



End Violence Against Women International
(EVAWI)

Notification of Advocates and HIPAA Protections

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Sgt. Joanne Archambault (Retired, San Diego Police Department) is the Chief Executive Officer for EVAWI. In 2003 prior to founding EVAWI, Sgt. Archambault worked for the San Diego Police Department for almost 23 years, in a wide variety of assignments. During the last 10 years of her service, she supervised the Sex Crimes Unit, which had 13 detectives and was responsible for investigating approximately 1,000 felony sexual assaults each year. Sgt. Archambault has provided training for tens of thousands of practitioners, policymakers and others – both across the country and around the world. She has been instrumental in creating system–level change through individual contacts, as well as policy initiatives and recommendations for best practice.



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Does it violate a patient's privacy rights when a health care provider calls out a victim advocate?

Health care professionals and others have asked whether routine notification of advocates violates the privacy protections outlined in HIPAA (the Health Insurance Portability and Accountability Act of 1996). Although the name of the patient might not be revealed when an advocate is called out to respond, some have interpreted the face to face contact that may be made as violating HIPAA. Many programs continue to struggle with this issue and have a real desire to assure meaningful access to advocacy services. As described by Kim Day, who is the SAFE Technical Assistance Coordinator at the International Association of Forensic Nurses (IAFN):

The argument often raised by programs is that the hospital cannot call anyone outside the hospital system without the patient's express consent. In some facilities the Triage Nurse or Forensic Nurse will tell the patient that volunteer advocates are available to talk to them and ask whether the patient would like the volunteer to be called. There are also some facilities that request the patient to sign a specific consent form to have an advocate called out to respond.

When this is the protocol, many times the patient will decline advocacy presence, for a variety of reasons, often the most compelling being the patient does not want to 'bother' having someone called in for them. It should be foremost in the healthcare provider's mind that the patient may be in crisis and may not have all the information necessary to make an informed decision right up front as they are beginning the episode of care. This results in the advocate not being called and the patient will probably not be provided any immediate crisis counseling or advocacy – nor will the patient be adequately connected with referrals to counseling, emergency assistance, health care services, legal resources, or assistance with crime victim compensation. The nurse may or may not have sufficient knowledge of the intricacies of these community referrals, and the hospital's social work department will not typically be involved to fill that void.

Best practice is for the advocate to be called to the hospital or other exam facility as soon as possible after a patient discloses a sexual assault. The advocate can then explain the services that she/he can offer, before asking the patient whether or not she/he should stay. This practice greatly increases the likelihood that the patient will take advantage of the many services an advocate can offer, including being connected to the other resources and referrals that are available in the community.

How to Respond: Check State Law

There are a variety of ways to address this issue, and the first step is to find out whether there is any state law explicitly requiring or allowing health care providers to notify a victim advocacy agency when a patient discloses sexual assault victimization. Fortunately, there is a [compilation of state statutes](#) that was prepared by AEquitas: The Prosecutors' Resource on Violence Against Women in collaboration with the National Sexual Violence Resource Center (NSVRC). It is current as of March 2011. As described in that compilation, state laws regarding victim rights generally "fall into one of two categories: (1) laws that specifically relate to victims of sexual assault and (2) laws that provide the right to advocate presence for all victims" (p. 2). As of March 2011, such laws had been enacted by 11 states and they can be used to argue that there is clear justification for health care providers to notify advocacy agencies.

Seek Legal Guidance

Other guidance suggests that health care facilities have a general authorization to notify advocacy agencies. For example, in a series of [fact sheets](#) and other materials created by the Office of the Attorney General in Texas, in conjunction with the Texas Association of Sexual Assault, the question is asked:

Can a hospital notify a sexual assault program that a survivor is in transport to, or is currently present in, an emergency room?

The answer provided in this material is YES.

A hospital may notify the program of a survivor's presence in the ER. The hospital may do so as long as it provides only 'de-identified information' to the program. At a minimum, the hospital can tell the crisis center the following information about the survivor:

1. *Gender*
2. *Ethnic or racial background*
3. *Age*
4. *Primary language*

The material concludes with the following recommendation:

We encourage you to make arrangements to receive such information from your local hospital as soon as possible. An agreement between the hospital and your program will not only facilitate the exchange of such information between the hospital and your program but will also ensure that the survivor receives the best possible service and care (Office of the Attorney General and Texas Coalition Against Sexual Assault, HIPAA Fact Sheet #2, p. 4).

Another strategy is therefore to seek similar legal guidance within your own state or territory.

Use an Alternative Notification Procedure

Yet another strategy is to implement a protocol where the victim advocacy agency is notified by an entity other than the hospital or exam facility. For example, many if not most sexual assault victims access a medical forensic examination as a result of contacting law enforcement. In these situations, it makes sense that law enforcement personnel would notify the advocacy agency to minimize delays and ensure that the advocate can respond to the exam facility as quickly as possible. Alternatively, the notification could be made by a dispatcher, communications personnel, switchboard operator and/or hotline worker, depending on the response protocol in a particular community – and the particular agency that serves as the initial access point for an individual victim.

For More Information

Readers are encouraged to consult the [fact sheets](#) and other materials that were previously described, that were created by the [Office of the Attorney General](#) in Texas, in conjunction with the [Texas Association of Sexual Assault](#).

Information is also available in a [webinar on victim privacy](#) archived by the IAFN. In it, the presenters discuss the issues of privacy, confidentiality, and consent. They also offer practical suggestions and solutions for the practitioners on common issues that may arise on patient privacy. Particularly helpful is the [handout](#) from the webinar that was developed by the IAFN to summarize the basic provisions of HIPAA and implications for medical forensic exams.

General support for the notification of advocates can be found in the [position statement](#) of the IAFN regarding the need for advocacy services to assist patients who disclose sexual assault victimization.

The chapter on Victim-Centered care in the [National Protocol for Sexual Assault Medical Forensic Examinations \(Adults/Adolescents, 2nd Edition\)](#) also strongly supports the need for advocacy services:

Utilize a system in which exam facility personnel, upon initial contact with a sexual assault patient, call the victim service/advocacy program and ask for an advocate to be sent to the exam site (unless an advocate has already been called). Prior to introducing the advocate to a patient, exam facility personnel should explain briefly to the patient the victim services offered and ask whether the victim wishes to speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted. Ideally, a patient should be assisted by the same advocate during the entire exam process (p. 35).