End Violence Against Women International
(EVAWI)

Notification of Advocates and HIPAA Protections

Kimberly Lonsway
Sergeant Joanne Archambault (Ret.)

January 2013
Updated November 2022

This project was supported by Grant No. 2013–TA–AX–KO21 awarded by the Office on Violence Against Women, US Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

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Recommended Citation

Lonsway, K.A., Archambault, J., (2022). *Notification of Advocates and HIPAA Protections.* End Violence Against Women International.

Authors

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Acknowledgements

We are extremely grateful to Kim Day, RN, FNE, SANE–A, SANE–P for her valuable contributions to this Training Bulletin. She serves as the SAFE Technical Assistance Coordinator for the International Association of Forensic Nurses (IAFN).

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 HIPPA. 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.

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).*

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More on Advocates, Routine Notification, and HIPAA

Kimberly Lonsway
Sergeant Joanne Archambault (Ret.)

February 2013
Updated August 2020

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Previously, we sent out a training bulletin addressing the question of whether notifying an advocate violates the federal law known as HIPAA (Health Insurance Portability and Accountability Act). Because the issues surrounding this question are critical, yet complex, we are sending out this follow–up bulletin to address some common questions and concerns we have heard over the years. Our goal is to extend the discussion and spark further conversation in communities across the country.

Need for Advocacy Services

As we have trained across the country, some medical professionals have raised concerns about statements that seem to underestimate the ability of health care providers to provide crisis intervention, resources, and referrals for victims. For example, the previous bulletin included the following statement from Kim Day, SAFE TA Coordinator for the IAFN:

> *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.*
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> *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.*

The point of a statement such as this one is not to question the competence or compassion of health care providers, who provide outstanding services every day, but rather to highlight the fact that the professional role of victim advocates goes far beyond that of forensic examiners in this particular arena.

Role of Advocates

At the time of the exam, the role of an advocate is to focus exclusively on the needs of the victim. Forensic examiners are certainly focused on the needs of the victim as well, but their professional role also includes preparing for and performing the exam, which is a complex and demanding task.

As Dr. Rebecca Campbell and colleagues described in a 2008 article in the *Journal of Forensic Nursing:*

> *The work of Sexual Assault Nurse Examiner (SANE) programs is complex and multifaceted as nurses must attend simultaneously to sexual assault patients' psychological, medical, forensic, and legal needs* (Campbell, Patterson, Adams, Diegel, & Coats, 2008, p. 19).

Moreover, the training advocates receive prepares them to offer victims a broader range of services and specific referrals. Advocates typically have the most thorough and up–to–date knowledge of services available in the community, so they are prepared for a wide range of questions, concerns, and requests from victims. As one example, advocates may be able to secure a bed at a local shelter if needed, either because they are part of a dual services agency that provides services for intimate partner violence as well as sexual assault, or because they have a memorandum of understanding with the shelter agency. Such intricate knowledge can reduce the need for repeated phone calls or other attempts to get information, as well as decreasing the likelihood that victims waste time pursuing services that are not appropriate for them or for which they are not eligible. Another example is mental health services; agencies typically have strict guidelines for referrals, so advocates can help ensure that victims are directed toward services that are most appropriate for them and for which they are eligible.

The support of an advocate can also help victims stay engaged in the criminal justice process. As two nurses interviewed by Campbell, Greeson, and Patterson (2011) explained:

> *Just that there is support for them for that [participating in prosecution]. You know, let them know of [the local rape crisis center's] counseling and availability to support them through that process. So…they'll know that they don't have to be alone in that, that there are people who can give them some guidance…and help them through that process.*
>
> *I think that right away, having a strong support system and advocacy, and whether it be family support as well as making sure that they get the information and get set up with an advocate or follow–up. And I think that that could potentially have an impact on them following through with prosecution* (p.21).

Depending on the laws in each jurisdiction, advocates may also be able to offer victims confidentiality in their private communications. This type of confidentiality is not available with health care providers within the context of a medical forensic examination, but it is often very important for victims to have someone with whom they can talk freely, without fear that the information will be shared with others.

Perhaps most important, advocates can work with victims far beyond the time of the exam, helping them to navigate the criminal justice system and other community services. When victims need help or support after the exam is concluded – through the process of their recovery and possible involvement in the criminal justice system – only an advocate can provide these services over time and with continuity.

Benefits of Both Professionals

Clearly, the roles of forensic examiners and victim advocates are very different, even if they do share some significant overlap. Both roles are absolutely crucial, and victims benefit when they can take advantage of the unique services and caring that both professionals can offer.

This conclusion is supported by the research, which documents a range of benefits for victims who receive services from a specialized forensic examiner (Campbell, Greeson, & Patterson, 2011; Campbell, Patterson, Adams, Diegel, & Coats, 2008; Campbell, Patterson, & Lichty, 2005) as well as victim advocates (for review, see Campbell, 2006; also, Wasco, Campbell, Barnes, & Ahrens, 1999). Research also documents the fact that support people are key in helping victims decide whether or not to engage the criminal justice system – and remain engaged over the course of an investigation and prosecution (Campbell, Bybee, Ford, & Patterson, 2009; Campbell, Greeson, Bybee, Kennedy, & Patterson, 2011). Therefore, anything we can do to increase the level of support victims receive – from health care providers and advocates as well as loved ones – will benefit victims and ultimately improve the criminal justice system's ability to hold offenders accountable.

Routine Callout of Advocates

A second concern has been raised regarding the recommendation to call out advocates to respond as a matter of routine practice, rather than asking victims whether or not they would like an advocate to be called out. We believe this is best practice, because victims will often decline the services of an advocate when they are asked to decide – when they would actually benefit and would likely accept those services if the advocate had in fact been called out to the exam facility to meet with the victim.

Some may see this as doubting a victim's ability to make an informed decision, so we want to be perfectly clear that victims are still presented with the opportunity to decide whether or not to access advocacy services. However, they are presented with the choice after an advocate has already been called out, and not beforehand. This way, advocates can best explain their unique role to victims – just as forensic examiners and law enforcement professionals are best equipped to explain their roles.

This practice also removes the burden victims often feel to avoid any "inconvenience" to the advocates by having them called out – perhaps from their families, in the middle of the night, on the weekend, etc. This way, victims' decisions are based solely on whether they want the services of an advocate (as they have been described by advocates themselves), not whether they want someone called out to respond. We also believe there is a great deal of social pressure felt by victims to handle the trauma "on their own" and appear strong and capable. They are frequently focused on doing whatever they can to simply get through the process, so they can get it over with and go home. However, if they get home and have a question or concern, or if they need support, assistance, or help accessing other services, forensic examiners are typically very limited in the assistance they can provide. This is where the role of an advocate picks up – they can offer support and assistance to victims in an ongoing way.

In fact, one forensic examiner told us that she has a routine response to victims who decline advocacy services – she asks them why. This nurse said that every once in a while, victims will say that they truly do not want an advocate involved, but often they will express these other concerns (e.g., I don't want to bother anyone, I don't want anyone called out in the middle of the night or on the weekend). With this practice of asking victims why they have declined, the nurse can address the victim's underlying concern which then increases their real and meaningful access to advocacy services.

Conclusion

Clearly, health care providers provide a critically important service when they perform a medical forensic exam, and the benefits for victims have been extensively documented. The competence and compassion of a well–trained forensic examiner are irreplaceable – as are the services of a well–trained victim advocate. The bottom line is therefore not whether victims should be given a choice about whether or not to access the services of a victim advocate – it is simply when and how they are presented with this choice. As in so many other areas of sexual assault response, the best way to do this for victims is to eliminate as many unnecessary barriers as possible.

Thanks to Kim Day, Jen Markowitz, Diana Faugno, Barbara Girardin, and Alison Jones–Lockwood for their helpful contributions to this bulletin.

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