Policy Memo

Evaluating Social Service Referral Platforms: Considerations for Domestic and Sexual Violence Referrals

July, 2022

It is becoming increasingly common for health care settings to respond to the non-medial, social needs of their patients, such as for housing or food insecurity and as part of that work increasingly addressing domestic violence. Health care providers now have access to a range of tools, including online supported referral and coordination platforms, sometimes called Social Service Referral Organizations (SSRO).

The SSROs help providers to connect patients with the help they need, including referrals to local supports and feedback loops to double check if their patients receive the help they need. For example, a provider may use an online tool that can give a targeted list of food pantries to patients experiencing food insecurity—and prompt follow up to make sure the connections were made. This can provide real value to survivors of DV/SA, helping to connect them to the services they need in real time and building trust with their health care providers.

Practice and policy have also evolved to strengthen linkages between health care providers and community-based DV/SA service providers. A solid partnership between a provider and a DV/SA service provider is the most effective solution because it leads to a warm referral—where the health care provider knows the DV/SA service providers and makes a personal referral. But online tools can also play an important role in building or supporting partnership between health and DV/SA providers, and in helping to coordinate care. If DV/SA programs are in the network of online referral networks, health care providers may be better able to support survivors and connect them to the support they need. This is a desirable outcome and one that would help providers and benefit survivors.

Some health systems are also exploring using online tools to manage reimbursement. This may include paying community-based DV/SA organizations for the services they deliver as part of the patient's care team. If an SSRO is being used to manage payment, DV/SA providers, the SSRO and/or health system using it 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.

Participation with SSROs may be desirable for DV/SA services providers and help build stronger connections with health care providers. It could lead to an increase in appropriate referrals for the DV/SA providers. However, it is important to consider the staffing implications for both the increase in referrals as well as the staff needed to monitor and participate in these programs.

Concerns exist about these emerging tools, including about the privacy and confidentiality of sensitive health care information. Survivors may be considering:

- What is written into 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?

It is critical that SSROs and other online tools explicitly address these unique privacy concerns when developing their platforms in order to ensure the safety and wellbeing of survivors. This should be done in advance of deploying the tool. At the same time, DV/SA service providers and DV/SA coalitions who are considering working with SSROs should ask questions about the tools and its network to better understand the role it can play in supporting survivors' needs while safeguarding their privacy and confidentiality.

What is a Social Service Referral Organization (SSRO)?

SSROs provide linkages and referrals to local social service providers, including food and nutrition, housing, transportation, and other non-medical supports. Increasingly, SSROs are interested in including DV/SA service providers as part of their networks to help health care providers locate, and survivors' access, local services.

There are many different types of SSROs, and many different models for how the referral networks work. Some SSROs operate 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 some models, CBOs actively participate in the SSROs network, providing real-time updates to about availability of the services offered and current capacity. Other SSROs have case managers who work as an intermediary between a health care provider and the CBO to do referrals and ensure a feedback loop so they know the patient received the help they need. Some SSROs are designed to be an integrated component of an electronic health record for use during a health care visit.

From the point of view of a survivor, a robust network that provides deep community expertise can help them connect with the services they need. For example, a health care provider could refer a survivor to a DV advocacy program that can provide immediate safety planning but also to food and housing supports. That health care provider will be able to learn from the platform which DV program has immediate capacity that fits the survivor's unique needs—and to facilitate that referral. The health care provider can indicate in the tool that the survivor has been offered resources—and track any necessary follow up to ensure the patient is getting the help they need. What's more, other members of the survivor's care team will know what services have been made available. This has great potential to streamline help, to build partnerships and facilitate warm referrals, and to provide more holistic, coordinated care to support both the health care and non-medical needs of a survivor.

From the point of view of the DV/SA community-based organization, the SSROs can play a vital role in building partnerships with the health care system and help manage a holistic set of services for the survivor. As these partnerships increase, there may be opportunities for sustained funding from the health care organization to the CBO. One promising example of this is North Carolina's Healthy Opportunity Pilot, where CBOs, explicitly including DV/SA service organizations, will be paid by the state Medicaid agency for providing non-medical services to survivors of IPV. One implemented, the delivery of the services will be coordinated by—and eventually paid through—the coordinated SSRO platform.

That said, there are some real concerns about how the SSROs collect and share data, who has access to this information, and about the strength of the network of DV service providers. [For more information about privacy and confidentiality in health information technology, read our privacy principles]. For patients who are experiencing DV/SA, this is not just an issue of privacy but also one of safety. 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.

- Patients should receive an explanation of how health information is used, shared disclosed, including specific notification of the limits of confidentiality;
- Patients should be made aware of their rights to access, correct, amend, and supplement their own health information;
- Personal and sensitive health information should be de-identified whenever possible;
- Providers must offer and respect patients' choice of communication preferences, including by phone, by email, etc., and under what circumstances. This should be built in to records as mandatory fields;
- Privacy safeguards and consents should follow the data if it is shared with another provider;
- Providers should have broad discretion to withhold information when disclosure could harm the patient;
- There should be strong and enforceable penalties for violations of privacy and consents both in a clinical setting, and across information exchanges.

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. Individuals must receive notice of how their health information is collected, used, and the circumstances under which it could be shared. Individuals must give consent for this information to be collected and used, and the consent must be revocable.

Health care providers and CBOs must understand how an SSRO documents, tracks and shares information: what is being documented; how it is being documented; why it is being documented; circumstances under which the information could be shared; and who will have access to this information. While there are no federal rules that would prohibit a DV/SA service organization from participating with the health care system or being listed in an SSRO's network, they must understand if and how the tool's protections are consistent with their internal practices and protocols and funding requirements. Special attention should be given to how an SSROs consent forms align with the providers' consent process.

It is also important to consider possible unintended consequences of a highly-networked care team. For example, some SSROs have expressed interest in including child welfare agencies in their network to support families with children who need services. While this is a laudable goal, there are potential ramifications of allowing child welfare caseworkers full access to a family record. For example, what if the parent or caregiver has received a referral for services related to DV. Could the caseworker use that information against the parent – arguing that exposure to domestic violence is a risk to the child? What are the ramifications of that information in states with mandatory reporting laws to law enforcement or CPS? Consider restricting sections of record when a caseworker inputs information that may benefit the child and their family. 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.

As DV/SA service providers consider participation in or partnership with a SSRO, there are several questions and considerations about the tool, the network and the privacy of survivor health information that must be answered. Listed below are some of the questions that a DV/SA provider should consider when making decisions about their participation. In addition, local DV service providers or DV coalition staff may be able to help 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 *<u>to the survivor</u>* 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 community-based organization? 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 service providers who are trauma-informed, 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 demonstrate the providers who are trained in trauma-informed care?
		How robust is the network in the region and who are the other participating providers?
		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 trauma-informed 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 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?
		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	Does the patient receive an explanation of how their

	use and disclosure of health information should respect patient autonomy and confidentiality while trying to improve the safety and health status of a patient.	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 it is 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 who?
		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?
Are survivors considered a "sensitive" population within the SSRO?	Health care platforms often provide an additional layer or privacy	If an individual discloses DV, how is that information noted in the tool? What information

	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.	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? For example, 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?
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	What are the prompt questions that may generate a disclosure of DV?

	prompts online to collect/enter information.	
		How is the call center staff trained and/or what do the online prompts ask when there is disclosure of violence?
		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 in the SSRO the services delivered?
		What opportunities for sustainable funding or partnerships with funding organizations are available through the SSRO?
What are the obligations/expectations of participating CBOs?	DV service providers may increase their referrals and increase their reach to survivors by participating with an SSRO. However, it is important to understand	What information does the CBO get from the referral platform in order to determine if they are able to serve the survivor?

	the obligations and expectations.	
		Is the tool a closed-loop referral that helps more actively manage the referrals of the patients and gets/collects information back from the receiving organization? If so, what information is collected and who gets notified of the receipt of services.
		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?

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