

<b>[Name of Community Health Center]</b>	
<b>MANUAL: Clinical</b>	<b>Section:</b>
<b>Exploitation, Human Trafficking, and Intimate Partner Violence</b>	
<b>Policy Approved:</b>	<b>Procedures Last Revision Date:</b>
<b>Policy Last Review Date:</b>	<b>Procedures Last Review Date:</b>

**Protocol for HRSA-supported Community Health Centers to Engage Patients through Universal Education Approaches on Exploitation (E), Human Trafficking (HT), Domestic Violence (DV) and Intimate Partner Violence (IPV)**

**Protocol Purpose:** The protocol purpose is to prevent exploitation, human trafficking, domestic violence, and intimate partner violence by helping patients have healthy relationships and promote their health as workers. This will occur through universal education about healthy relationships and fair labor practices for the prevention of abuse, violence, and exploitation. The protocol will enable the health center to provide trauma-informed, survivor-centered care; intervention with clinical and case management services; and formalized ways to connect patients with community-based services that provide resources for domestic violence, employment assistance, housing, food, civil legal aid, and other basic needs. Also, health centers will attend to the patients’ physical and mental health needs and create safety plans in partnership with community-based advocates. Patients often have physical and emotional safety needs that must be supported by trauma-informed protocols and healing services. For example, health impacts of domestic violence and human trafficking/exploitation include exacerbation of chronic illness, sexually transmitted infections, reproductive coercion, traumatic brain injuries and history of strangulation, anxiety, depression, and post-traumatic stress disorder (PTSD). *(For more information about the health impact of trauma and abuse, and to download community health center tools on these topics visit: <https://ipvhealthpartners.org/>).*

This protocol also serves as a support resource for health center staff. Given the prevalence of violence and exploitation in communities, health center employees also have personal experiences of violence, abuse, trauma, or exploitation, and may experience vicarious trauma, secondary traumatic stress, or PTSD re-traumatization from caring for patients affected by violence. The community-based resources in this protocol also serve as resources for staff. In addition, it is recommended that health centers create workplaces free from domestic violence, sexual harassment and violence, and stalking (helpful policies and toolkits are available through [Workplaces Respond to Domestic and Sexual Violence: A National Resource Center](https://www.workplacesrespond.org/), a project of Futures Without Violence, visit <https://www.workplacesrespond.org/>).

This protocol addresses both [intimate partner violence \(IPV\)](#) and [domestic violence \(DV\)](#) and the terms are used interchangeably (with “domestic violence” as the broader term across the document).

## **Definitions:**

**Healthy Relationships:** healthy relationships share several characteristics, including mutual respect, trust, honesty, compromise, individuality, good communication, anger control, fighting fair, problem solving, understanding, self-confidence, being a role model, and a healthy sexual relationship.

**Fair Labor Practices:** include practices covered under The Fair Labor Standards Act (FLSA) and Family Medical Leave Act. The FLSA is a federal law that establishes minimum wage, overtime pay eligibility, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in federal, state, and local governments.

**Human Trafficking:** the legal umbrella term for the act of recruiting, harboring, transporting, providing, or obtaining a person for compelled labor or adult commercial sex acts with the use of force, fraud, or coercion; and any commercial sex acts of those under age 18 (no force, fraud, or coercion needed).

**Labor Exploitation:** when an employer unfairly benefits from employee's work. Labor exploitation is not a legal term—in fact, not all forms of labor exploitation are illegal. **Labor violations** are a subset of labor exploitation, and it is a legal term used when employers violate federal, state, or municipal laws related to worker treatment, workplace safety, or recordkeeping requirements.

**Labor Trafficking:** recruiting, harboring, transporting, providing, or obtaining for labor or services, through force, fraud, or coercion, for the purposes of involuntary servitude, debt bondage, peonage, or slavery. If a child is victimized, this is a case of abuse and commercial exploitation.

**Sexual Exploitation:** actual or attempted abuse of a position of vulnerability, power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another. Examples include coercion from employers/workplace, coercive rent/debt exchange, and trading drugs/children's sex.

**Sex Trafficking:** recruiting, harboring, transporting, providing, or obtaining a person for a commercial sex act, through force, fraud, or coercion. CSEC (Commercial Sexual Exploitation of Children) is defined as the sexual abuse of a minor entirely or primarily for financial or other economic reasons. Economic exchanges may be monetary or non-monetary (food, shelter, or drugs). CSEC does not need force, fraud, or coercion to be sex trafficking and is considered as child abuse with mandated reporting.

**Intimate Partner Violence (IPV):** describes physical, sexual, or psychological harm by a current or former partner or spouse.

**Domestic Violence (DV):** violence that takes place within a household and can be between any two people within that household. DV can occur between a parent and child, siblings, or even roommates.

**Warm Referral:** A warm referral, as referred to in the CUES intervention below, is a supported referral to a community based organization (CBO) including domestic violence/sexual assault (DV/SA) advocacy organizations 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 health center's phone to call a local resource; or

offer the name and phone number so they can reach out independently, etc. If it is safe for the patient to take home, complement a warm referral with a Safety Card and/or brochure from a local DV/SA agency or CBO. Ideally, the provider has an established relationship with the DV/SA advocacy program or CBO and is familiar with the staff and services available, increasing the likelihood of the patient following through with the connection.

A warm referral to onsite behavioral health or case management services is a direct provider to provider consultation during the patient visit, with direct introduction of the behavioral health or case management provider to the patient.

**Trauma-Informed Care:** Encompasses six guiding principles for patient care, consisting of 1) safety, 2) trustworthiness, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice, and 6) cultural, historical, and gender considerations. [Trauma-Informed Care](#) is moving away from “what’s wrong with you?” to “what happened to you?”

### ***PROTOCOL DESCRIPTION AND DETAILS:***

#### ***General Approach:***

The general approach for this protocol is 1) to utilize a Universal Education framework to engage patients around the issue of domestic violence (including intimate partner violence), exploitation and human trafficking (both labor and sex), 2) to [build fruitful organizational partnerships with local domestic violence programs](#) and other community based organizations with familiarity of services and referral mechanisms, 3) to [provide supportive resources to patients while maintaining confidentiality, patient-centered, trauma-informed care](#), 4) to [maintain health records and documentation that support patient care](#), and 5) to follow all [applicable laws and regulations](#).

Universal Education (UE) is an approach to educate all patients about issues of abuse and exploitation, regardless of whether an incident of abuse or exploitation has been disclosed. The difference between UE and screening is that UE involves educating and offering resources regardless of whether a disclosure occurred, whereas screening is dependent upon directly asking a patient about violence or exploitation, relies on a positive disclosure, which only then triggers additional services or support. Challenges and barriers to a patient’s disclosure of experiences of violence or exploitation include:

- ✓ shame, judgement, stigma
- ✓ fear, threats
- ✓ fear of systems/police involvement
- ✓ afraid children can be taken away
- ✓ not knowing what is going to happen with the information
- ✓ lack of awareness of victim status and rights
- ✓ degree of trust and therapeutic alliance with treating provider
- ✓ lack of knowledge of U.S. laws and contractual obligations (in cases of labor trafficking)
- ✓ language barriers and illiteracy.

Furthermore, the UE approach is more equitable and recognizes harms that justice systems-involved people have experienced from documentation status, mandatory reporting, and carceral punishment.

Because community health centers provide primary care and can delve into the social determinants of health with patients, there are prime opportunities to prevent and provide early intervention in cases of suspected abuse and exploitation by utilizing the UE approach. Using a UE intervention with “CUES” [safety card tools \(see below\)](#), developed by FUTURES and tested in [CHCs to address IPV/HT](#) in the health setting, has shown evidence-based success with IPV - among women in the intervention who experienced recent partner violence, there was a 71% reduction in odds for pregnancy coercion compared to control, and women receiving the intervention were 60% more likely to end a relationship because it felt unhealthy or unsafe. The “CUES” intervention is centered on partnerships between DV agencies and CHCs, so they can adopt a team-based response.

[“CUES ” is an acronym :](#)

*C: Confidentiality*

Know reporting requirements and share any limits of confidentiality with patients. Always see patients alone for part of every visit.

*UE: Universal Education and Empowerment*

Give each patient two safety cards or other resources to start the conversation about IPV/HT/Exploitation and health impact, mentioning that you’ve included one for a friend or family member.

*S: Support*

Though disclosure is not the goal, it will happen—know how to support someone who discloses. Make a warm referral to local DV partner, or to a national hotline for support (see below) and offer health promotion information.

National resources and referrals for staff and patients:

- The **National Domestic Violence Hotline** responds to calls 24/7 and provides confidential, one-on-one support to each caller and chatter, offering crisis intervention, options for next steps and direct connection to sources for immediate safety. They offer referrals to over 5,000 agencies and resources in communities across the U.S. The Hotline also helps connect callers to DV programs nearest them 800-799-SAFE (7233); Text LOVEIS to 22522; Chat at [thehotline.org](#). The Hotline is also now [embarking on a new project](#) funded by US HHS agencies, the HRSA Office of Women’s Health and Bureau of Primary Health Care, and ACF’s Family & Youth Services Bureau, to train Hotline advocates to connect callers directly to community health centers.
- The **StrongHearts Native Helpline** is a safe, anonymous, and confidential service for Native Americans affected by domestic violence and dating violence. Stronghearts advocates are available Monday-Friday from 9am to 5:30pm CST. 844-7NATIVE (762-8483); [strongheartshelpline.org](#)
- **National Runaway Safeline** 800-RUNAWAY (786-2929); Email: [1800runaway.org/crisis-online-services/](#); Chat at [1800runaway.org/](#); Forum: [bulletinboards.1800runaway.org/forum](#)

- **The Trevor Project:** Crisis intervention and suicide prevention for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people ages 13-24. [www.thetrevorproject.org](http://www.thetrevorproject.org); 866-488-7386 LGBTQ Youth
- **RAINN the National Sexual Assault Hotline** connects to a trained staff member from a sexual assault service provider in the caller's area. 1-800-656-(HOPE) 4673 <https://www.rainn.org/>
- **Trans Lifeline Hotline** is dedicated to the well-being of transgender people. They run a hotline staffed by transgender people for transgender people. Translifeline 877-565-8860; [www.translifeline.org](http://www.translifeline.org)

**Policy:** [XXX Health Center Staff] will follow the domestic violence, human trafficking and exploitation protocol set forth below to provide services using a universal education approach to all patients.

**Scope:** All health center staff

**General Description:**

This protocol documents the procedures to provide universal education, assessment, and resource support for domestic violence, exploitation, and human trafficking prevention, and to provide crisis intervention, safety planning, supportive counseling, and referrals to community resources when patients are identified as someone who is, or may be experiencing domestic violence, exploitation or being trafficked.

**Operational Policies Required:**

1. **Establish Partnership with local DV program:** It is crucial that health centers have knowledge of and develop partnerships with [local domestic violence programs](#) and other community based organizations and social service agencies to provide resources and support for staff and patients vulnerable to abuse or exploitation. Building fruitful partnerships is key to prevention and support of patients; utilizing [Memorandum of Understandings \(MOUs\)](#) to formalize the partnership adds substantial benefit for patient care. Advocate partners may also review and provide feedback on your adaptation of this protocol.
2. **Interpretation:** A professional interpreter should be used with all patients, whether in person, or on the phone. Do not enlist the patient's family members, friends, or those accompanying them to the appointment to interpret for the patient.
3. **Clinic Confidentiality and Privacy:** A clinic-wide default policy is that "all patients are seen alone" where patients are seen alone for a portion of every visit. All patients should have the opportunity to speak with the provider alone to ensure privacy. Signs should be posted in the clinical areas noting this policy – this helps avoid potential conflict with accompanying individuals.
4. **Training:** Provide annual basic training for clinical and non-clinical staff on Exploitation, Human Trafficking, Domestic Violence, and Intimate Partner Violence.
5. **Documentation Sharing or No Sharing:** Develop an electronic health record (EHR) policy to protect and restrict sensitive documentation and diagnoses from after visit summaries if the provider deems the information as potentially harmful to the patient.

6. **Coding:** Develop ICD-10 coding policy for UDS reporting. Recommendation to NOT use ICD-10 codes for IPV or exploitation until a clinic-wide policy on protecting these documented codes is in place. Can substitute the use of ICD-10 codes with standardized data collection forms to report UDS metrics on Number of Visits, Number of Patients.
7. **Mandatory Reporting Compliance:** Staff and volunteers are expected to complete mandatory reporting training at the beginning of their service and annually.

### **Operational Procedures:**

8. All staff (especially patient-facing staff, including front desk or reception, security, social work, case management, community health workers, medical assistants, nursing, interpreters, NPs, PAs, physicians, as well as administrative staff including human resources) should be trained at a minimum on:
  - a. The Universal Education Approach, CUES framework
  - b. Trauma-informed approach (effects of trauma)
  - c. Exploitation, Human Trafficking, DV, IPV and Health Care intersection
  - d. Available resources for patients and working with community-based partners. Trainings should include inviting and introducing the local domestic violence advocacy program partner staff and services to the health center staff.
9. Create a health center environment which promotes a sense of safety for patients.
10. If a staff member (reception, security, nursing, health educator, etc.) has concerns due to direct observations that a patient is a victim of abuse, the staff member should relay that concern to the patient's provider or medical assistant, nurse, health coach or other staff working with the provider.
11. UE should be conducted one on one with the patient. Partners and parents should be asked to step out of the room prior to assessment. ([View a 2 minute video vignette](#) on this topic developed by Futures Without Violence that may help initiate staff discussions, or trainings).
12. The CUES approach: Confidentiality, Universal Education and Empowerment, and Support
  - a. Who does it? Every health center is different. May be medical assistants, community health workers, health educators, behavioral health, providers (MD, NP, PA), or nurses.
  - b. Who gets it? All adult patients, and adolescent patients > 12 years old should be assessed for DV/IPV, exploitation/human trafficking and provided universal education about the issues.
  - c. When is it done? UE should be provided to patients at first visit, then annually; with disclosures at next follow-up appointment; with new relationships; at onset of new health issues possibly connected to IPV/HT; once a trimester and post-partum, and as needed per provider determination. The difference between UE and screening is that UE involves educating and offering resources regardless of whether there is disclosure of abuse, exploitation, or human trafficking. Because abuse may begin during pregnancy, more frequent conversations may be held across the pregnancy.
13. When embarking on the UE approach, it is important to first note the limits of **confidentiality** and [reporting laws on abuse and violence](#), should there be any disclosure.

- a. **General script:** “Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone, or planning to hurt yourself.”
  - b. Transparently discuss the ground rules of clinical documentation – meaning that objectively documenting the clinical encounter is part of patient care, and that what you document can be accessible to health care providers to assist with their care and treatment plans, and the patients themselves.
14. Provide **universal education** and **empowerment** to patients about healthy relationships, fair labor practices, domestic violence, exploitation, and human trafficking. Start with open ended questions and conversation linking work with health conditions and status, and relationships/sexual history with health conditions and status:
- a. **Domestic Violence:** Give two safety cards. Discuss healthy relationships safety card.
    - i. **General Script:** “I’m giving two of these cards to all of my patients. They talk about relationships and how they affect our health. Take a look, and I’ve also included one for a friend or family member. On the back of the card there are resources you can call or text, and you can always talk to me about how you think your relationships are affecting your health. Is any of this a part of your story?”
  - b. **Labor Exploitation and Trafficking:** Let the patient know that you are going to talk about what kind of work or activities they do, because sometimes people’s health can be affected by their work, their work environment, or interpersonal dynamics at work. Conduct a robust occupational history, and ask about conditions at work which may affect the patient’s health (e.g., “what kind of work do you do, do you get breaks, do you think you are paid fairly, do you have stress at work, what is your work environment like?”) Offer the patient resources for worker’s rights, connections to DV programs, medical-legal partnerships, or other civil legal aid for general knowledge for both the patient or a friend, family member, or coworker.
    - i. **General Script:** “Many people are also feeling pressure around money and paying rent or bills—sometimes others take advantage of people for work and also for sex—so we’re sharing information about resources that are available if you find yourself in a situation like this. Can I give you unemployment resources, housing and food support, and other things to share if you know someone who needs it?”
  - c. **Sexual Exploitation and Trafficking:** Let the patient know that you are going to talk about relationships and will conduct a sexual history because these factors can affect people’s health.
    - i. **General Script:** “It is important to be aware of how your relationships and experiences can impact your health. Some of these signs are commonly found in individuals who have experienced or are experiencing increased stress or abuse in their relationships.” Offer resources and CUES safety card on healthy relationships to all patients

- d. **Adolescents:** Let the patient know that you are going to talk about relationships and will conduct a sexual history because these factors can affect people’s health. Conduct a developmentally appropriate psychosocial risk screen, such as the HEADS. assessment. Offer resources including CUES card titled “[Hanging out or Hooking up](#)”.
  - i. **General Script:** “It is important to be aware of how your relationships and experiences can impact your health. Some of these signs are commonly found in individuals who have experienced or are experiencing increased stress or abuse in their relationships. Because I know a lot of patients aren’t ready or may be afraid to share certain things about their health or relationships, I want you to know you can use these resources for yourself or for a friend, regardless of what you choose to share with me today.”
- e. **Social Determinants of Health and PRAPARE (NACHC):** If your health center is using the PRAPARE tool to evaluate social determinants, this can help prompt the provider to initiate universal education and offer resources to the patient. This can be incorporated into workflows depending on who conducts the PRAPARE intake at your health center
  - i. The Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health: <https://www.nachc.org/research-and-data/prapare/>
  - ii. Patients may focus on addressing other social determinants, such as food insecurity or unstable housing, before prioritizing safe relationships. Addressing these other factors can be important pathways to addressing violence and exploitation.
- f. **Empowerment** of the patient comes with offering and providing resources for both the patient and an extra copy for the patient to give to a family member or friend who they think might need it. This taps into altruism research showing that people are often first willing/able to help someone else before they help themselves. Resources could include the CUES cards, handouts on immigrant and worker rights, housing resources, or other harm reduction information.
- g. CUES Safety Cards in various languages [can be ordered](#) through Futures Without Violence’s [National Health Resource Center on Domestic Violence](#), M-F 9am-5pm PST phone: 415-678-5500, TTY: 866-678-8901, [health@futureswithoutviolence.org](mailto:health@futureswithoutviolence.org)

<p>15. If the provider has <b>concern or suspects</b> that the patient is being abused, or exploited for labor or for sex, it is important to provide <b>support</b>.</p> <ul style="list-style-type: none"> <li>a. Offer referrals, with or without a same day warm referral, to case management, internal integrated behavioral health, external domestic violence programs, and</li> </ul>	<p>16. If there is a <b>disclosure</b> of domestic violence, exploitation, or human trafficking, provide real time direct <b>support</b>.</p> <ul style="list-style-type: none"> <li>a. If a disclosure occurs, the provider should recognize and validate the patient.           <ul style="list-style-type: none"> <li>i. <b>Sample script:</b> “I’m glad you told me about this. I’m</li> </ul> </li> </ul>
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<p>medical-legal partnerships/civil legal aid.</p> <p>b. For &lt;18 years old, follow your state’s child abuse reporting laws and make referrals to supportive resources and youth programs.</p>	<p>so sorry this is happening. You’re not alone. Help is available. I’m concerned for your safety. You deserve to be treated with respect.”</p> <p>b. Provide a warm referral (same day/in real time) with patient’s permission to case management/integrated behavioral health (social work), and the external community partnered domestic violence/human trafficking program.</p> <p>c. If patient declines immediate warm referral, offer referrals to case management, internal integrated behavioral health, and external domestic violence programs and medical-legal partners/civil legal aid.</p> <p>d. Ensure patient’s immediate level of safety and devise a safety plan with the patient, providing ways to reach after-hours on-call clinicians and external community-based supports.</p> <p>e. For &lt;18 years old, follow your state’s child abuse reporting laws and make referrals to supportive resources and youth programs.</p>
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17. There is no mandatory reporting for labor exploitation, or sexual exploitation of adults. Very few states have mandated reporting laws specific to suspected abuse or domestic violence for individuals being treated by a health care professional, however, most do have laws which require the reporting of specified injuries and wounds (example gunshot, or significant burns). Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse and child abuse reporting laws, in that the individuals to be protected are not limited to a specific group but pertain to all individuals to whom specific health care professionals provide treatment or medical care, or those who come before the health care facility. The laws vary from state-to-state, but generally fall into four categories: states that require reporting of injuries caused by weapons; states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; states that specifically address reporting

in domestic violence cases; and states that have no general mandatory reporting laws. [Learn more](#).

18. If there is a disclosure of sexual assault, offer a facilitated referral for forensic exams at appropriate ER/hospital/SART (Sexual Assault Response Team)
19. Assess for and treat health impacts/medical needs for patients with disclosures, or when provider has concerns for, E/HT/DV/IPV:
  - a. [Reproductive coercion](#)
    - i. [Harm reduction](#) for emergency contraception with Levonorgestrel (may not be as effective among overweight women), Ulipristal acetate – UPA (effective for with a body mass index of 30 or greater), or Copper T/IUD (within 5 days of coercive sexual intercourse)
    - ii. Contraception: Offer LARCs – these may be preferable for patients since abusers/exploiters often interfere with contraception
  - b. STIs: prevention (PrEP, vaccinations, condoms), testing, treatment
  - c. Does the patient have access to medications for chronic illnesses? (Abuser/exploiter often withholds or interferes with medication adherence). Discuss if patient has access to extra or emergency supply of medications as part of safety planning.
  - d. Substance use, including substance use coercion: abusers/exploiters may interfere with substance use treatment plans as a means of power and control.
  - e. History of traumatic brain injury or strangulation: repeated head trauma or anoxic brain injuries can result in cognitive impairments. Studies show a range of 40%-91% of women experiencing IPV have incurred a traumatic brain injury (TBI) due to a physical assault, and more than two-thirds of IPV victims are strangled at least once (the average is 5.3 times per victim)
  - f. Delay of regular preventive care – assess for immunization schedule, and preventative screenings (breast cancer, cervical cancer, colon cancer)
  - g. Assess for mental health/behavioral health needs (PTSD, anxiety, depression, etc.)
20. After CUES is completed, proceed with visit and exam for which the patient is seeking care. Conduct and/or review any usual and customary directed screenings as normally administered during visits. For example, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Patient Health Questionnaire 2 (PHQ 2) or PHQ 9, Generalized Anxiety Disorder (GAD), or directed DV screenings (prenatal screenings).
21. Resources: In advance of need, it is important to [cultivate a partnership](#) with a local Domestic Violence Program and others that specialize in domestic violence and human trafficking.
  - a. Local resources – [develop locally]
  - b. National resources/hotlines (see above: Protocol description and details, General Approach, Support)
  - c. Additional indexed resources to include:
    - i. [TBI/strangulation](#)
    - ii. [Opioid Use Disorder/Substance Use Disorder and IPV intersections](#)
    - iii. Adolescents and healthy relationships/creating welcoming spaces for sexual and gender minority adolescents

- iv. [HIV and Trauma](#)
- v. Maternal health and [home visitation programs](#)

22. Make a follow-up appointment within 1-4 weeks to continue building rapport, trust, and surveillance over possible health effects from violence and/or exploitation.
- a. Patients may need ongoing care for aftereffects of violence and exploitation – including care for trauma, PTSD, anxiety, depression; reproductive health care; chronic pain, substance use disorders, among others. Addressing violence includes providing care after the emergent experience of violence.
  - b. Consider possible difficulties for patients to return for care – inquire about transportation needs and opportunities to schedule outside of work hours.

23. Documentation:

- a. Develop an electronic health record (EHR) policy to protect and restrict sensitive documentation and diagnoses from after visit summaries if the provider deems the information as potentially harmful to the patient. Determine whether insurance explanation of benefits or material will contain sensitive information.
- b. Supportive documentation is critical for the patient, given the 21<sup>st</sup> Century CURES Act and movement towards Open Notes.
- c. Transparently discuss with patient your concerns of E/HT/DV/IPV or disclosure of E/HT/DV/IPV.
- d. Inform the patient that the electronic record can be shared with other healthcare entities, and that documentation of objective history and examination findings from provider’s history and data collection is standard medical care, as noted in confidentiality section above.
- e. Assess whether the note should be set to “no information sharing” private settings and ask the patient if the electronic chart can be accessed by other people, whether the patient has control over their passwords, mail, and paperwork.
  - i. Oftentimes IPV/HT victims do not have control or agency over their portals/passwords/documents. Health care can be the one place where they have privacy and can speak freely. It may be best to develop a clinic wide policy of “no sharing” clinical notes when the provider is concerned for violence, abuse, exploitation.
- f. Inform the patient that the note can be set to private, so that it is not available for sharing on the patient portal/patient-facing documents.
- g. If patient agrees, set the note to restricted settings, and document the Information Sharing Exception in the encounter, or per the health center’s compliance policy.

24. Coding: FQHCs are required to report to HRSA non-identified volume metrics on patients visiting the health center for exploitation and intimate partner violence (Number of Visits by Diagnosis Regardless of Primacy, and Number of Patients with Diagnosis)
- a. It is not required for clinicians to use ICD-10 codes recommended by HRSA to collect data, but it is required for the CHC to report these Uniform Data Set (UDS) data collection measures to HRSA

- i. Recommendation to NOT use these codes until a clinic-wide policy on protecting these documented codes is in place.
- ii. Clinic-wide discussion on pros and cons of using ICD-10 codes
- iii. Know that UDS reports will be an undercount of patients
- iv. In lieu of using the ICD-10 codes for UDS reporting, health centers may opt to develop standard data collection forms within the electronic record, which can be used to generate counts of patients and visits. Free text documentation is not allowed for UDS reporting.
- b. An EHR policy to protect and restrict these sensitive diagnoses from after visit summaries, and electronic notes/chart available to the patient should be developed
- c. Like the confidentiality discussion about documentation, transparent discussion with the patient about coding should occur.
- d. “Suspected” ICD-10 codes refer to the clinical provider’s judgement, whereas “confirmed” ICD-10 codes refer to disclosures or external confirmation (law enforcement, social services, external partners).
- e. “Encounter for examination and observation” ICD-10 codes refer to acute medical visits for forced labor or sexual exploitation
- f. “Personal history” ICD-10 codes refer to a patient’s history of forced labor or sexual exploitation whether in childhood or as an adult

<p>ICD-10 codes for UDS data collection of <b>exploitation</b>:</p> <p><b>T74.5</b> – Forced sexual exploitation, confirmed  <b>T74.51</b> – Adult forced sexual exploitation, confirmed  <b>T74.52</b> – Child sexual exploitation, confirmed  <b>T74.6</b> – Forced labor exploitation, confirmed  <b>T74.61</b> – Adult forced labor exploitation, confirmed  <b>T74.62</b> – Child forced labor exploitation, confirmed  <b>T76.5</b> – Forced sexual exploitation, suspected  <b>T76.51</b> – Adult forced sexual exploitation, suspected  <b>T76.52</b> – Child sexual exploitation, suspected  <b>T76.6</b> – Forced labor exploitation, suspected  <b>T76.61</b> – Adult forced labor exploitation, suspected  <b>T76.62</b> – Child forced labor exploitation, suspected  <b>Z04.81</b> – Encounter for examination and observation of victim following forced sexual exploitation</p>	<p>ICD-10 codes for UDS data collection of <b>intimate partner violence</b>:</p> <p><b>T74.11</b> – Adult physical abuse, confirmed  <b>T74.21</b> – Adult sexual abuse, confirmed  <b>T74.31</b> – Adult psychological abuse, confirmed  <b>Z69.11</b> - Encounter for mental health services for victim of spousal or partner abuse  <b>Y07.0</b> - Spouse or partner, perpetrator of maltreatment and neglect</p>
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<p><b>Z04.82</b> – Encounter for examination and observation of victim following forced labor exploitation</p> <p><b>Z62.813</b> – Personal history of forced labor or sexual exploitation in childhood</p> <p><b>Z91.42</b> – Personal history of forced labor or sexual exploitation</p>	
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- 25. Staff may need support for secondary or vicarious trauma – supervisor, provider, and behavioral health staff will check in for support needs.
- 26. Notify within 24 hrs. of the suspected/ confirmed case that needs to be shared with the Compliance and Quality department
- 27. IPV/HT task force is responsible for reviewing and updating the protocol annually.
- 28. Defining success: Success is measured by our efforts to reduce isolation and improve outcomes for safety and health by:
  - a. Growing strong partnerships with DV advocacy programs
  - b. CUES approach versus screening alone
  - c. Confidential environment: see patients alone
  - d. Offer patients supportive messages
  - e. Offer patients harm reduction strategies to promote safety and health
  - f. Make warm, supported referrals to DV advocacy programs
  - g. Consider IPV, HT, and exploitation for differential diagnosis.

Procedure Authority, Signature, and Dates:

CEO: \_\_\_\_\_ Date: \_\_\_\_\_

CMO: \_\_\_\_\_ Date: \_\_\_\_\_

Dir. Behavioral Health: \_\_\_\_\_ Date: \_\_\_\_\_

**This protocol was developed by:** [Health Partners on IPV & Exploitation](#), a project of [Futures Without Violence](#) and authored by Kimberly S. G. Chang, MD, MPH, Asian Health Services, Alameda Health Consortium Human Trafficking-Medical Offramps Project and Anna Marjavi, FUTURES. Gratitude is extended to the HRSA-funded community health centers and domestic violence program staff who participated in the Learning Collaborative: *Health Center Protocols to Address IPV and HT: Developing, Adapting, and Formalizing A Universal Education Protocol in Partnership with Community-based Programs* (held in June 2021) for their insights and feedback on this tool.

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**Technical assistance:** *Health Partners on IPV & Exploitation* works with health centers and systems to support those at risk of experiencing or surviving intimate partner violence (IPV), human trafficking (HT), or exploitation (E) and to bolster prevention efforts. Health Partners on IPV & Exploitation is part of a network of 21 [“NTTAP”](#) organizations that provide training and technical assistance to address the operational, clinical, access, and technology needs of health centers.

*Health Partners on IPV & Exploitation* offers health centers educational programs on trauma-informed services, building partnerships, policy development, and the integration of processes designed to promote prevention and increase the identification and referral to supportive services for individuals at risk for, experiencing, or surviving IPV and HT/E.

#### **How to contact Health Partners on IPV and Exploitation:**

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Learn more: Visit [www.IPVHealthPartners.org](http://www.IPVHealthPartners.org) an online toolkit for building partnerships between community health centers and domestic violence programs to support survivor health.

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