Prevent, Assess, and Respond: A Domestic Violence Toolkit for Health Centers & Domestic Violence Programs

- a companion to www.ipvhealthpartners.org -

FUTURES WITHOUT VIOLENCE®

National Health Resource Center on Domestic Violence

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting edge advocacy and sophisticated technical assistance. The HRC offers a wealth of free materials that are appropriate for a variety of public and private health professions, settings and departments.

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This Toolkit is funded through Grant #90EV0414 from the U.S. Department of Health and Human Services (HHS), Administration for Children and Families, Family and Youth Services Bureau, Family Violence Prevention and Services Program. Funding was also provided, in part, from the HHS Health Resources and Services Administration (HRSA). Neither HHS nor any of its components operate, control, are responsible for, or necessarily endorse this toolkit including, without limitation, its content, technical infrastructure, and policies, and any services or tools provided. (revised November 2017)

Prevent, Assess, and Respond:
A Domestic Violence Toolkit for Health Centers & Domestic Violence Programs

Domestic violence (DV) is a public health problem of epidemic proportions.[1]

- 1 in 4 women in her lifetime is impacted by DV[2] and 1 in 7 men have been the victim of severe physical violence by an intimate partner.[3] LGBTQ communities experience violence at similar or higher rates to that of heterosexual women.[4 5 6 7 8 9]
- In addition to injuries, physical and psychological abuse are linked to a number of adverse health effects.[10]
- Medical costs of domestic violence and sexual assault (DV/SA) range from $2-7 billion annually.[11]

Health centers are key to violence prevention.

Use this toolkit to build a comprehensive and sustainable response to domestic violence and sexual assault (DV/SA) in partnership with DV/SA advocacy programs (social service organizations) to:
→ Improve how your health center identifies and responds to DV/SA and promotes prevention, and
→ Develop proactive partnerships with local DV/SA advocacy programs to address the health needs of patients and connect them to health centers for care.

1. 2013 WHO Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence

2. 2010 CDC National Intimate Partner and Sexual Violence Survey https://www.cdc.gov/violenceprevention/nisvs/

3. 2010 CDC National Intimate Partner and Sexual Violence Survey https://www.cdc.gov/violenceprevention/nisvs/

4. Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J, Merrick MT. Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. MMWR 2014; 63(SS-8): 1-18.

•http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

5 Landers S, Gilsanz P. The health of lesbian, gay, bisexual, and transgender (LGBT) persons in Massachusetts. Massachusetts Department of Public Health; 2009.

6 Braun V, Schmidt J, Gavey N, Fenaughty J. (2009). Sexual Coercion Among Gay and Bisexual Men in Aoteraroa/New Zealand. Journal of Homosexuality, 56:336-360.

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8 Houston E, McKirnan DJ. (2007). Intimate Partner Abuse Among Gay and Bisexual Men: Risk Correlates and Health Outcomes. Journal of Urban Health, Bulletin of the New York Academy of Medicine., 84(5):681-690.

9 Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J., and Keisling, M, Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

10 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.

11 Brown DS, Finkelstein EA, Mercy JA, 2008. Methods for Estimating Medical Expenditures Attributable to Intimate Partner Violence. Journal of Interpersonal Violence, 23(12): 1747-66.

Health centers and DV/SA advocacy programs are natural partners given their shared mission to improve the health, wellness, and safety of their clients. Tools developed specifically for DV/SA advocacy programs to promote partnerships with health centers are also offered. Research indicates that IPV, sexual violence and stalking disproportionately impact women and experience severe health consequences.[12] Therefore this toolkit primarily focuses on women, however the recommended interventions can be applied and adapted for men. The terms Intimate Partner Violence (IPV), Domestic Violence (DV) and Domestic and Sexual Assault (DV/SA) will be used interchangeably throughout this toolkit. Quotes from health centers and DV/SA agencies featured in this toolkit have been used with permission.

"When health center leadership commits to the system-wide integration of care, including developing formal partnerships with community based social service organizations to address intimate partner violence, we find they are better positioned to improve health outcomes for the patients they serve." - Judith Steinberg, MD, MPH, Chief Medical Officer, Bureau of Primary Health Care, Health Resources and Services Administration

What are the health and financial consequences of DV/SA?

- DV/SA is a key social determinant of health and impacts your patients: At least 1 in four women have experienced intimate partner violence (IPV)[13] and 1 in 7 men have experienced severe physical violence by an intimate partner.[14]
- Health consequences can be severe. The long term impact of domestic and sexual violence includes physical injuries, chronic health and mental health issues, and high risk health behaviors.[15] Click here for an infographic on the health impact of violence.
- DV/SA is costly and interferes with quality of care. Click here to read more about DV/SA health costs and utilization.
- The U.S. Preventive Services Task Force recommends screening and brief counseling for intimate partner violence (IPV), currently a required women's preventive service covered ebenefit. Click here to see the recommendation.
- Evidence-based interventions exist and preventive service codes can be used to bill for brief intervention and counseling.
- The U.S. Centers for Disease Control and Prevention defines intimate partner violence (IPV) as physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.

Learn additional facts on health and domestic violence.

12 2010 CDC National Intimate Partner and Sexual Violence Survey https://www.cdc.gov/violenceprevention/nisvs/

13 2010 CDC National Intimate Partner and Sexual Violence Survey https://www.cdc.gov/violenceprevention/nisvs/

14 2010 CDC National Intimate Partner and Sexual Violence Survey https://www.cdc.gov/violenceprevention/nisvs/

15 http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

Why Health Centers?

For millions of Americans, including some of the most vulnerable individuals and families, health centers are essential patient-centered medical homes that promote health and diagnose and treat chronic disease and disability. One in 13 people nationwide rely on a HRSA-funded health center for their health care needs.[16] Click here to locate a health center near you.

Given their enormous reach and overarching goals to promote health and safety, health centers are uniquely positioned to be leaders in violence prevention across the U.S. Many health centers have already partnered with DV/SA organizations to implement health interventions with promising results to achieve better health outcomes for patients navigating the health challenge of DV/SA.

Between 2014-2016, 10 health centers and 10 DV/SA programs across the country participated in the **Improving Health Outcomes Through Violence Prevention Pilot Project** to identify promising ways to promote the health and safety of patients. The U.S. Department of Health and Human Services, Health Resources and Services Administration, and the Administration for Children and Families funded this project, in collaboration with Futures Without Violence, who provided training and workflow redesign support. Under this pilot, health centers and partnering DV/SA programs tested all steps to address and respond to DV/SA. Key findings are distilled here into actionable steps for other health care providers, administrators, DV/SA advocates, and community partners to easily adapt for their own settings.

Follow these essential steps to integrate a response to IPV in your health center:

1. **Build partnerships** between health centers and local DV/SA programs.
2. **Prepare your practice** by implementing a new or updated DV/SA policy to identify and respond to survivors in partnership with community based DV/SA programs, and promote prevention.
3. **Adopt the simple evidence-based intervention** to educate all patients about the connection between IPV and their health and engage them in strategies to promote wellness and safety. This intervention consists of universal education using a safety card with all patients (see below for instructions).
4. **Train providers and all staff** on the impact of DV/SA on health outcomes, and how to assess and respond in collaboration with community based DV/SA programs.
5. **Evaluate and sustain your progress** as part of continuous quality improvement.

16 https://bphc.hrsa.gov/about/healthcenterprogram/index.html

1. Build Partnerships - For Health Providers

Include DV/SA advocates as part of your multidisciplinary care team/approach

"We developed a system where women who have been facing violence…can come to [our health center] and we help them to navigate the system. We have a primary partner for DV referral and support, DC SAFE, a crisis center in DC. [The health center] doesn't provide any DV crisis intervention, but we navigate them to DC Safe. And also when DC Safe deals with a client that needs health care or long term support, they also navigate back to us. Clients that need long term support because they're dealing with some legal issues…like immigration, or immigration status adjustment...we can also help these women so they're not standing alone."
- Suyanna Barker, DrPH Community Health Action Department Director, La Clinica del Pueblo (Washington, DC)

Domestic and Sexual Violence (DV/SA) advocates offer support, safety planning and coaching to address other social determinants of health

Local and state DV/SA programs are integral partners to a successful response. Many DV/SA partners are equipped to provide supportive services such as translation, transportation, and legal support which mirror the enabling services offered by health centers. DV/SA programs exist in many communities in which health centers are located and DV/SA advocates can offer a range of support to survivors identified in health centers. Such confidential patient support may include information on healthy and unhealthy relationships; emotional support; emergency and long-term safety planning; and supports related to other social determinants of health including housing, food insecurity and employment as well as court and legal advocacy. Some advocates staff crisis hotlines, run support groups or provide in-person counseling, and some agencies have programs for children. Domestic violence coalitions, local domestic violence programs, tribal domestic violence programs, and culturally-specific community-based organizations are an integral part of any coordinated healthcare and social service response to DV/SA.

Reach out to your local DV/SA program! Click here to find a domestic violence program near you, or contact your state DV coalition or tribal DV coalition.

DV/SA advocates can connect their clients to primary health care.

Partnerships promote access to health care for female survivors of violence because women seeking services at DV/SA programs may have been prevented from seeking care by their abusive partners. In one study 17% of abused women reported that a partner prevented them from accessing health care compared to 2% of non-abused women.[17]

DV/SA programs are in a unique position to reach clients as they come in for relationship and safety support. They can:

- **inquire about clients' health and help-seeking on intake forms;**
- **identify whether the client has a primary health care provider and offer referrals to partnering health centers, informing clients about health center services and sliding scale fees;**
- **offer onsite basic support such as contraception, pregnancy, and sexually transmitted infection (STI) testing; and**
- **partner with health centers to offer more robust health services onsite at DV/SA programs**

Health centers participating in the Improving Health Outcomes Through Violence Prevention Pilot Project found that establishing formal partnerships, including memoranda of understanding (MOUs), with community based DV/SA programs, as well as other organizations that support survivors of violence, was crucial to providing trauma informed care for survivors.

"One of our most important accomplishments was having our [domestic violence] advocate on site and available for a warm hand-off and regular communication from the advocate for updates and education" - Keri Scott, former Director of Quality, The Rinehart Clinic, (Wheeler, OR)

17 McCloskey LA, Williams CM, Lichter E, Gerber M, Ganz ML, Sege R. (2007). Abused women disclose partner interference with health care: an unrecognized form of battering. Journal of General Internal Medicine, 22(8):1067-1072.

Build Partnerships: Domestic Violence/Sexual Assault Advocates

Receiving Warm Referrals from Health Partners
Serving as the primary referral from your partnering health center increases patients' access to DV/SA services. Offer trainings and continuing education with the health center to introduce your agency's services and staff, along with the dynamics, prevalence, and health impact of IPV. Trainings for your partner will better equip providers and staff to address and respond to IPV at their health center.

Providing Health Services
Promote survivor health at your agency by offering important health services such as reproductive health resources, pain medication, and rapid HIV testing. Reflect a culture of health for your clients and staff through wellness classes, healthy food options, and info on health coverage and care. Another way that DV/SA advocates can promote health is by talking with survivors about reproductive coercion and offering reproductive health services like pregnancy tests, contraception, and condoms.

See our full toolkit on "Integrating Health Services into Domestic Violence Programs"

"Noemi [patient advocate at Mariposa Health Center] and Mercedes [domestic violence advocate at Catholic Community Services] have come together to not just provide single advocacy on the DV side…but also advocacy on the client care/health side. They enhanced [available] resources, they broadened those support circles…and in a small community you definitely need as much as help as you can get because sometimes the resources are slim to none." -Lisa Silva, Program Director, Catholic Community Services (Sierra Vista, AZ)

Tools to Build a Successful Partnership

Memorandum of Understanding (MOU): It is critical for health centers and DV/SA programs to form solid partnerships in anticipation of future needs. Roles and responsibilities of each organization should be clearly identified; establishing an MOU is one of the best tools to use.

Sample MOU

Tips on how to partner with DV/SA programs

Case Study: Oregon Guide to Health Care Partnerships

2. Prepare Your Practice

There are six steps to prepare your practice:

- ◊ Build buy-in for your DV/SA program
- ◊ Support staff in addressing their own experiences of violence
- ◊ Create or update policies or protocols on DV/SA
- ◊ Measure quality improvement
- ◊ Enhance the clinic environment by displaying patient and provider tools
- ◊ Document and code

Build buy-in for your DV/SA program: You will need support from all staff levels of your health center to create a sustainable and effective response to IPV. This includes CEOs, Board Members, clinicians, peer educators, billing and front desk staff. Identify one or more champions for your program to build and maintain buy in. Consider engaging a leader from the staff level and one from the provider level to lead and manage changes. This toolkit provides the designated champions all of the necessary tools to support their engagement.

Sample slide presentation for CEOs and Board Members on why health centers should create a response to DV/SA and the steps to get started.

Sample workflow that outlines each staff person's role – from the front office to the exam room -- in responding to DV/SA.

Sample blog posts for October Domestic Violence Awareness Month and April Sexual Assault Awareness Month

Supporting staff:

Creating a trauma informed health setting is a critical first step in building a response to IPV. Trauma informed workplaces recognize the needs of both clients and employees. Taking into account the high prevalence rates of IPV, it is likely that some health center employees are also personally affected by IPV and others will experience vicarious trauma.

Develop policies and implement training specific to health center employees:

- **Visit http://www.workplacesrespond.org/ to view an online toolkit for building workplace responses to IPV including a tool that allows customization of a protocol for staff exposed to violence.**
- **For a presentation for staff on vicarious trauma and self-care strategies, click here.**

"At the beginning of our IPV work we first offered information and resources for employees on vicarious trauma, including developing a support group just for staff, and because of that we were able to build staff resiliency before addressing IPV with patients."

—Sara Gavin, LMFT, LPCC, Director of Behavioral Health, CommuniCare Health Centers (Woodland, CA)

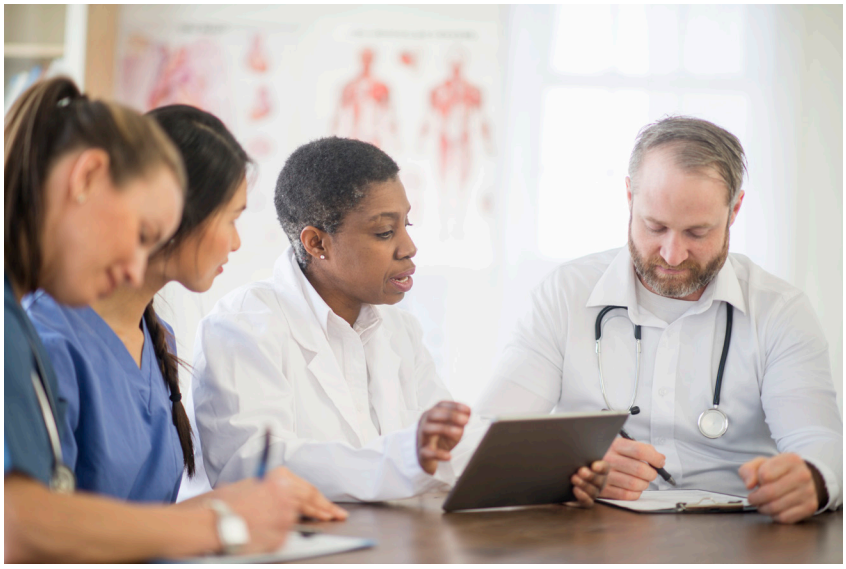
Create or update policies and protocols on DV/SA: It is critical to establish or update your protocol on DV/SA by identifying roles and responsibilities for staff, establishing a policy to see patients alone, and implementing uniform standards for documentation and reporting. Examples of adaptable protocols from health centers from across the U.S. are featured below.

View sample Health Center IPV Protocols that you can adapt for your own setting.

View a video vignette on the importance of seeing patients alone for part of every visit.

"A key success for us in supporting survivors was helping the health center establish a 'see patients alone' policy"

—Emily Fanjoy, Health Programs Project Coordinator, Tillamook County Women's Resource Center (Tillamook, OR)



Quality Improvement: Work with your quality improvement staff or committee to establish a baseline assessment of the quality of care currently provided to survivors of DV/SA. Identify appropriate tools to measure progress such as the following Quality Assessment/Quality Intervention (QA/QI) tool. Complete the tool at initial DV/SA program implementation, at the 6 month mark, and again as needed to measure change, address barriers, and evaluate sustainability. The QA/QI tool can also help inform the development of your protocol.

Enhance the clinic environment by displaying patient and provider tools: Research shows that creating a supportive environment helps survivors feel more comfortable talking about violence.[18] Hang posters in lobbies and exam rooms with IPV prevention and health messages; stock safety cards in exam rooms and bathrooms; and consider other culturally appropriate patient and provider tools.

Documentation and Coding: Be sure to train providers and the billing team on how to document and code for DV/SA as well as how to implement important privacy protections for what information gets shared about IPV. Current Procedural Technology (CPT) and International Classification of Diseases (ICD) codes are available for age appropriate counseling and risk factor reduction interventions as well as codes to record assessment and counseling for IPV.

- Coding and Documentation for Domestic Violence
- Privacy Principles for Protecting Survivors of Domestic Violence

18 Chang JC, Decker MR, Moracco KE, Martin SL, Peterson R, Frasier PY. (2005). Asking about intimate partner violence: advice from female survivors to health care providers. Patient Education and Counseling, 59:141-147

3. Adopt the Evidence-Based Intervention

What works? Educate all patients about the connection between IPV and their health and engage them in strategies to promote wellness and safety. The following are evidence-based steps that a multi-disciplinary care team can take to educate all patients on IPV, while also promoting prevention.

Evidence-based intervention on screening and brief counseling for DV/SA:
The following are evidence-based steps that a multi-disciplinary care team can take to conduct screening and brief counseling on IPV, while also promoting prevention:

Use the CUES intervention

1) **Confidentiality:** Always see the patient alone for at least part of the visit and disclose your limits of confidentiality before discussing IPV.

2) **Universal Education + Empowerment:** Use FUTURES' safety cards to talk with all patients about healthy and unhealthy relationships and the health effects of violence. Always give at least two cards to each patient so that they can share with friends and family.

3) **Support:** Disclosure is not the goal, but it will happen. Discuss a patient-centered care plan to encourage harm reduction. Make a warm referral to your DV partner and document the disclosure in order to follow up at the next visit.

Why universal education? It is important to address universal prevention education on the elements of healthy and unhealthy relationships and the impact of violence on health. Even when asked directly by skilled providers, women may not disclose abuse for reasons including distrust and concern for subsequent violence.[19, 20] One study asked what advice women who had experienced IPV would give health providers regarding how to ask about and discuss the issue of IPV.[21] The study advised that providers (1) give a reason for why they are asking about IPV to reduce women's suspicions and minimize stigma, (2) create an atmosphere of safety and support, (3) provide information, support and access to resources regardless of whether the woman discloses IPV. They emphasized that a provider's asking about IPV is an opportunity to raise patient awareness of IPV, communicate compassion and provide information and not merely a screening test to diagnose a pathologic condition.

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19 Bair-Merritt MH, et al. Primary care-based interventions for intimate partner violence:. Am J Prev Med 2014;46(2):188-94. McCloskey LA, et al. Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. Public Health Rep 2006;121(4):435-44.

20 Miller E, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. Contraception 2011;83(3):274-80. Rhodes KV, et al, Interventions for intimate partner violence against women: clinical applications. JAMA 2003;289(5):60

21 Chang J, Decker MR, Morocco K, Martin S, Petersen R, Frasier P. What happens when health care providers ask about intimate partner violence? A description of consequences from the perspectives of female survivors. J Am Med Womens Assoc. 2003;58(2):76-81.

Combining universal education on IPV (regardless of a disclosure on any screening tool), brief trauma-informed harm reduction strategies, and supported referrals is beneficial (i.e. offering access to an onsite DV/SA advocate, offering use of the phone in clinic to call a local resource, etc.). Education about IPV, harm reduction and warm referral to DV/SA advocacy services (regardless of disclosure and case identification) are often overlooked elements of a comprehensive health sector response which increase safety, reduces violence, and improves clinical and social outcomes.

Use FUTURES' safety cards to help: Universal education is aided by the use of safety cards. The evidence-based safety card tool was developed to help clinicians and DV/SA advocates open conversations about DV/SA with their clients. Because survivors may choose not to disclose abuse for a variety of reasons, universal education ensures that patients receive information regardless of disclosure and promotes primary prevention. With the support of FUTURES' safety cards and other patient education materials, survivors of DV/SA do not have to disclose abuse in order to receive help.

"FamilyCare Health Center has seen a large increase in disclosures of IPV since we've implemented universal education with the safety card. And we noted that our DV/SA advocacy partner, Branches was quite full in the month after we held the training on addressing and responding to IPV." - Kat Cadle Adams, PsyD Psychologist, FamilyCare Health Center (Scott Depot, WV)

"We combined [screening] with using [the safety card] and taking that universal education approach – we aren't really trying to get patients to disclose. We've done a good job in getting providers to understand that that's not [as] important, and the social workers are reinforcing that. We feel like we're doing more prevention and less of putting out a fire." - Diane Sorensen, LCSW Medical Social Worker, Eastern Iowa Health Center (Cedar Rapids, IA)

Tools to Promote Universal Education:
Safety Cards: Multi-lingual and population specific patient education cards. The resources panel may be localized by adding in a local DV/SA hotline number, health center logo, or other local resources for support. To learn more contact the National Health Resource Center on Domestic Violence.

Additional Tools:
Survivor Health Brochure: Trauma-informed health care tips for those who have survived childhood or adult violence or abuse and have difficulty going to their nurse practitioner, doctor, physician assistant, dentist, or other health care providers.

Clinical guidelines for reproductive and adolescent health settings.

4. Train Providers and All Staff

Promote team-based care by training the entire health center
Health centers participating in the Improving Health Outcomes Through Violence Prevention Pilot Project found that training all staff—from the front desk to physicians—promotes team-based care and was a key part of their success in sustaining a comprehensive response to IPV. Training all staff also increases awareness of workplace policies and support available to employees facing IPV.

Before introducing health center staff to DV/SA assessment, universal education and response (mentioned above) related to patients, first educate staff on IPV resources and referrals specific to employees. A partnering DV/SA advocate may help develop a workplace policy; offer training to health center staff; facilitate a wellness/resiliency staff support group; or serve as a primary referral for staff requesting support. They may also help offer education on the dynamics of DV/SA; vicarious trauma; self-care; and discuss institutional supports that help promote staff resiliency.

Key elements of clinical training:

- The health center's commitment to IPV system change, goals and timeline;
- Introduction of partnering local DV/SA advocate(s) and DV/SA advocacy services available to employees and clients;
- Vicarious trauma and staff self-care;
- IPV dynamics and prevalence;
- Physical and emotional health impact of abuse;
- Case examples to build clinical skills on how to offer universal education on healthy and unhealthy relationships;
- Assessment for IPV and harm reduction strategies including warm referrals to local DV/SA programs; and
- Information on documentation, reporting as needed and quality improvement.

A partnering DV/SA advocate may help deliver such training and education, in collaboration with IPV leaders at the health center, or other expert trainers.

"We have complete revamped our intake process. Because of the conversations from the training that we have had we dramatically increased the number (and effectiveness) of questions about health. We're looking at our clients' needs holistically. We're sending the clients a message that it's safe to talk about those issues here." –Maria Cancel, LMHC, Brockton Neighborhood Health Center (Brockton, MA)

Tools to Train Staff:
The following tools were designed to support health centers get started by holding short (1 hour) staff trainings or up to ½ day or full-day trainings. Tools include PowerPoint decks, short video vignettes, fact sheets and clinical guidelines.

- PowerPoint training decks for various health settings:
  - Primary Care
  - Adolescent health
  - Reproductive health
- HIV and Ryan White dually-funded programs: Includes an HIV-specific PowerPoint training deck, fact sheet, safety card, and other resources
- Training videos for health settings
- Training curricula for domestic violence programs partnering with health centers
- CUES Intervention Graphic (in development)
- National trainings such as the biennial National Conference on Health and Domestic Violence offer training and education opportunities for health center staff and DV/SA advocates.

5. Evaluate and Sustain Your Progress

Include IPV as a health center quality improvement goal.

Conduct Quality Improvement and Create Sustainable Programs:
Monitor quality of care by revisiting your Quality Assessment/Quality Improvement (QA/QI) tool, mandating training for all new staff and offering refresher training annually for all staff. Support staff as they implement the new DV/SA protocol through case consultations in morning huddles and reflective supervision. As your program advances, consider evaluating the impact your partnerships have on health outcomes of clients and conduct data review with other measures already collected and assess for opportunities to align efforts with other existing priorities. Also work to integrate prompts and resources into your electronic health record and monitor your health IT systems to ensure privacy protections are being enforced to keep patient data safe and secure. Every year, revisit partnerships, policies, and formal memoranda of understanding (MOUs), with community-based DV/SA programs, as well as other or new organizations to support survivors of violence, with an aim to ensure crucial partnerships are in place to provide trauma-informed care to survivors.

Keep the issue current and celebrate successes by featuring stories in health center newsletters, blogs, or at events.

"Implementing morning huddles and changes to our EHR have helped us to focus on how we can consistently support IPV survivors."- Abner Santiago, LPC, Behavioral Health Consultant, La Comunidad Hispana (Kennett Square, PA)

Tools to support sustainability and quality improvement:

- Quality improvement tools
- Reflective supervision questions
- Safeguarding health information in explanation of benefits
- Coding and Documentation for Domestic Violence
- Privacy Principles for Protecting Survivors of Domestic Violence

By doing this work, health centers are demonstrating their commitment to patient-centered care by helping to prevent IPV before it begins and by recognizing the impact IPV has on health. Working together and coordinating efforts with community-based programs help reduce isolation and improve health and safety outcomes for IPV survivors. Our vision is a future without violence that provides education, safety, justice, and hope for all.

Futures Without Violence staff wishes to thank the leaders from the Improving Health Outcomes Through Violence Prevention Pilot Project for informing this toolkit: Lisa Ambrose, Tiffany Flowers, Lisa Silva, Clara Vasquez, Celina Alvarez, Ana Soltero, Ruth Zakarin, Vanessa Volz, Kelly Henry, Heather Martin-Thomas, Emily Fanjoy, Erin Richardson, Maria Cancel, Sara Gavin, Tegwin Millard, Barb Boehler, Diane Sorenson, Abner Santiago, Yara Castro, Noemi Elizalde, Keri Scott, Marge Jozsa, Annajane Yolken, and Meghan Gilleylen.

Special thanks to the evaluation partners, Dr. Elizabeth Miller and Claire Raible at the Division of Adolescent and Young Adult Medicine, Children's Hospital of Pittsburgh, UPMC, for their guidance throughout this project. We also want to thank the Bureau of Primary Health Care and Office of Women's Health within the Health Resources and Services Administration: Sabrina Matoff-Stepp, Jane Segebrecht, Preeta Chidambaran, Nadra Tyus, Keisher Highsmith, Christina Lachance, Tess Joseph, Christiana Lang, and Harriet McCombs; staff at the Administration for Children and Families, Family Violence Prevention and Services Program: Marylouise Kelley, Rebecca Odor, Mao Yang and Kenya Fairley; and Christine Heyen and Sarah Keefe from Oregon Safer Futures for their collective wisdom, guidance and support throughout this project and their unwavering commitment to improving the health and well-being of survivors of DV/SA.

FAQ

1. What is Futures Without Violence?

Answer: For more than 30 years, FUTURES has been providing groundbreaking programs, policies, and campaigns that empower individuals and organizations working to end violence against women and children around the world. Striving to reach new audiences and transform social norms, we train professionals such as doctors, nurses, judges, and athletic coaches on improving responses to violence and abuse. We also work with advocates, policy makers, and others to build sustainable community leadership and educate people everywhere about the importance of respect and healthy relationships.Our vision is a future without violence that provides education, safety, justice, and hope. Learn more here.

2. What is the National Health Resource Center on Domestic Violence?

Answer: For more than two decades, the National Health Resource Center on Domestic Violence has supported health care professionals, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. The center offers personalized, expert technical assistance via email, fax, phone, postal mail and face-to-face at professional conferences and meetings around the nation. Contact us at health@futureswithoutviolence.org or call 415-678-5500.

3. What is domestic violence?

Answer: Domestic violence is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other. Learn more about the dynamics, signs, and prevalence of domestic violence here: http://www.ncadv.org/learn-more/what-is-domestic-violence

4. What is sexual violence (also referred to as sexual assault)?

Answer: Sexual violence is defined by the Center for Disease Control as: A sexual act committed against someone without that person's freely given consent. Sexual violence is divided into the following types: Completed or attempted forced penetration of a victim; Completed or attempted alcohol/drug-facilitated penetration of a victim; Completed or attempted forced acts in which a victim is made to penetrate a perpetrator or someone else; Completed or attempted alcohol/drug-facilitated acts in which a victim is made to penetrate a perpetrator or someone else; Non-physically forced penetration which occurs after a person is pressured verbally or through intimidation or misuse of authority to consent or acquiesce; Unwanted sexual contact; Non-contact unwanted sexual experiences

Read more here: https://www.cdc.gov/violenceprevention/sexualviolence/definitions.html

5. What is intimate partner violence (IPV)?

Answer: The U.S. Centers for Disease Control and Prevention defines IPV as physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.

6. What is trauma?

Answer: Trauma is a normal reaction to an abnormal situation. "Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." Read more here: http://www.integration.samhsa.gov/clinical-practice/trauma

7. What is trauma-informed care?

Answer: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a trauma-informed approach to care as:`
"A program, organization, or system that:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization.

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing." Learn more here: https://www.samhsa.gov/nctic/trauma-interventions

8. What is vicarious trauma?

Answer: Vicarious trauma happens when we accumulate and carry the stories of trauma—including images, sounds, resonant details—we have heard, which then come to inform our worldview. Learn more here: http://www.joyfulheartfoundation.org/learn/vicarious-trauma

9. What is universal education?

Answer: Universal education is the clinical strategy used to educate all patients on healthy and unhealthy relationships, and the health consequences of IPV. This approach differs from screening in that it advocates for all patients to be given information on the health impact of IPV, regardless of whether or not they disclose current or past experiences of violence, thus reaching more patients who may choose not to disclose for a variety of reasons, while also promoting prevention. Universal education should also be coupled with direct inquiry and an offer for a warm referral and available resources for IPV. Read more about our evidence-based clinical intervention here.

10. What is a warm referral?

Answer: A warm referral, as referred to in the CUES intervention, is a supported referral to DV/SA advocacy services from a health provider, in which the provider is able to offer a patient access to an onsite DV/SA advocate; offer use of the clinic's phone to call a local resource; or offer the name and phone number so they can reach out independently, etc. Complement a warm referral with a brochure or safety card from a local DV/SA agency, if it is safe for the patient to take home. Ideally, the provider has an established relationship with the DV/SA advocacy program and is familiar with the staff and services available, thus increasing the likelihood of the patient following through with the connection.

11. How often should I screen for and offer universal education on IPV?

Answer: It's important to talk to all patients at least once a year or with each new partner about healthy relationships, ones that aren't, and how it affects their health. Ensure that screening questions are accompanied with a discussion about the health impact of IPV and available resources. Because of the higher prevalence of abuse during pregnancy, check in with pregnant women about how their relationship is going at least once a trimester and postnatal.

12.Should I screen and offer universal education to just women or to all patients?

Answer: Everyone deserves to have respectful and caring relationships and anyone can be a victim of intimate partner and sexual violence. LGBTQ people experience IPV at rates similar to or higher than heterosexual women–another reason to talk to all patients about the health impact of IPV and available resources. All patients can benefit from universal education about the health impact of healthy and unhealthy relationships. Because the majority of IPV survivors are women, most health centers begin by offering universal education and screening to just women later expanding to all patients once the practice has been solidified.

13. What screening tool is best to use in our EHR?

Answer: We support a universal education approach--talking to all patients about the health impact of IPV, in addition to asking direct questions about current and past experiences of IPV. Universal education also provides patients with resources of where to get help if they need it, and offering brief counseling and a warm referral to a DV/SA advocate in the event of a disclosure. Universal education can be combined with screening tools that are integrated into the electronic health records (EHRs). The US Preventive Services Taskforce also recommends a number of screening tools, including Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions); Slapped, Threatened, and Throw (STaT);and Humiliation, Afraid, Rape, Kick (HARK).

14. What is a safety card?

Answer: The Health Resource Center on Domestic Violence, a project of Futures Without Violence offers a number of multilingual, low-literacy patient education safety cards that provide information on healthy and unhealthy relationships, their impact on health and list national referrals for support. The evidence-based safety card tool was developed to help clinicians and DV/SA advocates open conversations about DV/SA and healthy relationships with their clients. They are typically a 4-5 panel double-sided tool that folds into a 2.5 x 3 inch card (business-card sized). The Health Resource Center on Domestic Violence offers a number of setting-specific and population-specific safety cards offered here.

15. How can I protect survivor privacy and still promote improved health?

Answer: Federal legislation and state and local statutes are crucial to establishing a comprehensive baseline of regulations and protections for the use and disclosure of sensitive electronic information. Health information technology (HIT) developers and vendors also have a role in building the software and hardware necessary to deal with the information in an appropriate fashion.

Here are guiding principles that should be applied by clinicians, administrators, policy makers, and developers when designing, building, or regulating health information systems that will hold or exchange sensitive health information.These principles build on past work to protect information collected in paper health records, and expand the consideration to electronic health records and health information exchanges.

16. What are the health care reporting requirements for IPV in my state, tribe, or U.S. territory?

Answer: Click here for a Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care.

17. Domestic Violence and Sexual Assault (DV/SA) programs: What are they and where can I find one?

Answer: Many DV/SA partners are equipped to provide supportive services such as translation, transportation, and legal support which mirror the enabling services offered by health centers. DV/SA programs exist in many communities in which health centers are located and DV/SA advocates can offer a range of support to survivors identified in health centers. Such confidential patient support may include information on healthy and unhealthy relationships; emotional support; emergency and long-term safety planning; and supports related to other social determinants of health including housing, food insecurity and employment as well as court and legal advocacy. Some advocates staff crisis hotlines, run support groups or provide in-person counseling, and some agencies have programs for adolescents and children. In some instances, a community may only have one such program available to support DV/SA survivors and their families. However, other communities may operate both a domestic violence program and a distinct sexual assault program.

The National Hotline on Domestic Violence can help identify local programs and offer safety planning assistance to survivors, concerned family members, or professionals working with clients who need help. The Hotline is staffed by DV/SA advocates available to talk 24/7 at 1-800-799-SAFE (7233) in over 170 languages and online: www.thehotline.org. All calls are confidential and anonymous. There is also a national helpline for Native American communities, the StrongHearts Native Helpline, 1-844-7NATIVE (1-844-762-8483) Monday through Friday, from 9 am to 5:30 pm CST. The StrongHearts Native Helpline is a culturally-appropriate, confidential service for Native Americans affected by domestic violence and dating violence. You may also contact your state domestic violence coalition or tribal coalition to find a local domestic violence program near you. Additionally, RAINN (Rape, Abuse & Incest National Network) operates the National Sexual Assault Hotline (800.656.HOPE) and www.rainn.org (with a live chat) in partnership with more than 1,000 local sexual assault service providers across the country.

18. What is the Domestic Violence Resource Network (DVRN)?

Answer: The Domestic Violence Resource Network (DVRN) is funded by the U.S. Department of Health and Human Services and funds a network of organizations working to improve the country's response to domestic violence. In addition to funding two national resource centers, National Resource Center on Domestic Violence and National Indigenous Women's Resource Center, the DVRN also funds three culturally-specific resource centers. These include:

- Casa de Esperanza, the national resource center for working with Latinx communities. Casa de Esperanza offers a webinar series on topics such as "Trauma Informed and Culturally Specific Practice with Latin@ Survivors" and "Safety Planning for Immigrant Survivors of Domestic and Sexual Violence."
- Asian & Pacific Islander Institute on Gender-Based Violence, which offers training and technical assistance for survivors in Asian & Pacific Islander communities. Their resource library has culturally-specific materials available for various forms of gender-based violence that are prevalent in Asian & Pacific Islander communities.
- Ujima, the National Center on Violence Against Women in the Black Community, which offers training and technical assistance and educational resources for prevention and responding to domestic, sexual, and community violence in the Black community.

Five special issue resource centers:

- Battered Women's Justice Project Criminal and Civil Justice Center
- National Clearinghouse for the Defense of Battered Women
- National Council of Juvenile and Family Court Judges
- National Health Resource Center on Domestic Violence
- National Center on Domestic Violence, Trauma, & Mental Health

In addition, the DVRN supports the National Domestic Violence Hotline, and the National LGBTQ Institute on Intimate Partner Violence.

19. Do you provide training onsite?

Answer: As a national program, we are unable to provide onsite trainings, but contact us at health@futureswithoutviolence.org to see how we can best support your training needs. The Health Resource Center on Domestic Violence offers a number of training curricula and other tools to facilitate trainings in addition to hosting a biennial annual National Conference on Health and Domestic Violence and an ongoing webinar series, where you can learn more about promising practices and research in the field.

20. What resources are available for American Indian/Alaska Native (AI/AN) communities?

Answer: The National Health Resource Center on Domestic Violence offers a number of resources tailored specifically for American Indian and Alaska Native (AI/AN) communities, including safety cards, posters, and a Promising Practices Report. Visit here to learn more about our work with AI/AN communities, and click here to order hard copies and download PDFs of our materials. See also www.niwrc.org, the National Indian Resource Center Addressing Domestic Violence and Safety for Indian Women.

There is also a national helpline specifically for Native American survivors of domestic violence or dating violence, the StrongHearts Native Helpline, 1-844-7NATIVE (1-844-762-8483) Monday through Friday, from 9 am to 5:30 pm CST. Indian Health Services also has a protocol for Intimate Partner Violence.

21. What resources are available for Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) and Gender-non-conforming (GNC) communities?

Answer: The National Health Resource Center on Domestic Violence offers a number of resources tailored specifically for LGBTQ/GNC communities, including safety cards and posters. Visit here to learn more about our resources for working with LGBTQ/GNC communities, and order materials here.

Also get more information at the LGBTQ DV Capactity Learning Center at The NW Network.

22. What languages are your materials in, and what culturally-specific resources do you offer?

Answer: The National Health Resource Center on Domestic Violence has developed materials to meet the unique needs of all individuals and families. Culturally-specific resources include patient safety cards, posters, fact sheets and reports, and some are multi-lingual. For example:

- American Indian/Alaska Native safety cards (3 versions), posters, a care giver/parent brochure, fact sheet, and promising practices report. See also the FAQ entry for resources for American Indian/Alaska Native (AI/AN) communities.
- Lesbian Gay Bisexual Transgender Queer (LGTBQ) and Gender-Nonconforming (GNC) safety cards (English and Spanish) and a poster. See also the FAQ entry for resources for LGBTQ and GNC communities.
- General health safety card in five languages commonly spoken in Hawaii (Chinese, Chuukese, Hawaiian, Marshallese, and Tagalog).
- Spanish language safety cards, posters, and brochures.
- General health safety card in Tagalog for a national audience, as well as a guide for organizing a community-based response to domestic violence, using the Filipino community as a model.
- General health safety card in Chinese for a national audience.
- Safety card for high school and college-aged Muslims.

See all culturally-specific tools here.

23. What resources do you have for rural or remote communities?

Answer: Rural and remote communities have unique needs related to distance, isolation, inclement weather, and access to services and emergency responses, among others. A 2011 study published in the Journal of Women's Health found that 22.5% of women in small rural areas and 17.9% in isolated areas reported being victims of intimate partner violence, compared to a national average of 16.1%.* Futures Without Violence contributed to the Violence and Abuse in Rural America Guide that addresses the wide range of abuses that may take place in rural communities. FUTURES also offers an archived webinar: Collaborating to Address Trafficking in Rural Communities: Lessons from the Field, and the manual, Building the Rhythm of Change: Developing Leadership and Improving Services Within the Battered Rural Immigrant Women's Community. View additional resources for American Indian/Alaska Native communities and a partnership model for rural areas.

*Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural Disparity in Domestic Violence Prevalence and Access to Resources. Journal of Women's Health, 20(11), 1743-1749. doi:10.1089/jwh.2011.2891

24. What does it mean to be a *survivor of domestic violence/sexual assault* (DV/SA)?

Answer: The terms 'victim' or 'survivor' may be used to refer to a person who has experienced or is experiencing domestic violence/sexual assault (DV/SA). Some organizations or individuals use the terms interchangeably while others feel that the terms 'victim' and 'survivor' have very different connotations. It is important for providers to let individuals label their own experience and to mirror this language. We largely use the term 'survivor' in this toolkit.

25. Where can I find more information on programs addressing human trafficking and its health impact, as well as intervention and support strategies?

Answer: Human trafficking has severe adverse effects on the health, well-being, and human rights of millions of vulnerable adults and young people in the U.S. and globally. Learn more about FUTURES' programs, policies, and initiatives working to prevent and respond to human trafficking.

Learn more about trafficking among American Indian women and girls in Minnesota in the Shattered Hearts report from the Minnesota Indian Women's Resource Center. View this webinar for more information on addressing trafficking in rural communities.

Health professionals can play a significant role in early intervention of human trafficking and reducing the profound suffering it causes. The U.S. Department of Health and Human Services SOAR training program helps health care and social service providers identify and respond to survivors of human trafficking. HEAL Trafficking also takes a public health perspective to ending trafficking and provides trainings for healthcare professionals on addressing and responding to survivors of trafficking.

FUTURES also has resources that address human trafficking:

· The adolescent health safety card and the reproductive health safety card integrate information on trafficking
· Webinar: Collaborating with Community-based Organizations and Faith-based Communities to Address Trafficking
· Webinar: Legal Aspects of Human Trafficking for Health Providers
· Webinar: Collaborating to Address the Needs of Trafficked Survivors with Disabilities

Reach out to the National Human Trafficking Hotline if you or someone you know is a victim of human trafficking and also for more information on the prevalence of trafficking and how to get involved.

26. What is the health impact of IPV?

Answer: IPV has serious implications for health and wellbeing of its survivors. As the leading cause of female homicides and injury-related deaths during pregnancy, IPV also accounts for a significant proportion of injuries and emergency room visits for women. IPV is a significant yet preventable public health problem that affects millions of people regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Women who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of physical and mental health conditions including frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems, and Post Traumatic Stress Disorder (PTSD). Despite these alarming facts, a critical gap remains in the delivery of comprehensive health care to women. For more information, visit https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

get more at:

ipvhealthpartners.org

online toolkit for community health centers and domestic violence agencies

resources | information | partnership

futureswithoutviolence.org | ipvhealthpartners.org | 415.678.5500