HEALTH PARTNERS ON IPV + EXPLOITATION

Using Community Referral Technology Platforms to Safely Connect Health Center Patients with Community-based Domestic Violence Services

This memo provides recommendations for health center (HC) staff as they implement, tailor, and use electronic tools to connect their patients to community-based domestic violence (DV) and human trafficking (HT) services, including how to protect patient/survivor confidentiality. HCs increasingly play an important role in addressing the non-clinical factors of health, including housing, food insecurity, and domestic violence. Today, referrals are often facilitated through online platforms, sometimes known as community referral networks or community referral technology platforms, to assist providers in connecting patients with necessary services and providing a mechanism for follow-up. However, concerns about privacy and confidentiality exist, particularly regarding sensitive health information such as experiences of violence. This memo addresses key questions and considerations for HC staff, emphasizing survivors' rights and control over their health information.

A note about terminology used in this paper: the terms intimate partner violence (IPV) and domestic violence (DV) will be used interchangeably throughout this paper.[1]

Introduction

Health centers often respond to the non-clinical factors of health, including housing, food insecurity, domestic violence and human trafficking. Examples of this long history of connecting patients with community services include offering health enrollment, and co-locating food and nutrition services. Addressing these upstream factors can prevent or mitigate negative health outcomes and increase health care access. Online supported referral and coordination platforms, sometimes called community referral networks or platforms, can support this work. Community referral systems may be integrated into an electronic health record (EHR) or may be stand-alone or hyper-local platforms.

Community referral technology platforms help HC providers connect patients to social service agencies and national hotlines, and offer a feedback loop to review access. For example, a provider using an online tool giving a targeted list of food pantries to patients experiencing food insecurity can promptly follow-up to make sure the connections were made. Technology platforms provide impactful value to survivors of DV/HT, connecting them with supportive safety services in real time and building trust with their providers.

A solid partnership between a provider and a DV/HT service provider is the most effective solution because it helps facilitate a warm referral[2]—where the health care provider makes a personal referral to a known DV/HT service provider.

[1]The CDC defines IPV as physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner. DV is defined as the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another

[2]A warm referral, as referred to in the evidence-based CUES intervention, is a supported referral to DV/SA advocacy programs from a health provider, in which the provider is able to offer a patient access to an onsite DV/SA advocate; offer use of the clinic's phone to call a local resource; or offer the name and phone number so they can reach out independently, etc. Complement a warm referral with a brochure or safety card from a local DV/SA agency, if it is safe for the patient to take home.

Community referral technology platforms play an important role in facilitating referrals and coordinating care between HCs and DV/SA advocates. When local DV/SA programs participate in the network, health care providers can refer survivors to their programs for support related to safety and children's services.

However, concerns about these emerging tools include who has access to private and confidential sensitive health care information. Survivors may be considering:

- What is documented in the online record about my experiences of violence and other sensitive health information?
- Who has access to the information submitted to the platform, including my personally identifiable health data?
- What will happen if my partner finds out that I have been talking to my provider about the violence?
- How will I be treated differently if other people on my care team know that I am surviving violence?
- What control do I have over my health information and what are my rights as a patient and as a survivor?

To ensure participation and the success of the partnership with DV/SA advocates and state DV/HT coalition staff, it is critical that privacy and confidentiality questions about the tools and its network are addressed in advance. The underlying platform must explicitly address these unique privacy concerns when developing the technology and external interface to protect the safety and wellbeing of survivors. This should be done prior to deploying the tool or suggesting it to community organizations.

What is a Community Referral Technology Platform?

The type and range of the community referral platforms continue to proliferate.[3] Examples of platforms with a national footprint include:

- CrossTx
- FindHelp (Formerly Aunt Bertha)
- Healthify
- NowPow
- One Degree
- Unite Us

A study of health care providers suggests that they seek out referral tools because they provide an easy to use and effective search function for regularly-updated community resources. Some were interested in referral tools integrated with a search function so that identified needs automatically generated resource lists or outgoing electronic referrals to social service organizations.

Complement a warm referral with a brochure or safety card from a local DV/SA advocacy programs, if it is safe for the patient to take home. Ideally, the provider has an established relationship with the DV/SA advocacy program and is familiar with the staff and services available, thus increasing the likelihood of the patient following through with the connection. For more information on CUES and building partnerships with DV/SA advocates, see our bi-directional infographic: https://healthpartnersipve.org/resources/partnerships-between-hcs-and-dv-and-sv-advocacy-programs-bi-directional-infographic/

[3] More detailed information about these and other community referral platforms is available in Community Resource Referral Platforms: A Guide for Health Care Organizations. SIREN. 2019.

There are different types of community referral technology platforms with different strengths and functions, including the possibility of integrating a component of an electronic health record for use during a health care visit.

Some platforms function like a directory that lists available community-based organizations (CBO) in a geographic region (e.g., all food banks in a certain zip code). In others, case managers work as an intermediary between a health care provider and the CBO to make referrals and ensure a feedback loop so they know the patient received the help they need.

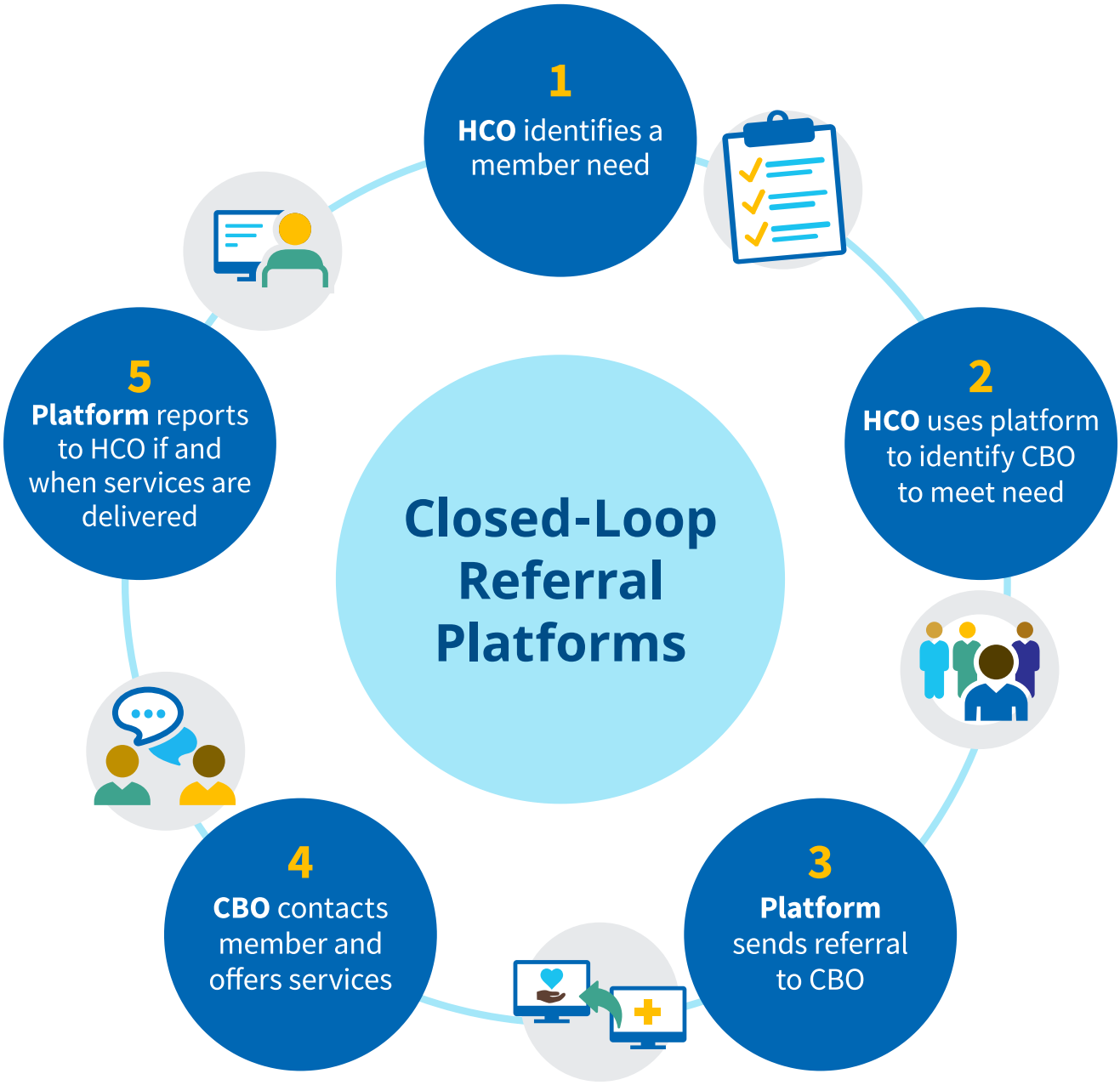
Key Functionalities of Community Referral Technology Platforms

Table adapted from *Community Resource Referral Platforms: A Guide for Health Care Organizations. SIREN. 2019*

Functionality	**Description**
Primary functionality	
Resource directory	A searchable, regularly-updated directory of community-based organizations and agencies providing services that can help address patients' social needs
Referral management	The ability to send referrals to community organizations and to track referral outcomes (i.e., close the loop)
Other Functionalities & Characteristics	
Privacy protection	Compliance with HIPAA and other privacy regulations
Systems integration	The ability to seamlessly move from the referral platform to the electronic health record (EHR) and vice versa, and to automatically transfer data between the two systems
Care coordination/case management	Longitudinal needs and care tracking, ability to define care goals and see referrals, services and other activities
Reporting and analytics	The capacity to analyze social needs screening and referral activities and outcomes
Social needs screening	The capacity to record patients' responses to a questionnaire and identify social needs
Auto-suggested resources	The ability to tailor resource lists to the patients' social needs screening results and/or other data

A tool that incorporates a robust network with deep community expertise can help connect survivors to services including CBOs that actively participate in the network, providing real-time updates about availability of the services offered and current capacity. For example, a health care organization (HCO) could refer a survivor to a DV advocacy program that can provide immediate safety planning but also connect them to food and housing supports. That health care provider can use the platform to determine which DV program has resources that fit the survivor's unique needs—and facilitate that referral. The health care provider can also use the tool to indicate that the survivor was offered resources.

In a closed loop referral system, it may be possible to track follow up to ensure the patient obtained access to necessary support. Other members of the survivor's care team will also know what services were offered to the survivor.



Graphic from Adopting a Community Resource and Referral Platform: Considerations for Texas Medicaid Stakeholders Center for Health Care Strategies. 2019

The Role of the Community Referral Technology Platform for DV/SA Programs

Community referral network platforms help HCs build and facilitate connections with DV/SA advocates. The adaptable Protocol for HRSA-supported Community Health Centers to Engage Patients through Universal Education Approaches on Exploitation (E), Human Trafficking (HT), Domestic Violence (DV) and Intimate Partner Violence (IPV) offers a model to empower HCs to provide healing-focused, survivor-centered care and formalize strategies to connect patients with community-based services. Consistent use of community referral technology platforms and referral networks could lead to an increase in appropriate referrals of HC patients to community-based DV/SA advocates.

There are opportunities for sustained funding from the health care organization to the CBO. One example is North Carolina's Healthy Opportunity Pilot, where CBOs, including DV service organizations, are paid by the state Medicaid agency for providing non-medical services to survivors of IPV. The service delivery is coordinated by—and may eventually be paid through—the state-run, state-wide referral platform, NCCARE360.

As noted above, there are concerns about data collection and sharing, access to information, and the strength of the network of DV service providers. For patients who are experiencing DV/HT, this is not just an issue of privacy but also one of safety. (For more information about privacy and confidentiality in health information technology, see A Practical Guide on Intimate Partner Violence, Human Trafficking, and Exploitation and Technology Tools.

Good policy and practice surrounding the use and disclosure of health information respects patient autonomy and confidentiality while trying to improve the safety and health status of a patient. Because these tools collect and store sensitive health information and track patient health data, it is extremely important to safeguard sensitive information and to be deliberate and very careful with what information is shared with the online platform.

Best practice ensures:

- Patients receive an explanation of how health information is used, shared, and disclosed, including specific notification of the limits of confidentiality;

The North Carolina Interpersonal Violence Medicaid Opportunity

A Medicaid pilot program in three regions of North Carolina will provide survivors of interpersonal violence additional services through their Medicaid health insurance. The program—known as the Healthy Opportunities Pilot—is designed to support the health and well-being of individuals enrolled in Medicaid by providing health-related supports and services that are not typically covered by health insurance. The pilot focuses on providing services to individuals who need support with housing, food, transportation, or interpersonal violence and toxic stress. Community-based organizations focused on DV can participate as providers and systematically be reimbursed by Medicaid for services they provide.

Individuals who screen positive for needing support, including for interpersonal violence and toxic stress, are offered the opportunity to participate in the pilot and referred to an appropriate supportive community-based provider.

- Patients are made aware of their rights to access, correct, amend, and supplement their own health information;
- Personal and sensitive health information is de-identified whenever possible;
- Providers offer and respect patients' communication preferences, including by phone, by email, etc., and under what circumstances information might be shared, built into records as mandatory fields;
- Privacy safeguards and consents follow the data if shared with another provider;
- Providers have broad discretion to withhold information when disclosure could harm the patient; and
- Strong and enforceable penalties for violations of privacy and consents both in a clinical setting, and across information exchanges.

Some health systems are also exploring using online tools to manage reimbursement. If a technology platform is being used to manage payment, all participants–the DV/HT providers, the health center, and the platform itself–must work together to ensure that the tool is able to protect the confidentiality of the services to survivors and includes a robust consent process.

To facilitate and track a referral between a health care provider and the community-based organization, the state has developed an online community referral tool to provide real-time availability of services. NCCARE360, powered by Unite Us, provides hyper-local, closed-loop referrals between health care providers and DV and other community-based providers. Over time, NCCARE360 will track referrals and services delivered for the purpose of providing payment to DV advocates—becoming the first wide-scale payment mechanism between Medicaid and DV advocates.

Survivors benefit from NCCARE360 because they get a referral to a DV advocacy service (or other service) that has availability, providing the exact set of services needed and where there is real-time availability to accept clients. But to realize its potential for survivors, NCCARE360 had to engage in an ongoing conversation with DV service providers in the state who paused before committing to participation. There were deep concerns about the privacy and confidentiality of the information collected by the referral platform—and who could access it.

The Healthy Opportunities Pilot program and NCCARE360 platform are now live. State policymakers and DV advocates continue to work together to carefully monitor the implementation of this program to ensure that the privacy and confidentiality needs of survivors are met.

Considerations for Building Effective Referral Network Platforms to Engage DV/SA Programs

Developing meaningful partnerships between HCs and DV/SA programs is crucial to support survivors in every community.

Federal rules do not prohibit DV/SA programs from participating with the HC as part of a referral platform or being listed in a community referral platform, but DV/SA programs must be aware of the tool's privacy protections and investigate if the protections are consistent with internal practices, protocols, and funding requirements.

A memorandum of understanding between the HC and the DV/HT service organization can outline the expectations and responsibilities governing the use of the community referral platform. We offer an adaptable memorandum of understanding (MOU) in English and Spanish to formalize partnerships, and enrollment tools to support health care access

The National Quality Forum Leadership Consortium identified several key practices for using digital platforms to connect patients to referral networks and resources:

- Evaluate digital literacy levels of both patients and care teams to reduce the risk of barriers to engagement;
- Improve communication by discussing post-discharge plans and establish patient preferences and care goals;
- Use alternative communication platforms (e.g., secure digital messaging) to allow for multiple avenues to connect with patients and share referral networks and resources;
- Regularly review and revise communication language and survey tactics to optimize patient engagement;
- Identify opportunities to mitigate barriers for patients with limited English proficiency using translation tools within the digital platform;
- Use digital platforms for patients able to manage their own health, and prioritize human resources for complex patients;
- When possible, create warm hand-offs to case managers outside HC settings;
- Give patients resources tailored to their needs rather than general catalogs of information; and,
- Capture direct patient feedback to assess their engagement with referrals and identify improvement opportunities.

It is also important to consider possible unintended consequences of referral networks particularly, as they expand to include new types of partners. In these cases, transparency about who has access to information, how it can be shared, and the possible consequences is critical for the survivor and their family and limiting that information to only the minimum required to receive services is paramount.

Listed below are some of the questions that should be considered as HCs consider participation or partnership with DV/SA programs that leverage a Social Service Referral organization (SSRO). In addition, local DV/HT service providers or DV/HT coalition staff may be able to help a HC better understand which services and tools are trusted in the community.

Overarching Question	Key Consideration	Details
What benefit does the tool have for survivors?	The SSRO should add value to *the survivor* by facilitating their (and/or their providers') ability to find and access local, appropriate and available services.	What is the tool trying to achieve and who is the target audience? Is it designed to help health care providers make stronger links to CBOs? Or to help individuals find local resources?
		Who is the tool designed for—and who uses it? • The staff of a single CBO? In other words, would an organization use the software as a client management tool? • Individuals who log in to get referrals for themselves or their family members? • A network of health care and community-based partners?
		How does the tool make the referral and help ensure that a survivor gets access to the services they need?
Does the tool help link survivors with the services they need?	Survivors benefit from referrals from the health care system to DV advocates who are healing-centered, experienced, and able to meet their needs.	What information does the tool list about the services available and how does it make the referral?
		What are the criteria for a service provider to be listed in the network, and how can it highlight the providers who are trained in healing-centered care?
		How robust is the network in the region and who are the other participating providers?

Overarching Question	Key Consideration	Details
		What is the vetting process for participating organizations—and how does the tool guarantee quality?
Who participates in the network of providers?	Survivors may benefit from a referral to a local DV service provider—but it is important that the network comprise of high-quality providers.	How are the DV service providers in the referral system vetted? What qualifications and/or credentials are required to ensure that all participating providers are high-quality?
		How do participating providers document the services they provide and how is quality assessed?
		Is there a measure of consumer satisfaction after a referral so that the SSRO can better target referrals?
		Is it possible to ensure that the network of providers is healing-centered and can provide appropriate care for survivors of DV/SA?
		Under what circumstances would an SSRO remove an underperforming or low-quality provider from its network?
		Will child welfare agencies or law enforcement be included in the network? Will caseworkers be able to see individual's information, or will they only be able to input information?
Who will be using the tool—and to what end?	Providers and CBOs may use the tool to help connect survivors to local, available services.	Who will be using the tool? Is it designed for use by health care providers and CBOs? Or are there other individuals who can be users of the tool?

Overarching Question	Key Consideration	Details
		Who pays for the tool? For example, is the tool used by a hospital to support the health of the whole community?
How does the tool protect client privacy?	SSRO policy and practice surrounding the use and disclosure of health information should respect patient autonomy and confidentiality while trying to improve the safety and health status of a patient.	Does the patient receive an explanation of how their health information is used, shared, disclosed, including specific notification of the limits of confidentiality? How much information is collected about the survivor to make the referral? What information is mandatory?
		How are patients made aware of their rights to access, correct, amend, and supplement their own health information and is it simple to change those preferences through the SSRO's platform?
		Do the privacy safeguards and consents follow the survivor's data when it is shared with another provider in the network?
		How and when is personal and sensitive health information de-identified and under what circumstances would personally identifiable information be shared— and with whom?
		Does the SSRO offer and respect patients' choice of communication preferences, including by phone, by email, and under what circumstances? How is this protected?
		Are there strong and enforceable penalties for violations of privacy and consents both in a clinical setting, and across information exchanges?

Overarching Question	Key Consideration	Details
Are survivors considered a "sensitive" population within the SSRO?	Health care platforms often provide an additional layer or privacy for individuals with sensitive health conditions, such as HIV or substance use disorders. Survivors of DV should always be considered a sensitive population and have their information safeguarded.	If an individual discloses DV/HT, how is that information noted in the tool? What information is collected? How is it documented?
		Are there safeguards in place for survivors and other individuals with sensitive health conditions?
		Who is able to access the information of an individual with a sensitive health condition and under what circumstances? What information is shared?
		What data will be accessible to users beyond the provider sending the referral—and the user who receives the referral?
		What filters are used to ensure that sensitive information is always redacted (e.g., are keywords used to safeguard open note fields if sensitive phrases are used)?
How does the survivor maintain control over their health information?	Survivors need to have control over how, when, and with whom health information is shared.	How can the survivor maintain control over what information is put into the database?
		What is the process for giving consent to collect and share information—and how can a survivor rescind the consent?

Overarching Question	Key Consideration	Details
What does the user (e.g., the provider) see when entering data?	Depending on its structure, the SSRO may provide prompts to its call center and/or cascading prompts online to collect/enter information.	What are the prompt questions that may generate a disclosure of DV/HT?
		How is the call center staff trained and/or what do the online prompts ask when there is disclosure of violence or abuse?
		If violence is disclosed, what happens in the online platform?
		What information is collected and/or is additional information shared with the survivor (e.g., limits of confidentiality)?
What does the CBO get for participating in the network?	When participating with an SSRO, a CBO will be listed in directories and able to share accurate information about the services they provide. Some health systems are considering how to integrate payment to CBOs as part of the delivery system—and using the SSROs as a tool for payment.	How will the SSRO promote the CBO, and under what circumstances?
		Is there payment to the CBO for participation in the network?
		Is there an opportunity for a CBO to get paid for covered services if it documents the services delivered in the SSRO?
		What opportunities for sustainable funding or partnerships with funding organizations are available through the SSRO?

Overarching Question	Key Consideration	Details
What are the obligations/expectations of participating CBOs?	DV/SA advocates may increase their referrals and increase their reach to survivors by participating with an SSRO. However, it is important to understand the obligations and expectations.	What information does the CBO get from the referral platform in order to determine if they are able to serve the survivor?
		Is the tool a closed-loop referral that helps CBOs actively manage patients' referrals? Does the tool allow the referring entity to receive information back from the receiving organization? If so, what information is collected and who gets notified of the services rendered?
		How often will the CBO be required to update their information?
		What happens if the receiving organization doesn't have the space or capacity to handle the unique patient needs?
		What information will the CBO be required to report back to the SSRO? Will the CBO be required to provide information about the services delivered to a survivor? Who is able to see/access the information that the CBO includes?
What does participation in an SSRO mean for internal staffing?	DV programs may need additional staffing to manage and coordinate participation with the SSRO. DV service providers may see an increase in referrals.	What staffing is needed to maintain the partnership with the SSRO? Does this staffing already exist internally or is additional training or skills needed?

Listed below are some of the questions for NCCARE360 raised by DV programs to better understand how survivors' information was handled. While specific to this situation, they provide a framework for HCs and DV/HT programs as they consider participating with a community referral tool.

The concerns and conversations around the platform include:

- **Who is using the tool and how will they use the information?**
  Specifically, DV providers needed to understand who can view a client's personal health information—and how broadly the information can be accessed. In NC, any health care provider or individual can log in and initiate a referral. One use case that came up in discussions is a story about a hairdresser who has an account with NCCARE360 to connect clients who are food insecure with resources. By allowing him to initiate a referral on NCCARE360, the State hopes to broaden where and how people get connected to services. However, this type of access can provide a risk to survivors if all users can see all personal information. In this case, while anyone can initiate a referral, there are safeguards around who can see other health information.

- **Are survivors of DV considered a "sensitive population" within the platform?**
  There are concerns about the ability to fully protect survivor privacy and confidentiality. A patient's record in NCCARE360 can be seen by the referring provider and the receiving provider. A health care provider in the system may be able to access the client's whole record however because they are part of the health care system utilizing the tool. If a client specifically discloses DV, their record is put behind a firewall where only certain people will be able to see it. Clients cannot proactively request that their information is deemed "sensitive".

- **Who is able to see information behind the firewall, and under what circumstances?**
  If a client does not explicitly disclose violence, or if the user doesn't code the record appropriately, the client might not be entered as a sensitive client. If this is the case, the client's record would not be hidden. A user may be able to infer from the record that the client has experienced violence.

- **How does the tool handle references to DV put in an "open notes" field?**
  Users of the tool would need to be highly trained to never input references to disclosures of violence in open fields—or the tool needs to recognize that references to violence should be automatically flagged as sensitive.

- **Can a survivor revoke their consent to participate in NCCARE360?**
  Clients must consent to participate in NCCARE360 before their information is collected and shared. However, it is possible, but challenging to rescind the consent. Clients do not have access to their own information (no direct client interface) and would need to work with a provider to revoke the consent.

- **Can limited consent be provided?**
  For example, can a survivor designate specific providers who are, or are not permitted to view their files? At this time, there is no ability to give limited consent for who is able to access a client profile. Clients are not able to allow specific providers to view their information—or to block certain providers from accessing their information.

- **How will staff be trained to protect sensitive information?**
  Training is provided on how to use the tool and how to place sensitive information behind a firewall (and not in open notes). It is appropriate for the referral platform to share detailed plans about how it will train staff and others using their tool to support survivors. Staff need training on how to input data and to ensure that individuals experiencing violence are deemed "sensitive" and that their information is behind a firewall. For referring organizations, training on how to complete a referral in a sensitive manner will be important.

- **What information is required to "close the loop"?**
  NCCARE360 requires receiving organizations (the organization to whom the referral is made) to "close the loop". This means that the receiving organization would report back that they have accepted the referral and would provide information about what service they delivered. Sharing information is permissible under federal VAWA and FVPSA rules so long as the patient provides informed consent. If patient does not provide consent, there is an option for the CBO to indicate whether any follow up is needed without disclosing whether they are serving the client.

Key Resources

- Health Partners on IPV + Exploitation works with HCs to support those at risk of experiencing or surviving intimate partner violence, human trafficking, or exploitation and to bolster prevention efforts. Learn more here
- Adaptable Health Center Protocol on IPV/HT/E
- Sample Memorandum of Understanding
- Partnerships Between Health Centers and Domestic and Sexual Violence Advocacy Programs (Bi-directional Infographic). Learn more here

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HEALTH PARTNERS ON IPV + EXPLOITATION

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