

Oregon Guide to Health Care Partnerships

For community-based organizations and advocates supporting survivors of domestic violence in health care settings





Oregon Coalition

Against Domestic & Sexual Violence

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Oregon Safer Futures at the National Conference on Health and Domestic Violence in Washington D.C., on March 21, 2015. Pictured left to right: Melanie Prummer, Nicole Bennett, Christine Heyen, Myste French, Anna Williams, Sami Gloria, Courtney Gallant, Mercedes Hill.

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- ▶ Bradley Angle
- ▶ Call to Safety
- ▶ Center for Hope & Safety
- ▶ Clackamas Women’s Services
- ▶ Domestic Violence Resource Center
- ▶ HAVEN from Domestic and Sexual Violence
- ▶ Health Share CCO
- ▶ Illinois Coalition Against Domestic Violence
- ▶ Leading Edge Public Affairs
- ▶ Legal Aid Services of Oregon
- ▶ Multnomah County Domestic Violence Coordination Office
- ▶ Oregon Department of Justice Crime Victims’ Services Division
- ▶ Oregon Health Authority Public Health Division
- ▶ Oregon Law Center
- ▶ Partnership for Safety and Justice
- ▶ Raphael House of Portland
- ▶ Tillamook County Women’s Resource Center
- ▶ Victim Rights Law Center
- ▶ Volunteers of America Home Free
- ▶ Womenspace

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EXECUTIVE SUMMARY

Safer Futures is a practice and partnership model that benefits survivors of intimate partner violence. This model demonstrates how community-based, non-clinical domestic and sexual violence (D/SV) intervention advocates can better serve survivors of intimate partner violence (IPV) in partnership with health care providers. Such partnerships strengthen services for survivors of IPV in various health care settings including, but not limited to, public health departments, Federally Qualified Health Centers, primary care clinics, and hospitals.

Partnerships between advocates and health care providers improve IPV survivors' access to health care, advocacy services, resources and support. The model works best when a health care provider refers patients in need of IPV-specific support and services to an advocate, who may provide services on-site in the clinic setting and/or off-site in community-based settings. Studies show that partnerships between health care providers and advocates increase survivors' access to health care information, including information about healthy relationships that can prevent violence from occurring. Most significantly, such partnerships help survivors access care that improves their overall safety and well-being.

Over 1 in 3 women (37%) and 1 in 3 men (34%) in Oregon report having experienced rape, physical violence and/or stalking by an intimate partner at some point in their lifetime.¹ This data is presumed to represent only cisgender women and men; further research into experiences of transgender and non-binary people is needed.

According to the Centers for Disease Control and Prevention (CDC), women who have experienced domestic violence are 80% more likely to have a stroke, 70% more likely to have heart disease, 60% more likely to have asthma and 70% more likely to drink heavily than women who have not experienced IPV.² Fifty three percent of women aged 16-29 in family planning clinics reported physical or sexual violence from an intimate partner.³ Similar findings specific to Oregon were reported by a University of Pittsburgh-led

survey at an Oregon coastal clinic in 2016: over half the clinic's population identified a history of IPV.⁴

These health effects have severe costs to the system beyond the human toll of violence. A 2009 study of more than 3,000 women from a large Pacific Northwest-based health plan found that health care costs for women suffering ongoing abuse were 42% higher than for women who were not abused.⁵ Health care costs remained higher even when the abuse was over.⁶ Women who suffered physical abuse five or more years earlier had health care costs that were 19% higher than costs for women who were never abused.⁷

Given the prevalence, health effects, and costs, it is critical that D/SV intervention programs and health care systems partner to better serve survivors of IPV. The *Safer Futures* model of partnerships between advocates and providers is recent to Oregon and made possible through Pregnancy Assistance Fund Grant #1SP1AH00019 from the Office of Adolescent Health, U.S. Department of Human Services. From 2013 to 2017, the Oregon Department of Justice, Crime Victims' Services Division administered this federal grant using the title *Safer Futures*. Its focus was to serve pregnant and newly parenting women who were survivors of IPV in diverse health care settings across the state of Oregon.

The aim of the *Oregon Guide to Health Care Partnerships* is to support D/SV organizations in replicating the *Safer Futures* model with health care systems. The *Safer Futures* model evolved to improve services for survivors of IPV while also helping health care systems improve health outcomes for survivors, improve quality of patient care, and reduce overall health system costs through partnership with community-based advocates. This *Guide* provides practical recommendations, supportive literature, and program experiences to help D/SV organizations successfully place, support, evaluate, and finance advocates in health care settings.

1. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR (2011). The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf.

2. Centers for Disease Control and Prevention. Adverse health conditions and health risk behaviors associated with intimate partner violence--United States (2005). PsycEXTRA Dataset. doi:10.1037/e410562008-001.

3. Miller E, Decker MR, Mccauley HL, Tancredi DJ, Levenson RR, Waldman J, Silverman JG (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322. doi:10.1016/j.contraception.2009.12.004.

4. Tillamook County Women's Resource Center 2016 Evaluation of *Safer Futures* Project, <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>.

5. Bonomi AE, Anderson ML, Rivara FP, Thompson RS (2009). Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research*, 44(3), 1052-1067. doi:10.1111/j.1475-6773.2009.00955.x.

6. Ibid.

7. Ibid.

SECTION 1: INTRODUCTION

About the *Oregon Guide to Health Care Partnerships*



The *Oregon Guide to Health Care Partnerships* is a resource for community-based D/SV intervention organizations to support advocacy responses in health care settings. This *Guide* builds on the experience of D/SV organizations under the *Safer Futures* project. From 2013 to 2017, Oregon received over \$1 million annually through Pregnancy Assistance Fund (PAF) Grant #1SP1AH000019 from the Office of Adolescent Health, U.S. Department of Health and Human Services. These funds were administered by the Oregon Department of Justice Crime Victims' Services Division. Christine Heyen, MA, was the Grant Fund Coordinator for the project. The Oregon PAF grant award was titled: "*Safer Futures Funding: Interventions in Child Welfare, Public Health and Local Health Care Systems for Pregnant and Parenting Women Who are Victims of Intimate Partner Violence.*"

This *Guide* also draws from the experience of past D/SV and health care system integration projects from 2012 to the present. These include the Oregon Coalition Against Domestic & Sexual Violence (OCADSV) interdisciplinary IPV & Health Care Workgroup (2012-2015), the Oregon Health Authority's *Project Connect* (2012-2015), and independent OCADSV member program projects designed to address the intersection of health and domestic violence. This *Oregon Guide to Health Care Partnerships* is a project of OCADSV, funded by *Safer Futures*.

THIS SECTION INCLUDES:

- ▶ Overview of the *Safer Futures* model P. 8
- ▶ Supportive theories..... P. 8
- ▶ Considerations for implementing health care partnerships..... P. 9
- ▶ About *Project Connect*..... P.10
- ▶ Oregon Coalition Against Domestic & Sexual Violence..... P. 11

ABOUT SAFER FUTURES

VISION:

Safety and well-being for all pregnant and newly parenting women.

MISSION:

To reach pregnant and newly parenting women who are survivors of IPV through partnerships with child welfare, public health and local health care systems.

For Oregon, this was a large multi-year project which began in 2013 and ended in September of 2017.

The health care cohort included work with survivors of IPV at the following locations:

- ▶ Battered Persons’ Advocacy – Roseburg, OR
- ▶ HAVEN from Domestic and Sexual Violence – The Dalles, OR
- ▶ Tillamook County Women’s Resource Center – Tillamook, OR
- ▶ Volunteers of America, Home Free – Portland, OR
- ▶ Women’s Crisis Support Team – Grants Pass, OR

THE SAFER FUTURES MODEL

Safer Futures supports on-site advocacy interventions in a variety of settings for pregnant and newly parenting cisgender women who are victims of intimate partner violence. *Safer Futures* and Oregon Department of Justice supported two cohorts during the grant period: one in child welfare and one in health care. This *Guide* is solely focused on the deep learning accomplished by the health care cohort.

Safer Futures is a comprehensive intervention dedicated to serving pregnant and newly parenting cisgender women survivors of IPV in Oregon. *Safer Futures* serves as a model for partnerships between community-based domestic and sexual violence (D/SV) organizations, health care providers and health care systems. Because this *Guide* is based in *Safer Futures* work, it specifically draws from research in the women’s health field pertaining to IPV. This gender specificity is supported by research that suggests women who are experiencing IPV are at significant risk of serious injury or death, and that IPV is the leading cause of maternal mortality in the United States.⁸

The five *Safer Futures* health care cohort project sites partnered with public health clinics, Federally Qualified Health Centers, Title X family planning clinics, Tribal health and wellness centers, midwifery coalitions, addiction and recovery organizations, primary care, and other types of health centers.

Each project implemented three main strategies:

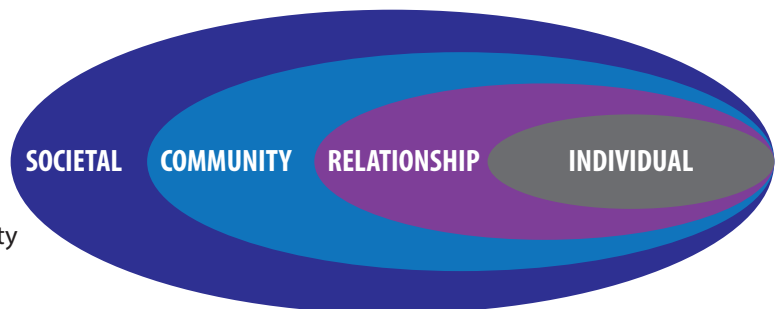
1. Intervention, accompaniment, and supportive services provided to survivors of IPV;
2. Case consultation, provider training, and technical assistance provided to health care partners; and
3. Capacity building to sustain the *Safer Futures* model beyond the grant funding.

These strategies were led by at least two FTE staff at each site, including:

1. On-site Advocate
 - a. Provided intervention, accompaniment and supportive services
 - b. Provided case consultation
2. Training and Partnership Development Coordinator
 - a. Provided training and technical assistance
 - b. Developed organizational capacity for effective IPV services in partnership with health care systems
 - c. Helped to create partnerships and collaborations, and promoted the role of the advocate to health care providers

SUPPORTIVE THEORIES

The collaborative work of the Advocate and the Training Coordinator is informed by the Social Ecological Model. According to the Centers for Disease Control and Prevention (CDC), the Social Ecological Model (or SEM) “considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.”⁹



SOCIAL ECOLOGICAL MODEL (OR SEM)

8. Chang J, Berg CJ, Saltzman LE, Herndon J (2005). Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991–1999. *American Journal of Public Health*, 95(3), 471–477. doi:10.2105/ajph.2003.029868.

9. Violence Prevention (2015, March 25). Retrieved January 02, 2018, from <https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>.

The SEM illustrates that, in order to effectively prevent and respond to violence, it is necessary to engage at each of these overlapping levels. The *Safer Futures* model recognizes that a sole focus on individual-level behavior change is ineffective and potentially dangerous. Therefore, the *Safer Futures* model operates across social levels, specific to the community setting in which the survivor is located.

Safer Futures also draws from a D/SV advocacy model, emphasizing empowerment-based intervention that works **with** survivors to address their health and safety needs. Community-based D/SV advocacy services seek to address the “social and structural determinants of intimate partner violence,” as led by the survivor on their self-identified path towards health, safety and well-being.¹⁰

Safer Futures sites report the need for extensive education with health care providers on the role of advocates as well as how advocacy benefits survivors of IPV. When initiating partnerships with health care, it is important to discuss a **Theory of Change** for the advocacy intervention. This is in part because the word “advocate” may have negative connotations in some health care systems due to common conceptions of lobbying and law.

A Theory of Change is “the thinking behind how a particular intervention will bring about results.”¹¹ A sample outreach tool to communicate the *Safer Futures* advocacy model Theory of Change is included in the Appendix, page 62 (“*Safer Futures* Model Summary”).

Safer Futures operates within and across four levels: participant, provider, program and policy. The first level focuses on the participant — that is survivors and their children experiencing IPV. The next level considers the role of health care providers in promoting the safety and well-being of survivors. The remaining two levels address programs, organizations and system-wide policy change. Each level includes primary prevention of IPV, effective interventions that improve survivor health and safety, increases in

organizational capacity, and long-term system change and structural sustainability.

Sustainability planning is woven into the *Safer Futures* model. Thus, the Oregon Department of Justice, OCADSV, and the *Safer Futures* project sites have partnered to produce this *Guide* and commit to ongoing investment in the intervention. For more information about *Safer Futures* and its full Sustainability Plan document, please visit the Oregon Department of Justice’s Crime Victims’ Services Division website: https://www.doj.state.or.us/wp-content/uploads/2017/06/safer_futures_sustainability_plan.pdf

CONSIDERATIONS FOR IMPLEMENTING HEALTH CARE PARTNERSHIPS

From 2013 to 2017, the pilot implementation of *Safer Futures* in five health care cohort sites evolved from its original design. This evolution was necessary as the *Safer Futures* model was adapted to meet the demands of a rapidly changing health care system. *Safer Futures* sites and their health care partners continuously improved the quality of the project model and the advocacy services based on evaluation findings.

Moving forward into 2018 and beyond, OCADSV and the Oregon Department of Justice recommend the following implementation considerations:

- ▶ Although *Safer Futures* was designed to respond to the needs of pregnant and newly parenting women, the *Safer Futures* model may be used to serve other populations of survivors of IPV.
- ▶ Originally, the screening and assessment model for health care providers was left to the discretion of each participating *Safer Futures* project site. However, all *Safer Futures* sites adopted a “universal education-based screening” (described further under *Project Connect* on next page), and in Section 4, pages 32-34) as developed by Futures Without Violence.
- ▶ Finally, *Safer Futures* project sites maintained flexibility with their on-site advocacy services in order to be responsive to health care partner needs. Thus, there is no standardization in placement or structure for how an advocate works in the clinic setting. This differs from D/SV co-located advocate projects found in DHS Child Welfare and Self Sufficiency Programs.

Beyond the *Safer Futures* model, there are further considerations for D/SV organizations consulting this *Guide*. While community-based D/SV organizations often use the terms IPV and domestic violence interchangeably,

10. Mehrotra GR, Kimball E, Wahab S, Koncikowski J (2016). The Braid That Binds Us: The Impact of Neoliberalism, Criminalization, and Professionalization on Domestic Violence Work. *Affilia* vol. 31 no. 2 153-163.

11. Bullen PB (2014). Theory of Change vs Logical Framework – what’s the difference? Retrieved from: <http://www.tools4dev.org/resources/theory-of-change-vs-logical-framework-whats-the-difference-in-practice/>.

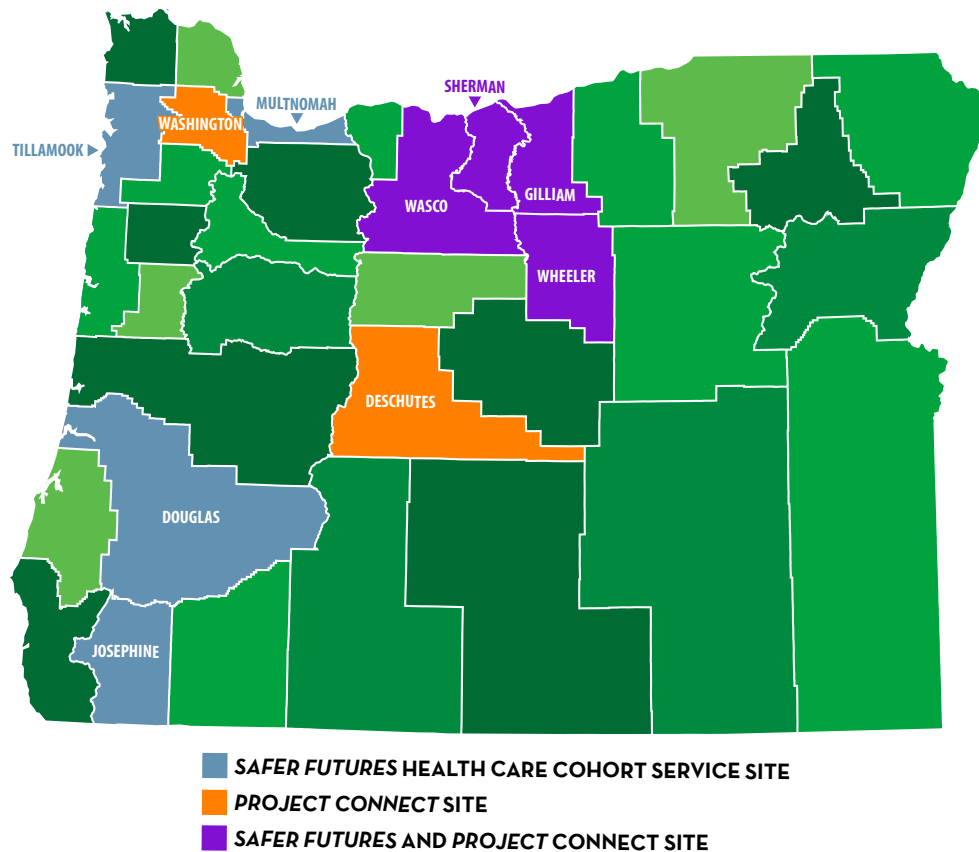
in the context of health care interventions IPV is the preferred term. And while there are commonalities between IPV and sexual violence interventions, sexual violence interventions are a distinct body of work. (Most OCADSV member programs are dual D/SV organizations.)

From a D/SV movement perspective, *Safer Futures* work represents a significant limitation in that it focuses exclusively on pregnant and newly parenting cisgender women who are survivors or victims of IPV. This focus excludes survivors who are not cisgender women; even some people who are pregnant/newly parenting are not women. Survivors who are transgender and gender non-conforming often face the greatest barriers to supportive health care and social services,¹² and experience high rates of depression, anxiety, trauma, toxic stress, and suicide.¹³ D/SV affects people of all genders, and everyone has the right to live healthy lives free from sexual, domestic and other forms of gender-based violence. Gender essentialism, the gender binary, and heteronormativity limit the movement’s ability to provide gender-inclusive services. The D/SV field, and health care partnerships, can grow stronger and more effective by expanding trans-inclusion.¹⁴

ABOUT PROJECT CONNECT

Oregon *Project Connect* was a grant funded from 2012 to 2015 through the Futures Without Violence *Project Connect* 2.0 initiative, from the Office on Women’s Health of the U.S. Department of Health and Human Services, made possible through the Violence Against Women Reauthorization Act of 2005. It was administered by the Public Health Division of the Oregon Health Authority. Julie McFarlane, MPH, led the project in partnership with OCADSV, public health family planning clinics, and select D/SV organizations.

The Oregon Health Authority (OHA) implemented *Project Connect* to prevent and respond to intimate partner violence through partnerships between local public health departments and D/SV organizations. Nationwide, *Project Connect* was extensively evaluated, and trained over 7,000 health care providers to assess for and respond to domestic and sexual violence in over 80 clinical settings. *Project Connect* uses the Futures Without Violence CUES intervention (Confidentiality, Universal Education, Support; see pages 32-34) which is the preferred screening and referral pathway for *Safer Futures* sites.



12. Domestic Violence in the Transgender Community. (2017, May 31). Retrieved January 02, 2018, from <https://nomore.org/domestic-violence-transgender-community/>.
 13. NAML. (n.d.). Retrieved January 02, 2018, from <https://www.nami.org/Find-Support/LGBTQ>.
 14. Advancing Gender-Inclusive Services. (2017, September 29). Retrieved January 02, 2018, from <https://www.ocadsv.org/blog/advancing-gender-inclusive-services>.



In Oregon, *Project Connect* sought to improve health care screening and response to IPV and reproductive coercion by integrating IPV screening and advocacy services in reproductive health clinics in three pilot communities, in partnership with D/SA organizations: Domestic Violence Resource Center (Hillsboro), HAVEN From Domestic and Sexual Violence (The Dalles), and Saving Grace (Bend). Training was provided to family planning clinic and D/SV organization staff for IPV screening and to support a “warm hand-off” in cases where reproductive health patients disclosed IPV. In addition, *Project Connect* supported Saving Grace to improve reproductive health access for survivors in shelter by funding on-site services by a partner nurse.

Project Connect trained participating public health clinics on the Futures Without Violence CUES intervention. *Project Connect* helped the Oregon Health Authority to develop stronger statewide policy for IPV screening in Title V Maternal and Child Health Services Block Grant programs throughout Oregon. After implementation of *Project Connect* and improved Oregon Health Authority policies and protocols in public health, the percentage of family planning visits where relationship safety was discussed significantly increased. The year 2013 saw an increase from 12.4%

of family planning visits including IPV screening to 35.2%. In 2015, 47.1% of family planning visits reported discussing relationship safety — a 34.7% increase statewide overall in IPV screening by public health.¹⁵

ABOUT THE OREGON COALITION AGAINST DOMESTIC & SEXUAL VIOLENCE

This *Guide* is organized and published by OCADSV. OCADSV promotes equity and social change in order to end violence for all communities. Its mission is to transform society by engaging diverse voices, supporting the self-determination of survivors and providing leadership for advocacy efforts. OCADSV is a statewide membership organization, representing 48 domestic and sexual violence prevention and intervention organizations. Members are community-based nonprofits and represent every county in the State of Oregon as well as several Tribal nations.

In order to improve survivor safety, health and self-determination, OCADSV is committed to supporting partnerships between community-based D/SV organizations and health care systems. Among other services, OCADSV provides technical assistance to member programs at the intersection of health and IPV. Connect to support and other resources at health.ocadsv.org.

15. Oregon Health Authority, Public Health Division, Oregon *Project Connect* report to Futures Without Violence 2015.

SECTION 2: SURVIVOR HEALTH NEEDS

A complex web of social determinants of health (including racism and intimate partner violence) has created historical and still-existing health effects and barriers to care. Oregon’s D/SV organizations and health care systems are charged with responding in ways that promote survivor health and safety.

Extensive evidence in the literature links intimate partner violence (IPV) to severe and ongoing health effects for survivors,¹⁶ and identifies it as a key social determinant of health.¹⁷ The impacts of IPV on survivor health are particularly significant for those who are pregnant and newly parenting; pregnancy-related problems, such as prenatal fetal injury, low weight gain, and infections, are notably higher for abused women.¹⁸ Racism is also recognized as a social determinant of health.¹⁹ People from marginalized communities, particularly communities of color, experience disproportionate health impacts, and often encounter significant barriers to accessing health care and overall well-being.²⁰

A myriad of negative health outcomes translate to high costs for health care systems. A 2009 study of more than 3,000 women (ages 18-64) from a large health plan located in the Pacific Northwest found costs for women suffering ongoing abuse were 42% higher when compared with non-abused women.²¹

The prevalence of IPV is staggering. **In Oregon, over 1 in 3 women (37%) and 1 in 3 men (34%) reported having experienced rape, physical violence and/or stalking by an intimate partner at some point in their lifetime.**²² This data is presumed to represent only cisgender women and men; further research into experiences of transgender and non-binary people is needed. Adverse health effects exist for survivors from all demographic groups, regardless of gender or sexual orientation. While most information documented in the literature focuses on cisgender women, anyone can experience IPV, and everyone has the right to live healthy lives free from violence.

THIS SECTION WILL REVIEW:

- ▶ Social determinants of health..... P. 13
- ▶ Racial health disparities..... P. 13
- ▶ Trauma and Adverse Childhood Experiences..... P. 14
- ▶ Health effects of intimate partner violence P. 15
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16. Campbell JC (2002). Health consequences of intimate partner violence. *Lancet*, 359, 1331-1336.
 17. Injury and Violence Prevention. (n.d.). Retrieved January 08, 2018, from <https://www.healthypeople.gov/node/3497/objectives#4771>.
 18. Parker B, McFarlane J, Soeken K (1994). Abuse during pregnancy: Effects on maternal complications and birth weight in adult and teenage women. *Obstetrics & Gynecology*, 3, 323-328.
 19. Paradies Y, Priest N, Ben J, Truong M, Gupta A, Pieterse A, Gee G (2013). Racism as a determinant of health: a protocol for conducting a systematic review and meta-analysis. *Systematic Reviews*, 2(1). doi:10.1186/2046-4053-2-85.
 20. Racism and Health. (2017, November 02). Retrieved January 02, 2018, from <https://www.rwjf.org/en/library/collections/racism-and-health.html>.
 21. Bonomi AE, et al (2009). Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence.
 22. Black MC et al (2011). The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report.

SOCIAL DETERMINANTS OF HEALTH

The U.S. spends more on health care than any other country, yet has some of the poorest health outcomes of any comparable nation.²³ It ranks 43rd in average life expectancy from birth,²⁴ and among comparable countries has the highest rate of avoidable health care related deaths.²⁵ Several studies have tried to discern what helps a person live a healthy life. Many studies have found that it is not health care, but other factors, termed “social determinants of health.”

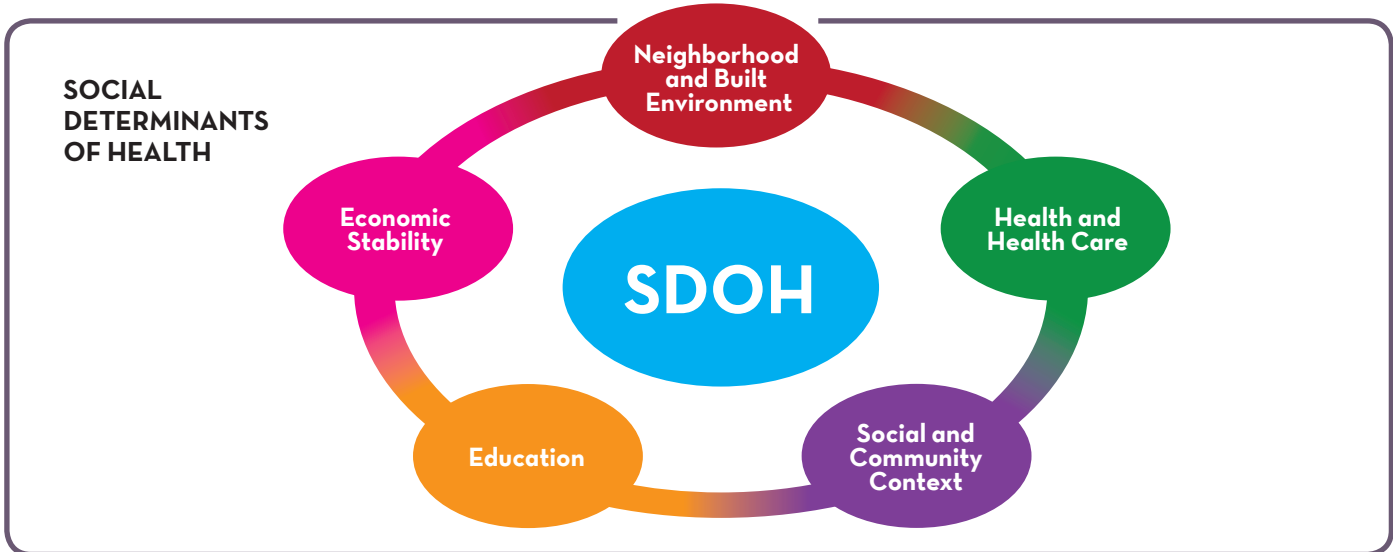
According to the World Health Organization (WHO), social determinants of health are the conditions (beyond direct medical experiences) within which people are born, grow, live, work and age.²⁶ These circumstances (such as income, education level, employment, working conditions, cultural experiences, family and intimate relationships, etc.) are shaped by the distribution of money, power and resources at global, national and local levels. These factors are interrelated, and cannot be addressed independently of one another. Based in theories of empowerment and an understanding of systemic oppression, D/SV advocacy can strengthen health care approaches to social determinants of health.

Intimate partner violence itself is recognized as a core social determinant of health.²⁷ In order to support patient and community health, and to reach their goal of better care at lower cost, Coordinated Care Organizations (and health care systems more broadly) can address IPV as a social determinant of health.

RACIAL HEALTH DISPARITIES

Health effects of IPV are compounded in communities of color in Oregon. In order to promote survivor safety, health and well-being, D/SV organizations and health care providers can become aware of health disparities (also known as health inequities), health needs, and barriers to accessing services for survivors of color.

According to the CDC, “Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.”²⁸



23. Brink S (2017, April 20). What Country Spends The Most (And Least) On Health Care Per Person? Retrieved January 02, 2018, from <https://www.npr.org/sections/goatsandsoda/2017/04/20/524774195/what-country-spends-the-most-and-least-on-health-care-per-person>.

24. COUNTRY COMPARISON :: LIFE EXPECTANCY AT BIRTH. (n.d.). Retrieved January 02, 2018, from <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html>.

25. How does the quality of the U.S. healthcare system compare to other countries? (n.d.). Retrieved January 02, 2018, from <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/#item-30-day-mortality-heart-attacks-ischemic-stroke-lower-u-s-comparable-countries>.

26. About social determinants of health. (n.d.). Retrieved January 02, 2018, from http://www.who.int/social_determinants/sdh_definition/en/.

27. Injury and Violence Prevention. (n.d.). Retrieved January 08, 2018, from <https://www.healthypeople.gov/node/3497/objectives#4771>.

28. Adolescent and School Health. (2015, September 01). Retrieved January 02, 2018, from <https://www.cdc.gov/healthyyouth/disparities/>.

Oregon ranks 20th among U.S. states for overall health.²⁹ However, for communities of color, Oregon is a “uniquely toxic place.”³⁰ Health disparities for African American, Native American, Latino and Asian communities — to varying degrees, and specific to each community — include disproportionate rates of teen pregnancy, HIV, asthma, diabetes, and lack and/or underutilization of prenatal care.^{31, 32, 33, 34}

These disparities are a key issue for health care and social service systems, in their treatment of populations accessing care. Because one in eight Oregonians is a person of color,³⁵ and people of color comprise 40% of the Oregon Health Plan client base,³⁶ Oregon policy has clearly indicated health equity as a priority for health care in Oregon (see Section 3, page 26 for information on Regional Health Equity Coalitions). Racial health disparities intersect with IPV, ACEs, reproductive and sexual health, and other impacts of trauma and abuse on survivors, as seen below.

TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

Health care settings in Oregon are investing in learning about the health effects of violence and other trauma. The most influential study in the field that highlighted the importance of trauma as a health risk is one that named violence, and other life experiences, under the umbrella term of “adverse childhood experiences,” or ACEs. It found that 12.7% of respondents reported witnessing their mother physically assaulted by her intimate partner.³⁷ This witnessing was one of the identified risk factors connected to life-long health effects leading to illness and early death.

This ACEs study has been replicated by many health care settings, and is an important field of study for supporting partnerships with health care organizations. *Safer Futures* site Battered Persons’ Advocacy in Roseburg, OR, has used the ACEs conversation as a leverage point for strengthening partnership work on behalf of survivors in Douglas County, Oregon.³⁸

HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE

It is imperative that advocates and health care providers work together in serving survivors, as violence, health and safety are related in complex and interlocking ways. Based on rates of violence, it is assumed that health care providers serve survivors of IPV every day. It is important to note that some service settings either encounter or identify a higher prevalence of IPV in their service population. For example, in a study of 1,278 women (ages 16-29) sampled in five family planning clinics in California, 53% reported physical or sexual violence from an intimate partner.³⁹

In Oregon, one Tillamook County *Safer Futures* partner clinic conducted a patient survey similar to the tool implemented in the California study. They found that over half of their patient population identified an occurrence of IPV at some point in life. Studies show that IPV prevalence rates in health care settings are often higher than health care providers realize.

The National Intimate Partner and Sexual Violence Survey (NISVS) referenced in table on page 15, illustrates health outcomes of IPV, rape and stalking. According to the CDC, the definition of IPV is broader than physical violence, and includes “sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner).”⁴⁰ This data highlights significantly higher rates of negative health outcomes for people who have experienced violence.

Relationship violence has well-documented direct health effects in the literature, with a 1997 study by the U.S. Department of Justice showing that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.⁴¹

In addition to the immediate harm caused by physical injury, ongoing violence and trauma contributes to tremendous health effects over the course of a survivor’s life. Women who have experienced domestic violence are 80% more likely to

29. America’s Health Rankings (2017). Retrieved January 02, 2018, from <https://www.americashealthrankings.org/learn/reports/2017-annual-report/state-summaries-oregon>.
30. Jhar@oregonian.com, JH (2010, May 07). Communities of Color Coalition finds ‘toxic’ conditions for Multnomah County minorities. Retrieved January 02, 2018, from http://www.oregonlive.com/portland/index.ssf/2010/05/communities_of_color_coalition.html.
31. Oregon’s Health System Transformation (2013). Quarterly Progress Report. Retrieved on 2 January 2018 from <http://www.oregon.gov/OHA/OEI/Reports/Coordinated%20Care%20Organization%20Metrics%20by%20Race%20and%20Ethnicity.pdf>.
32. Teen Pregnancy and Birth (2017, September). Oregon Health Authority. Retrieved on 2 January 2018 from <http://www.oregon.gov/oha/PH/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/teenpregnancy.pdf>.
33. AIDSvu (2017, November 30). Oregon. Retrieved January 09, 2018, from <https://aidsvu.org/state/oregon/>.
34. Count Her In (2016). Women’s Foundation of Oregon. Retrieved on 2 January 2018 from <https://womensfoundationoforegon.org/count-her-in>.
35. QuickFacts. (n.d.). Retrieved January 02, 2018, from <https://www.census.gov/quickfacts/OR#qf-headnote-a>.
36. Wang, E (2014). Engaging Oregonians in Identifying Health Equity Policy Priorities: A Modified Dephi Approach. Oregon Health Authority.
37. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Marks JS (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4), 245-258. doi:10.1016/s0749-3797(98)00017-8.
38. Engaging Douglas County Communities in Systematic Planning Efforts to Integrate ACEs Science, Battered Persons’ Advocacy, available on ocadsv.org.
39. Miller E, et al (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy.
40. Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR (2015). Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
41. Rand MR (1997). Violence-related Injuries Treated in Hospital Emergency Departments. U.S. Department of Justice, Bureau of Justice Statistics. Washington, DC.

Prevalence of Physical and Mental Health Outcomes Among Those With and Without a History of Rape or Stalking by any Perpetrator or Physical Violence by an Intimate Partner —US. Women, NISVS 2010			
Health Outcome	Weighted %		p-value ²
	History	No History ¹	
Asthma	23.7	14.3	<.001
Irritable Bowel Syndrome	12.4	6.9	<.001
Diabetes	12.6	10.2	<.001
High Blood Pressure	27.3	27.5	n.s. ³
Frequent Headaches	28.7	16.5	<.001
Chronic Pain	29.8	16.5	<.001
Difficulty Sleeping	37.7	21.0	<.001
Activity Limitations	35.0	19.7	<.001
Poor Physical Health	6.4	2.4	<.001
Poor Mental Health	3.4	1.1	<.001

1. No history of rape, stalking, or intimate partner physical violence
 2. p-value determined using chi-square test of independence in SUDAAN™
 3. Non-significant difference

have a stroke, 70% more likely to have heart disease, 60% more likely to have asthma and 70% more likely to drink heavily than women who have not experienced domestic violence.⁴² This CDC study analyzed data from 70,156 respondents (42,566 women and 27,590 men) in 16 states and two territories.

Abused women (aged 21 to 55 years) interviewed in a 2002 case control study at a multisite health maintenance organization were found to experience a 50% to 70% increase in gynecological, central nervous system and stress-related problems.⁴³ Women who were physically and sexually abused reported the highest number of health problems. Compared to the control group, abused women reported more:

- ▶ sexually transmitted diseases,
- ▶ vaginal infections,
- ▶ painful intercourse,
- ▶ pelvic pain,
- ▶ urinary tract infections,
- ▶ abdominal pain,
- ▶ headaches,
- ▶ backaches, and
- ▶ digestive problems.

Another study analyzed data from the Women’s Health Effect Study (WHES), an ongoing prospective study of the patterns of women’s physical and mental health in the early years after leaving an abusive partner. More than one-third (35.3%) of IPV survivors experienced high disability pain and 43.2% reported swollen/painful joints.⁴⁴

Chronic pain is a major form of disability accounting for \$125 billion in annual health care costs. Women with a history IPV or child abuse are significantly more likely to report pain symptoms even after controlling for depression.⁴⁵ According to researcher Wuest, “more than one-third of female IPV survivors experience high disability chronic pain.”⁴⁶

Safer Futures has continued to learn about the impacts of IPV on survivor health. Population needs assessments conducted by the project sites early on revealed that women who are survivors of IPV:

- ▶ face significant barriers to accessing resources of any kind (i.e. low-income housing, transportation, employment options especially for marginalized and/or underserved populations),
- ▶ need information and support to enroll in a health plan and access health services and benefits, and

42. Adverse health conditions and health risk behaviors associated with intimate partner violence—United States, (2005). *PsycEXTRA Dataset*. doi:10.1037/e410562008-001.
 43. Campbell JC (1994). Domestic homicide: risk assessment and professional duty to warn. *MD Med J*.1994;3:885–889.
 44. Wuest J, Merritt-Gray M, Ford-Gilboe M, Lent B, Varcoe C, Campbell JC (2008). Chronic pain in women survivors of intimate partner violence. *Journal of Pain*. 2008;9:1049–1057. &. doi:10.1016/j.jpain.2008.06.009.
 45. Kendall-Tackett KA, Marshall R, Ness KE (2003). Chronic pain syndromes and violence against women. *Women and Therapy*, 26.
 46. Wuest J et al (2008). Chronic pain in women survivors.

- ▶ need better connections to prenatal care, parenting support and basic resources such as diapers, clothing and formula.⁴⁷

Safer Futures project sites report the critical importance of advocacy partnerships with health care systems, due to the unique health needs of survivors, especially those who are pregnant and newly parenting.

“If it weren’t for my advocate, I would be homeless and not getting my baby back.” Survivor, *Safer Futures* participant⁴⁸

REPRODUCTIVE AND SEXUAL HEALTH EFFECTS

In addition to these broader health risks and effects, there are extensive implications specifically for reproductive and sexual health. In a literature review, researchers found that IPV was consistently associated with sexual risk taking, inconsistent condom use, unplanned pregnancies, induced abortions, STIs and sexual dysfunction.⁴⁹

Researchers have found that survivors do not access reproductive health care as often as they may need. In one study, adolescent girls who experienced IPV were nearly 2½ times more likely to have forgone health care in the past 12 months compared to non-abused girls.⁵⁰ This has important implications for advocacy, as advocates can help connect survivors to health care services.

Additional barriers to care that survivors face are coupled with increased health needs. For example, women who have experienced IPV are 2.6 times more likely to be diagnosed with invasive cervical cancer. In a study of 4,732 women, patients were asked about adult exposure to rape and childhood exposure to sexual abuse. Rates of cervical cancer were highest for those women who experienced both types of victimization compared to women who had never been victimized.⁵¹

Women experiencing physical abuse by an intimate partner are three times more likely to have a sexually transmitted infection (STI), while women who have experienced psychological abuse have nearly double the risk for a STI compared to non-abused women.⁵³ Research suggests, and survivors who are diagnosed with STIs sometimes report, that the “powerlessness they feel leads to a sense of acceptance that STIs are an inevitable part of their lives, stigma, and victimization.”⁵⁴ Adolescent girls interviewed in a study by Decker et al. found that more than one half of those who were diagnosed with a STI or HIV had experienced dating violence.⁵⁵

The American Foundation for AIDS Research reports that violence is both a significant cause and a significant outcome of HIV infection in women. Women who were HIV-positive experienced more frequent and severe abuse compared to survivors in abusive relationships who were HIV-negative. According to *Futures Without Violence*, a history of IPV is a common denominator in studies of women who are HIV-positive: “In a review study of U.S. and international research on the intersection between IPV and HIV/AIDS, the increased risk of HIV/AIDS related to IPV among women and adolescents was related to several mechanisms including compromised negotiation of safer sex practices, forced sex with an infected partner, and increased sexual risk-taking behaviors.”⁵⁶

“Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls.”⁵²

REPRODUCTIVE COERCION AND BIRTH CONTROL SABOTAGE

Partnerships between advocates and health care providers also benefit from increased knowledge of specific types of abuse related to birth control and reproductive health. Advocates and health care providers alike have a role in addressing coercive tactics affecting survivors’ health.

According to *Futures Without Violence*, reproductive coercion involves behaviors related to reproductive

47. Evaluation findings as concluded by Portland State University in support of the *Safer Futures* project. More information available at <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>.

48. *Ibid.*

49. Coker AL (2000). Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine*, 9(5), 451-457. doi:10.1001/archfami.9.5.451.

50. Miller E et al (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy.

51. Coker AL (2000). Physical Health Consequences of Physical and Psychological Intimate Partner Violence.

52. Information for Teens . (n.d.). Retrieved January 02, 2018, from <http://www.odvn.org/prevention/teens.html>.

53. *Ibid.*

54. Champion JD, Shain RN, Piper J (2004). Minority adolescent women with sexually transmitted diseases and a history of sexual or physical abuse. *Issues in Mental Health Nursing*. 2004;25:293-316.

55. McCaw B (2017). Transforming the Health Care Response to Intimate Partner Violence. *The Permanente Journal*. doi:10.7812/tpp/17-140-04

56. Campbell JC, Baty ML, Ghandour RM, Stockman JK, Francisco L, Wagman J (2008). The Intersection of Intimate Partner Violence Against Women and HIV/AIDS: A Review. *International Journal of Injury Control and Safety Promotion*. 2008;15(4):221-231.

BIRTH CONTROL SABOTAGE

Birth control sabotage is active interference with a partner’s contraceptive methods. Tactics may include:

- ▶ Destroying or disposing contraceptives (pills, patch, ring)
- ▶ Impeding condom use (threatening to leave if partner requests/requires condom use, poking holes in condoms)
- ▶ Not allowing them to obtain, or preventing them from using, birth control
- ▶ Threatening physical harm if they use contraceptives

health that a partner uses to maintain power and control in an intimate relationship.⁵⁷ These may include:

- ▶ Explicit attempts to impregnate a partner against that person’s wishes
- ▶ Controlling outcomes of a pregnancy
- ▶ Coercing a partner to have unprotected sex
- ▶ Interfering with birth control methods (birth control sabotage)

Reproductive coercion and birth control sabotage are very common forms of IPV. A survey by Futures Without Violence and the National Domestic Violence Hotline of over 3,000 callers found a high rate of reproductive coercion among survivors calling the hotline for assistance. The survey questions and response rates were as follows:

1. *Has your partner or ex-partner ever told you not to use any birth control (like the pill, shot, ring, etc.)?* Of the 3,169 callers who responded, 25% said yes.
2. *Has your partner or ex-partner ever tried to force or pressure you to become pregnant?* Of the 3,166 callers who answered this question, 25% said yes.
3. *Has your partner or ex-partner ever taken off the condom during sex so that you would become pregnant?* Of the 3,103 callers who responded, 16% said yes.
4. *Has your partner or ex-partner ever made you have sex without a condom so that you would become pregnant?* Of the 3,130 callers who responded, 24% said yes.^{58,59}

Qualitative and quantitative research has shown an association between birth control sabotage and IPV. In interviews with a random sample of 2,790 women who have had sexual intercourse, Fanslow et al found that women who had experienced domestic violence were more likely to have had partners who refused to use condoms or prevented them from using contraception (5.4%) compared to women who had not experienced domestic violence (1.3%).⁶⁰

Miller et al conducted interviews with 53 sexually active adolescent women. The results underscore those of the above-referenced hotline survey: one-quarter (26%) of participants reported that their abusive male partners were actively trying to get them pregnant. Common tactics used by abusive male partners included manipulating condom use, sabotaging birth control use, and making explicit statements about wanting them to become pregnant.⁶¹ Another study found that among teen mothers on public assistance who had experienced recent IPV, 66% disclosed birth control sabotage by a dating partner.⁶² Raiford et al found that women who were highly knowledgeable about STIs, but who were fearful of abuse, were less likely to consistently use condoms than non-fearful women with low STI knowledge.⁶³ Without addressing relationship safety, birth control education and family planning are incomplete.

Futures Without Violence has training for providers, “Did You Know Your Relationship Affects Your Health?”, that emphasizes what is needed is not necessarily more condom education.⁶⁴ Some people are afraid of what will happen when they ask their partner to use a condom. Among women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use.⁶⁵ The threat of harm may cause more fear than the risk of negative health consequences.

Due to these types of abuse and other factors, IPV increases women’s risk for unintended pregnancies. A study by Hathaway et al found that, among women experiencing IPV who had been pregnant in the past 5 years, approximately 40% reported that the pregnancy was unwanted, as compared to 8% of women not experiencing IPV.⁶⁶

57. Chamberlain L, Levenson R (n.d.). Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings. *PsycEXTRA Dataset*. doi:10.1037/e603552012-001.

58. 1 in 4 Callers surveyed at the Hotline Report Birth Control Sabotage and Pregnancy Coercion. (2011, February 18). Retrieved January 09, 2018, from <http://www.thehotline.org/2011/02/18/1-in-4-callers-surveyed-at-the-hotline-report-birth-control-sabotage-and-pregnancy-coercion/>.

59. Futures Without Violence (n.d.). Retrieved on 2 January 2018 from https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf.

60. Fanslow J, Whitehead A, Silva M, Robinson E (2008). Contraceptive use and associations with intimate partner violence among a population-based sample of New Zealand women. *The Australian and New Zealand Journal of Obstetrics and Gynaecology*, 48(1), 83-89. doi:10.1111/j.1479-828x.2007.00805.

61. Miller E et al (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy.

62. Raphael J (n.d.). Teens Having Babies: The Unexplored Role of Domestic Violence. *PsycEXTRA Dataset*. doi:10.1037/e401342005-002.

63. Raiford JL, Wingood GM, Diclemente RJ (2007). Prevalence, Incidence, and Predictors of Dating Violence: A Longitudinal Study of African American Female Adolescents. *Journal of Womens Health*, 16(6), 822-832. doi:10.1089/jwh.2006.0002.

64. Did You Know Your Relationship Affects Your Health?: A Train the Trainers curriculum on Addressing IPV, Reproductive and Sexual Coercion (2015, September 21). Retrieved January 09, 2018, from <https://www.futureswithoutviolence.org/did-you-know-your-relationship-affects-your-health-a-train-the-trainers-curriculum-on-addressing-ipv-reproductive-and-sexual-coercion/>

65. Wingood GM, Diclemente RJ (1997). The effects of an abusive partner on condom use and sexual practices. *American Journal of Public Health*. 1997;87(6):1016-1018.

66. Hathaway JE, Mucci LA, Silverman JG, Brooks DR, Mathews R, Pavlos CA (2000). Health Status and Health Care Use of Massachusetts Women Reporting Partner Abuse. *American Journal of Preventive Medicine*. 19 (4): 302-307.

Futures Without Violence, a wealth of information on the impact of violence on health, shares additional implications for advocacy and health services in their invaluable report, *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings*.⁶⁷

IMPLICATIONS OF IPV ON PREGNANCY

The Guttmacher Institute conducted a literature review on the intersection of IPV and pregnancy, and found that the estimated prevalence of violence during pregnancy ranged, depending on the study, between 1% to 20% in the general population. However, the majority of researchers reported prevalence estimates of between 4% and 8%. If this is generalizable, this would mean that IPV “is a more common experience during pregnancy than preeclampsia, gestational diabetes and placenta previa.”⁶⁸

However, studies designed specifically to identify survivors, versus more broad surveys of health issues, tend to find higher prevalence rates. A study of over 1,000 prenatal patients at public clinics in the U.S. revealed 15% were abused during pregnancy,⁶⁹ as did a study of nearly 1,000 women seeking care in U.S. family practice clinics who completed the Abuse Assessment Screen.⁷⁰ In more behaviorally specific surveys, with more granular examples of abuse, higher prevalence is often found. In a U.S. study that used the Conflict Tactics Scale, an astounding 81% of prenatal patients at a family practice clinic reported some type of IPV during pregnancy; 28% reported physical IPV, and 20% reported sexual violence.⁷¹

Whether impacting 4% of the general population of pregnant women, or more, IPV is one of the most important health issues affecting pregnant women in the United States. Beyond health effects for the mother and the developing fetus, there are additional risks. Homicide by an intimate partner is the number one cause of death for pregnant and postpartum women in the United States, accounting for 31% of maternal injury deaths.⁷²

Women experiencing IPV during pregnancy are significantly more likely than non-abused women to miss three or more prenatal visits (45% vs 28%).⁷³ Much of the published research suggests inadequate prenatal care utilization is linked to poor outcomes for the mother and the infant.



Health effects documented in the literature for the mother include:

- ▶ Miscarriage,
- ▶ Exacerbated chronic problems such as hypertension and gestational diabetes,
- ▶ Nine-fold increase in risk for a mood or anxiety disorder, including more likely to be hospitalized for mental health related problems,
- ▶ Increased risk of cervical and uterine infections,
- ▶ Increased risk of STIs and HIV, and
- ▶ Increased risk of alcohol and substance use during pregnancy.⁷⁴

In addition to effects on maternal health, the effects of IPV on pregnancy outcomes are important to note, and include increased likelihood of low birth weight and increased rates of preterm births. One study found that, compared with non-abused women, those abused had significantly increased rates of preterm deliveries (22% vs 9%) and low birth weight babies (16% vs 6%). Premature and low birth weight babies are at risk of cognitive deficits, including delayed mental development.⁷⁵

67. Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings. Retrieved on 8 January 2018 from https://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf.

68. Gazmararian J et al (1996). Prevalence of violence against pregnant women, *Journal of the American Medical Association*. 275(24):1915-1920.

69. McFarlane J, Groff JY, O'Brien JA, Watson K (2006). Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial. *Nursing Research*. 2006;55(1):52-61.

70. Coker AL, Reeder CE, Fadden MK, Smith PH (2004). Physical partner violence and Medicaid utilization and expenditures. *Public Health Rep*. 2004; 119: 557-567.

71. Bailey BA (2010). Partner violence during pregnancy: prevalence, effects, screening, and management. *Int. Journal of Women's Health*. 2010; 2: 183-197.

72. Chang J et al (2005). Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women.

73. Dunn LL, Oths KS (2004). Prenatal predictors of intimate partner abuse. *Journal of Obstetrics and Gynecology*. 2004;33:54-63.

74. Bailey BA (2010). Partner violence during pregnancy: prevalence, effects, screening, and management.

75. Ibid.

HEALTH SYSTEM COSTS

These health outcomes also represent significantly higher health costs to the systems that serve survivors. A 2009 study of more than 3,000 women in a Pacific Northwest-based health plan found costs for women suffering ongoing abuse were 42% higher when compared with non-abused women. The same study found that health care costs remain higher even when the abuse is over. Women who suffered physical abuse five or more years earlier had health care costs that were 19% higher than women who were never abused.⁷⁶

SURVIVOR PERSPECTIVES

Survivors of IPV want clinicians to address IPV in health care settings. In four separate studies of survivors of abuse, 70% to 81% of patients reported that they would like their health care providers to ask them privately about IPV.⁷⁷

An evaluation of *Project Connect* also found that patients want their clinician to ask about relationship safety. (See pages 10-11 for more information about this pilot project between D/SV organizations and public health departments.) In settings where participating clinicians received robust training, patients reported high rates of satisfaction:

- ▶ 84% 'agree' or 'strongly agree' that it is helpful for providers to talk about healthy and unhealthy relationships
- ▶ 90% 'agree' or 'strongly agree' that their provider cares about their safety
- ▶ 85% 'agree' or 'strongly agree' that their provider would know what to do if they reported being in an unhealthy relationship
- ▶ 91% 'agree' or 'strongly agree' that they felt safe coming here (to this clinic/health center)

Safer Futures partnered with Portland State University Regional Research Institute on an evaluation of services that included focus groups and interviews with participant survivors. Survivors reported that they felt comfortable talking about IPV with clinicians when the advocate was present at appointments; when the provider made it a conversation, starting with general questions; when the health care provider showed concern, and seemed like they wanted to help; and when they were seen privately without their partner.⁷⁸

Survivors reported that they felt uneasy or unsafe talking about IPV with clinicians when providers focused on physical issues and didn't seem comfortable talking about IPV; when they heard other staff members talking about them; when the partner was present in appointments or in the waiting

room; and because of their own initial feelings of guilt.⁷⁹ Other learnings from this evaluation are shared in Section 4, pages 30-31 and Section 5, pages 41-43.

Even with existing challenges to confidentiality and resulting potential safety risks (further discussed below), health care settings provide a unique opportunity for assessment and intervention. Patients confide in health care providers because of the trust placed in those relationships. Health care appointments are often the only time a survivor is apart and separate from the person who is doing harm. This crucial opportunity to intervene in support of someone experiencing abuse, considered in conjunction with health effects and costs of IPV, emphasizes the importance of investing in serving victims of IPV in health care settings. There is unfortunately limited data on direct health effects of advocacy services for survivors of IPV. However, survivor responses demonstrate some of the positive impacts advocacy can have. Even if specific health effects have not yet been documented, research suggests that on-site advocacy interventions have important implications for reducing violence and improving a person's well-being over time.⁸⁰

SURVIVOR STORY

A D/SV organization referred a survivor with a complicated health issue to a provider. Before the appointment, the abusive person seriously injured the survivor, leaving significant and obvious marks. The nurse made a report to law enforcement (without notifying the survivor) under Oregon's Adult Injury mandatory reporting law (ORS 146.750) for serious injuries that nurses or doctors suspect might be intentional. Police officers knocked on the survivor's door before she got home, and the perpetrator answered the door. Neither the D/SV organization or the health care provider saw the survivor again.⁸¹

SAFETY CONCERNS AND INFORMED CONSENT

The above story highlights the serious safety concerns that survivors of domestic and sexual violence face when disclosing abuse by their intimate partner. While they are important sites of intervention, health care settings also present new risks to survivor safety, particularly around

76. Bonomi AE et al (2009). Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence.

77. Chamberlain (n.d.). Addressing Intimate Partner Violence, Reproductive and Sexual Coercion.

78. Evaluation findings, Portland State University.

79. Ibid.

80. Bybee DI, Sullivan CM (2002). The Process Through Which an Advocacy Intervention Resulted in Positive Change for Battered Women Over Time. *American Journal of Community Psychology*, 30(1), 103-132. doi:10.1023/a:1014376202459.

81. Evaluation findings, Portland State University.

information sharing; survivors must be informed, and have the opportunity to weigh in. Survivors have a right to choose who they seek out for support, and to control their information. Advocates specialize in the unique safety needs of survivors of IPV. An advocate's role is to present options and information; the role of a well-trained and trauma-informed health care provider is to ensure that patients, including survivors, can give true informed consent for services.

Additional safety challenges sometimes posed by health care settings include:

SCREENING ISSUES

- ▶ Domestic violence screening conducted in presence of friends and family, and/or while the abusive person is present.
- ▶ Patients not having private time with health care provider.
- ▶ Health care provider not understanding the importance of normalizing IPV screening, i.e. only providing this intervention when suspecting violence rather than through universal practice.

BILLING AND DIAGNOSTIC CODING AND DOCUMENTATION ISSUES

- ▶ Potential for IPV-specific information or documentation to be entered into the medical record or Electronic Health Record.
- ▶ Accessibility of private patient IPV-related information to other staff in health care system.
- ▶ Possibility of information to be accessed remotely, potentially by the abusive partner.
- ▶ Possibility that information will be recorded on an insurance bill and visible to abusive person.
- ▶ Some providers may want to describe abuse or take pictures, especially of a serious injury that necessitates a mandatory report; if images or descriptions are included in the record, and potentially visible to the abusive person, survivor privacy and safety may be compromised.

INFORMATION SHARING

- ▶ Patients not given adequate options or control over flow of information shared by the health care provider, including what is sent to their mailing address or preferred mode of contact.
- ▶ Patients not adequately informed of options for communication with health insurance, including what is sent to their mailing address or preferred mode of contact.

MEDICAL ABUSE ISSUES

- ▶ Health care provider may not be aware of dynamics of IPV, a cycle of power and control, and tactics that abusive partners engage in around health that prevent the survivor from following care plans as prescribed.
- ▶ Provider may blame the patient for being non-compliant or difficult.
- ▶ Provider may blame the survivor for the abuse or neglect.

Training health care providers on IPV is critical. Training begins with the dynamics of emotional, physical and sexual abuse, and the importance of trauma-informed care. Additional training can cover how the abusive partner may deny the survivor's right to privacy, destroy or tamper with medicines, deny access to care, prevent attendance at treatment groups, encourage opioid, drug and/or alcohol dependence, prevent the survivor from following treatment plans entirely or in part, break medical equipment, or limit access to or sabotage financial or health information.

Please see "Medical Power and Control Wheel" in the Appendix, published by The Domestic Violence Project and the National Center on Domestic and Sexual Violence (page 71).

Providers need training on screening and assessment best practices before implementing any intervention. This includes the importance of reviewing the limits of confidentiality, seeing patients alone, and the importance of follow-through. It is ill advised to screen for IPV without a plan for how the health care provider will respond. When IPV is disclosed, the health care provider must follow-up with an effective intervention. If a survivor discloses and no follow-up intervention or conversation occurs, the survivor may become further isolated or discouraged from reaching out again.

For additional detail on addressing the above safety barriers, and further information on mandatory reporting requirements, confidentiality issues, and health care-specific challenges presented by electronic health records and health information communication, please see Section 6, pages 44-49.

SECTION 3: OREGON HEALTH CARE CLIMATE



Safer Futures is a community-level intervention that weaves together advocacy services and healthy relationship education in partnership with health care providers and their systems. In order to implement *Safer Futures*, it is imperative to have health care system support for the provider, survivor and advocate, and for the partnership. These dynamic partnerships require a higher degree of innovation and compromise than is typical of other system integration challenges. To prepare the D/SV organization to engage in the shared work of health care system transformation, *Safer Futures* sites have found it helpful to develop an understanding of the health care climate.

THIS SECTION PRESENTS INFORMATION THAT D/SV ORGANIZATIONS HAVE USED TO PROACTIVELY LEVERAGE PARTNERSHIP DEVELOPMENT, AS FOLLOWS:

- ▶ Health care 101 P. 22
- ▶ Affordable Care Act P. 22
- ▶ Oregon health care P. 23
 - Coordinated Care Organizations P. 23
 - The Triple Aim..... P. 24
 - Traditional Health Workers P. 25
 - Role of community-based D/SV organizations..... P. 26
- ▶ Opportunities for engagement and partnership leverage points..... P. 26
 - System safety and patient-centered care.. P. 26
 - Regional health equity coalitions..... P. 26
 - Trauma-informed care..... P. 27
 - Adverse Childhood Experiences and resiliency P. 27
 - Metrics and Scoring Committee Measures for CCOs..... P. 27
 - Traditional Health Workers P. 27
 - Early Learning Hubs P. 27
 - Conclusion P. 27

HEALTH CARE 101

Every community in Oregon has a different constellation of hospitals, doctors, social services, specialty practices, public health clinics, and other providers. In addition to diverse options for care, there are also different health insurance plans, including private and public, through employers, through the Oregon Health Plan (OHP), and now on the marketplace that individuals can purchase. Even the same plans and providers can function differently and present different costs depending on the individual patient.

This complex environment is faced with new laws and regulations that seek to change this system: health system transformation. Health care providers are under more scrutiny, pressure and rules than ever before. Health system transformation, however, also brings an increase in funding and resources focused on improving health care in Oregon. This presents new opportunities for partnership for community-based D/SV organizations.

Since the Affordable Care Act (ACA) passed, the percentage of Oregonians who have health insurance has grown by 10%. As of 2017, 3.7 million Oregonians (or nearly 94%) have insurance coverage. Of that percentage, 47.5% of Oregonians have private group insurance, 26% have Medicaid through the Oregon Health Plan, 15.1% have Medicare, 5.2% have individual private insurance; 6.2% are uninsured.⁸²

The real number of uninsured people may be even higher, as this number does not include undocumented people. In 2014, Pew Research Center counts showed 130,000 undocumented immigrants in Oregon.⁸³ This population, already marginalized due to racism and xenophobia, has health needs that have so far gone unaddressed by health care system transformation. Survivors from marginalized communities, such as undocumented people, have higher barriers to safety and well-being than those with U.S. citizenship. D/SV organizations can advocate for their inclusion in health care benefits moving forward.

Health insurance coverage has clear benefits. The Oregon Health Study found that health insurance helps people: improve their health, decrease symptoms of depression, decrease the likelihood of having medical bills sent to collections, and decrease the average amount owed to medical collection.⁸⁴

D/SV organizations can help survivors enroll in Oregon Health Plan, and can connect survivors to navigators who review and help select health care options. Find more information on local enrollment navigators here: <http://www.oregonhealthcare.gov/get-help-2.html>. Navigators are trained to help expedite the Oregon Health Plan enrollment process for survivors.

The Oregon Health Plan, this state's Medicaid program, covers over 1.1 million Oregonians.⁸⁵ The Oregon Health Authority reports that:

- ▶ 50% of babies born in Oregon are on OHP (2015)⁸⁶
- ▶ OHP covers 26% of Oregonians (almost doubling from 16% covered in 2013)⁸⁷
- ▶ OHP is the fastest growing portion of state budget, and one of the largest line items

AFFORDABLE CARE ACT

In addition to expanding coverage in Oregon, there have been other health care reform efforts at the federal level. The largest health care reform legislation ever to pass is known as the Patient Protection and Affordable Care Act, or Obamacare. In summary, the ACA:

- ▶ Requires most U.S. citizens and legal residents to have health insurance.
- ▶ Creates exchanges through which individuals can purchase coverage, with credits for those with income between 133-400% of the federal poverty level (the poverty level is \$20,420 for a family of three in 2017).⁸⁸
- ▶ Provides new rules for employers.
- ▶ Imposes new regulations on health plans in the exchanges, such as not allowing health insurance companies to deny survivors due to histories of domestic violence.
- ▶ Expands Medicaid to 133% of the federal poverty level (in Oregon, pregnant women and children have additional accessibility).
- ▶ Reforms Medicaid and Medicare payment methods.

In Oregon, the ACA was implemented with an additional goal, co-signed by the Obama administration: to decrease the rate of growth of health costs. In support of this aim,

82. Oregon Health Insurance Survey (2017). Oregon Health Authority. Retrieved on 02 January 2018 from <http://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2017-OHIS-Early-Release-Results.pdf>.

83. Mitchell T (2016, November 03). U.S. unauthorized immigration population estimates. Retrieved January 02, 2018, from <http://www.pewhispanic.org/interactives/unauthorized-immigrants/>.

84. The Oregon Health Insurance Experiment. (n.d.). Retrieved January 02, 2018, from <http://www.nber.org/oregon/1.home.html>.

85. Annual health insurance report. (n.d.). Retrieved January 04, 2018, from <http://dfr.oregon.gov/business/report-data/health-report/Pages/enroll-total-enrollment.aspx>.

86. Births Financed by Medicaid (2017, March 03). Kaiser Family Foundation. Retrieved January 04, 2018, from <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colld%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D>.

87. Ibid.

88. Federal Poverty Level (FPL) - HealthCare.gov Glossary. (n.d.). Retrieved January 02, 2018, from <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/>.

the federal administration gave Oregon \$1.9 billion dollars, funding the state needed to enroll additional hundreds of thousands of people in OHP (i.e. Oregon’s 1115 Medicaid Demonstration, or Oregon Health Plan.)⁸⁹

Oregon’s initial 1115 Medicaid Demonstration waiver established Medicaid and CHIP services through the Oregon Health Authority. The Medicaid Demonstration waiver has given Oregon numerous opportunities to expand and improve health care throughout the state, including the creation of Oregon’s Coordinated Care Organizations (CCOs). The goal is for Oregon’s Medicaid program to grow at a rate 2% slower than the rest of the country, ultimately generating \$11 billion in savings over the next decade. Oregon’s Medicaid Demonstration waiver was renewed on January 12, 2017 and is in effect through June 30, 2022.

In 2017, several attempts at the federal level were made to repeal the ACA. As of January 2018, Oregon Health Plan benefits were still in place, including no changes to OHP members’ eligibility, CCO enrollment or access to health care services.⁹⁰

**OREGON HEALTH CARE
COORDINATED CARE ORGANIZATIONS**

Health care reform in Oregon is structured to address what is called the “Triple Aim:” better health, better care, lower cost (described in detail on page 24). The main mechanism to accomplish this is Coordinated Care Organizations (CCOs).

CCOs serve Oregon Health Plan (Medicaid) members. There are 17 CCOs across the state, coordinating physical and mental health care for their patients (find local CCOs here: <http://www.oregon.gov/oha/HSD/OHP/Documents/CCO-Service-Area-Map.pdf>). CCOs are designed to encourage wellness, not merely to treat illness; therefore, they place priority on prevention, chronic disease management, and Traditional Health Workers. CCO system transformation focuses on metrics, defined by the state, and is responsive to Community Health Improvement Plans designed by Community Advisory Councils. Effective innovations are scaled up from pilot interventions to the CCO level and disseminated as appropriate.

As a part of their initial founding legislation, CCOs were mandated to partner with Traditional Health Workers, and were set up with a global budget designed so clinicians could prescribe upstream solutions. Unlike Health Management Organizations (HMOs), CCOs are tasked

WHY CCOs?

The famous thought experiment for the founding of CCOs is the story of an older woman with congestive heart failure who lives in an apartment without air conditioning. On a hot day, her apartment heats up so much that it strains her cardiovascular system and sends her into full-blown congestive heart failure. Under previous health systems, Medicare would pay for the ambulance and \$50,000 to stabilize her at the emergency room – but would not pay \$200 for a window air conditioner, which is all she needs to stay in her home, healthy, and out of the hospital. The difference to the health care system is \$49,800 – and to this woman, a significant increase in well-being. CCOs are meant to address this type of opportunity to save money and improve overall patient wellness.

not only with administering care of their members, but the actual health of their membership. Yet, despite this legislative mandate to address health equity and prevention by covering services beyond those that are purely clinical, CCOs struggle to fund such services.

Two mechanisms support CCOs to fund more community-based, upstream solutions to patient health care issues:

Flexible services funding refers to cost-effective services offered instead of covered medical benefit services (e.g., home modifications such as that air conditioner, healthy cooking classes, Traditional Health Workers, or advocacy services).

Community benefit initiatives are community-level (as opposed to individual patient-level) interventions, such as investments in provider capacity and care management capabilities.

Both flexible services and community benefit initiatives (collectively referred to as “health-related services”) aim to address social determinants of health, of which IPV is an important component (see page 13 for a description of social determinants of health). As part of these health-related services, and in support of survivor health outcomes,

89. “Section 1115 of the Social Security Act gives the federal Department of Health and Human Services’ (HHS) Centers for Medicare and Medicaid Services (CMS) the authority to approve state-level experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children’s Health Insurance Program (CHIP) programs. Medicaid Demonstrations give states flexibility to design and improve programs and to show how new policy approaches such as eligibility expansion, service expansion, or using innovative service delivery systems can improve care, increase efficiency, and reduce costs.” Retrieved on 02 January 2018 from <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Pages/index.aspx>.
 90. Oregon Health Authority and Federal Policy Updates (May 2017). Retrieved on 2 January 2018 from <http://www.oregon.gov/oha/HSD/OHP/Pages/Election.aspx>.

Alternative Payment Methodologies, community benefit dollars, or charitable budgets may be leveraged to cover training and/or advocacy by D/SV organizations.

D/SV organizations are encouraged to connect with their local CCOs. *Safer Futures* has found that each community and CCO approaches community-based partnerships differently. Many sites have found success in visiting or joining their local Community Advisory Council. CCOs are required to provide a Community Health Improvement Plan. Advocates may wish to find out whether IPV and/or sexual violence are addressed in this plan, and if not, to engage in partnership building and system change by advocating for their inclusion. Advocates may also choose other priority areas for partnership, such as ACEs or trauma-informed care (see pages 26-27).

In order to achieve the Triple Aim, CCOs must address IPV and health equity – and partnerships with D/SV advocacy organizations help them do this effectively.

THE TRIPLE AIM

The Triple Aim is a concept developed in 2007 by Dr. Donald Berwick and the Institute for Healthcare Improvement, and used to guide health care reform in Oregon. Its three dimensions are “improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.”⁹¹



Achieving the Triple Aim (to improve the health of all Oregonians, to improve the quality of care, and to lower the cost of health care) necessitates that health systems address social determinants of health such as IPV. In order to partner with health care systems to address IPV in support of the Triple Aim, D/SV organizations may find the following messaging helpful:

1. **Better health:** *trauma and violence create adverse health effects that are preventable.*
Survivors of IPV must receive services that improve safety and well-being. Health care settings provide a unique opportunity for screening and intervention because of trusting relationships and confidentiality. Health visits may be the only time a survivor is apart from their abusive partner.⁹² Ineffective screening tools should be updated and health systems should move beyond disclosure-based interventions to more trauma-informed interventions, preferably a universal education model.
2. **Better care:** *interventions can be survivor-centered, provide holistic support, and address safety concerns (this requires patient engagement and a team of knowledgeable care providers).*
Health care providers can be trained in more modern, non-disclosure, evidence-based interventions. These involve universal screening, Memoranda of Understanding with local D/SV organizations, and an intervention that takes less than a minute with each patient. (The CUES intervention uses an educational safety card available through Futures Without Violence; see Section 4, pages 32-33). In Oregon, both *Project Connect* and *Safer Futures* piloted this model. *Safer Futures* advances the process with placement of an on-site advocate in healthcare settings to improve safety and provide immediate access to advocacy services.
3. **Lower cost:** *D/SV advocates are lower cost than medical care providers.*
Advocates already have relationships, resources, and training that prepare them to effectively address the unique needs of IPV survivors, and to provide these services at a lower cost than non-IPV-specific behavioral health counterparts.

CCOs may also reference the “Quadruple Aim.” This includes a fourth goal, “improving the work life of health care providers, including clinicians and staff.”⁹³ Through partnership with health care providers and systems, D/SV organizations can also support achievement of this fourth aim by providing training on vicarious trauma and self-care. Simultaneously,

91. The IHI Triple Aim. (n.d.). Retrieved January 02, 2018, from <http://www.ihio.org/Engage/Initiatives/TripleAim/Pages/default.aspx>.

92. Miller E, Decker MR, Mccauley HL, Tancredi DJ, Levenson RR, Waldman J, Silverman JG (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322. doi:10.1016/j.contraception.2009.12.004.

93. Bodenheimer T (n.d.). Retrieved January 02, 2018, from <http://www.annfamned.org/content/12/6/573.full>.

it is crucial for D/SV systems and health systems to address the fourth aim for advocates themselves.

TRADITIONAL HEALTH WORKERS

With historical and current conditions of racism and access issues exacerbating racial health disparities, Oregon also faces a shortage of funding and legitimacy for culturally specific services. Yet recently, culturally specific health care has been identified as a key response to health disparities (described in more detail on pages 13-14).⁹⁴

In response to community need, marginalized communities have for decades implemented innovative social services programming into conventional health care. These responses (blossoming since the 1960s and earlier in migrant farmworker communities, Tribes, and communities of color) utilize Community Health Worker (CHW) and Traditional Health Worker (THW) models.⁹⁵ El Programa Hispano C atolico in Gresham is an OCADSV member D/SV organization and is unique in Oregon for its dual programming with advocates and CHWs.

A COMMUNITY HEALTH WORKER IS:
 “A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. The trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”⁹⁶

In 2011, policy makers in the legislature (increasingly concerned with health inequities) mandated Oregon Health Authority to develop and establish a framework for CHWs and other “non-regulated health care workers” so they might partner with CCOs. Accordingly, the OHA Oregon Health

Policy Board (OHPB) mapped out the information needed to support “non-traditional health workers” in integrating with CCOs in Oregon. “Non-traditional health worker” was the umbrella term that encompassed CHWs, personal health navigators, peer wellness specialists, and others who are not regulated or certified by the state. The OHPB Non-Traditional Health Worker Subcommittee defined the scope of work of Non-Traditional Health Workers (now defined as Traditional Health Workers to recognize their emergence from cultural traditions older than conventional medicine) as fulfilling four roles:

1. Outreach and mobilization
2. Community and cultural liaising
3. Case management, care coordination and system navigation
4. Health promotion and coaching⁹⁷

The role of CHWs and THWs has thus been formally legitimized at the state level, and the foundation is in place for THWs to be incorporated into CCOs. This defined role is critical to helping CCOs achieve the Triple Aim (see page 24). Even the ACA recognizes CHWs as a best practice.⁹⁸ One study in Baltimore examined African-American Medicaid patients with diabetes. These patients participated in a CHW intervention and saw a 40% decrease in emergency room (ER) visits, a 33% decrease in ER admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid reimbursements.⁹⁹

Though they are required to work with CHWs and THWs, how CCOs do so remains to be seen. Yet the literature is clear that THWs improve health access, outcomes, and patient satisfaction for marginalized communities, as well as reducing costs.

D/SV organizations can help champion integration of THWs into CCOs and other health care systems, in support of increased access and better health outcomes for survivors. D/SV organizations can also learn from this legitimization, partnership and integration process, about how advocates may eventually come to fit within the THW designation, and more broadly, how IPV services can collaborate with conventional health systems.

94. Oregon Healthcare Workforce Committee (2014, May 6). The Diversity of Oregon’s Health Care Workforce. Retrieved on 02 January 2018 from <http://www.oregon.gov/OHA/HPA/HP-HCW/Documents/2014%20Workforce%20Diversity%20Report.pdf>.
 95. Angus L, Cheney C, Clark S, Gilmer R, Wang E (n.d.). The Role of Non-Traditional Health Workers in Oregon’s Health Care System. Oregon Health Authority. Retrieved on 02 January 2018 from <http://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf>.
 96. Community Health Workers. (n.d.). Retrieved January 02, 2018, from <https://www.apha.org/apha-communities/member-sections/community-health-workers>.
 97. Angus L (n.d.). The Role of Non-Traditional Health Workers in Oregon’s Health Care System.
 98. Community Health Worker Opportunities and the Affordable Care Act (May 2014). Maricopa County Department of Public Health. Retrieved on 02 January 2018 from <http://coveraz.org/wp-content/uploads/2013/09/Community-Health-Workers.pdf>.
 99. Fedder DO, Chang RJ, Curry S, Nichols G (2003). The effectiveness of a community health worker outreach program on health care utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. *Ethn Dis*. Winter 2003.

ROLE OF COMMUNITY-BASED D/SV ORGANIZATIONS

D/SV organizations can support health systems in accomplishing the Triple Aim by partnering with CCOs, hospitals, THWs, and other providers to educate on the dynamics of IPV and the importance of addressing it as a public health issue and a social determinant of health. Ideally this education lays groundwork for eventual placement of community-based advocates on-site or responding to healthcare settings, as in *Safer Futures* and other partnership models that connect survivors to advocacy services.

Engaging in health care reform presents D/SV organizations with opportunities to influence an entire far-reaching system. Survivors want IPV interventions in health care settings, yet health care providers do not always have the capacity or expertise in IPV (nor feel they have the time) to address it with patients. The role of community-based D/SV organizations can be to train on and support this intervention. These partnerships may also eventually result in new funding streams for D/SV advocacy.

OPPORTUNITIES FOR ENGAGEMENT AND PARTNERSHIP LEVERAGE POINTS

The following are potential points of engagement or leverage when partnering with health care systems. Health care providers may be familiar or involved with below Oregon initiatives which present opportunities for cross-pollination, mutual learning, and new ways to introduce the discussion of IPV and survivor needs into health care practice.

SYSTEM SAFETY AND PATIENT-CENTERED CARE

D/SV advocacy philosophy aligns with that of the Institute of Medicine – empower patients/survivors to control their care and reach their own goals. The Institute of Medicine has ten rules; the first two are that “care is based on continuous healing relationships” and that “care is customized according to patient needs and values.”¹⁰⁰ This commonality is an ideal leverage point for partnership.

D/SV advocates play a similar role to some other care workers, such as THWs, working individually to support patients. A patient advocate, such as a D/SV advocate, can also help navigate and coordinate care across health systems, advocate for the patient, and help ensure clinicians and health care systems are educated about IPV and safety risks. Health system efforts to make the sharing of information easier among many health care providers and their patients can inadvertently place IPV survivors at risk.

Navigating these issues to ensure that “safety is a system priority” requires special expertise that advocates can bring to bear on health care partnerships, in support of patient-centered care.¹⁰¹

REGIONAL HEALTH EQUITY COALITIONS

To help shape Oregon health care reform to better serve communities of color and other marginalized groups, Oregon Health Authority created Regional Health Equity Coalitions (RHECs). RHECs are regional, coordinated, community-driven collaborative groups. They identify policy, system, and environmental changes, and craft and implement strategies to increase health equity, reduce health disparities, and address the social determinants of health (see pages 13-14). RHECs work with CCOs, local public health departments, and other health system partners.

RHECs often include community partners, and are an excellent opportunity for D/SV organizations to partner with progressive health system policy change work. In five-year plans, each RHEC identifies community priorities for improving health outcomes. Advocates can support RHEC work to address the needs of survivors, and to promote community engagement, policy development, community health improvement planning, evaluation, and data collection and analysis.

Find up-to-date information at: <http://www.oregon.gov/oha/oei/Pages/rhec.aspx>

CURRENTLY OPERATING RHECs INCLUDE:

- ▶ Klamath Regional Health Equity Coalition - Klamath County
- ▶ Let’s Talk Diversity Coalition - Confederated Tribes of Warm Springs & Jefferson County
- ▶ Linn Benton Health Equity Alliance - Linn & Benton Counties
- ▶ Mid-Columbia Health Equity Advocates - Hood River & Wasco Counties
- ▶ Oregon Health Equity Alliance (OHEA) - Clackamas, Washington & Multnomah Counties
- ▶ Southern Oregon Health Equity Coalition (SO Health-E) - Jackson, Josephine & Douglas Counties

100. National Academy of Engineering (US) and Institute of Medicine (US) Committee on Engineering and the Health Care System (1970, January 01). Crossing the Quality Chasm. Retrieved January 02, 2018, from <https://www.ncbi.nlm.nih.gov/books/NBK22857/>.
 101. Clinical Preventive Services for Women (2011). *The National Academies Press*. doi:10.17226/13181.

TRAUMA-INFORMED CARE

With developments in neurobiology and learnings from the ACEs study, health systems are advancing their understanding of trauma and its effects on physical and behavioral health. Trauma-informed care is a developing initiative in Oregon, supported by a new policy and by the creation of an organization called Trauma Informed Oregon in 2014.

D/SV organizations have a depth of experience responding to trauma and providing trauma-informed care through survivor-centered services. Another important leverage point is the opportunity for D/SV organizations to train health care systems on best practice.

ADVERSE CHILDHOOD EXPERIENCES AND RESILIENCY

Another effective leverage point is CCOs' increasing understanding of and interest in addressing Adverse Childhood Experiences (ACEs) and resiliency. According to the CDC, "childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences."¹⁰²

Safer Futures has successfully utilized the intersection of IPV and ACEs in support of partnerships with health care systems. Battered Persons' Advocacy encourages health care providers to use an approach that focuses on resiliency when working with survivors of trauma.

METRICS AND SCORING COMMITTEE MEASURES FOR CCOs

One of the most powerful leverage points for partnership with CCOs is helping them meet specific metrics, designated by the state, that determine the amount of money they receive in their global budgets. Information about these measures is available on Oregon Health Authority's website; CCOs often reference them in Community Health Improvement Plans and other public documents. Reviewing these can provide valuable information in support of partnerships with CCOs.

The Metrics and Scoring Committee was established legislatively in 2012 for the purpose of recommending outcomes and quality measures for CCOs. The nine members are appointed by the Director of the Oregon Health Authority and serve 2-year terms. Their purview

includes developing measures of outcome and quality for ambulatory care, chemical dependency and mental health treatment, oral health care, and all other health services provided by CCOs. These metrics and quality measures are used by OHA to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations they serve.

TRADITIONAL HEALTH WORKERS

Health care systems can partner with D/SV advocacy organizations in a similar manner to their work with traditional health workers (described in depth on page 25). Traditional health workers provide patient-centered services, are non-clinical providers, and are often organized and supervised by community-based programs.

Oregon Health Authority's Traditional Health Worker Commission promotes the use of traditional health workers, such as community health workers, peer support and peer wellness specialists, personal health navigators, and doulas. Learn more from the Commission at <http://www.oregon.gov/oha/oei/Pages/thw-commission.aspx>.

EARLY LEARNING HUBS

An Early Learning Hub is a coordinating body that convenes resources focused on children and families in its defined service area, in support of positive outcomes for children and their families. In the Early Learning Hub model, all of the sectors that affect early childhood (health care, early childhood educators, human and social services, K-12 school districts, and the private sector) have a common place to focus their efforts, resources, and strategies with a shared purpose. Learn more at <http://oregonearlylearning.com/>.

Advocates may consider becoming involved with Early Learning Hubs in their communities, as a way to influence early childhood and family health and well-being.

CONCLUSION

The above are some of the projects and initiatives used to strengthen health care transformation across communities, and within and across CCOs. They serve as points where D/SV advocacy organizations can share expertise and build relationships needed for successful partnership. Bringing survivor perspectives to this work further enhances system knowledge and improves future response to those who have experienced IPV.

102. Violence Prevention (2016, April 01). Retrieved January 02, 2018, from <https://www.cdc.gov/violenceprevention/acestudy/index.html>.

SECTION 4: PARTNERING WITH HEALTH CARE



Many survivors of intimate partner violence interact with health care providers on a regular basis; and this makes health care an ideal setting for supportive intervention. Influencing these interactions through partnership is a prime leverage point in reaching and effectively promoting the safety, health, and self-determination of survivors of IPV.

One study found that, of the 44% of survivors of IPV who talked to someone about the abuse, the most commonly utilized supports were friends and family, followed by health care providers.¹⁰³ This is vital information that supports D/SV advocacy and health care partnerships. Many survivors may never utilize a hotline or a shelter, but will speak with a health practitioner about the abuse they are experiencing.

Health care settings present a tremendous opportunity to provide important information about healthy and unhealthy relationships to all individuals, and offer support to survivors who might not be able to connect directly to D/SV organizations.

SURVIVOR STORY

One survivor was very grateful for the advocate being located at the health department, stating, *“I can only access my advocate at the health department because my partner is so controlling.”*¹⁰⁴

THIS SECTION WILL COVER CONSIDERATIONS FOR D/SV ORGANIZATIONS, WHEN INITIATING AND FOSTERING PARTNERSHIPS WITH HEALTH CARE. TOPICS INCLUDE:

- ▶ Potential partners P. 28
 - ▶ Cultivating partnerships P. 29
 - ▶ Health care partner settings..... P. 29
- ▶ Partnership models P. 30
- ▶ Screening and referral practices P. 31
 - ▶ Recommended IPV screening tools and procedures..... P. 32
 - ▶ Universal education model for screening and identification of IPV P. 32
 - ▶ Referral practices P. 34
- ▶ Working with providers P. 35
 - ▶ Training..... P. 35
 - ▶ Consultation P. 35
 - ▶ Provider feedback..... P. 35
- ▶ Sustainability P. 35
- ▶ Conclusion P. 35

103. RMC Research Corporation (2003). The Dorchester Community Roundtable Coordinated Community Response to Prevent Intimate Partner Violence. Portsmouth, New Hampshire.
 104. Evaluation findings, Portland State University.

**POTENTIAL PARTNERS
CULTIVATING PARTNERSHIPS**

Safer Futures recommends that D/SV organizations plan to invest time and resources in cultivating partnerships, training partner clinic sites on the mutually chosen screening and referral process, and the basics of IPV. One way *Safer Futures* sites accomplished this was by funding full-time Training and Partnership Development Coordinators. This role was instrumental in building relationships with initial health care sites, providing technical assistance and training to clinic staff, and providing consultation on clinic flow and system safety issues. However, some D/SV organizations have arranged on-site advocacy projects without this dedicated project staff person in place.

Conduct an environmental scan of local health care systems to identify where natural partnerships may first flourish, and best benefit survivors. Often health care settings most committed to women’s health have the greatest knowledge of or openness to learning about IPV. In *Safer Futures* sites’ experience, many health care settings have not prioritized addressing IPV; only after careful cultivation by the D/SV organization have larger systems taken on new projects and initiatives to address IPV. However, with health care transformation’s emphasis on social determinants of health, some providers and systems may be increasingly open to these collaborations.

To connect to the grant-identified service population (pregnant and newly parenting survivors), and to expand the community’s access to advocacy services, *Safer Futures* project sites initiated new partnerships with local hospitals, birthing centers, OB/GYN clinics and family health clinics. *Safer Futures* advocates and training coordinators attended provider staff meetings and conferences whenever possible to increase the visibility of their projects. Person-to-person and face-to-face interactions were the most powerful mode of communication.

Three of the project sites were represented on the local Community Advisory Council of their region’s CCO. Due to this increased representation, the projects successfully included IPV as a concern in their CCOs’ Community Health Needs Assessments and Community Health Improvement Plans. In addition to this systems advocacy, several projects were represented on community coalitions such as the local family violence council, child abuse multi-disciplinary team, or sexual assault response team, all of which also intersect with health care systems.

Networking and systems advocacy are core components of the community-building needed to establish partnerships. Another mechanism for *Safer Futures* partnership cultivation

was the creation of leadership teams. These leadership teams were specific to each project and involved health care partners in the development and implementation of the partnership.

SAFER FUTURES PARTNERSHIP FEATURE

One project established a formal partnership with one of Oregon’s nine federally recognized confederated Tribes, the Cow Creek Band of Umpqua Tribe of Indians. A representative from the Tribe’s Health and Wellness Center became a member of the *Safer Futures* Leadership Team. Cow Creek Band of Umpqua Tribe of Indians developed its brochure, “Violence Against Women - It’s Not Traditional,” to augment the project. This partnership has thrived, and grew to include an on-site advocate at the Tribe’s Health and Wellness Center.

To begin partnerships, *Safer Futures* sites often requested permission to post safety cards in clinic bathrooms or break rooms. Other times, partnerships began with conversations regarding needed IPV or trauma training for health care providers. As health care settings learn more about the health effects of IPV and the resources available, they often become even more motivated to improve services for survivors.

Other strategies for implementing a successful health care partnership project may include:

- ▶ Participating in CCO Community Advisory Council meetings;
- ▶ Creating ways for health care providers to contribute expertise on project leadership teams;
- ▶ Community education efforts about IPV and advocacy services; and
- ▶ Engaging on topics identified in Section 3, pages 26-27.

HEALTH CARE PARTNER SETTINGS

Safer Futures has found that health care settings are each unique to their community and to the type of health care provided. The partnership structure, the referral pathways, and how the advocate operates differ from site to site.

Safer Futures on-site advocacy sites included:

- ▶ Public health clinics
- ▶ Title X clinics such as Planned Parenthood
- ▶ Obstetrics and gynecology clinics
- ▶ Women, Infants and Children (WIC) programs

- ▶ Maternal and child health home visiting programs
- ▶ Federally qualified health centers (FQHCs)
- ▶ Community-based health centers
- ▶ Tribal health and wellness centers
- ▶ Drug and alcohol treatment programs
- ▶ Doula associations and midwives' groups
- ▶ Maternity homes
- ▶ Naturopathic physician groups
- ▶ Behavioral and mental health
- ▶ Patient Centered Primary Care Homes (PCPCHs)
- ▶ Hospitals
- ▶ School-based health centers

This is not an exhaustive list; each community may have other health care settings that present opportunities for partnering to reach and serve survivors. For example, "Resilience Clinics" are setting up around Oregon to respond to chronic pain management issues, and could be potential partnership sites. Under Oregon Public Health Modernization, many communities find that their local public health clinics are no longer providing direct services, or are providing reduced direct services. Oregon is attempting to transition the marginalized populations these safety net clinics serve to their CCOs and PCPCHs, as well as other providers.



Each clinic site will have different focus populations and priorities for providing care, as well as challenges to addressing IPV more broadly. It is important to develop an understanding of the goals of each health care setting to find intersections with D/SV organization strengths and resources. For example, a PCPCH will desire a different screening tool for universal application to its patient panel, versus a Title X reproductive health safety net clinic such as Planned Parenthood. Some clinics will want a universal screening model and others will want to tailor their intervention to certain visit types, such as a well-woman visit or an effective contraceptive use visit. Additionally, some clinics will be able to provide office space for advocates, and others will not be able to host an on-site advocate due to lack of space. In some communities, creative solutions such as a response team model may be necessary.

Ultimately, the best site for partnership will likely be the one that cares most about serving survivors, and has the strongest existing connection to the D/SV organization. Creating a successful partnership will be a learning curve for both the health care clinic site and for advocates. Health care providers will learn about IPV and advocacy services. D/SV organizations will learn about health care provider needs and goals, opportunities and barriers to receiving referrals, and challenges associated with hosting an advocate at the health care clinic.

PARTNERSHIP MODELS

New partnerships take time to develop, and implementing a new project also takes time. *Safer Futures* found that it took a minimum of one year to implement and streamline screening and referral processes and associated protocols for clinic work flow. Success in health care settings requires a holistic approach, and it is not as simple as establishing a referral procedure. In health care settings, screening and referral is a complex process and requires ongoing training on subject matter as well as project partner resources for successful implementation.

From 2014-2017, Portland State University Regional Research Institute and OCADSV evaluated the strength of partnerships established under the *Safer Futures* model. Findings from this evaluation resulted in these recommendations for cultivating strong health care partnerships:

- ▶ Negotiate information-sharing and confidentiality issues in advance;
- ▶ Make clear that D/SV advocates are not mandatory reporters;
- ▶ Address concerns about confidentiality of services and survivor privacy in the electronic health record;
- ▶ Develop a process in which survivors do not have to disclose abuse in order to receive information, relationship safety education, or referral information (i.e. the CUES intervention or other universal education);

- ▶ Place signs around the clinic that clearly state every patient will be seen alone for a portion of the health visit;
- ▶ Integrate on-site advocacy services and referrals into the existing business model and make sure practice flows well for all involved;
- ▶ Have the advocate physically present – this can normalize conversations about healthy and unhealthy relationships for both staff and patients;
- ▶ An advocate who is consistently on-site and integrated into the clinic’s daily operation is the best way to make advocacy services “part of business as usual”;
- ▶ Advocates must be proactive in engaging health care providers by offering “on the spot” education and consultation about IPV;
- ▶ Continuity of practice in IPV screening and advocacy response is essential for reaching survivors who are experiencing IPV;
- ▶ It is always preferable for a health care provider to make a warm referral to an advocate rather than provide a phone number or business card;
- ▶ In-house social workers or other behavioral health specialists may be able to help survivors connect with D/SV services, or refer to or host an on-site advocate;
- ▶ Survivors should be provided multiple opportunities to meet or connect with advocates; and
- ▶ D/SV organizations are encouraged to approach health care partnerships from a growth, rather than a fixed, mindset.¹⁰⁵

SAFER FUTURES PARTNERSHIP FEATURE

An example of how the partnership is structured and maintained between the community-based program and the health care provider is explained in this video: <https://youtu.be/YJEIBZpmtIU>. The video is a comprehensive review of the HAVEN From Domestic and Sexual Violence partnership with North Central Public Health District. This is an excellent example of a partnership co-training for on-site community-based advocacy in healthcare settings and the *Safer Futures* model collaboration.

SCREENING AND REFERRAL PRACTICES

Health care work typically uses an evidence-based diagnosis model, where treatment is provided to address a given diagnosis that has been identified by the provider through screening and assessment.

Screening usually consists of one or a limited number of questions that identify whether an assessment for a given health condition is required. If a “positive” screen occurs, sometimes an assessment is needed to gather further information from the patient about the possible health issue and develop a treatment plan. Other times, screening does not lead to further assessment.

Health care providers will not refer patients to a specialist, such as an advocate, without a screening or assessment tool that indicates a referral is necessary. Providers typically do not invest in building new referral pathways unless routine screening and appropriate assessment is established, and will not perform the intervention without protocols and policies that support routine screening for IPV. *Safer Futures* model projects invested in extensive partnership development and implementation planning in order to encourage health care settings to change work flow. Eventually these investments resulted in stronger referral practices to on-site or community-based advocates.

The mechanism for partnership with local health systems is built around screening and referral for IPV-specific services, such as advocacy. To start, find out how local providers and hospitals are screening for IPV and what their protocol is for a “positive screen.” D/SV organizations may need to encourage, train, and follow up with providers to help them refer survivors, and to support improvements in how they provide health services to survivors of IPV.

D/SV organizations may also remind health care providers of the Affordable Care Act mandates that women and children receive certain preventive health services at no additional cost to the patient. IPV screening and counseling is among the eight core preventive health services covered by this guidance. The Affordable Care Act says, “[IPV] screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts.”¹⁰⁶ Additionally, the U.S. Preventive Services Task Force (USPSTF) recommends universal screening for IPV occur at least once a year for all women of child-bearing age.¹⁰⁷ USPSTF is one of the most well-respected organizations in health care, and thus their recommendation carries significant weight.

Changes in federal administration bring certain tenets of the Affordable Care Act into political peril. However, the Affordable Care Act draws from older recommendations from multiple provider professional associations as well as regulatory bodies in health care. For example, one standard to reference when encouraging investment in IPV screening is the Joint Commission, the primary accreditation

105. Evaluation findings, Portland State University.

106. *Aca_implementation_faqs12*. (2013, May 08). Retrieved January 02, 2018, from https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.

107. USPSTF A and B Recommendations (n.d.). Retrieved January 02, 2018, from <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

organization for hospitals: “In addition to legal requirements for screening, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has created standards for treating suspected victims of abuse. These recommendations state that it is necessary for healthcare provider staff to demonstrate and prove competency in assessing for and reporting abuse. While only three brief standards are written, JCAHO has also noted in detail that the intent of these standards carries as much weight as the standard itself.

1. Possible victims of abuse are identified using criteria developed by the hospital.
2. Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process.
3. Leaders ensure that the competence of all staff is assessed, maintained, demonstrated and improved continually.”¹⁰⁸

“I am in labor giving birth to my baby and my partner is holding my hand. The nurse turns to me and says, ‘now I know this doesn’t apply to you, but do you feel safe at home?’”¹⁰⁹
 Survivor, *Safer Futures* participant

Guidelines and standards for best practice IPV screening are minimal, but evolving. For example, one of the most common screens for IPV that healthcare providers use is “do you feel safe at home?” However, no published studies have found a one-question screen to be a reliable and valid IPV screening tool. This is paradoxical in health care, where most other screening, assessment and treatment procedures are held to a high standard of evidence. D/SV organizations can support health care in adopting new practice that is consistent with existing and forthcoming evidence.

RECOMMENDED DISCLOSURE-BASED IPV SCREENING TOOLS AND PROCEDURES

- ▶ USPSTF performed a systematic evidence review and noted several screening instruments with high sensitivity and specificity for identifying IPV in the health care setting. Their recommendations may be viewed here: <http://www.uspreventiveservicestaskforce.org/3rduspstf/famviolence/famviolrs.htm>

- ▶ The CDC also published a compilation of assessment tools for IPV that compares existing tools, available at: <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>

Disclosure-based IPV screening tools (whose purpose is to identify survivors of IPV) on their own are not helpful in improving the health and safety of survivors. Survivors who are most in need of help sometimes will not disclose, because of fear and trauma impacts. To address this gap in practice, new tools are being developed and evaluated. Universal education methods provide information to all patients, rather than relying on disclosure to promote information and referral, and thereby reach everyone who may currently or in future experience IPV. By providing information about healthy relationships and information on local advocacy resources, health care providers can contribute to prevention, in addition to supporting access to services for those currently experiencing IPV. The CUES intervention is one such approach and is based on universal education about healthy and unhealthy relationships.

UNIVERSAL EDUCATION MODEL FOR ASSESSMENT AND IDENTIFICATION OF IPV

The CUES model (Confidentiality, Universal Education, Support) was developed by Futures Without Violence, and is recommended by the American Congress of Obstetricians and Gynecologists. CUES is a brochure-based universal education intervention that uses a pocket-sized safety card designed to prompt a brief conversation about healthy relationships and IPV between the health care provider and the patient.

Safety cards have relationship self-assessment questions on the back, information about why healthy relationships are important for good health, and the D/SV organization’s contact information. The CUES model was first piloted in Oregon with *Project Connect*. It is identified as the preferred practice model by most *Safer Futures* sites and OCADSV.

The CUES intervention is adapted by Futures Without Violence to fit distinct types of health care settings. Health care providers can find guidance on www.ipvhealth.org about customizing the CUES intervention so it best fits within the flow of a routine visit. Health care providers who receive training on the CUES intervention are taught how to appropriately respond to disclosures of IPV and to refer to a community-based advocate. CUES emphasizes:

1. Confidentiality
 - a. Disclose any limits of confidentiality
2. Universal education
 - a. Normalize the activity: “I’ve started giving this card to all of my patients...”

108. Scott CJ, Matriccian RM (1994). Joint Commission on Accreditation of Healthcare Organizations standards to improve care for victims of abuse. *Maryland Med Journal*. 43(10): p. 891-8.
 109. Evaluation findings, Portland State University.

- b. Open the card and do a quick review: "It talks about healthy and safe relationships... and how relationships affect your health."
- c. Ask patients: "Is this happening to you?"
- 3. Support
 - a. Discuss specific harm reduction strategies
- 4. Warm referral to advocate, and follow-up by provider at next visit

The intervention's online toolkit, provided free of charge by Futures Without Violence's National Health Resource Center on Domestic Violence, can be found at www.ipvhealth.org.

PROJECT CONNECT PARTNER STORY

The Futures Without Violence CUES intervention is not designed to elicit disclosures of abuse: it is focused on patient education and outreach about healthy relationships, and referrals to local D/SV advocates when IPV is identified. Survivors are connected to appropriate resources, although sometimes not in the way health care providers initially anticipate. One health care clinic that was a *Project Connect* partner used the Futures Without Violence CUES safety card intervention. After its rollout, the health care providers at the clinic wondered if the intervention was successful. The nurses implementing the model went to great lengths to update protocols to better address IPV. Naturally they expected to receive more disclosures of violence from patients, yet they did not see an increase in disclosures. However, front-line staff at the clinic said brochures about the local D/SV organization were "flying" out the door, and they regularly restocked the safety cards. The D/SV organization also reported seeing a significant increase in referrals from the clinic staff who were connecting survivors to advocacy services.

Each health care setting will determine protocols for IPV screening and assessment that best meet the needs of their clinic practice and patient population. The following are examples from *Safer Futures* sites:

- ▶ *Establish clinic protocols that ensure all patients are seen privately by a health care provider at some point during an appointment.* This allows providers an opportunity to

privately discuss healthy relationships and relationship safety without the presence of a potentially abusive partner. A survivor is more likely to talk about IPV with their health care provider when they are alone. Tillamook County Community Health Center posted a sign in the lobby that reads, "In this clinic, we respect the patient's right to privacy and always see patients alone for some portion of the visit." Umpqua Community Health Clinic has implemented a similar approach.

- ▶ *Include an IPV screening question in the Electronic Health Record (EHR).* In Roseburg, OR, Umpqua Health Authority created a screening tool algorithm for its EHR. In The Dalles, OR, North Central Public Health Department added a similar screening option to its EHR. Providers there are required to ask about IPV and make a referral to an advocate if there is a disclosure. Planned Parenthood Columbia Willamette also included IPV assessment (based on the CUES intervention) as a part of its EHR. In these examples, *Safer Futures* sites reviewed clinic practices for identifying IPV and making referrals to an advocate. This review informed the training health care providers received about IPV.



Tillamook County Women's Resource Center staff and partners.

- ▶ *Establish clinic protocols that allow for advocates to meet with people who have appointments for pregnancy tests or new pregnancies.* Tillamook County Community Health Center makes note of anyone who receives a pregnancy test or is newly pregnant in the clinic. The attending nurse asks the patient if they would be willing to meet with an advocate, introduced as "my colleague who specializes in healthy relationships." The nurse offers this meeting as a way to learn about how relationships impact health. The advocate is then able to discretely determine if IPV is a risk factor for the patient while offering helpful, preventive information.

REFERRAL PRACTICES

Some patients choose to disclose IPV directly to their health care provider, with or without the process of a screening

tool. One study found that those who disclosed recent IPV had a 71% reduction in the odds of pregnancy pressure and coercion.¹¹⁰ Women who received information about safety were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe, regardless of whether they had disclosed a history of IPV.¹¹¹ After a disclosure, providers have several options for ways to make referrals to advocates. Referrals may occur:

- ▶ In person or by phone from a provider. These referrals are most successful when the provider makes the connection with the advocate before the survivor leaves an appointment (i.e. warm referral). When an advocate is on-site, providers are encouraged to introduce the survivor to the advocate in-person. This can happen by inviting an advocate into the appointment room or arranging for the advocate to meet with the survivor immediately after the appointment;
- ▶ By phone when the survivor calls the crisis line or advocate’s direct line (when the advocate is off-site or cannot be reached immediately). Sometimes the survivor calls the crisis line or the advocate’s direct number because it was given to them by the provider. Many times the survivor called after seeing a flyer, poster or brochure advertising the D/SV organization’s services;
- ▶ Via a paper referral form and release of information the provider completes and routes to the advocate’s desk;

- ▶ Via electronic referrals that are embedded as a function of the EHR. At the time when a provider makes an electronic referral to an advocate, it is possible for the provider to see a screen that provides the D/SV organization’s crisis line number and/or webpage address; and
- ▶ Via referral software which can be used to submit referrals confidentially via an intra-software email system.

SAFER FUTURES PROGRAM FEATURE

A nurse practitioner from the family health center shared this ‘ah-ha!’ moment. She had completed a routine wellness questionnaire with a patient that included the question, “Does your partner shame or humiliate you in front of others or in private?” The patient answered yes to this question, and the provider connected the patient to the *Safer Futures* advocate. At the six-month follow up appointment, the patient voluntarily mentioned that she benefited from the referral to the advocate. The nurse practitioner came away from this experience with a new appreciation for how a brief intervention on her part combined with a referral to advocacy services has a meaningful impact. This nurse practitioner is now a ‘true believer’ in speaking to patients about IPV.¹¹²



Project sites have developed several ways to prompt providers to make referrals. Referrals most often come from providers when IPV is disclosed after a screening question is asked or a safety card conversation occurs. Consultations with and trainings for providers also result in more referrals. Other key strategies for prompting provider referrals are:

- ▶ Safety cards, flyers, brochures on display in clinic exam rooms and waiting areas;
- ▶ Strong relationships with health care providers;
- ▶ Visibility of advocate at the clinic; and
- ▶ Sample scripts for providers to use in screening and referring survivors.

As partnerships become established, survivors also learn about advocacy services through word of mouth. *Safer Futures* sites report survivors contacting them after hearing about services from a friend or family member. Universal education models such as CUES often result in word of mouth referrals, as all patients receive the information and resources.

110. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*. 2011;83:274-280.

111. McFarlane J et al (2006). Secondary Prevention of Intimate Partner Violence.

112. Evaluation findings, Portland State University.

WORKING WITH PROVIDERS TRAINING

By providing training to health care providers, D/SV organizations improve health care provider response to survivors of IPV. Training ensures that providers have the knowledge and tools necessary to appropriately respond to IPV and safely connect survivors to advocates or other support. Training content may include subjects such as:

- ▶ Screening and intervention tools for IPV in health and maternal care settings
- ▶ Dynamics of IPV
- ▶ Promoting healthy relationships as violence prevention
- ▶ IPV and its adverse impact on health and pregnancy outcomes
- ▶ Trauma-informed care (including trauma-informed birth planning and safety planning)
- ▶ Recognizing and responding to human trafficking in health care settings
- ▶ Reproductive and sexual coercion
- ▶ Adverse Childhood Experiences and resiliency
- ▶ Vicarious trauma
- ▶ Supporting staff

Safer Futures project staff also trained their own organizations on health effects of IPV, for the purpose of incorporating health considerations into advocacy practice. Futures Without Violence has a wealth of training materials with train-the-trainer support. An example of a training is stored online as a recorded webinar, and introduces the Futures Without Violence *Project Connect* model. This training reviews tools and materials to assess and respond to IPV, reproductive and sexual coercion, impacts of IPV on long-term health, evidence-based intervention and referral practices. The training may be viewed here: <https://www.ocadsv.org/resources/browse/741>

CONSULTATION

In order to strengthen clinic response to IPV, D/SV advocates consult with health care providers on a variety of issues. Advocates consult about the indicators and dynamics of IPV, adverse health and pregnancy impacts of IPV, safety planning, resources for patients (including culturally specific resources), and how to use Futures Without Violence CUES safety cards and other interventions. However, it may take time for advocates to establish relationships and build trust with clinic staff before consultations are likely to occur.

An important area of consultation is privacy and confidentiality (for more information on legal requirements, see Section 6). Because of mandatory reporting laws and



other limits to provider confidentiality, it is important for providers who do ask an IPV screening question to divulge any obligations they have to share or report information that patients may disclose to them. This gives the survivor an opportunity to control their own information, a vital practice in support of survivor empowerment and safety.

PROVIDER FEEDBACK

Measuring health care provider satisfaction with new IPV training, screening and referral processes helped *Safer Futures* projects make improvements. Most *Safer Futures* projects used training evaluations with Likert scales that asked health care providers to rate their understanding of the topic before and after the presentation, as well as to rate the quality of the speaker. Focus groups and interviews with health care providers qualitatively measured the impact of the trainings and of the partnership. See pages 30-31 for results of focus groups and interviews with health care providers conducted by *Safer Futures*.

SUSTAINABILITY

Safer Futures asked its sites to incorporate and engage in sustainability planning from the very beginning of the project. *Safer Futures* used a sustainability framework called "Building Sustainable Programs: The Resource Guide."¹¹³ D/SV organizations that created sustainability plans were much more likely to secure continued resources to continue implementation of the *Safer Futures* model based on the following actions:

- ▶ Seeking future funding opportunities
- ▶ Finding pathways for advocacy services to successfully interface with health care systems

113. Health (2017, March 01). Sustainability & Community Mobilization. Retrieved January 09, 2018, from <https://www.hhs.gov/ash/oah/resources-and-training/tpp-and-paf-resources/community-mobilization-and-sustainability/index.html>.

- ▶ Evaluating project activities
- ▶ Finding new opportunities to improve IPV interventions and promoting practice change
- ▶ Replicating and extending the reach of on-site advocacy

Sustainability of *Safer Futures* projects was largely informed by assessment and evaluation, and considered the following measures of success:

- ▶ How well the project integrated into local infrastructure
- ▶ Impact of services on the community
- ▶ Investment of project leadership team
- ▶ How well project leveraged strategic partnerships
- ▶ Ability to secure future funding
- ▶ Ability to change and adapt
- ▶ Ability to execute an action strategy
- ▶ How well project knew its environment

Health care systems and communities rely on information about the impact and positive outcomes of a new intervention in considering whether to make a future investment. Thus, research and evaluation are essential to the iterative process of sustainability planning and development.

CONCLUSION

While health care systems typically prioritize evidence-based approaches, studies have shown that current health care practice related to IPV has not kept pace with this expectation; many screening and intervention practices commonly used in health care settings are not effective. Beyond a few limited studies there is a gap in existing literature regarding which health care-based interventions truly improve the health and safety of victims of IPV.¹¹⁴

Policy makers such as the Institute of Medicine and USPSTF have identified the importance of addressing IPV, yet there are no clear mechanisms for incentivizing health care systems to provide IPV screening and counseling, and best practice data is limited. Incomplete or ill-informed interventions can prove ineffective, and can even increase danger for survivors of IPV; it is vital for health care providers to have a knowledgeable plan, when screening for and responding to IPV.

Even with existing challenges to related best practice, as well as limits of confidentiality and increased safety risks, health care settings provide a unique opportunity for screening and intervention. This is due to trusting relationships that many providers cultivate with patients, and because health appointments are sometimes the only time a person has away from their abusive partner. Most IPV survivors do want their clinician to address IPV in the health care setting. In four separate studies of abuse survivors, 70% to 81% of the patients studied reported they would like their health care provider to ask them privately about IPV.¹¹⁵

D/SV advocacy organizations present solutions to some of these challenges. Existing best practice from the D/SV field can inform and strengthen health care response. On-site advocates placed in health care settings – like advocates co-located with law enforcement, child welfare, WIC offices, and other human service departments – can be powerful allies in promoting survivor health and safety. They can support health care providers and systems to design sensitive, effective methods for IPV intervention and response.



114. O'Doherty LJ, Taft A, Hegarty K, Ramsay J, Davidson LL, Feder Gene et al (2014). Screening women for intimate partner violence in health care settings: abridged Cochrane systematic review and meta-analysis. *BMJ*. 348:g2913.

115. Chamberlain (n.d.). Addressing Intimate Partner Violence, Reproductive and Sexual Coercion.

SECTION 5: ON-SITE ADVOCACY IN HEALTH CARE SETTINGS

SAFER FUTURES PROGRAM FEATURE

“This woman and her family visited the clinic for their medical needs. Providers and medical assistants talked about how she always missed her children’s appointments, never followed through with routine or preventive medical care, always seemed to be in a hurry, was demanding, etc. After some training and further consultations with the medical team, I received a referral to meet with the woman. After learning about domestic violence dynamics, the team changed their mindset from ‘victim blaming’ comments to focus instead on the extensive barriers the woman was facing in order to just meet her children’s needs. The woman and her children were surviving in an extremely violent relationship. Together we made progress supporting her and her family with various advocacy and health services. With emergency funds from *Safer Futures*, the family was temporarily put up in a hotel until safer, more sustainable housing was available. Through support groups, peer counseling, and advocacy the woman is achieving personal goals she thought were impossible. Instead of having to constantly react in crisis mode, she is now able to plan for the future, for the health and happiness of her family. She has attained custody of her children, found safe and sustainable housing, and is actively engaged in accessing preventive and routine physical and mental health care for herself and her children.”¹¹⁶

Community-based D/SV advocates use an empowerment approach to serve survivors of IPV, domestic violence, sexual assault and stalking. This work is survivor-centered, trauma-informed, anti-oppressive, and promotes survivor choice, self-determination and safety. D/SV advocacy is informed by an understanding of structural oppression and cultures of violence. According to researcher Cris Sullivan, “The advocacy intervention is holistic, client-driven (vs. services-, funding-, or diagnosis-driven), and strengths-based.

Advocates partner with women who have experienced IPV and work with them to define what their needs are, seek help from multiple service providers, and obtain effective help that meets their self-defined needs.”¹¹⁷

Because marginalized communities experience disproportionate impacts, addressing IPV is both a public health and an equity issue, and advocacy interventions center the experiences of underserved survivors and communities. Advocacy positions IPV intervention within social justice movements, connected to economic justice, reproductive justice, ending hyper-incarceration, etc.¹¹⁸

In accordance with ORS 40.264 (passed by the Oregon legislature in 2015 as HB 3476), advocates in Oregon who are certified to work with survivors are granted legal privilege (see Section 6, page 45 for more information). In order to become certified, advocates must work at an approved community-based or higher education D/SV organization, receive a minimum of 40 hours of training, and fulfill additional requirements. OCADSV offers core advocacy training online and in person to member program staff.

THIS SECTION PROVIDES INFORMATION ABOUT INTEGRATING ADVOCACY SERVICES IN HEALTH CARE SETTINGS USING ABOVE-DESCRIBED PARTNERSHIP OPPORTUNITIES. TOPICS COVERED INCLUDE:

- ▶ Advocacy interventions in the literature ... P. 38
- ▶ Advocacy roles P. 39
 - Supportive social services P. 39
 - Intervention services P. 40
 - Accompaniment services P. 40
 - Support and education groups P. 40
 - Common barriers to advocacy services P. 41
 - Emergency assistance P. 41
- ▶ *Safer Futures* evaluation of advocacy services P. 42

116. Evaluation findings, Portland State University.

117. Sullivan CM (2012, October). Examining the Work of Domestic Violence Programs Within a ‘Social and Emotional Well-Being Promotion.’ Conceptual Framework, Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved 05/17/2016, from: <http://www.dvevidenceproject.org>.

118. Mehrotra GR (2016). The Braid That Binds Us.

ADVOCACY INTERVENTIONS IN THE LITERATURE

Safer Futures draws from best practice intervention models proven to enhance the health and well-being of IPV survivors, coupled with the depth of experience of Oregon's community-based D/SV organizations. This survivor-centered advocacy model emphasizes access to social and community support and resources to foster enhanced quality of life as well as feelings of control and self-efficacy. A sense of control and self-efficacy is "understood to contribute to positive mental health outcomes among sexually and physically victimized women."¹¹⁹



When considering instituting new practices, health care systems typically look to the literature for evidence of efficacy. Advocacy services are a demonstrated means of promoting safety, self-determination, well-being, and enhancing social support and access to community resources. In an evaluation of five empirical studies affirming the efficacy of advocacy services for survivors of IPV, Sullivan demonstrates that women who worked with advocates experienced less violence over time and reported a higher quality of life, including improved depression and self-esteem. Sullivan hypothesizes that the improvement of subjective well-being served as a protective factor in minimizing the likelihood of future victimization. However, Sullivan argues that this upward mobility can only be sustained through the retention of access to community resources and social support.¹²⁰

Further, Sullivan cites an advocacy study through legal system responses, in which survivors proactively contacted by local D/SV organizations reported less depression, fear, and fewer PTSD symptoms than women referred to D/SV services by court advocates.¹²¹ This supports the findings from Bell and Goodman's study, "Supporting Battered Women Involved with the Court System: An evaluation of a law school-based advocacy intervention." In this study, survivors who received intensive advocacy reported decreased physical and psychological abuse six weeks later and comparably higher emotional well-being to the control group that received "services as usual."¹²² Taking these empirical findings into account, Sullivan ultimately concludes, "domestic violence programs are engaging in effectual practices that are likely to achieve their goal of enhancing the well-being of survivors and their children."¹²³

Other studies resoundingly confirm this assertion. In Bradshaw and Lyon's report, "Meeting Survivors' Needs Through Non-Residential Domestic Violence Services and Supports: Results of a Multi-State Study," data was analyzed from 90 community-based D/SV programs. Ninety-five percent of survivors reported feeling more knowledgeable about planning for their safety and more hopeful for their futures.¹²⁴

Further research focused specifically on advocacy services in health care settings is needed. However, several studies indicate potential for advocacy in these settings to help survivors achieve better health outcomes. One study evaluated the efficacy of counseling-specific interventions in reducing IPV recurrence during pregnancy and postpartum, as well as improving birth outcomes in African American women. In "An integrated intervention to reduce intimate partner violence in pregnancy: A randomized trial," women randomly assigned to the intervention group (counseling sessions provided by master's level social workers or psychologists) were less likely to have recurrent episodes of IPV victimization and had significantly fewer very preterm (28-32 weeks) births. These results show that utilizing an intervention model targeting culturally specific risk factors not only reduces IPV during and post pregnancy, but also reduces neonatal mortality rates. Thus, interventions in health care settings offer potential positive health outcomes for survivors and their children.¹²⁵

119. Bybee DI, Sullivan CM (2002). The process through which an advocacy intervention resulted in positive change for battered women over time. *American Journal of Community Psychology*, 30, 103–132.

120. Sullivan CM (2012). Examining the Work of Domestic Violence Programs Within a 'Social and Emotional Well-Being Promotion.'

121. DePrince AP, Labus J, Belknap J, Buckingham S, Gover A (2012). The impact of community-based outreach on psychological distress and victim safety in women exposed to intimate partner abuse. *Journal of Consulting and Clinical Psychology*, 80 (2), 211–221.

122. Bell ME, Goodman LA (2001). Supporting battered women involved with the court system: An evaluation of a law school-based advocacy intervention. *Violence Against Women*, 7(12), 1377–1404.

123. Sullivan CM (2012). Examining the Work of Domestic Violence Programs Within a 'Social and Emotional Well-Being Promotion.'

124. Bradshaw J, Lyon E, Menard A (2012, February). Meeting Survivors' Needs Through Non-Residential Domestic Violence Services and Supports: Results of a Multi-State Study. Key Findings and Frequently Asked Questions. Prepared for the National Institute of Justice by the National Resource Center on Domestic Violence. Grant No. 2009-IJ-CX-0027.

125. Kiely M, El-Mohandes E, El-Khorazaty MN, Gantz MG (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized trial. *Obstetrics & Gynecology*, 115, 273–283.

COMMUNITY-BASED ADVOCATES ARE “trained professionals specializing in confidential, trauma-informed services for survivors of IPV. Advocates work from a social justice and equity lens, providing a broad range of essential services to survivors and their families. They offer support, information, safety planning, referrals, assistance with protective orders, trauma informed system navigation and accompaniment, including connections to legal, medical and community resources. D/SV organizations generally offer a mix of emergency safe housing and long-term shelter while connecting survivors to employment services, financial supports (i.e. WIC, SNAP, DHS TANF and TADV grants), food and housing supports and health care services. Advocates individualize services to each survivor’s resources and needs in order to increase safety, self-efficacy, and to reduce the chronic toxic stress and other effects of trauma exposure.”¹²⁷

A study entitled “Effect of an in-clinic IPV advocate intervention to increase help seeking, reduce violence and improve well-being,” that examined the efficacy of clinic-based IPV advocacy, showed that survivors referred to on-site advocates experienced reduced violence and depressive symptoms, leading to a reduction in suicidal ideation. These positive impacts were more significant than those associated with usual care, pointing to the impact of on-site advocacy on safety and health outcomes for survivors. Furthermore, immediate access to on-site advocates increased provider screening rates, confidence and self-efficacy. Collaboration between D/SV organizations and health care providers ensured an ongoing relationship that facilitated future transitions to care.¹²⁶ The on-site advocacy model benefits both survivor and health care provider, supplying the survivor with intensive support and access to IPV resources that a health care provider may be unable to deliver.

ADVOCACY ROLES

Safer Futures sites provided an array of advocacy services to 1,720 pregnant and newly parenting survivors during the four year project period. Supportive social services accounted for the largest percentage of *Safer Futures* services offered (46%), of which in-person and phone information and referral was

most frequently provided. Intervention services accounted for 35% of the advocate’s services, of which safety planning was most frequently provided. Accompaniment services accounted for 19% of the services offered.

Examples of each service type are:

SUPPORTIVE SOCIAL SERVICES

- ▶ Information about and referral to community resources (provided in person or by phone)
- ▶ Child care referral and assistance
- ▶ Transportation assistance (bus tickets, pre-paid taxi rides)
- ▶ Transitional housing assistance
- ▶ Home visitation
- ▶ Connecting survivors to self-care options like yoga or parent/baby play groups
- ▶ Education assistance (GEDs, community college classes, parenting classes)
- ▶ Employment assistance (resume development, job search)
- ▶ Help applying for cash assistance (TANF), food stamps (SNAP), etc.



126. Guanciale K et al (2017). *Integrating Intimate Partner Violence Advocacy in Health Care Services and Benefits*. Find this report at <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>

127. O’Campo P, Kirst M, Tsamis C, Chambers C, Ahmad F (2011, January). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Elsevier Journal of Social Science and Medicine*, 73, 855-866.

SAFER FUTURES PROGRAM FEATURE

Safer Futures advocacy services were expanded to include doula support (pregnancy, birth, and postpartum) and prenatal yoga. Battered Persons’ Advocacy and Tillamook County Women’s Resource Center added doula services to their service menus as a tool for providing support to survivors during pregnancy, birth and postpartum. Advocates received doula training and became certified as birth and postpartum doula practitioners. Certification as doula practitioners has improved the advocates’ reputation among health care providers resulting in increased referrals for service. Both D/SV organizations reported on the tremendous benefits the doula services had for pregnant women who are survivors of IPV.

Suggested reading for D/SV organizations and their advocates regarding the benefits of doula services include: 1) *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women* written by Penny Simkin, PT and Phyllis Klaus, MFT, and 2) *Survivor Moms: Women’s Stories of Birthing, Mothering and Healing after Sexual Abuse* written by Mickey Sperlich, MA, CPM and Julia S. Seng, PhD, CNM.

Over the course of the *Safer Futures* project, advocates expanded supportive social services to include:

- ▶ Connecting survivors to health care providers and services
- ▶ Help with health care enrollment
- ▶ Assistance obtaining and understanding insurance benefits and coverage
- ▶ Relationship safety assessment and healthy relationship education
- ▶ Information about birth control options
- ▶ Pregnancy and parenting education
- ▶ Yoga/prenatal yoga instruction
- ▶ Connecting survivors to maternal/infant health programs (WIC, La Leche League)

INTERVENTION SERVICES

- ▶ Safety planning
- ▶ In-person crisis counseling
- ▶ Legal and court advocacy
- ▶ Assistance with restraining orders
- ▶ Emergency assistance (vouchers for attorney consultations, baby supplies, gas, food, etc.)

- ▶ Emergency housing support (including advocacy around tenant rights for IPV victims)

ACCOMPANIMENT SERVICES

- ▶ Accompaniment to court hearings (criminal, child custody, divorce, Citizen Review Board)
- ▶ Accompaniment to child welfare/child protective services case planning meetings
- ▶ Accompaniment to medical appointments (and help scheduling appointments)

SUPPORT AND EDUCATION GROUPS

Safer Futures advocates are cross-trained in additional skills to complement their advocacy services. Training in mindfulness-based stress reduction and mindfulness movement can provide advocates with useful skills to pass on to survivors. Mindfulness-based stress reduction techniques teach survivors to harness their own innate

SAFER FUTURES PROGRAM FEATURE

A *Safer Futures* advocate supported a pregnant adolescent survivor of IPV who was to give birth while she was incarcerated. The advocate made special arrangements with the public health department and the corrections facility to support the survivor during her last weeks of pregnancy and at birth. The survivor gave birth at a local hospital and remained there for three days after birth. This gave the survivor and her baby an opportunity to bond and begin breastfeeding. Afterward the survivor was permitted to keep the baby with her at the correctional facility for seven days. After the seven days was over, the advocate coordinated with the survivor’s parent to care for the infant. The D/SV organization¹²⁸ made space in its shelter for the survivor’s parent to stay with the infant for 45 days. This allowed the survivor to continue breastfeeding the infant twice a day. The advocate arranged for the survivor to have a breast pump so that milk could be sent back to the shelter. After 45 days, the survivor was permitted to finish her sentence at another correctional facility near her parent’s home. The survivor’s attorney filed a downward motion with the court and secured her early release from the correctional facility. The survivor reunited with her infant two months after giving birth.¹²⁹

128. Haven From Domestic Violence, The Dalles, OR.
 129. Evaluation findings, Portland State University.

abilities to diminish stress and pain. The intended result is that survivors experience improvements to their overall physical and mental health.^{130,131} Art-based therapies are also useful in helping survivors of IPV find healing.^{132,133} Battered Persons' Advocacy offered support groups using *A Window Between Worlds* art-based curriculum. The support groups use a combination of art, journaling, discussion, embodied movement (i.e. hula-hoop and yoga), and mindfulness practices to empower participants and promote healing. One activity asked participants to write a safety plan and create a mandala to symbolize their plan. Participants in this group reported that the groups were useful for gaining freedom from domestic violence, and helped them find the courage to make healthy decisions for their future. One participant offered this feedback about the group, "I like this group. It seems like it will help me keep me and my children safe, and there is fun stuff to do."¹³⁴

SAFER FUTURES PROGRAM FEATURE

The advocate at HAVEN From Domestic and Sexual Violence routinely joined public health staff on their long drives to remote areas of the region. During the car ride, the advocate consulted with the nurses about the value of the CUES intervention and the advocacy services. The advocate used the time to debrief with the nurses about their experiences using the CUES intervention. The advocate was included as a regular part of the monthly WIC (Women, Infant and Children) clinics. Survivors living in these remote areas were able to regularly access the advocate's services.

- ▶ Stable, long-term, safe and affordable housing
- ▶ Adequate income (some survivors report having no income at all)
- ▶ Physical and mental well-being, especially after years of experiencing violence, oppression and instability
- ▶ Affordable and accessible legal assistance

EMERGENCY ASSISTANCE

Safer Futures sites used emergency assistance funds to decrease barriers survivors faced and to improve maternal/infant health and well-being. Examples of emergency assistance provided include:

- ▶ Baby supplies such as formula, bottles, diapers, wipes, clothing, car seats, cribs, etc.
- ▶ Child care assistance for survivors to attend health care appointments
- ▶ Breast-feeding support such as lactation consultation and breast pumps
- ▶ Housing assistance (e.g. rental security deposit, first month's rent)
- ▶ Fee for initial attorney consultation
- ▶ Emergency shelter (e.g. limited hotel stay)
- ▶ Emergency transportation assistance (e.g. gas or taxi vouchers, bus tickets, minor repairs to cars and bicycles)
- ▶ Utility assistance (e.g. purchasing cell phone minutes, one-time assistance with water and electric bills)
- ▶ Replacement of birth certificates, social security cards, and other personal identification
- ▶ Grocery and household items
- ▶ Secure and confidential mailbox
- ▶ Changing locks on a survivor's place of residence
- ▶ Pregnancy tests
- ▶ Emergency contraception
- ▶ Legal filing and service fees (e.g. custody, divorce, sheriff)
- ▶ Attorney consultation for contested protective orders

COMMON BARRIERS TO ADVOCACY SERVICES

Survivors faced various barriers that restricted their ability to fully participate in *Safer Futures* advocacy services. *Safer Futures* sites reported that survivors often lacked:

- ▶ Safe, affordable and flexible child care
- ▶ A means of communication (i.e. cell phones with usable minutes; restricted cell phone service in remote areas)
- ▶ Sufficient and reliable transportation, particularly in rural/frontier areas
- ▶ Access to everyday necessities such as groceries and gas, particularly in rural/frontier areas

"I can provide for my children's basic needs because she bought me a mini-fridge. She also helped me with diapers, clothing and basic needs."
Survivor, *Safer Futures* participant¹³⁵

130. Goldsmith R, Gerhart J, Chesney S (2014). Mindfulness-Based Stress Reduction for Posttraumatic Stress Symptoms: Building Acceptance and Decreasing Shame. *Journal of Evidence-Based Complementary & Alternative Medicine*, 19(4) 227-234.
 131. Grossman P, Niemann L, Schmidt S, Walach H (2004). Mindfulness-Based Stress Reduction and Health Benefits: A Meta-Analysis. *Journal of Psychosomatic Research*, 57(1), 35-43.
 132. Schouten K, de Niet G, Knipscheer J, Kleber R, Hutschemaekers G (2015). The Effectiveness of Art Therapy in the Treatment of Traumatized Adults: A systematic review on art therapy and trauma. *Trauma, Violence, Abuse*, 16(2), 220-228.
 133. Schouten K, de Niet G, Knipscheer J, Kleber R, Hutschemaekers G (2015). The Effectiveness of Art Therapy in the Treatment of Traumatized Adults: A systematic review on art therapy and trauma. *Trauma, Violence, Abuse*, 16(2), 220-228.
 134. Bolwerk A, Mack-Andrick J, Lang F, Dörfner A, Maihöfner C (2014). How Art Changes Your Brain: Differential Effects of Visual Art Production and Cognitive Art Evaluation on Functional Brain Connectivity. *PLOS ONE* 9(12): e116548.
 135. Evaluation findings, Portland State University.

“I am safe. My children are safe.
 I don’t live every day in fear.
 I feel stronger than ever.”
 Survivor, *Safer Futures* participant¹³⁶

SAFER FUTURES EVALUATION OF ADVOCACY SERVICES

Portland State University (PSU) Regional Research Institute conducted an evaluation of the *Safer Futures* model to measure the impact of its advocacy services on survivors’ lives. The evaluation took place in stages between 2014 and 2017. PSU conducted a study to better understand the pathways through which referrals came to advocates from health care providers. The results of this study are found in pages 30-31. PSU also helped *Safer Futures* design a participant survey comprised of eight questions. The five project sites asked survivors to respond to this survey online using a tablet provided by the advocate or via a link sent directly to the survivor’s phone. The three main questions that were asked yielded very positive results.

- ▶ 100% of respondents strongly agreed or agreed that because of working with the advocate, “I can make more informed choices about my situation.”
- ▶ 100% of respondents strongly agreed or agreed that because of working with the advocate, “I know more about resources available to me, including how to get them.”
- ▶ 97% of respondents strongly agreed or agreed that because of working with the advocate, “I have new ideas for how to stay safe.”

PSU also supported *Safer Futures* sites in conducting local evaluations. Both Tillamook County Women’s Resource Center (TCWRC) and HAVEN evaluated the impact of their services on survivors and assessed health care partners’ capacity to implement the Futures Without Violence CUES intervention and advocate referral process. Both sites convened focus groups and conducted interviews with English and Spanish speaking survivors. Participants were provided with child care, transportation assistance and a gift card for their participation. TCWRC also gathered qualitative data to supplement quantitative data gleaned from individual participant surveys. Findings from the evaluation included:

- ▶ A significant number of those surveyed reported that their health care provider had discussions with them about their relationship;

- ▶ In those cases where relationships were discussed with the health care provider, it was after the patient had self-disclosed IPV;
- ▶ Only a few survivors reported having received a Futures Without Violence safety card from their health care provider;
- ▶ Nearly all those interviewed had seen the Futures Without Violence safety cards and other printed material about IPV displayed in the clinic;
- ▶ Multiple survivors reported having experienced intergenerational violence and a sense of pride for interrupting the cycle of violence for themselves and their children. One survivor said “My kids are actually able to go outside and play;”
- ▶ Survivors expressed gratitude for the advocate and the services provided. One survivor shared, “Whether she knows it or not, she built up my confidence. That’s a big thing.”

In the fourth year of the *Safer Futures* project, TCWRC, OCADSV and PSU conducted an evaluation using an Explanatory Sequential Mixed Methods design to measure the outcomes of the local project.¹³⁷ TCWRC used qualitative and quantitative methods such as a patient feedback survey, an “advocate tracking tool”, and interviews with survivors and health care providers. Throughout the fall 2016, TCWRC worked with its leadership team (comprised of health care professionals from its two partnering health care clinics and representatives from the local CCO) to develop the evaluation design and tools.



136. Evaluation findings, Portland State University.

137. Guanciale K, Leighton M, Knopf N, White H, Keefe S, Fanjoy E, Widener-Richardson E, Bundy V (2017). *Integrating Intimate Partner Violence Advocacy in Health Care Services and Benefits*. Find this report at <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>.

TCWRC conducted a patient feedback survey to learn about patients' experiences addressing IPV in a healthcare context. The survey results were compiled by a team at the University of Pittsburgh, a connection made possible by TCWRC's involvement in a Futures Without Violence national pilot project. PSU assisted TCWRC in developing an "advocate tracking tool" to measure the breadth of advocate services and the time spent and frequency of delivering these services. PSU and OCADSV conducted survivor and health care provider interviews in order to learn what impact the advocate's services had on survivors' lives and to learn about providers' experiences working with advocates. TCWRC conducted several short preparatory trainings on the CUES intervention with health care providers at the Tillamook County Community Health Center. These trainings were finished just prior to the two week collection period of the patient feedback survey. The goal was to collect a minimum of 50 surveys from patients at the Tillamook County Community Health Center. Sixty-two (62) surveys were returned in both English and Spanish.

Key findings from the patient feedback survey were:

- ▶ Over 92% of the respondents said their health care provider talked to them about IPV and health impacts;
- ▶ 54% of respondents reported a lifetime experience of intimate partner or sexual violence, though fewer than half of them disclosed it to their provider;
- ▶ 70% said they were likely or very likely to share the Futures Without Violence self-assessment card with a friend or family member, which speaks to the preventive benefits of IPV universal education.

Over a period of six months, the advocate saw 64 unique clients, and completed 374 contacts either in person or by phone. The findings collected from the advocate tracking tool revealed:

- ▶ The advocate averaged six contacts per client (within a range of one to 58 contacts per client);
- ▶ 2% (n=5) of contacts were greater than 2 hours; 6% (n=21) of contacts were 90 minutes to 2 hours; 18% (n=67) of contacts were 60-90 minutes; 34% (n=124) of contacts were 30-60 minutes; and 42% (n=157) of contacts were less than 30 minutes;
- ▶ The majority of advocate contacts were by phone;
- ▶ Safety planning was addressed in 83% (n=309) of the contacts between the advocate and the client;
- ▶ 56% (n=29) of referrals resulted from a positive disclosure of IPV to the health care provider;
- ▶ 23% (n=12) of referrals resulted from a health care provider initiated referral; and
- ▶ 21% (n=11) of referrals came from other sources.



Survivor interviews reinforced the impact the advocate had on addressing social determinants of health, increasing their self-efficacy through empowerment-based support, and supporting healthy outcomes in their pregnancy. When asked what was different because of working with the advocate, one pregnant survivor replied, "My baby didn't die." Another survivor reported that her "brain wasn't working" after the abuser was arrested, making it very difficult to remember what was needed to qualify for assistance. The survivor credited the advocate who "helped me keep doing the things I needed to do."

PSU and OCADSV interviewed several health care providers from the Tillamook County Community Health Center. Those interviewed expressed gratitude for the CUES intervention and process for making referrals to an advocate. They also appreciated the advocate as an additional support and resource for patients beyond the clinic staff. One provider stated, "I think this has been a real game changer for me... Not just another screening... This project has helped me see how this is significant and problem-solve to make it happen." Another provider said, "Having someone available who has significant experience working with families has been a gift to us."

SECTION 6: CONFIDENTIALITY, LAWS, COMPLIANCE & REPORTING



Health care settings and D/SV systems are experienced in keeping certain records and patient/survivor information private and secure. Similarities and differences exist in the federal policy which governs each system’s treatment of information: for health care settings, the Health Insurance Portability and Accountability Act (HIPAA), and for D/SV organizations, the Violence Against Women Act (VAWA) and the Family Violence Prevention and Services Act (FVPSA). In addition, D/SV organizations in Oregon are governed by Advocate Privilege, which includes much more stringent requirements for information confidentiality than HIPAA regulations due to serious safety concerns unique to abuse survivors. In health care partnerships, it is helpful to understand the differences between federal and state policies affecting each system, and to plan for potential conflicts that may arise related to information sharing.

THIS SECTION INCLUDES:

- ▶ Certified advocate-victim privilege..... P. 45
- ▶ Confidentiality P. 45
 - HIPAA and VAWA confidentiality P. 45
 - HIPAA FAQ..... P. 45
- ▶ Mandatory reporting in health care settings P. 47
- ▶ Electronic health records and health information communication P. 48
 - OpenNotes in Oregon..... P. 49
 - Insurance communication P. 49
- ▶ Conclusion P. 49

CERTIFIED ADVOCATE-VICTIM PRIVILEGE¹³⁸

In 2015 the Oregon Legislature passed a law, ORS 40.264, which makes the communication between a “certified advocate” from a “qualified victim services program” and a “victim” “privileged.”

Privilege is a legal protection that empowers an IPV survivor (or victim) to decide whether their confidential communication with an advocate will be disclosed to a third party. The privilege applies to “confidential communications” between a “certified advocate” and a “victim” (defined in the next section). It is important to recognize that the privilege is held by the survivor, who has the privilege to refuse to disclose and to prevent any other person from disclosing their information.

When privilege applies, this means:

“A court cannot force a victim or their advocate to disclose the contents of confidential communications, and neither the advocate nor the survivor can be punished for refusing to disclose the information.”¹³⁹

A “victim” is a person who is seeking safety planning, counseling, support or advocacy services related to domestic violence, sexual assault or stalking at a qualified victim services program.

A “certified advocate” refers to any volunteer or paid person who has attended at least 40 hours of training in advocacy for victims of domestic violence, sexual assault or stalking, approved by the Attorney General by rule, and works for a qualified victim services program.

A “qualified victim services program” refers to a non-governmental, non-profit, community-based program receiving moneys administered by the Oregon Department of Human Services or the Oregon or United States Department of Justice, or a program administered by a tribal government, that offers safety planning, counseling, support or advocacy services to victims of domestic violence, sexual assault or stalking, or a sexual assault center, victim advocacy office, women’s center, student affairs center, health center or other program providing safety planning, counseling, support or advocacy services to victims that is on the campus of or affiliated with a two- or four-year post-secondary institution that enrolls one or more students who receive an Oregon Opportunity Grant.

The communication must be “confidential”. Confidential communication is communication not intended for further

disclosure, except to: (1) persons who are present to further the interests of the DV victim (survivor) in seeking safety planning, counseling, support or advocacy services; (2) an interpreter; or (3) other persons, in the context of group counseling.¹⁴⁰

CONFIDENTIALITY

HIPAA AND VAWA CONFIDENTIALITY

HIPAA and VAWA are different laws with distinct purposes. HIPAA creates rules that help providers share information. VAWA rules exist to protect survivors. Advocates and programs can help health care providers understand the critical importance of the D/SV field’s philosophy of, and investment in, confidentiality (typically a more restrictive framework for handling information than privacy).

Futures Without Violence and National Network to End Domestic Violence (NNEDV) have additional resources on this topic that can be found on their websites: futureswithoutviolence.org and nnev.org. The following information is copied from NNEDV’s *Safety Net Project*, in partnership with The Confidentiality Institute and the U.S. DOJ Office of Violence Against Women:

“Is our domestic violence or sexual assault victim advocacy agency required to follow HIPAA? Generally not. U.S. HIPAA regulations apply to “covered entities”, which are health plans, health care clearinghouses, and health care providers. Domestic violence and sexual assault agencies rarely fall into one of those three categories. If you want to determine whether your agency is a covered entity, answer the series of questions on the U.S. HHS website, which is: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/Downloads/CoveredEntitiesChart20160617.pdf>. If you are a covered entity, you will be required to follow the specific HIPAA regulations, so you should seek help from an attorney in your community who specializes in health care law to be sure you are complying with HIPAA requirements.”¹⁴¹

HIPAA FAQ¹⁴²

“What is HIPAA?”

The Health Insurance Portability and Accountability Act (HIPAA) is a U.S. federal law originally enacted in 1996 with extensive security and privacy regulations, which guides how medical providers must handle patients’ protected health information in the context of payment for services. HIPAA set out a national minimum standard for privacy of health information; state standards

138. Oregon Department of Human Services (2017). Working Together: Domestic Violence Advocates Co-Located at DHS Offices – Policies and Practices Guide. Salem, OR. Available at <http://dhs.state.or.us/cdf/dv/index.htm> or <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>.

139. A Legal Guide for Oregon Advocates. Retrieved on 02 January 2018 from <https://oregonlawhelp.org/resource/a-legal-guide-for-oregon-advocates>.

140. Definitions taken from the Oregon Revised Statutes. Retrieved 02 January 7, 2018 from <https://www.oregonlaws.org/ors/40.264>.

141. FAQs About US Federal Laws and Confidentiality for Survivors. (n.d.). Retrieved January 04, 2018, from <https://nnev.org/mdocs-posts/faqs-about-us-federal-laws-and-confidentiality-for-survivors/>.

142. Ibid.

may provide more protections. HIPAA applies to medical records maintained by health care providers, health plans, and health clearinghouses, and to the maintenance and transmission of those records. The extent of the privacy protection for an individual's medical information can depend on where the records are located and the purpose for which the information was compiled, and whether insurance payment is requested for a given medical procedure or service. See 45 CFR §§164.501 to 164.534.

What is the HIPAA privacy rule?

The HIPAA privacy rule creates a minimum standard for protection of private, protected health information, regardless how that information is maintained (i.e., on paper or electronically) (45 CFR §164.520), and describes permitted uses and disclosures, and when consent for disclosure is and is not required. See 45 CFR §§164.506 to 164.514.

Which is the most protective: HIPAA, VAWA, or my state law?

As between HIPAA and VAWA, both are protective of personal information, but VAWA is generally seen as more protective, and having fewer exceptions to confidentiality. State laws can vary, and may be more or less protective than either HIPAA or VAWA. In any event, advocacy programs should follow the most protective confidentiality law that applies to them (in Oregon, this is VAWA).

What are some exceptions to HIPAA confidentiality?

HIPAA permits certain limited disclosures of protected health when there is a risk of domestic violence, even in some circumstances where the patient does not consent

to the disclosure. 45 CFR §164.512. The HIPAA privacy rule provides for a permitted disclosure of protected health information about an individual whom the provider reasonably believes to be a victim of abuse, neglect or domestic violence. 45 CFR §164.512. When a provider makes a permitted disclosure, the provider is required to notify the individual of the disclosure unless informing the individual of the disclosure would place the individual at risk of serious harm. See 45 CFR §164.512(c). Victims of domestic violence who seek medical help are at grave risk if the fact that they sought help is revealed. Although HIPAA permits disclosure of protected health information of a victim of domestic violence without her consent in certain, limited circumstances, it does not require it, and advocacy agencies can help medical providers understand that they should rarely, if ever, share a victim's protected health information with government authorities unless absolutely required to do so.

We've been hearing a lot of information about electronic health records. What does that mean for victims and confidentiality?

HIPAA sets out specific security standards for electronically maintained health information. See 45 CFR §164.302 to §164.318 (minimum requirements for administrative safeguards, physical safeguards, technical safeguards, organizational requirements, and requirements for policies and procedures and documentation of electronically maintained protected health information). Victim advocacy programs should be aware of what the HIPAA regulations specifically require so that victim information can be as protected as possible.

What if the abuser wants access to a child's medical records under HIPAA?

Under federal HIPAA regulations, the personal representative of a minor normally acts on behalf of a minor vis a vis medical records. This means the personal representative (usually the parent) has a right to control access to the minor's health and mental health records. However, health care providers may refuse to treat a parent as a personal representative (and thus refuse to provide the parent with access to the minor's medical records) if the providers have a "reasonable belief" that: (a) the minor has been or may be subjected to domestic violence, abuse or neglect by the parent, guardian or other giving consent; or (b) treating such person as the personal representative could endanger the minor; and the provider, in the exercise of professional judgment, decides that it is not in the best interest of the minor to give the parent, guardian or other such representative access. 45 CFR. §164.502(g)(5). Victim advocacy agencies can provide training to medical providers on how to make this type of assessment more safely and accurately."



MANDATORY REPORTING IN HEALTH CARE SETTINGS

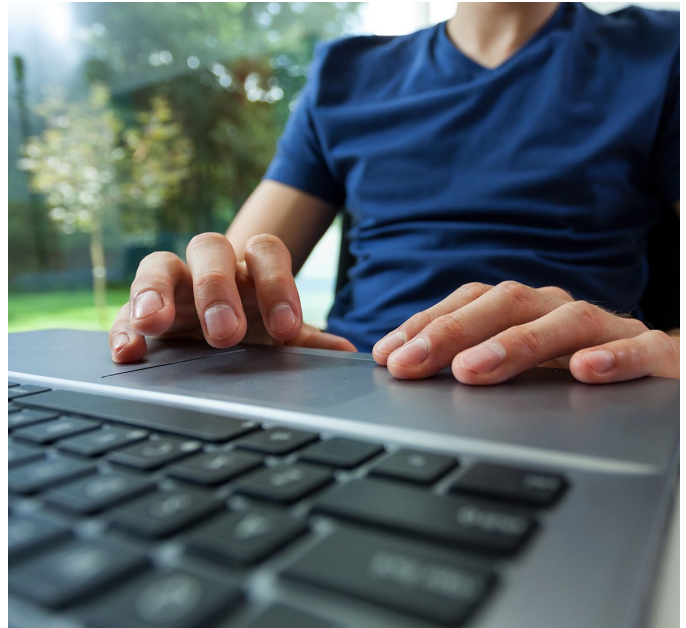
Many medical providers are mandatory reporters for a variety of issues — advocates are not. For some survivors, accessing health care may present safety concerns due to risks stemming from mandatory reporting. Nurses and doctors bear a significant burden of responsibility and are regulated by a wide range of statutes and professional directives.

In Oregon, in addition to reporting of non-accidental injury that must be made to law enforcement (ORS 146.750), other mandatory reporting laws include child abuse reporting (ORS 419B.010), elder abuse reporting (ORS 124.060), abuse of mentally ill or developmentally disabled persons (ORS 430.765), abuse of long-term care facility residents (ORS 441.645), and others.

There is variability within the health care profession: some providers, such as medical or physician’s assistants, are not mandated to report non-accidental injury to law enforcement. Nurses and doctors are typically the only health care providers covered by the non-accidental injury adult mandatory reporting law in Oregon. Providers receive professional guidance on best practice for implementation of mandatory reporting laws, and are expected to have and follow internal policies on how to make reports.

Oregon Health Authority published a memo for mandatory reporting providers, entitled “Mandatory ‘Non-Accidental’ Injury Reporting, Oregon Revised Statute 146.750, Guidance for Public Health Nurses.”¹⁴³ It answers common questions and provides a decision tree, including the following information:

- ▶ **Who do I report to?**
Law enforcement — local police department, county sheriff, Oregon State Police. RNs should note that this is different than child abuse reports which can be made to the Department of Human Services (DHS) or law enforcement.
- ▶ **What is the time limit to report?**
An oral report must be made immediately followed by a report in writing.
- ▶ **If I make a report, should I also document it in the medical record?**
Yes, reporting is NOT a substitute for documentation in the medical record. Workplace documentation policies should be in place and reviewed by legal counsel.



- ▶ **If the injured person is a minor, under which law is the report made?**
Reports should be made pursuant to the Child Abuse reporting law. ORS 146.750 is specific to adults with non-accidental physical injuries.
- ▶ **Am I required to tell clients that I am mandated to make a report?**
There is no legal requirement to inform the client of the report. However, consider ethical nursing practice and your responsibilities as a mandated reporter.
- ▶ **What can I do to minimize some of the potential dangers to my client from intimate partner violence?**
Provide ongoing, supportive care, address client safety and guide the client through available options. Work with the client and law enforcement authorities (when safe to do so) to meet client needs when handling the report, and strive to give the client input into any future plan of action.

D/SV organizations and advocates can learn which health care partners are mandatory reporters, and can support health care systems to develop survivor-centered safety and ethics practices regarding reporting. Survivors have not only a right but a real safety need to know which of their providers may have mandatory reporting obligations. Best practice suggests this information be communicated prior to any disclosure a patient may choose to make to a health care provider.

143. Guidance for PHNS (2013 October). Retrieved on 02 January 2018 from http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/LOCALHEALTHDEPARTMENTRESOURCES/Documents/ORS146_750_Guidance_for_PHNs.pdf.

Health care settings may wish to implement policies and protocols that use a virtual and electronic “firewall” to protect confidential information from access by mandatory reporters without a survivor’s written and informed consent. This is especially important for those health care partnerships where there is shared access to an electronic health record or other similar communication.

One survivor disclosed abuse to a health care provider with whom there was a longstanding and trusting relationship. The health care provider documented the survivor’s disclosure of abuse in the electronic health record. A few months later, the survivor went to see an eye doctor. The eye doctor saw the note documenting the survivors’ disclosure of abuse. Much to the survivor’s surprise, the eye doctor asked probing, unsolicited questions about the abuse — abuse that the survivor did not want to talk about with the eye doctor. The survivor is deeply concerned about who may have access to this information or how it may be shared with others. Ultimately, the survivor is afraid the abusive partner will learn about the disclosure. The survivor no longer feels safe discussing the abuse with any health care provider.¹⁴⁴

For more information about D/SV organization confidentiality policies, VAWA confidentiality requirements, child abuse reporting, elder abuse and mandatory reporting laws for adults with disabilities, and various medical professionals with these reporting requirements, please see “Frequently Asked Legal Questions – A Manual for Program Advocates” by OCADSV at ocadsv.org.¹⁴⁵

ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION COMMUNICATION

Health care reform presents new challenges in keeping patient information private and confidential. Health care systems are encouraged to use electronic health records (EHRs), and in Oregon, health care systems are incentivized to share information among health care providers to coordinate care and reduce duplication of services. However, this means that more information is being collected than ever before, and shared more widely.

Most EHRs do not have internal privacy measures, relying on personal provider judgment regarding what gets

recorded. Some EHRs have billing and diagnostic codes for IPV that are obvious, and some are coded less overtly.

When forming health care partnerships, it is important to review with health care partners:

- ▶ how screening and/or referral is documented in the EHR
- ▶ what information is recorded
- ▶ if and/or when the provider bills for IPV screening and counseling, if that is noted in the medical record
- ▶ what access the patient and/or their abusive partner might have to the medical record

Best practice for clinical providers with EHRs is to ensure, before screening or assessment for IPV, that their internal processes regarding patient privacy and confidentiality are reviewed in partnership with an advocate. Each clinic will have different protocols and technological capabilities.

Confidentiality and privacy concerns will vary between large health systems and smaller/rural clinics. “Numeric or alpha coding (a code assigned to a sensitive medical record that de-links a patient’s name from sensitive information)” may be a practical solution in Portland, but it may not be an adequate solution for a provider in Burns. However, providers must recognize a survivor’s inherent autonomy to make decisions that increase their safety and well-being. Ultimately, this will result in the kind of trust and relationship that will lay a foundation for long-term health and best possible care.¹⁴⁶

D/SV organizations can find out whether the partner health care system has the ability to de-identify information before it is used and disclosed, and what system safeguards are in place to ensure information will be protected. Advocates can encourage and support health care providers to develop a routine practice of discussing with each patient the limits of confidentiality, options related to insurance communication, and how access to the medical record is granted for patients and family members.

Some health care settings use a nonsensical combination of letters to note IPV screening in their medical record system. Others choose not to track or identify their IPV-related processes at all, however, this can pose difficulties for evaluation and payment. In the short term, the safest way to address IPV information in health care settings is not to record IPV-specific information. This is particularly relevant for those health care settings with little control over their EHR system.

144. Evaluation findings, Portland State University.

145. Frequently Asked Legal Questions: A Manual for Oregon’s Domestic and Sexual Violence Advocates (Legal Manual). (2017, September 29). Retrieved January 02, 2018, from <https://www.ocadsv.org/resources/browse/681>.

146. Futures Without Violence (2013). The Facts on Health Care and Domestic Violence. *PsycEXTRA Dataset*. doi:10.1037/e602122012-001.

Partnerships with advocates, whose VAWA-funded programs are built with more confidentiality safeguards, can strengthen health care treatment of this sensitive information. D/SV organizations are experienced in measuring and reporting types and levels of service without endangering survivors, and can support health system improvements to promote survivor safety and self-determination.

OpenNotes IN OREGON

The risk posed by EHRs is of particular concern for those Oregon-based health care systems that are adopting the OpenNotes initiative. It is important to know if the health care provider has adopted OpenNotes, and to know their policy around recording sensitive information, such as IPV screening and intervention (especially since each of the participating Oregon health care systems has implemented this initiative slightly differently).

The OpenNotes initiative gives patients online access to their EHR. However, this opens up new avenues for abuse by perpetrators of violence, and new risks for survivor safety and well-being. OpenNotes reports that currently only the individual would have access to their own notes through the patient portal unless they made somebody else a proxy. This functionality is part of the patient portal, and is not necessarily related to the idea of opening up notes, but becomes more important as patients have access to the more detailed notes. Yet it is all too easy for abusive partners to gain access to this information, if they become aware the information may be available to them through the survivor.

Within the OpenNotes program, providers do have the option to hide individual notes. In OpenNotes training, IPV is a common example used when providers discuss reasons they may choose to hide a note. However, participating providers voice concern that an abusive partner may wonder why some notes are marked “hidden” and others are not. Because it is up to the provider to choose when to hide information, and contingent on the practice to provide training on IPV, practices vary on when information is hidden. This presents a serious safety concern. For more information about OpenNotes and the Northwest OpenNotes Consortium, visit: <https://www.wecandobetter.org/what-we-do/northwest-opennotes-consortium/>

INSURANCE COMMUNICATION

While most providers do not itemize screening or counseling for domestic violence, some may. This could potentially trigger a bill to the payer for payment for these services. The payer, or insurance company, would then send an Explanation of Benefits (EOB) letter to the policy holder,

One survivor moved across the country to escape an abusive relationship. The survivor had not yet enrolled in the Oregon Health Plan and remained on the abusive partner’s insurance plan. The survivor avoided seeing a doctor about chronic health issues for fear the abusive partner would see the Explanation of Benefits statement. As the insurance policy holder, the abusive partner could see where the survivor received health services. Upon becoming pregnant, the survivor felt it was important to seek care. However, the survivor worried about what the abusive partner would learn from the Explanation of Benefits statement.¹⁴⁷

who may be the abusive partner, presenting increased risks to survivor safety. Abusive partners have also used these EOB letters to discern the location of survivors and/or their children, when survivors have moved to other communities for safety reasons yet remain on the same insurance plan.

Oregon recently passed a law for insurers, informed by OCADSV, that created an option where survivors can present a form to their provider prior to the service that designates that communications from the insurer go to a specified address instead of being routed to the policy holder. The Confidential Communication Request Form, effective 1/1/16, can be found in the Appendix of this *Guide*, and is available online at <http://www.oregon.gov/DCBS/Insurance/gethelp/health/Pages/confidential-communications.aspx>

CONCLUSION

Health care settings present important opportunities for survivors to access resources and support that they otherwise may not have; however, health care settings also pose unique and significant risks. Survivors rely on D/SV organizations and advocates to protect their private information; these practices are vital to survivor safety and autonomy. Health care professionals often report that they ensure information privacy. Yet the above examples demonstrate that health care information privacy lacks the rigor of advocacy program practices in maintaining effective confidentiality. D/SV organizations and advocates cannot guarantee information shared in health care settings will remain confidential. These facts must be presented to survivors so they can decide when, how, and with whom to share information, and provide true informed consent to services.

147. Evaluation findings, Portland State University.

SECTION 7: PAYMENT METHODOLOGIES

The imperative of Oregon’s original Triple Aim — to improve the health of all Oregonians, to improve the quality of care, and to lower the cost of health care — necessitates that health care systems address social determinants of health such as domestic and sexual violence (D/SV). A fourth goal of reducing provider burnout (now Oregon’s Quadruple Aim) further supports partnering with advocates to address the health impacts of D/SV.

Much of the evidence for successful interventions that address the health and safety of D/SV survivors supports those that engage a community-based advocate. As Oregon health care systems increasingly invest in partnering with non-clinical providers, health care can turn to local community-based D/SV organizations as a means to better serve survivors of IPV. Advocates already have relationships, resources, and training that prepare them to address the unique health and safety needs of survivors, and to provide these services at a lower cost than their non-IPV-specific behavioral health counterparts in health systems.

As outlined in the 2011 and 2012 authorizing bills (Oregon House Bill 3650 and Senate Bill 1580 respectively) and as added to ORS 414, Coordinated Care Organizations (CCOs) have the transformational expectation to account for social determinants of health by supporting patients’ access to community and social support services. Additionally, a 2015 Center for Outcomes Research and Education (CORE) report identified that “there will be expanded multidisciplinary focus that incorporates non-traditional, and non-clinical, roles such as community health workers or peer support networks to help address social determinants of health” as a result of Oregon health care workforce transformation.¹⁴⁸

With the Affordable Care Act and Oregon health care transformation, health care systems are incentivized to increase their screening levels and improve interventions around social determinants of health. Oregon-based health care systems and their providers use a variety of screening and intervention methods to address IPV. D/SV organizations have an opportunity to inform health care systems on screening and intervention methods that are considered best practice. The *Safer Futures* model is a prime

example. D/SV organizations can assert themselves in this work by informing health care systems about the unique needs of survivors, and health care systems can partner with local D/SV organizations to provide survivor-centered care by offering advocacy services on-site in health care settings.

The ACA does not provide information on who can receive reimbursement for providing screening and brief counseling. “It will be up to individual insurers under the scope of state law to determine who can provide screening. This will apply to all private plans and those plans in the health insurance marketplace. In other words, it is possible for a wide range of providers, including traditional medical providers, mental health counselors, and more, to become eligible for reimbursement for providing IPV screening and counseling. However, it will be up to the individual insurers, under the scope of state law, to make those determinations.”¹⁴⁹

OCADSV works with state partners to identify pathways for payment or reimbursement for screening and brief counseling as billable services where funds ultimately support D/SV advocacy services. Visit ocadsv.org for the full report, “Reimbursement for Domestic Violence Advocacy Services Provided to Members of Oregon’s Coordinated Care Organizations,” by Health Management Associates, released in Fall 2016.¹⁵⁰

THIS SECTION COVERS:

- ▶ **Grants** P. 51
- ▶ **Contracts** P. 51
- ▶ **Fee for service** P. 52
- ▶ **Alternative payment methodologies and partnership opportunities** P. 53

148. Wright B, Broffman L, Rinaldi JB (2015). Tracking Transformation: Assessing the Spread of Coordinated Care in Oregon. Center for Outcomes Research and Education, Providence Health and Services. Retrieved on 2 January 2018 from <http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Tracking%20Transformation%20-%20Assessing%20the%20Spread%20of%20Coordinated%20Care%20in%20Oregon.pdf>.

149. Chamberlain (n.d.). Addressing Intimate Partner Violence, Reproductive and Sexual Coercion.

150. Health Management Associates (2016 July). Reimbursement for Domestic Violence Advocacy Services Provided to Members of Oregon’s Coordinated Care Organizations. Retrieved on 02 January 2018 from https://www.ocadsv.org/sites/default/files/resource_pub/Final_report_for_OCADSV_with_Ex_Sum.pdf.

GRANTS

Grant funding is often what supports D/SV organizations when they initially provide services to survivors in partnership with a larger system. Beginning in the 1990s, D/SV organizations established “co-location” partnerships with Oregon Department of Human Services (DHS) Self Sufficiency and Child Welfare programs. These early partnerships laid the groundwork for securing state funding to support co-located advocates in DHS branch offices across Oregon, and inform partnership building efforts with health care systems. Initially, grant funds have been used to establish partnerships between D/SV organizations and health care systems. D/SV organizations use the time covered to demonstrate the advocate’s value to health care systems. Oregon Department of Justice’s Pregnancy Assistance Fund award #1SP1AH000019 (i.e. *Safer Futures*) was used for this purpose.

The intended result is that health care systems are motivated to make a longer-term financial investment in the partnership. This can include securing grants through charitable budgets or community benefit dollars from CCOs and hospitals. For example, CareOregon Columbia Pacific CCO granted its Community Wellness Investment Funds (CWIF) to Tillamook County Women’s Resource Center (a *Safer Futures* project site) for the purpose of expanding advocacy and health care partnerships into a tri-county service region.

CONTRACTS

Another approach is for regional CCOs or health care systems (including hospitals) to allocate funds from their global budget or general operating budget for a flat, contracted amount to the D/SV organization for a negotiated level of IPV advocacy and counseling services. One example of this approach is The Medical Response Collaborative Model (MRC) which was first piloted by the Chicago Metropolitan Battered Women’s Network, and presented as a workshop at the 2015 National Conference on Health and Domestic Violence.¹⁵¹

Members of the *Safer Futures* team traveled to Chicago, IL, to meet with the Chicago Metropolitan Battered Women’s Network and the Illinois Coalition Against Domestic Violence about the medical response collaborative. This collaborative boasts a network of Chicago-based non-profit advocacy organizations who have established partnerships with hospitals in the metropolitan area. This collaborative allows multiple advocacy organizations centralized coordination of services and the ability to receive bundled payment (thus de-identifying patient information).

There are several strengths of the MRC model:

1. There is no individual level, fee-for-service information that must be provided between organizations, meaning that D/SV organizations can aggregate data in reporting that does not identify the survivors they served. Partners can agree upon an estimated level of service to be provided and adjust as needed.
2. The model benefits CCOs and hospitals that are accustomed to and have processes in place for sub-contracting for work.
3. This model allows time for health care systems to pilot new IPV interventions (i.e. community-based on-site advocacy) while Alternative Payment Methodologies mature.

Sub-contracts between D/SV organizations and health care systems are a good way for both parties to implement a pilot project, measure its impact, and use those results to justify further investment in the model.



151. Doherty KA (n.d.). Chicago’s medical response collaborative: A model for improving the health systems response to domestic violence. Retrieved January 02, 2018, from <https://nchdv.confex.com/nchdv/2015/webprogram/Paper11497.html>

FEE FOR SERVICE

Current fee-for-service models that allow billing for advocacy services fall under a mental health model primarily structured for clinical providers, who provide treatment for such conditions as depression and anxiety. The current fee-for-service model is a fit for clinical counseling programs, and not yet applicable for D/SV advocacy programs. This is because advocates are not considered clinical providers and advocacy services are not aligned with a mental health model.

Some community-based D/SV organizations with separate clinical counseling programs do have providers on staff that can bill OHP for IPV screening and counseling. Clackamas Women's Services is piloting one such program as a complement to their advocacy services. However, due to Violence Against Women Act (VAWA) and other federal funding regulations, the D/SV organization must ensure appropriate firewalls between fee-for-service funded clinicians and advocates who are funded by VAWA. For this example to work, a clinician can only operate on a fee-for service basis or with private funds. All advocacy services must be provided to survivors free of charge. Thus, organizations must consider how to keep services free of charge while integrating elements of a fee-for-service payment model.

Futures Without Violence has a resource library¹⁵² that includes information about billing for screening and counseling for domestic and intimate partner violence. Of particular interest are:

- ▶ "Reimbursement and Payment Strategies for DV/Health Partnerships" webinar recorded April 14, 2016¹⁵³
- ▶ "California DV Advocates Guide to Partnering with Healthcare: Models for Reimbursement and Collaboration"¹⁵⁴

It may be feasible for a licensed, clinical provider to bill Medicaid for IPV counseling and pass the reimbursement through to a non-clinical, community-based advocate who is supervised by that clinical provider. This is similar to the model that Oregon policy makers proposed to fund Traditional Health Workers (THWs). THW is a unique designation established in Oregon law that recognizes doulas, peer support specialists, peer wellness specialists, personal health navigators and community health workers as non-clinical direct service providers whose services can be reimbursed through Medicaid (for more information, see Section 4 page 25, or visit <http://www.oregon.gov/oha/OEI/Pages/index.aspx>).

In order for advocates to be able to accept Medicaid payment, or for advocates to implement a THW-type payment model:

- ▶ Advocates would need to be recognized as a health worker type at the federal level (included as eligible for Medicaid payments in Oregon's 1115 Waiver), or
- ▶ Advocates would need to be included as a type of Traditional Health Worker; this designation would allow Medicaid payments to pass through to advocates in the same way it is currently possible for Medicaid payments to pass through to CHWs.

If advocates were designated as a type of traditional health worker, or were separately granted an exception in Oregon's 1115 Waiver, then it may be possible for advocates to accept Medicaid payments through a supervising, partner clinician. Either way, a VAWA-funded, community-based D/SV organization would need to assess, with appropriate counsel, what implications for privilege and mandatory reporting this would have for an advocate accepting fee-for-service Medicaid payments under the supervision of a clinician.

In the 2017 Oregon legislative session, OCADSV proposed an amendment to House Bill 2304 that would have added community-based advocates as members under the traditional health worker umbrella. The amendment sought to add community-based advocates to the Personal Health Navigator category of traditional health workers. The effort to add advocates under the traditional health worker umbrella would have provided the policy mechanism for CCOs to contract and pay for community-based, non-clinical advocacy services using non-administrative Medicaid dollars. As it stands, CCOs are limited to paying for advocacy services through their global budget administrative/charitable cost allocations.

At the end of the session, community-based advocates were not formally added as members under the THW umbrella. Rather, HB 2304 passed with the following:

"SECTION 9.

- (1) The Attorney General and the Director of the Oregon Health Authority, or their designees, shall develop and implement a plan for incorporating advocates for domestic and sexual violence survivors into the workforce of traditional health workers under ORS 414.665 to increase access by medical assistance recipients to services provided by the advocates.

152. Futures Without Violence. Retrieved January 02, 2018, from <http://www.futureswithoutviolence.org/search/>.

153. Reimbursement and Payment Strategies for DV/Health Partnerships Webinar (2017, July 11). Retrieved January 02, 2018, from <https://www.futureswithoutviolence.org/reimbursement-and-payment-strategies-for-dv-advocates-partnering-with-health-webinar/>.

154. O'Rourke L, Duplessis V, Hogan L, James L, Stewart K (2012). DV Advocates' Guide to Partnering with Health Care. Futures Without Violence. Retrieved on 02 January 2018 from <https://www.futureswithoutviolence.org/wp-content/uploads/DV-Advocate-Memo-Final.pdf>



To summarize, if CCOs or other providers could bill for specific services and pass through the reimbursement to the sub-contracted, community-based, non-clinical provider, it could facilitate more sustainable and scalable partnerships. However, this model would have to be refined given survivor safety concerns and VAWA restrictions on D/SV programming and survivor services. This is being explored by OCADSV and its stakeholders.

ALTERNATIVE PAYMENT METHODOLOGIES AND PARTNERSHIP OPPORTUNITIES

Flexible services are an alternative payment methodology specifically authorized to help CCOs offer cost-effective services (or health-related services) instead of or as an adjunct to covered benefits. CCO budgets allow for local flexibility, including services and supports that may not meet the definition of “medically necessary” but could eventually help satisfy the Triple Aim of reducing costs, improving care, and improving health outcomes. Like the aforementioned community benefit initiatives (i.e. the CWIF grant), these flexible services aim to address the social determinants of health.

(2) In developing the plan described in subsection (1) of this section, the Attorney General and the director, or their designees, shall consult and collaborate with coordinated care organizations, as defined in ORS 414.025, the Oregon Coalition Against Domestic & Sexual Violence and other groups that advocate for survivors of intimate partner violence.”¹⁵⁵

This compromise allows work to continue at the state policy level to pursue designation of community-based advocates as Traditional Health Workers.

Another payment methodology to consider is sub-contracts under capitated payment amounts. This is a step removed from the above-mentioned direct fee-for-service arrangement. One example is the behavioral health, capitated per-member-per-month payments granted by some CCOs to clinics for an annual period where the clinic sub-contracts with chosen specialists. If advocates pursued designation as an appropriate worker type under the Waiver or traditional health worker umbrella, they could position themselves as an accepted specialist. Some CCOs in Oregon have found this model to better accommodate traditional health worker implementation.

A pure fee-for-service billing model presents many new challenges for community-based advocates, as it is embedded in the work of licensed clinicians. Advocates would need to investigate how this model would or would not support the field’s newly won certification and privilege in Oregon.

Flexible services (or “flex dollar services”) are dependent upon the current Section 1115 Medicaid demonstration waiver. Under the current waiver, CCOs have the ability to fund health-related services like those offered by THWs. Potentially these flexible services dollars could fund advocacy services provided by community-based organizations serving survivors of domestic and sexual violence. Flex dollars would have to come out of the medical portion of the CCOs’ global budget versus its administrative budget; this offers some of the same strengths as negotiated contracts. If seen as a benefit to the CCO, then potentially more funds could become available for D/SV advocacy interventions.

On a related note, flexible service dollars are designed to do such work as “address social service needs of high-risk, high-need individuals by ensuring development of infrastructure, partnerships and resources to deliver care in appropriate settings and provide supportive housing services.” This pertains specifically to housing supports, which has profound implications for advocacy.

In order to sustain advocacy services to survivors in Oregon, it is critical that D/SV organizations diversify their funding sources. Healthcare system transformation presents an opportunity to forge new partnerships and facilitate investment in D/SV advocacy services that will benefit survivors, healthcare service providers, and D/SV organization capacity to thrive.

155. Quote from text of Oregon House Bill 2304. Retrieved on 02 January 2018 from <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2304/B-Engrossed>.

SECTION 8: RESOURCES

OCADSV provides resources and links to materials related to this *Guide* on its website, health.ocadsv.org. Join the OCADSV COINN site on ocadsv.org for more intensive technical assistance resources, such as sample Memoranda of Understanding for use with health care partners as well as evaluation tools, recorded webinars and other members-only resources.

OCADSV is available to provide individualized, specific guidance and expertise on a wide variety of topics. Referred to as technical assistance (TA), these services are designed to facilitate individual or agency change in a systematic manner by providing expertise to solve a problem. These services are provided free of charge to member programs.

Individuals and organizations can request technical assistance on a variety of subjects, including but not limited to:

- ▶ Organizational development
- ▶ Program planning and management
- ▶ Information technology (IT) systems assessment and planning
- ▶ Anti-oppression, equity and inclusion practices
- ▶ Training and curriculum development
- ▶ Collaboration with other systems (including health care, law enforcement, courts, DHS, etc.)
- ▶ Prevention
- ▶ State and/or federal compliance issues

Contact OCADSV, ocadsv.org or **503.230.1951**, to learn more.

OTHER RECOMMENDED RESOURCES:

Oregon Department of Justice is a wealth of *Safer Futures*-focused resources, specifically regarding on-site advocacy and serving pregnant and newly parenting survivors: <https://www.doj.state.or.us/crime-victims/grant-funds-programs/safer-futures/>

Futures Without Violence is cited throughout this *Guide*, is a technical assistance provider to *Safer Futures*, and is the lead organization for *Project Connect* in Oregon (in partnership with Oregon Health Authority). Their website, futureswithoutviolence.org, is the best resource for providers and for training materials. Their intervention website, ipvhealth.org, provides information about CUES, the universal education model most often recommended by OCADSV.

Links to specific Futures Without Violence materials:

- ▶ [Interpersonal and Domestic Violence Screening and Counseling: Understanding New Federal Rules and Providing Resources for Health Providers](#) (May 2012)
- ▶ [IPV Screening and Counseling Toolkit](#)
- ▶ [Supporting Survivor Access to Health Care: Open Enrollment, Updates on Changes to Health Policy and Implications for Survivors](#) (October 2017)
- ▶ Recorded webinar: [Open Enrollment! How DV Advocates Can Help Survivors Access Health Care](#) (December 2017)
- ▶ [First Steps to Building a Safe EHR for Women](#)
- ▶ [Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings](#) (2012)
- ▶ [Did you know your relationship affects your health? Reproductive Safety Card](#)
- ▶ [Integrating Health Services into Domestic Violence Programs: Tools for Advocates](#)

Additional reading

- ▶ [Engaging Douglas County Communities in Systematic Planning Efforts to Integrate ACEs Science](#)
- ▶ [Integrating Intimate Partner Violence Advocacy in Health Care Services and Benefits](#)
- ▶ [Reimbursement for Domestic Violence Services Providers to Members of Oregon's Coordinated Care Organizations](#) (2016)
- ▶ [Person-centered, Coordinated and Affordable Care](#) – OHA handout
- ▶ [Oregon Community Health Workers Association](#)
- ▶ [Traditional Health Worker \(THW\) Program](#) – OHA Office of Equity and Inclusion
- ▶ [Count Her In](#) (2016)
- ▶ [Communities of Color in Multnomah County: An Unsettling Profile](#) (2010)

SECTION 9: APPENDICES



- ▶ Glossary of health care terms..... P. 56
- ▶ *Safer Futures* model summary P. 62
- ▶ Outreach flyers
 - Preparing Your Practice to Address Intimate Partner Violence P. 63-64
 - Recommendations and Resources for Intimate Partner Violence, Domestic Violence Screening and/or Assessment P. 65-66
 - Fact Sheet: Benefits of Domestic and Sexual (DSV) Advocates in Health Care Settings P. 67-68
- ▶ Oregon Request for Confidential Communication P. 69-70
Advocates/survivors can use this form to request that information be kept confidential, not shared on EOB letters, etc.
- ▶ Medical Power and Control Wheel P. 71

GLOSSARY OF HEALTH CARE TERMS

Health care in America is an especially complicated system. Its evolving nature in Oregon necessitates ongoing learning, agility, and a greater investment in time than may be required in partnering with other service systems. Safer Futures advocates report a long learning curve on the language of health care, yet they also emphasize the importance of gaining knowledge and improving comfort with health care terms, as this facilitates relationship development and collaborative work with health care providers.

The following is a glossary to aid in this learning process and to serve as a reference guide. While the volume may be overwhelming, a solid grasp of health care terms can greatly increase an advocate’s effectiveness in partnering with health care systems in support of survivor safety and self-determination.

Adapted from “The ABCs of Health Care in Oregon,” published by the Office of Rural Health Oregon Health Sciences University, as well as the 2014 “Committee Briefing Paper” by the Medicaid Advisory Committee (MAC) to the Oregon Health Authority. (Exceptions noted.)

Access: Term commonly used to describe the ability to obtain health care services. Access to health care may be compromised by inability to pay, lack of available providers/ resources, or social/cultural or safety factors.

Accountable Care Organizations (ACO): A type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Acute Care: Health care received in response to a particular episode of illness or injury, as opposed to chronic or preventive care.

Addictions and Mental Health (AMH): OHA division focused primarily on behavioral health.

Aging and People with Disabilities (APD): Division of Department of Human Services (DHS) focused primarily on long term care issues.

Affordable Care Act (ACA): A federal statute signed into law in March 2010 as a part of the health care reform agenda of the Obama administration. Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility to 133% of federal poverty level (FPL), the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions. ACA also refers to a set of specific conditions identified by the Oregon Legislation in which practices will get enhanced reimbursement.

Alternative Payment Mechanisms (APMs): Alternatives to fee-for-service payment, including capitation, payment for episodes of care, pay for performance, and other payments tied more to health outcomes and less to volume of services. Also, Alternative Payment Methodologies.

Ambulatory: Health care services that do not require overnight or in-patient care. Also called outpatient care.

Beneficiary: The person who is entitled to services under a third-party payment plan; employees and their dependents may also be beneficiaries. Also called subscriber, member or enrollee.

Benefits: The specific services members are entitled to use in their health plan. May be flexible benefits from which employees choose the types of coverage they want or can be standard benefit packages that employers buy and offer to their employees.

Capitation: Third party payment system in which providers are paid a contracted amount in advance (usually monthly) per enrolled person regardless of the volume of services provided.

Case Management: Process of having a patient’s varied health care needs coordinated by using an ongoing individualized plan. Professional case managers may work for health plans, large providers or be independent contractors.

Centers for Medicare & Medicaid Services (CMS): The federal agency responsible for administering the Medicaid and Medicare programs.

Children's Health Insurance Program (CHIP): A federal program passed in 1997 allocating approximately \$24 billion over five years to provide health insurance coverage to low-income children who are not already eligible for Medicaid. CHIP offers states an enhanced matching rate and provides states with considerable flexibility in designing their programs, which may consist of simple Medicaid expansion or separate insurance-based models. Also referred to as SCHIP. (CHIP can also be Community Health Improvement Plan.)

Chronic Illness: A medical condition of a continuing nature that may result in life-long care needs.

Claims: Bills for services sent by health care providers to third party payers.

Clinician: A health care professional directly involved with patient care. Primarily used to describe practicing physicians, nurses or physician assistants as opposed to researchers and administrators.

Co-insurance: The share of health care premiums paid by the insured person.

Co-payment: A flat fee (e.g., \$5 per visit or \$10 per prescription) collected from the patient at the time of service, usually under a managed care health plan like an HMO.

Commercial Insurers: Generally refers to for-profit insurance companies that typically offer products that pay for health care on a fee-for-service basis. Also called "indemnity" plans.

Common Procedural Terminology (CPT): A set of codes commonly used by health care providers to bill for patient services. The codes identify what services were provided and are used to determine the amount of payment.

Community Advisory Council (CAC): The CAC is how the community is able to provide input to their Coordinated Care Organization. Oregon Revised Statute (ORS) 414.625 requires CCOs to create Community Advisory Councils (CACs), which must include representatives of the community of each county served by the CCO and meet regularly to ensure the CCO is addressing the health care needs of CCO members and the community. Consumer representatives must constitute a majority of the membership (at least 51%) and a representative from each county government in the service area must be included.

Community and Migrant Health Centers: Offering primary care health services for underserved, uninsured and marginalized populations, these clinics exist with the support of donations, grants and fundraising. They are also referred to as Federally Qualified Health Centers (FQHCs), and their federal support is authorized under Sections 329 and 330 of the Public Health Services Act.

Community Health Assessment (CHA) and Community Health Improvement Plans (CHIPs): Identification, prioritization, and reduction of health disparities across populations defined by race, ethnicity, age, sex, disability status, LGBTQ status, rural and urban location, etc.

Community Mental Health Center (CMHC): A publicly funded or private non-profit entity, which provides ambulatory mental health services to individuals within a geographic area. Services are generally available to the public on a sliding fee scale.

Conference of Local Health Officials (CLHO): An organization of county health department officials charged by Oregon statute with advising the Health Division on matters relating to local public health needs.

Coordinated Care Organizations (CCOs): Community-based organizations governed by a partnership among providers of care, community members, and those taking financial risk who have agreed to work together for people who receive health care coverage under the Oregon Health Plan (Medicaid).

Cost-based Reimbursement: A payment method whereby the provider of services is paid based on costs incurred to provide the service. Prior to 1983, Medicare paid all hospitals on a cost-based formula. In Oregon, eligible rural hospitals receive cost-based Medicaid reimbursement. Federally-qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) also receive a type of cost-based reimbursement. See FQHC, RHC.

Cost Sharing: The share of costs covered by insurance that a patient pays out of their own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Cover Oregon (Oregon's Health Insurance Exchange): Program that made available several health coverage options, with subsidies for low-income members. However, Oregon now uses the federal exchanges. This is a key feature of the Affordable Care Act.

Custodial Care: Basic ongoing personal or nursing care for an incapacitated patient with a terminal or chronic illness.

Deductible: The amount of medical expense an individual or family must incur from their own funds before insurance starts to cover their medical expenses.

Dental Care Organization (DCO): An OHP health plan covering and delivering oral health care and services.

Division of Medical Assistance Programs (DMAP): The agency that administers Medicaid and the State Children's Health Insurance Program (CHIP) in Oregon.

Durable Power of Attorney for Health Care: An advance directive authorized by Oregon law that allows a competent person to designate a willing "surrogate" to make health care decisions in the absence of ability to consent to treatment. See Living Wills, Advance Directives.

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT): A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Electronic Health Record (EHR): An electronic record of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider (including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports). The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

Federally Qualified Health Center (FQHC): A clinic supported by the US Public Health Service that is either in a federally-designated medically underserved area (MUA) or serving a medically underserved population (MUP). FQHCs receive cost-based Medicare and Medicaid reimbursement (except that, under the Oregon Health Plan, the Medicaid payment methodology is waived) and may be classified as Community Health Centers (CHCs), Migrant Health Centers (MHCs) or FQHC "look-alikes," which receive no grant funds.

Fee-for-Service (FFS): The historically dominant system of paying for health care services in the U.S. Under this system, providers send a bill to the patient and/or insurance company for services rendered and are paid their negotiated fee.

Fee Schedule: A list of services and the negotiated amount health plans or insurers will pay for those specific services.

Frontier Area: An area with six or fewer people per square mile. Ten of Oregon's 36 counties are designated frontier areas.

Health Care Reform: Refers to changes to the health care delivery system, how it is structured, how it is financed, and how people obtain access to care. Sometimes referred to as "transformation."

Health Evidence Review Commission (HERC): Provides comparative effectiveness and benefit design research to inform OHA and private sector development efforts. Mechanism for public comment on covered benefits under the Oregon Health Plan and the prioritized list.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Written by the federal Health and Human Services agency (HHS) to provide specific direction regarding the security and confidentiality of health information, as well as the standardization of transaction standards and code sets, and how health care information is billed and identified.

Health Maintenance Organization (HMO): A system of coordinated care, which delivers a basic set of health services to a group of enrollees. The HMO generally receives capitated payments from individuals, employers or the government.

Health Professional Shortage Area (HPSA): An area designated by the Secretary of DHHS as having an acute shortage of health care providers and therefore eligible for various federal benefits. Designations are originated on the state level; in Oregon, the Health Division's Primary Care Program coordinates this activity.

Health Systems Transformation (HST): The reform of Oregon's health care financing and delivery systems to achieve the Triple Aim, including: patient-centered primary care home (PCPCH); integrated care including physical, behavioral, and dental health services; global budgeting; alternative payment mechanisms, community health assessments and community health improvement plans for the identification, prioritization, and addressing of health disparities; and traditional health workers.

Home Health Agency (HHA): An agency that provides skilled nursing care and some therapeutic services in the home to the aged, disabled, sick, or convalescent.

Home Health Care: Services provided to people in their own homes. Third party payers cover some services, but other services may not be covered because they are not deemed medically necessary. In order to be eligible for Medicare reimbursement, home health services must be delivered by a certified HHA.

Hospice: Facilities or programs for terminally ill people. Hospice programs help patients and families through the death and dying process rather than prolonging life with additional medical interventions.

Innovator Agents: Facilitators of health systems transformation who will support the work of CCOs and participate in the Transformation Center's learning collaboratives and best practices work.

Inpatient: Services provided to a patient who has been admitted to a hospital and has occupied a hospital bed for at least 24 hours.

Long Term Care (LTC): Non-acute care provided to persons with chronic illnesses in non-hospital settings, e.g., nursing homes, adult foster care or home care.

Managed Care: An organized system of health care services, which may take a variety of forms. Usually features a full range of integrated health care services, facilities, and products and the patient's access to services is coordinated and managed by a primary care provider. Health maintenance organizations are the most conspicuous examples of managed care systems.

Managed Care Plans: Health insurance products characterized by managed care, i.e., organized and integrated health care delivery systems that can be HMOs or arrangements in which the plan and the practitioners share risk or have other financial incentives for efficient and appropriate patient care.

Marginalized Communities: Communities systematically blocked from (or denied full access to) various rights, opportunities and resources that are normally available to members of other groups, and which are fundamental to social integration and observance of human rights (e.g., housing, employment, health care, civic engagement, democratic participation, and due process).

Maternal and Child Health (MCH): Organized health services for mothers and their children. MCH programs take into account the risks of this group and work to provide preventive care, usually through a public health organization. Federal funds for MCH are made available through Title V of the Social Security Act.

Medicaid: Authorized by Title XIX of the Social Security Act, Medicaid is a health care program jointly administered by state and federal government which provides medical benefits for eligible low-income people in five categories: (1) mothers and dependent children; (2) aged; (3) blind; (4) disabled; (5) children in foster care. Oregon's Medicaid program is atypical because it has received a waiver to extend care to all persons under the federal poverty level. See Oregon Health Plan.

Medically Underserved Area (MUA): A geographic location that has insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Health status of the resident population is also important in this federal designation. Obtaining designation as an MUA is a precondition to receiving community health center federal grant monies. There is sometimes a difference between state and federal criteria for designating medically underserved areas. See HPSA.

Medicare: Title XVIII of the Social Security Act of 1965 which helps pay for medical and health services for persons age 65 and over and persons who are disabled. This program is financed through Social Security deductions from employee/employer payrolls and is handled through national trust funds.

Migrant Health Center (MHC): A type of FQHC funded under Section 329 of the Public Health Service Act. These centers provide health services to migrant workers and their families. See FQHC, Community Health Center.

Morbidity: A measure of the frequency, level of intensity and loss of function from accidents, illness or injury within a specific age, geographic, occupational or other specifically defined group. Morbidity measures describe the rate of illness or accidents, such as breast cancer in women.

Mortality: Measures the death rate based on past statistical measures. Usually measured by sex and age and is expressed as a rate per 100,000 population.

Office of Equity and Inclusion (OEI): This OHA office works with state and local government and community partners to improve health and human services programs and policies for underrepresented populations in Oregon through culturally specific and culturally responsive approaches. OEI also supports affirmative action, cultural competency and diversity initiatives to create and sustain welcoming environments that are inclusive and respectful of staff, customers and partners.

Oregon Health Authority (OHA): A state governmental organization charged with lowering and containing costs, improving quality, and increasing access to health care in order to improve the lifelong health of Oregonians. The Health Authority is overseen by the nine-member citizen Oregon Health Policy Board working towards comprehensive health and health care reform in the state.

Oregon Health Plan (OHP): Also known as Oregon's Medicaid program, OHP provides health care coverage to low-income Oregonians through programs administered by the Oregon Health Authority. Currently, more than 1 million Oregonians receive health care coverage through OHP. First passed by the legislature in 1989 and authored by then-Senate President John Kitzhaber, this effort to offer universal health care to all Oregonians consists of three parts: (1) an expansion/reform of Medicaid to include all Oregonians whose income is less than the federal poverty level regardless of eligibility "category"; (2) a risk pool that offers insurance coverage to Oregonians whose medical conditions have rendered them uninsurable; and (3) a mandate that all Oregon employers make health insurance available to their employees who work more than 17.5 hours per month. A unique feature of the plan is the ranking of condition-treatment pairs in numerical order based on cost-effectiveness and potential for successful outcome (See Health Evidence Review Commission). Depending upon available funds, conditions "below the line" are not covered. Parts one and two of the plan have been implemented; part three has been repealed by the legislature. See Medicaid, HERC.

Out-of-Pocket Costs: Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Patient-Centered Primary Care Home (PCPCH) Program: State program that recognizes clinics for their commitment to a patient-centered approach to care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Clinics reduce costs and improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions.

Payer (Payor): Also called "third party payer." Any agency, insurer or health plan that pays for health care services in an organized fashion. Payers include the government (Medicare and Medicaid); commercial insurance such as Aetna and Travelers; employers' self-insured plans and nonprofit plans like Blue Cross/Blue Shield. See Third Party Payer.

Per Member/Per Month (PMPM): A capitation payment method where an insurance company pays an amount to a primary care physician based on the number of members in the physician's care.

Peer Review: The evaluation of specific health care services and procedures conducted by professionals who have similar training and background. Peer review is used to analyze quality of care, individual competency and the effectiveness of certain procedures.

Physician: Generally used to describe doctors who have a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) degree. Oregon statute also allows naturopaths and chiropractors to refer to themselves as physicians.

Premium: The amount that must be paid for an individual's health insurance or plan, usually paid monthly, quarterly or yearly.

Preventive Care: Health care services that stress regular testing, screenings and early intervention. Annual physicals and other preventive measures were traditionally not covered by insurance under a fee-for-service or indemnity system. Managed care generally stresses preventive care and rewards enrollees for seeking such care.

Primary Care: Basic level of health care usually rendered by general practitioners, family physicians, internists, pediatricians, and more recently, mid-level practitioners. This entry-level care emphasizes caring for the patient's comprehensive health needs as opposed to a more specialized or fragmented approach to medical care. Obstetricians and gynecologists are sometimes designated as primary care physicians.

Prior Authorization: A cost-control procedure which requires a medical service or medication to be approved in advance by the doctor and/or the insurer. Without prior authorization, the health plan or insurer usually will not pay for the service.

Provider: Describes people and/or institutions that give health care services and includes physicians, hospitals, nurses, chiropractors, social workers or any other licensed health care practitioner or entity.

Public Health Service, U.S. (PHS): A principal operating component of the US Departments of Health and Human Services, charged with administering public health programs including the Indian Health Service, biomedical research, health professionals training, family planning, emergency medical services, health maintenance organizations, community health programs, and health planning.

Qualified Medicare Beneficiary: Someone who qualifies for Medicare, but whose income is at or below the poverty level. The state must pay for the person's Part B payment as well as their co-payments and deductibles.

Quality Assurance: Term used by health care industry to describe method by which quality patient care is provided and maintained. May include peer review, employee performance reviews, patient satisfaction surveys, hospital tissue committee, morbidity and mortality conferences and other measures.

Referral: May refer to (1) an informal suggestion from a provider for the patient to see another provider or (2) a more formal process within managed care plans by the primary care doctor to specialists, hospitals, or other services. Within the context of managed care, primary care physicians may be financially at risk for the cost of referrals and thereby have an incentive to minimize unnecessary referrals.

Sliding Fee Scale: A schedule of discounts in charges for services that is based on the consumer's ability to pay, according to income and family size. Bureau of Primary Health Care programs, such as the Community Health Center program, require that projects have sliding fee scales based upon the federal government poverty guidelines.

Single Payer System: Sometimes referred to as "Medicare for All," Single Payer is a reform proposal that advocates paying for health care through one payer (usually proposed to be the government) rather than a multitude of existing payers, e.g., private insurance companies, Medicare, Medicaid, etc.) Similar to a Canadian model of health care delivery, this system would substitute tax levies for current insurance premiums and supplement those funds from other tax revenues to provide universal coverage, lower administrative costs, and reduce corporate profit-motivated abuse.

Third Party Payer (or Payor): An insurance company or government agency, such as Blue Cross/Blue Shield or Medicare, that pays for hospital and doctor bills and certain other health care services for subscribers. (First party = patient; second party = provider of service.) Payment from these payers is commonly referred to as third party reimbursement. See Payer/Payor.

Transformation Center: Newly created agency funded through a grant from the CMS Center for Medicare and Medicaid Innovation, with responsibility for HST Innovator Agents, learning collaboratives, best practice identification and replication, and the rapid spread of key elements of the CCO model.

Traditional Health Workers (THWs): Under Oregon law, includes community health workers, personal health navigators, peer wellness specialists, and other health care workers. THWs are certified and enrolled in a registry maintained by OHA. OHA established curriculum guidelines and procedures for Authority approval of training programs.

Triple Aim: Proposed by Berwick and Nolan in 2007, the Triple Aim was adopted as the goal of Oregon health care reform. The Triple Aim is the simultaneous pursuit of: improved health, improved experience of care, and reduced cost.

Uncompensated Care: Care a provider gives without being paid. Includes free care or charity care for people who have no insurance and cannot afford services, as well as bad debt.

Underinsured: People who have some type of health care insurance, but not enough insurance to cover all their health care costs such as co-payments and deductibles.

Universal Coverage: Term used to describe system under which all individuals would have some form of insurance coverage, financed through a combination of private and public funds.

Veterans Administration: An independent division of the federal government that offers health care services to veterans who have been injured in action during wars or have injuries that are a result of combat. Includes hospitals as well as outpatient care and nursing home care.

Waiver: Used in the health care context, refers to an exception to a particular law or regulation, usually federal. Not all federal laws relating to health care can be waived, but the Medicaid and Medicare laws are occasionally waived by Centers for Medicaid and Medicare (CMS) for the purposes of conducting a demonstration project such as the Oregon Health Plan. Oregon has received the 1115 Waiver for OHP since 1993. Oregon's 1115 Waiver was recently approved in 2017 to continue through 2022, providing the federal exception needed to continue Coordinated Care Organizations.

Women, Infants, and Children Program (WIC): A federally funded nutrition program for women, infants, and young children that consists of nutrition supplements and counseling.

Safer Futures Model Summary

Improving Health for Intimate Partner Violence Survivors in Oregon



Increase the safety and well-being of survivors of intimate partner violence (IPV) through partnerships with local health care systems. Community-based advocates provide safety planning, resource referral, crisis intervention, care coordination, case management, and other services.

CONTACT US

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LEARN MORE

ocadsv.org/saferfutures

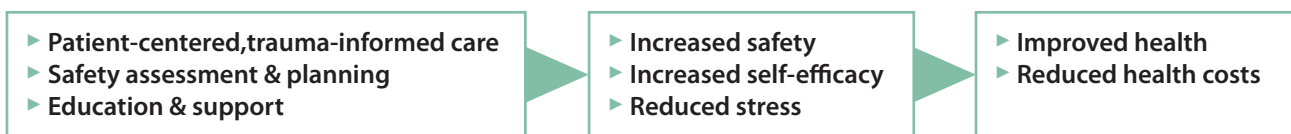
This was a short intervention that took almost no time on my part, but made a huge difference for the patient.

HEALTH CARE PROVIDER, SAFER FUTURES PARTNER

One study found that 12% of Medicaid-eligible women currently experience IPV, and that their average cost of care was twice as high as for those not currently experiencing IPV1. Health care based interventions that partner with community-based advocates have been found to increase the health and safety of survivors of IPV2.

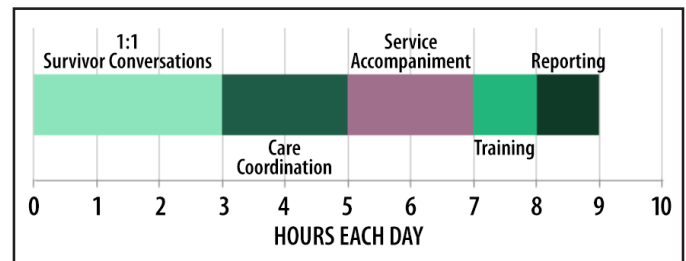
HOW WE ARE MAKING CHANGE

Working with us can improve health outcomes and lower health costs for your patients experiencing intimate partner violence.



COMMUNITY-BASED ADVOCATES

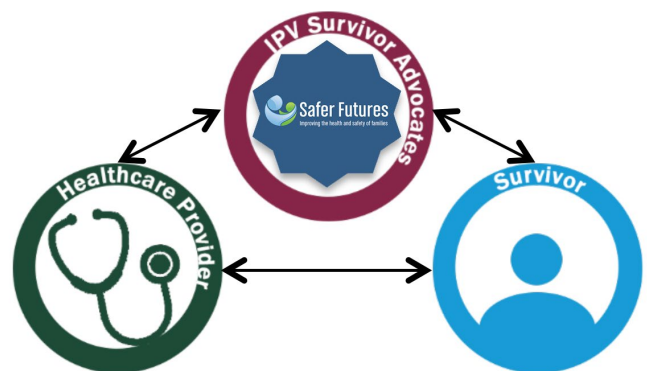
52 community-based domestic and sexual violence intervention organizations provide 24-hour advocacy response in every county and several tribal nations across Oregon. Services provided on a typical day for an advocate in a health care setting include:



* Service Accompaniment includes the advocate supporting the survivor in visits to other social service system resources, criminal justice system appointments, medical referrals, legal or housing resource support visits, and other systems.

WHAT YOUR PATIENTS EXPERIENCE

We work with you, referring survivors with health concerns to you, and accepting referrals from your providers to our advocate.





Oregon Coalition Against Domestic & Sexual Violence 2015 IPV & Healthcare Workgroup Product

Preparing Your Practice to Address Intimate Partner Violence

Summary:

- ▲ Explanation of health impact and cost of domestic and intimate partner violence.
- ▲ The Affordable Care Act recommends universal screening for intimate partner violence for women of child-bearing age to improve health and safety.
- ▲ Domestic violence advocates and community-based organizations are prepared to support providers in delivering best practice care.

The Problem

Intimate partner violence (IPV) is defined as “physical violence, sexual violence, threats of physical or sexual violence, and psychological/ emotional violence. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy” (CDC, 2010).

Prevalence: Nearly one in four women in the United States report experiencing violence by a current or former intimate partner at some point in her life. Vulnerable populations, such as youth, can be especially at risk for violence. 53% women aged 16-29 in family planning clinics reported physical or sexual violence from an intimate partner.¹

Health effects: Exposure to IPV has significant adverse consequences for physical and mental health. 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former partner.² Women who have experienced domestic violence are 80% more likely to have a stroke, 70% more likely to have heart disease, 60% more likely to have asthma and 70% more likely to drink heavily than women who have not experienced IPV.³

Health cost: A 2009 study of more than 3,000 women from a large Pacific Northwest-based health plan found that healthcare costs for women suffering ongoing abuse were 42% higher than for women who were not abused. Healthcare costs remain higher even when the abuse is over. Women who suffered physical abuse five or more years earlier had healthcare costs that were 19% higher than women who were never abused.⁴

Clinical importance of addressing IPV: Since experiencing abuse contributes to factors such as smoking, substance abuse, and stress interventions aimed at these problems will not succeed without addressing IPV. Healthcare settings have a central role in connecting women experiencing abuse to services that will reduce violence and promote positive health outcomes. Interventions as short as two minutes have been shown to be effective in clinical settings.⁵

¹ Miller E, Decker MR, McCauley HL, Levenson R, Silverman JG. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception* April 2010 (Vol. 81, Issue 4, Pages 316-322, DOI: 10.1016/j.contraception.2009.12.004)

² Rand, Michael R. 1997. *Violence-related Injuries Treated in Hospital Emergency Departments*. U.S. Department of Justice, Bureau of Justice Statistics. Washington, DC.

³ Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, *Morbidity and Mortality Weekly Report*. February 2008. Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/mmwr/PDF/wk/mm5705.pdf>

⁴ Bonomi AE, Anderson ML, Rivara FP, Thompson RS. 2009. Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research*, 44(3): 1052-67.

⁵ Soeken, K., McFarlane, J., Parker, B. 1998. “The Abuse Assessment Screen. A Clinical Instrument to Measure Frequency, Severity and Perpetrator of Abuse Against Women.” *Beyond Diagnosis: Intervention Strategies for Battered Women and Their Children*. Thousand Oaks, CA: Sage.



Oregon Coalition Against Domestic & Sexual Violence 2015 IPV & Healthcare Workgroup Product

The Solution

The U.S. Preventive Services Task Force recommends that clinicians universally “screen women of childbearing age for intimate partner violence.”⁶ Given the new policies in support of addressing IPV in healthcare settings, and the imperative in Oregon to achieve the Triple Aim, **improving practice around serving survivors of IPV is a clinically recommended, evidence-based solution.**

Why your practice?

- Healthcare settings provide a unique opportunity for screening and intervention because of trusting relationships, confidentiality, and space away from the abusive partner.
- A recent study found that 44% of survivors of domestic violence talked to someone about the abuse; 37% of those women talked to their healthcare provider.⁷ Women may present to their doctor before a social service provider or legal advocate.
- In four different studies of survivors of abuse, patients reported that they would like their healthcare providers to ask them privately about IPV.⁸
- Women in family planning clinics who received both assessment and counseling on IPV-specific harm reduction strategies were 60% more likely to end a relationship because it felt unhealthy or unsafe.⁹ Assessment for reproductive coercion during family planning clinic visits was associated with a 70% reduction in pregnancy coercion.¹⁰

How do I start?

- **Get training on tools to support screening and counseling for IPV and the effects of abuse on survivors.** There are safety concerns when serving survivors. An uninformed intervention can cause potential harm. Learn more at www.healthcaresaboutipv.org.
- **Contact your local community-based organization or domestic violence advocate.** Advocates have up-to-date resources to help support your patient to be safe and healthy. A domestic violence advocate can play a similar role to a community health worker or social worker in partnering with providers on patient support and care coordination.
- **Learn about promising practices in the field.** Screening alone is not enough. When a patient discloses, support and harm reduction strategies must be implemented, and often a supported referral is needed. Oregon is home to many innovative pilots around partnership models for this supported referral. Learn more by calling the Oregon Coalition Against Domestic & Sexual Violence at (503) 230-1951.

Get started today! Contact your community-based program advocate:

Place holder for local program contact information.

⁶ Nelson HD, Bougatsos C, Blazina I. Screening Women for Intimate Partner Violence and Elderly and Vulnerable Adults for Abuse: Systematic Review to Update the 2004 U.S. Preventive Services Task Force Recommendation [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012 May. (Evidence Syntheses, No. 92.)

⁷ The Dorchester Community Roundtable Coordinated Community Response to Prevent Intimate Partner Violence. 2003. RMC Research Corporation. Portsmouth, New Hampshire.

⁸ McCauley J, Yurk R, Jenckes M, Ford D. 1998. “Inside ‘Pandora’s Box’: Abused Women’s Experiences with Clinicians and Health Services.” *Archives of Internal Medicine*. 13:549-555.

⁹ Miller E, Decker M, McCauley H, Tancredi D, Levenson R, Waldman J, Schoenwald P, Silverman J.A Family Planning Clinic Partner Violence Intervention To Reduce Risk Associated with Reproductive Coercion. *Contraception* - 01 September 2010 (10.1016/j.contraception.2010.07.013).

¹⁰ Ibid.



RECOMMENDATIONS AND RESOURCES FOR INTIMATE PARTNER VIOLENCE, DOMESTIC VIOLENCE SCREENING AND/OR ASSESSMENT

Recommended IPV Screening and Assessment

The Affordable Care Act (ACA) mandates that women and adolescents receive certain preventive health services at no additional cost to the patient. Domestic and interpersonal violence screening and counseling for all women is among the preventive health services covered by this guidance.¹

The U.S. Preventive Services Task Force recommends that clinicians screen women of child bearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services.

In a recent systematic evidence review, the U.S. Preventive Services Task Force noted several screening instruments with high sensitivity and specificity for identifying IPV in the health care settings:

<http://www.uspreventiveservicestaskforce.org/3rduspstf/famviolence/famviolrs.htm>

The Centers for Disease Control and Prevention (CDC) also published a compilation of IPV and sexual violence assessment instruments, comparing existing tools:

(<http://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>).

Evidence for a Universal Education Based Assessment

A 2014 meta-analysis showed that, while screening for IPV was successful in identifying people experiencing IPV, it had no effect on rates of violence, health, or follow-up for support.² Thus, **it is important in clinical settings to use interventions that go beyond asking standardized screening questions.**

Disclosure-based IPV screening tools *on their own* are not helpful in improving the health and safety of survivors. **A screen for IPV is best accompanied by an appropriate, supportive response along with a warm referral to a community-based advocate.** (For a list of community-based advocacy organizations, visit <http://www.ocadsv.org/find-help>.)

¹ <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/#CoveredPreventiveServicesforWomenIncludingPregnantWomen>

² O'Doherty Lorna J, Taft Angela, Hegarty Kelsey, Ramsay Jean, Davidson Leslie L, Feder Gene et al. Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis BMJ 2014; 348:g2913



One of the more up-to-date recommendations for this model comes from the American Congress of Obstetricians and Gynecologists (ACOG). ACOG recommends using a brochure-based intervention to facilitate a conversation between the clinician and the patient that takes less than a minute, unless IPV is disclosed. If IPV is disclosed, the clinician is trained to respond appropriately and to partner with a community-based advocate. <https://www.acog.org/-/media/Departments/Violence-Against-Women/Reproguidelines.pdf?dmc=1&ts=20160217T1746414883>

Unlike many of the older tools reviewed by USPSTF, this is **not a disclosure-based screen. It is a universal education based intervention** on healthy and unhealthy relationships that is specific to a reproductive health visit and provides guidance on tailoring the conversation to the content of the visit. The intervention's online toolkit is provided free of charge by Futures Without Violence National Health Resource Center on Domestic Violence (HRC) with support of the Department of Health and Human Services (DHHS), Administration for Children and Families: <http://www.healthcaresaboutipv.org>

When IPV is disclosed during this assessment, one study found that among those with recent IPV, there was a 71% reduction in the odds of pregnancy pressure and coercion (a form of IPV) at the follow-up appointment (12 to 24 weeks later).³ Additionally, women who received information about safety were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of IPV.⁴

This intervention has been piloted in Oregon at several sites through Project Connect⁵ and Safer Futures⁶ in partnership with OCADSV. This intervention also serves as primary prevention, as it sets a norm that safe and healthy relationships are an important part of a person's health. People trust their healthcare providers, so discussing relationships provides a critical point of intervention that may not otherwise occur.

For more information, please contact the Oregon Coalition Against Domestic & Sexual Violence at info@ocadsv.org or (503) 230-1951.

³ Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*. 2011;83:274-280.

⁴ McFarlane J, Groff JY, O'Brien JA, Watson K. Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial. *Nursing Research*. 2006;55(1):52-61.

⁵ Project Connect contact: Julie M. McFarlane, Women's Health Program Manager, Maternal & Child Health Section, Public Health Division, Oregon Health Authority; julie.m.mcfarlane@dhsosha.state.or.us; (971) 673-0365.

⁶ Safer Futures contact: Christine Heyen, Safer Futures Project Coordinator, Crime Victims' Services Division, Oregon Department of Justice; Christine.p.heyen@doj.state.or.us; (503) 378-5303; http://www.doj.state.or.us/victims/pages/safer_futures.aspx.



*Oregon Coalition Against Domestic & Sexual Violence 2015 IPV & Healthcare Workgroup Product
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Fact Sheet: Benefits of Domestic and Sexual Violence (D/SV) Advocates in Health Care Settings

Domestic and sexual violence (D/SV) have short and long-term impacts on survivors' health. In addition to injuries sustained during violent episodes, abuse is linked to a number of adverse health effects including depression, substance abuse, arthritis, chronic neck and back pain, migraines, problems seeing or speaking, sexually transmitted infections, and stomach ulcers.¹ The Affordable Care Act requires health plans to cover women's preventative services including screening and counseling for interpersonal and domestic violence.²

Health Care Based D/SV Advocacy

Establishing or strengthening a professional collaboration between D/SV programs and health care organizations provides opportunities for advocates to work directly with survivors identified in the health care setting. Advocates working in partnership with health care systems have unique opportunities to reach survivors accessing primary care, women's health, prenatal care, labor and delivery, urgent care, behavioral health, addictions treatment, dentistry and more.

The Role of the DSV Advocate

Advocates can offer patients safety planning, emergency shelter, housing resources, support groups, youth services, legal advocacy, and referrals which may be beyond a health care provider's scope of practice. Within the health system an advocate might accompany a survivor to medical appointments, provide crisis counseling, facilitate on-site support groups, or even participate with the health care team in conducting D/SV screening and assessment.

Through consultation, training, and technical assistance advocates can support providers in improving their skills and sensitivity in assessing and responding to D/SV. Advocates should place particular emphasis on the importance of discussing the limits of confidentiality prior to screening for D/SV. Advocates can encourage providers to define success in terms of efforts to reduce isolation, options to improve survivor safety, and referrals to D/SV advocacy.

Advocates can also support health care systems in creating an environment that encourages the identification of abuse and its impacts on health, and that prioritizes victim safety, confidentiality, integrity, and autonomy over their own life choices. D/SV advocates may also provide health care facilities with posters, safety cards, screening tools, and other materials and products to enhance identification and response to violence.

On Site or Co-Located Advocacy Model

Advocates may have full time offices in a health care facility, be on site for specific days of the week when appointments can be made for patients, or may respond on site on an as needed basis. On site advocates work to integrate D/SV awareness into the health care setting's day-to-day operations including training health care providers to recognize the signs and symptoms of domestic violence, and how to talk to patients about what may be happening at home.

¹ Coker, A., Smith, P., Bethea, L., King, M., McKeown, R. (2000). Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine*, 9.

² U.S. Department of Health and Human Services. Women's Preventive Services: Required Health Plan Coverage Guidelines. Health Resources and Services Administration. <http://www.hrsa.gov/womensguidelines>. Accessed March 21, 2013.



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Advocates may also meet regularly with a multi-disciplinary task force within facilities, making sure that policies support a proactive approach to domestic violence intervention.³ Examples of policy-level improvements include clinics establishing expectations of patient privacy during D/SV screening; incorporating a screening tool into patients' electronic medical records; and requiring providers to receive domestic and sexual violence training.

Confidentiality, Mandatory Reporting, and Follow-Up

D/SV advocates operate under the regulations of the Violence Against Women Act (VAWA 2013). As such, advocates are legally required to protect survivors' confidentiality and are "prohibited from sharing personally identifying information about victims without informed, written, reasonably time-limited consent."⁴ Unless an advocate's status or licensure requires them to be one, they are not considered Mandatory Reporters.

Without a written release of information, advocates are unable to confirm whether they have followed up with specific patients referred by providers. Advocates can supply aggregate data on the number of referrals received from a given facility on a quarterly basis. Advocates partnering with health care facilities can also encourage providers to follow up with patients during their next visit, to determine if they were successful in accessing D/SV services.

Provider Training

As a result of D/SV advocacy and health care partnerships, D/SV organizations may be invited to offer trainings to providers. These trainings can build on the skills of health care staff so that they understand the dynamics of D/SV, are able and willing to assess for abuse, and can effectively respond to victims and their children. Training topics may include intimate partner violence and health outcomes, confidentiality and trauma-informed mandatory reporting, and screening and intervention tools for intimate partner violence in health care settings.

When a D/SV organization is offering training to health care providers, advocates can play a vital role. Advocates partnering with health care should be aware of current research related to health and domestic violence and existing tools available to support survivors. Allowing providers an opportunity to connect with an advocate during training can result in greater likelihood of providers making "warm" referrals to D/SV advocacy organizations.

Support and Advocacy for Providers

The D/SV advocate may also be presented with the opportunity to provide assistance directly to health care employees. Providers with a personal history of domestic or sexual violence might turn to the advocate as a resource, to consult with them regarding their own personal experience or concern over a friend or family member who is in an unsafe situation. Advocates are in a unique role and can extend their confidentiality practices to support survivors who are working within the health care system.

³ Durborow, Nancy (2013). How to Create a Healthcare-based Domestic Violence/Sexual Assault Program. Futures Without Violence; National Health Resource Center on Domestic Violence. Accessed at: <http://www.futureswithoutviolence.org/how-to-create-a-healthcare-based-domestic-violencesexual-assault-program/>.

⁴ Universal Grant Conditions: Nondisclosure of Confidential or Private Information. VAWA 2013 Section 3:42 U.S.C. 13935 (a)(20) & (b)(2).

OREGON REQUEST FOR CONFIDENTIAL COMMUNICATION

You have the right to have protected health information* sent to you instead of the person who pays for your health insurance plan. You can ask to be contacted:

- At a different mailing address
- By email
- By telephone

To make this request, complete, sign, and send this form to your insurer. You can send it by mail, fax, or email. To find contact information for your health insurance plan, visit <http://www.oregon.gov/DCBS/Insurance/gethelp/health/Pages/confidential-communications.aspx>.

Please note: It can take up to 30 days from the date your insurer receives your hard-copy request to process it. Requests made by telephone, by email, or over the Internet must be implemented by your insurer within seven days of receipt.

Name of your health insurance company

Your name

Your date of birth

Your insurance member # (if available)

Your insurance group # (if available)

Please tell us how we should contact you. If you mark more than one way, put a "1" next to your first choice, "2" next to your second choice, and so on. Your health plan must contact you through at least one of the communication methods noted below:

- Email to the following email address: _____
- U.S. Mail at this address: _____

- Text to the following phone #: _____
- Message through online insurance patient portal: _____
- Phone call to the following number: _____

IMPORTANT! The following two sections MUST be completed:

1. If a communication cannot be sent in the above selected formats, or if you want information by U.S. mail, provide the address below:

2. Is there a phone number or email to use if there are questions regarding this request?

Signature

Date

PLEASE NOTE: If you change insurance companies, you will need to make a new request to the new insurance company. Until your request is processed, the insurance company may continue to send your protected health insurance to the person who is paying for your health insurance.

*Protected Health Information means individually identifiable health information your insurer has or sends out in any form. Confidential communication of protected health insurance covered under this request includes:

- An explanation of benefits notice

- Information about an appointment

- A claim denial

- A request for additional information about a claim

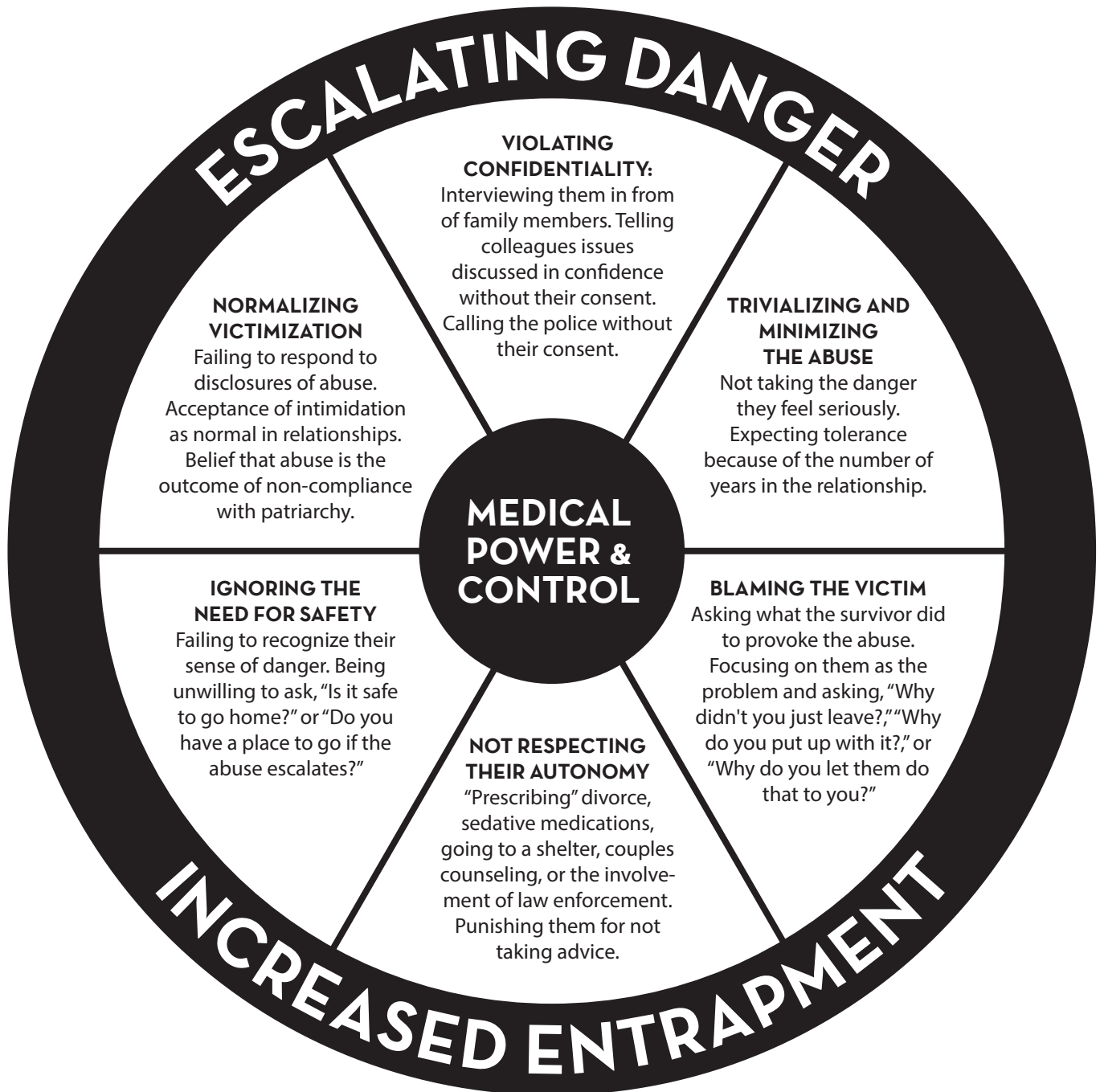
- A notice of a contested claim

- The name and address of a provider, a description of services provided, and other visit information

- Any written, oral, or electronic communication described on this list to a policyholder, certificate holder, or enrollee that contains protected health information

MEDICAL POWER & CONTROL WHEEL

Adapted from work developed by The Domestic Violence Project (Kenosha, WI) and the original wheel by the Domestic Violence Intervention Project (Duluth, MN).



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