HIPAA and SARTs

SART Listserv
August 2007

States are listed as a reference; not as a statewide perspective.

Background: Rape crisis centers are not being called when an adult victims present at the emergency departments (ED). Prior to HIPAA, advocates were called automatically. The hospitals say they must have victims' consent before contacting advocates. In some cases, victims are required to sign consent forms.

General Responses:

- How does this hospital discuss activating the SART Team? Perhaps the same justification that they use to activate a forensic examiner could be used to activate the advocate?
- We suggest hospitals add a bullet to the HIPAA form documenting the multidisciplinary responders who are contacted when a survivor seeks medical attention. When the patient signs the form, there is no violation.
- One way to get through the maze of HIPPA is to call the advocate, and then when he/she arrives, tell the patient that one of the "team" members that respond to SA is there to see them.
- If the patient ***declines*** assistance of an advocate, referral materials can be given to the patient.

Alaska

- We call the advocate the same time the SANE and/or Law Enforcement is called.
- No names are given; they are just told that we have a patient.

Maryland

- There are really two issues here – privacy and consent. We assure hospitals that we do not expect any private patient information to be shared, including victim's name, when the advocate is called out.
- We have persuaded most of the emergency departments to call us if a sexual assault or domestic violence (which we also cover) victim comes in.
- We have been able to persuade hospitals that if victims are *asked* if they want an advocate to be called, they often say no because they do not want to inconvenience anyone.
- Through data collection, we have been able to show hospitals/EDs/FNEs that over 90% of the victims agree to speak with an advocate. And over 85% of the victims

seen by an advocate agree to follow/outreach contact. We have framed this as providing reasonable *access* to available services.

- We also make sure the hospital/ED/FNE program knows that we include privacy and consent issues in our training of advocates: I think it has made a difference for the hospitals to realize that advocates are knowledgeable about and sensitive to these issues. In turn, we have been able to get EDs to change some of *their* procedures that compromise privacy (such as having the victim wait in the general area with a uniformed police officer! And calling out patient names).
- I think for the most part we have been able to convince most of the hospitals that it is *best practice* to provide victims access to an advocate, and that just providing referral information is not adequate.
- Because we respond to DV victims as well, and because the majority of sexual assault victims know their attackers, we educate hospitals about the need to provide a good *risk assessment* and safety planning.
- Hospitals are required by JCAHO to screen all patients for DV, and we've been able to point out to hospitals that busy emergency department staff is more likely to screen if they have resources they can call on. I think most hospitals are quite responsive to issues relating to (1) regulations (privacy, screening), (2) best practice, (3) access to services, and of course (4) risk management.
- If you are developing your program, I would suggest getting your rape crisis center and a SANE to approach the nurse education dept. about being part of the new staff orientation and other in-service trainings.

Rhode Island

- In Rhode Island, hospital personnel offer advocacy services to the victim and, once the victim chooses to have an advocate, one is dispatched.
- I believe this alleviates the hospital's HIPAA concerns and also gives the victims some choice in the matter.

Texas

- The advocate's job begins before the SANE arrives and is needed regardless of whether law enforcement is involved or if the victim consents to an exam.
- We request hospitals not ask victims if they want an advocate before activating an advocate.
- When the advocate arrives at the hospital, the nurse advises the patient (or guardian) an advocate is present and the patient is free to accept or refuse services.

Medical Models and HIPAA

SART Listserv
November 2006

Issue: Advocacy Best Practices for adult multidisciplinary teams that work within a medical model.
Background: The Rape Crisis Center is essentially a child advocacy center that is funded through the local hospital. The child advocacy center also serves adults. With this being a medical model, the advocates have run into problems with HIPPA. Does anyone have information on best practices?

Utah

- Our local Emergency Departments call Advocates and notify them of a "sexual assault" case. (No identifying information)
- This allows advocates to respond to the facility without breaking confidentiality.
- Victims are informed that advocates are present and available to assist them if they desire.
- Advocates learn victim's identity only when the victim consents.
- By activating advocates and then giving patients choices, relieves victims of any distress about calling advocates in the middle of the night. (Patients are often concerned about "bothering someone".)
- Law Enforcement Dispatchers can also activate on-call advocates to the forensic examination site.

Louisiana (New Orleans)

- There should not be a HIPAA "problem" with activating advocates.
- If advocates understand HIPAA (receive education about the law) and sign a confidentiality statement, then they would be in that 'need to know' loop and would be considered a part of the health care team.

Georgia (Duluth)

- Program includes a child advocacy center & sexual assault center in a free-standing facility (all forensic-medical examiners are on site).
- No HIPAA issues.

California (Sacramento)

- Some hospitals feel that it violates HIPAA to call an advocate to respond to the hospital for a sexual assault exam.
- HIPAA may be a mechanism to exclude advocates where the relationships between forensic examiners and advocates have been strained.
- Fortunately most counties in CA have had only minor modifications under the HIPAA regulations.

Florida (Pinellas Park

- Adult model
- No HIPPA issues.
- Most clients don't want the advocate in the exam room during the exam.

HIPAA and SART Activation

SART Listserv
April 2006

Issue: How do SARTs activate advocates in light of HIPPA laws?

General Comments and Perspectives:

There is an inconsistent application of HIPAA around the country.

Some agencies have made advocates employees of the SANE/SART. There is actually a clause in the legislation that mandates the hospital to release records to law enforcement, prosecution, or other agencies when there is mandatory reporting legislation on the books. (Question to consider: Does this strategy impact privileged communications?)

HIPAA was mandated to protect individuals who seek services from hospitals and health care providers. Increased access to patient information equals the increased risk of the misuse of information. PRIVACY is central to the licensed health care provider-patient relationship.

There are inherent ethical and legal standards nurses and physicians are held to and obligated to uphold in the patient-provider relationship. Disclosure of patient information to individuals such as Victim Advocates prior to consent from a patient seeking services from a health care provider, breaches patient confidentiality.

Patients have the inherent right to be informed of the services provided and be given the opportunity to accept or reject said services.

While I certainly appreciate the opinion of health care providers regarding HIPAA, healthcare providers need to understand the standard of privileged communications advocates uniquely offer on SART.

I cannot understand how inviting an Advocate to the hospital and then asking the victim is she would like services violates HIPPA.

If the Advocate is not included immediately, the victim may not be given information on services available and how to contact advocacy agencies at a future date. Once the person has left the hospital, the nurse's responsibility has ended--but the trauma and confusion and interaction with the criminal justice system hasn't.

The Texas Office of the Attorney General and TAASA put together HIPAA fact sheet and authorization forms (attachments) about a year and a half ago. I believe most of what they contain should apply, since HIPAA is federal. Contact Debbie Rollo drollo@nsvrc.org if copies are needed.

Statewide Perspectives

(Note: states listed represent a point of reference and do not necessarily represent a perspective)

California

- HIPAA applies unless other laws require the disclosure of information (see attached section of the Code of Federal Regulations).
- Most of the counties in California are able to circumvent the HIPAA issue due to a state statute that says law enforcement must call the rape crisis center. However, in practice, the hospital has typically done this instead of law enforcement because the perception is that this is overly burdensome to law enforcement.
- We have a few counties in California where hospitals are refusing to contact rape crisis centers, but instead ask the survivor if they want an advocate called - probably not a best practice.
- Once advocates arrive at the hospital, victims are asked if they would like to meet with an advocate. Once the patient consents then personal information can be provided.

Illinois

- In our county, we are called when the victim presents.

- Forensic examiners then ask victims if they would like advocacy support during the exam.
- Occasionally we have a nurse who will ask the patient if they want advocates called. Many times victims are already feeling like a burden and calling in someone else, especially late at night, doesn't seem like a good idea to victims. But if we are already there, then they are more likely to use our services.
- The few times that victims refuse services, advocates wait at the site in case victims change their minds.
- Victims have changed their minds, so waiting on-site is a good practice.

Indiana (Richmond)
- The policy is that the advocate at the domestic violence shelter (or at the college) cannot be called until the victim agrees.

New York (Schenectady)
- Rape crisis advocate is always dispatched at the same time as SANEs are dispatched
- Upon the advocates' arrivals, victims make the decision whether or not they want advocacy support.

Nevada (Reno County)
- Advocates, law enforcement and RN's are activated at the same time.
- If a victim declines advocacy support, the advocates provide agency information

North Carolina
- Advocates are not called when victims initially present to the local hospital for sexual assault, due to HIPPA regulations. Advocates are only called at the patient's request
- Prior to HIPAA, the local hospital called the Advocacy Hotline when the victim presented.

Ohio
- Hospitals call advocates when victims arrive.
- When advocates arrive, the victim is given the option of advocacy support.
- If the victim declines, the advocate leaves with no information about the patient,
- If hospitals ask victims if they want a rape crisis advocate, victims generally decline
- Hospitals give program information because may need or want assistance at a later date

Pennsylvania
- In Pennsylvania, Senate Bill 990 & House Bill 2159 (called the "Care Act") is before the legislature
- This legislation will very simply require hospital emergency rooms in Pennsylvania to offer the presence of a victim advocate, information regarding

emergency contraception and the medication availability to patients who are victims of sexual assault.

- Locally our county protocol clearly requires the option of an advocate to be present for the victim **(This Protocol Does Not Apply to Victim's Under the Age of Fourteen)** :

CENTRE COUNTY PROTOCOL FOR A COORDINATED COMMUNITY RESPONSE TO CRIMES OF SEXUAL VIOLENCE

I. PURPOSE

A. The prevalence of sexual assault in our community is an issue of great concern to law enforcement and other professionals who consistently deal with victims of crimes of sexual violence. It is an offense which touches members of every gender and sector of our community: females; males; adults; children; the elderly and the mentally retarded. The pervasiveness of this crime necessitates a coordinated community response.

B. The principal purpose of this protocol is to establish guidelines and procedures to be followed by police officers, and other personnel in our community involved in the response to crimes of sexual violence, namely, prosecutors, victim advocates, health care providers, Child Protective Services, and emergency dispatchers. Uniformity of procedure throughout the county will result in more effective investigation and prosecution of crimes of sexual violence in the following respects:

1. By establishing a uniform response to crimes of sexual violence by all law enforcement agencies, community hospitals and other health care providers in Centre County;

2. By providing for specially trained personnel within the county to aid in evidence collection, from victims of sexual violence crimes;

3. By affording protection and support to victims of sexual assault through a coordinated program of law enforcement, protective services, and victim assistance;

4. By enhancing the ability of law enforcement and the criminal justice system to hold perpetrators of sex crimes accountable for their actions.

II. **POLICY**