency department providers to document in the sexual assault victim's medical record: (1) the triage level of care assigned; (2) whether providers offered and documented a Sexual Assault Forensic Examination to the victim; and (3) whether the Sexual Assault Response Coordinator, Sexual Assault Prevention and Response Victim Advocate, or Family Advocacy Program clinical provider was notified, and the details of the notification including who was notified and when they were notified.

Assistant Secretary of Defense (Health Affairs) Comments

The ASD(HA) agreed with the recommendation.

Our Response

Comments from the ASD(HA) addressed the recommendation; therefore, the recommendation is resolved but open. We will close the recommendation once we obtain the revised DoD Instruction 6310.09 and verify that the Instruction includes requirements to document the triage level, SAFE offers, and notification information for sexual assault victims in the victim's medical records.

b. Develop a process to review and ensure that emergency department providers implement and consistently apply the new guidance on documentation requirements for sexual assault victims.

Assistant Secretary of Defense (Health Affairs) Comments

The ASD(HA) partially agreed, stating that the DHA is responsible for ensuring compliance with DoD Instruction 6310.09. The ASD(HA) also stated that they will work with the DHA to develop processes to ensure compliance with the documentation requirements.

Our Response

Although the ASD(HA) partially agreed, their response meets the intent of the recommendation; therefore, the recommendation is resolved but open. We will close the recommendation once we obtain documentation that verifies that the

ASD(HA) developed a process to review and ensure that ED providers implement and consistently apply the new guidance on documentation requirements for sexual assault victims.

c. Update Military Health System GENESIS to add an automated control requiring emergency department providers to enter: (1) triage level of care assigned; (2) whether providers offered a Sexual Assault Forensic Examination; and (3) whether providers notified the Sexual Assault Response Coordinator, Sexual Assault Prevention and Response Victim Advocate, or Family Advocacy Program clinical provider for care provided at medical treatment facility emergency departments for sexual assault victims, and the details of the notification, including who was notified and when they were notified.

Assistant Secretary of Defense (Health Affairs) Comments

The ASD(HA) partially agreed, stating that they will work with the DHA to determine whether such automated controls are feasible within MHS GENESIS and will achieve the desired goal.

Our Response

Although the ASD(HA) partially agreed, the recommendation is unresolved. The ASD(HA) did not agree to implement automated controls, but agreed only to determine whether such automated controls are feasible within MHS GENESIS. Therefore, we request that within 30 days of the final report, the ASD(HA) describe the specific actions they will take to implement automated controls into MHS GENESIS to address the finding in this report.

Appendix

Scope and Methodology

We conducted this performance audit from January 2022 through May 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Documentation, Interviews, and Observations

We reviewed the following regulations and guidance.

- Sexual Assault Prevention and Response (SAPR) Program Procedures, Title 32 Code of Federal Regulations section 103
- DoD Directive 6495.01, "Sexual Assault Prevention and Response (SAPR) Program," January 23, 2012 (Incorporating Change 4, September 11, 2020))
- DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015 (Incorporating Change 1, April 11, 2017)
- DoD Instruction 6310.09, "Health Care Management for Patients Associated with a Sexual Assault," May 7, 2019
- DoD Instruction 6495.02, volume 1, "Sexual Assault Prevention and Response: Program Procedures," March 28, 2013 (Incorporating Change 4, September 11, 2020)
- DoD Instruction 6495.02, volume 1, "Sexual Assault Prevention and Response: Program Procedures," March 28, 2013 (Incorporating Change 5, April 9, 2021)
- DoD Instruction 6400.06, "Domestic Abuse Involving DoD Military and Certain Affiliated Personnel," August 21, 2007 (Incorporating Change 4, May 26, 2017)
- DHA Procedural Instruction 6025.03, "Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFs) to Support an Integrated Health Care System (IHCS)," January 30, 2018
- "Implementation Handbook 2020 Edition, ESI (Emergency Severity Index), A Triage Tool for Emergency Department Care," Version 4

We interviewed and briefed key officials at the Office of the ASD(HA), the DHA, and the Military Departments.

We obtained data from the MHS System Data Repository for individuals who visited an MTF ED with a diagnosis of sexual assault from October 1, 2020, through September 30, 2021. The data identified 630 individuals. We statistically selected 209 of the 630 individuals. We examined the individuals' medical records, using the Joint Longitudinal Viewer (JLV), to determine whether MTF providers:

- provided priority treatment as emergency cases;
- offered a SAFE, if applicable; and
- notified the SARC, SAPR VA, or FAP clinical provider.[18]

We further examined the Defense Sexual Assault Incident Database (DSAID) to determine whether the victim had a SAFE conducted and whether the SARC or SAPR VA was notified.

Statistical Projections and Interpretation

We projected the results across 630 individuals. Below are the details for each projection.

Based on the sample results, we project at a 95-percent confidence level that medical records indicated that ED providers triaged sexual assault victims at level 2, ranging from 376 to 450 victims, with a point estimate of 413 victims, as shown in Table 3.

Table 3. Number of Sexual Assault Victims Triaged at Level 2

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	376 (59.7%)	413 (65.6%)	450 (71.4%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that medical records indicated that ED providers triaged sexual assault victims at level 3, ranging from 64 to 118 victims, with a point estimate of 91 victims, as shown in Table 4.

Table 4. Number of Sexual Assault Victims Triaged at Level 3

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	64 (10.2%)	91 (14.5%)	118 (18.7%)

Source: The DoD OIG.

[18] According to the "DoD Healthcare Management System Modernization Joint Longitudinal Viewer," website: the "[] JLV is a clinical application that provides an integrated, read-only display of health data from the [] DoD, Department of Veterans Affairs [], and private sector partners in a common data viewer." DoD users can use the JLV to access electronic health records systems, including MHS GENESIS and AHLTA. "JLV users can access … patients' available health care data regardless of whether patients previously received care from the DoD, V[eterans] A[ffairs], or participating private sector providers."

Based on the sample results, we project at a 95-percent confidence level that medical records indicated that ED providers triaged sexual assault victims at level 4, ranging from 15 to 51 victims, with a point estimate of 33 victims, as shown in Table 5.

Table 5. Number of Sexual Assault Victims Triaged at Level 4

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	15 (2.3%)	33 (5.2%)	51 (8.2%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that medical records and the DSAID indicated that ED providers offered a SAFE to sexual assault victims, ranging from 403 to 472 victims, with a point estimate of 438 victims, as shown in Table 6.

Table 6. Number of Sexual Assault Victims Offered a SAFE

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	403 (64.0%)	438 (69.5%)	472 (74.9%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that medical records and the DSAID did not indicate that ED providers offered a SAFE to sexual assault victims, ranging from 67 to 124 victims, with a point estimate of 96 victims, as shown in Table 7.

Table 7. Number of Sexual Assault Victims Not Offered a SAFE

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	67 (10.7%)	96 (15.2%)	124 (19.6%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that ED providers were not required to offer a SAFE to sexual assault victims, ranging from 60 to 112 victims, with a point estimate of 86 victims, as shown in Table 8.

Table 8. Number of Sexual Assault Victims Not Requiring a SAFE

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	60 (9.6%)	86 (13.7%)	112 (17.8%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that medical records and the DSAID indicated that ED providers notified a SARC, SAPR VA, or FAP clinical provider for sexual assault victims, ranging from 481 to 543 victims, with a point estimate of 512 victims, as shown in Table 9.

Table 9. Number of Sexual Assault Victims for Whom MTF Personnel Notified a SARC, SAPR VA, or FAP Clinical Provider

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	481 (76.3%)	512 (81.2%)	543 (86.1%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that medical records and the DSAID did not indicate that ED providers notified a SARC, SAPR VA, or FAP clinical provider for sexual assault victims, ranging from 78 to 137 victims, with a point estimate of 108 victims, as shown in Table 10.

Table 10. Number of Sexual Assault Victims for Whom MTF Personnel Did Not Notify a SARC, SAPR VA, or FAP Clinical Provider

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	78 (12.4%)	108 (17.1%)	137 (21.8%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that we were unable to locate the medical records for sexual assault victims, ranging from 3 to 22 victims, with a point estimate of 11 victims, as shown in Table 11.

Table 11. Number of Sexual Assault Victims for Whom We Were Unable to Locate Medical Records

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	3 (0.5%)	11 (1.7%)	22 (3.5%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that there was evidence recorded in their medical records by ED providers for the assigned triage level, ranging from 509 to 566 victims, with a point estimate of 537 victims, as shown in Table 12.

Table 12. Number of Sexual Assault Victims That Had Evidence Recorded for Assigned Triage Level

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	509 (80.8%)	537 (85.3%)	566 (89.8%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that there was no evidence recorded in their medical records by ED providers for the assigned triage level, ranging from 55 to 109 victims, with a point estimate of 82 victims, as shown in Table 13.

Table 13. Number of Sexual Assault Victims That Had No Evidence Recorded for Assigned Triage Level

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	55 (8.7%)	82 (13.0%)	109 (17.3%)

Source: The DoD OIG.

Based on the sample results, we project at a 95-percent confidence level that the DoD did not assign consistent triage levels for sexual assault victims, ranging from 94 to 155 victims, with a point estimate of 124 victims, as shown in Table 14.

Table 14. Number of Sexual Assault Victims That Were Not Assigned Consistent Triage Levels

	Lower Bound	Point Estimate	Upper Bound
No. of Victims	94 (14.9%)	124 (19.7%)	155 (24.6%)

Source: The DoD OIG.

Internal Control Assessment and Compliance

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed whether sexual assault victims were given priority and treated as emergency cases and offered a SAFE. We also assessed whether a SARC, SAPR VA, or FAP clinical provider was notified. During our audit work, we determined that some ED providers did not consistently assign triage levels. In addition, documentation we reviewed did not indicate whether ED providers offered a SAFE or notified a SARC, SAPR VA, or FAP clinical provider for sexual assault victims. However, because our review was limited to these internal control components and underlying principles, our review may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

Use of Computer-Processed Data

We used computer-processed data from the MHS Data Repository. Specifically, we extracted data for all victims who had a sexual assault diagnosis with an MTF ED visit from October 1, 2020, through September 30, 2021, and identified 630 victims. We identified other individuals with a sexual assault diagnosis, but the health care data were not coded by the ED providers with an ED procedure code. Therefore, we are only projecting over the 630 victims in the audit and not across the entire DoD.

We used data from the DSAID to answer the objectives if victims' medical records were not available or medical records did not include the necessary information. We compared medical records to the DSAID data we used and we did not identify errors.

Use of Technical Assistance

We obtained support from the DoD OIG Quantitative Methods Division in developing a statistical sample of 209 victims to review. The DoD OIG Quantitative Methods Division then projected the results of the 209 victims across the 630 individuals we identified in the audit. See the Scope and Methodology Section of this Appendix for more details.

Prior Coverage

No prior coverage has been conducted on DoD emergency medical care at MTFs during the last 5 years.

Management Comments

Assistant Secretary of Defense (Health Affairs)

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

July 24, 2023

[redacted]
Department of Defense Office of the Inspector General

Dear [redacted],

This is my office's formal response to the Department of Defense Inspector General "Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities", Project Number D2022-D000AW-0031.00. My office partially concurs to the report, as written, and has provided comments directly within the draft report to correct factual inaccuracies and inconsistencies.

Attached is my response to the subject report. My point of contact is [redacted]

Sincerely,

[redacted]
Lester Martínez-López, M.D., M.P.H.

Attachments:
As stated

Assistant Secretary of Defense (Health Affairs) (cont'd)

Health Affairs Response to the Department of Defense Office of the Inspector General "Audit of Triage and Support Services for Sexual Assault Victims at DoD Medical Treatment Facilities" Project Number D2022-D000AQ-0031.00

The Department of Defense (DoD) partially concurs with the report, as written, and has provided comments directly within the draft report to correct factual inaccuracies and address inconsistencies. The following is the Department's response to the report recommendations addressed to the Assistant Secretary of Defense for Health Affairs.

Recommendation A.1a: Conduct a study concerning triage levels of sexual assault victims including a review of industry standards and revise DoD guidance to prescribe specific triage level for sexual assault victims or a minimum level that meets the requirements of priority and uniformity.

Health Affairs Response: Partial Concur. The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) agrees uniform standards of priority triage of sexual assault victims is necessary. However, as noted in this report, Department of Defense Instruction (DoDI) 6310.09, "Health Care Management of Patients Associated with a Sexual Assault", May 7, 2019, already provides clear DoD guidance on the minimum level of triage for sexual assault victims. As stated in the DoDI (page 8) "*If an eligible patient discloses that they have been sexually assaulted. The patient will be given priority as an emergency case (triaged in the category of life-threatening emergency responses) when presenting to an ED for sexual assault, in accordance with DoDD 6495.01 and DoDI 6495.02".* The inconsistent priority triage of sexual assault victims identified in this audit are not in compliance with DoD guidance and reflect an implementation issue. Updating the Defense Health Agency (DHA) Procedural Instruction 6025.03, "Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFS) to Support an Integrated Health Care System (IHCS)," January 30, 2018, or other appropriate procedural guidance, will ensure compliance with the requirements as outlined in DoDI 6310.09.

Recommendation A.1b: Develop a process to review and ensure that emergency department providers implement and consistently apply the new guidance for assigning a triage level for sexual assault victims.

Health Affairs Response: Partial Concur. OASD(HA) agrees that ensuring uniform compliance to current guidance is necessary and will work with the DHA to identify the appropriate mechanism to ensure compliance with DoDI 6310.09 and procedural guidance developed by DHA.

Recommendation B.1a. Review guidance to required emergency department providers to document in the sexual assault victim's medical record (1) the triage level of care assigned; (2) whether providers offered and documented a Sexual Assault Forensic Examination to the victims; and (3) whether the Sexual Assault Response Coordinator, Sexual Assault Prevention and Response Victim Advocate or Family Advocacy Program clinical provider was notified, and the details of the notification, including who was notified and when they were notified.

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Assistant Secretary of Defense (Health Affairs) (cont'd)

Health Affairs Response: Concur.

Recommendation B.1b: Develop a process to review and ensure that emergency department providers implement and consistently apply the new guidance on documentation requirements for sexual assault victims.

Health Affairs Response: Partial Concur. DHA is responsible for complying with DoDI 6310.09. OASD(HA) will work with DHA to develop processes to ensure compliance with the documentation requirements.

Recommendation B.1c: Update Military Health System GENESIS to add an automated control requirement emergency department providers to (1) the triage level of care assigned (2) whether providers offered and documented a Sexual Assault Forensic Examination to the victims; and (3) whether the Sexual Assault Response Coordinator, Sexual Assault Prevention and Response Victim Advocate or Family Advocacy Program clinical provider was notified, and the details of the notification, including who was notified and when they were notified.

Health Affairs Response: Partial Concur. OASD(HA) will work with the DHA to determine whether such automated controls are feasible within MHS GENESIS and will achieve the desired goal.

Acronyms and Abbreviations

AHLTA	Armed Forces Health Longitudinal Technology Application
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
DHA	Defense Health Agency
DOJ	Department of Justice
DSAID	Defense Sexual Assault Incident Database
ED	Emergency Department
ESI	Emergency Severity Index
FAP	Family Advocacy Program
JLV	Joint Longitudinal Viewer
MHS	Military Health System
MTF	Medical Treatment Facility
SAFE	Sexual Assault Forensic Examination
SAPR	Sexual Assault Prevention and Response
SARC	Sexual Assault Prevention and Response Coordinator
VA	Victim Advocate

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