



Formerly Family Violence Prevention Fund

How to Create a Healthcare-based Domestic Violence/Sexual Assault Program

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I. ABOUT THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

This paper was developed by the **National Health Resource Center on Domestic Violence**, supporting 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. The Center is funded by a grant from the **Family Violence Prevention & Services Program**, Family & Youth Services Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, and is a member of the **Domestic Violence Resource Network (DVRN)**.

The Center offers:

- Personalized, expert **technical assistance** via email, fax, phone, Internet, postal mail and face-to-face at professional conferences and meetings around the nation.
- Free, downloadable **health care information folios** focusing on various specialties, populations and key issues. These include fact sheets, model programs and strategies, bibliographies and protocols.
- **Educational and clinical tools** for providers and patients. These include: clinical practice recommendations for adult and child health settings; an electronic business case tool for health institutions seeking to create comprehensive domestic violence programs; papers on health privacy principles that protect victims; coding and documentation strategies, and more; screening and response training videos; comprehensive resource and training manuals; clinical reference tools; and patient and public education materials.
- **Models** for local, state and national health care and domestic violence policymaking.
- A free **webinar series** with expert presenters, and cutting edge topics.
- Tools, strategies and personalized assistance to help health care professionals and advocates join the annual **Health Cares About Domestic Violence Day**, which is dedicated to raising awareness about abuse among health care professionals and the public.
- A biennial **National Conference on Health and Domestic Violence** – a scientific meeting at which health, medical and domestic violence experts and leaders explore the latest health research and programmatic responses to domestic violence.

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II. HEALTH CARE EFFECTS AND COSTS OF DOMESTIC VIOLENCE

Most women visit health care providers for routine medical care, and victims of domestic violence also see health care providers for treatment of their injuries. This puts health care providers in a unique position to help victims of abuse if they know how to detect domestic violence and provide victims with referrals and support. In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse medical health effects including: arthritis; chronic neck or back pain; migraine or other types of headache; sexually transmitted infections (including HIV/AIDS); chronic pelvic pain; peptic ulcers; chronic irritable bowel syndrome and frequent indigestion, diarrhea, or constipation.ⁱ

The impact of domestic violence and sexual assault on women's reproductive health is pervasive but largely unrecognized. Pregnancy complications including: low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women, as are maternal rates of depression suicide attempts and substance abuse.^{ii iii} Domestic violence can also result in homicide and is the second leading cause of death for pregnant women.^{iv v vi} Other sexual and behavioral health implications are equally serious.

Victims of domestic and sexual violence are more likely to experience: coercive unprotected sex; birth control sabotage; unintended pregnancy; teen pregnancy; rapid repeat pregnancies and multiple abortions. The impact of domestic violence on women makes reproductive health, behavioral health and primary care settings critical places for identification of domestic violence and early intervention.^{vii}

The health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed \$5.8 billion each year. Of this total, nearly \$4.1 billion are for direct medical and mental health care services and productivity losses account for nearly \$1.8 billion, according to a U.S.-based report from the Centers for Disease Control and Prevention (CDC).^{viii}

III. HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

During the past twenty years, there has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most individuals are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even primary prevention of abuse. Studies show that assessing for domestic violence in medical settings has been effective in identifying women who are victims and that patients are not offended when asked about current or past domestic violence.^{ix x}

For over two decades, numerous professional medical organizations have promoted routine screening and counseling for domestic violence and effective responses to victims in health care settings.

Organizations that recommend screening and counseling for domestic violence include: the American Medical Association; American College of Obstetrics and Gynecology; American Nurses Association and the American Academy of Pediatrics.

For health facilities pursuing accreditation with the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission), new standards (the first standards on domestic violence were adopted in the early 1990's) on the provision of care, treatment and services for victims of abuse were instituted in 2004. The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States. The Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. These standards, including links to online resources to help hospitals and other health care organizations comply, may be found online via the National Health Resource Center on Domestic Violence's website: www.futureswithoutviolence.org/health.

Additionally, the Government Performance Results Act (GPRA) requires that every Indian Health Service facility institute a policy and procedure on domestic violence, and conduct routine screening, intervention and referral for intimate partner violence with women age 15-40. Specific information about these requirements may be found in the publication developed by the National Health Resource Center on Domestic Violence, *Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report*.

IV. FEDERAL HEALTH CARE REFORM, INSTITUTE ON MEDICINE RECOMMENDATIONS ON DOMESTIC VIOLENCE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES GUIDELINES

In July of 2011, the Institute on Medicine (IOM) released its much anticipated report, *Clinical Preventive Services for Women: Closing the Gaps*, at the request of the U.S. Department of Health and Human Services to identify critical gaps in preventive services for women that will be included in basic insurance packages under the federal Patient Protection and Affordable Care Act. In a historic move, the IOM committee recommended that all women and adolescent girls be screened and counseled for interpersonal and domestic violence in a culturally sensitive and supportive manner. The screening will address current and lifetime exposure to violence and abuse. The IOM Committee found that rates of violence are significant, and the data they reviewed supports that women can be helped by screening and counseling. As one of the Committee members stated, "not only can women be identified by screening, but it can lead to positive interventions." Other recommendations by the IOM included coverage for a full range of reproductive health services and the well-woman visit.^{xi}

On August 1, 2011, less than two weeks after the release of *Clinical Preventive Services for Women: Closing the Gaps*, the U.S. Department of Health and Human Services Secretary Sebelius adopted the IOM's recommendations outlining which women's health services should be included. Now, a full range of preventive services for women, including: annual well-woman visits; screening for gestational diabetes; breastfeeding support; HPV testing; STI counseling

and HIV screening; contraception methods and counseling; and screening and counseling for interpersonal and domestic violence will be covered by new health plans without additional co-payments or deductibles. New health plans and plans that make changes to coverage were required to comply with these guidelines for policies with plan years beginning on or after August 1, 2012. Through this coverage, training and education of health care providers, it is a historic opportunity to reach thousands more women and children experiencing domestic violence who are not currently being helped.

Additionally, the federal Patient Protection and Affordable Care Act of 2010 included provisions to support America's Healthy Futures Act, a \$1.5 billion dollar 5-year national initiative to support maternal infant and early childhood home visitation programs. In addition to providing funds to support these services, the legislation also included new benchmark measures requiring home visitation programs to measure a reduction in "crime or domestic violence."

V. IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS CAN MAKE A DIFFERENCE

Women turn to health care providers by the thousands every day, seeking safety during an emergency room visit, seeking care for old injuries and chronic pain, and for ongoing support. In health care, the practice of assessing for diseases and conditions where early identification makes a difference is common. However, providers often are reluctant to assess for domestic violence because there is no specific medical treatment available to prescribe. Routine screening and counseling, with a focus on early identification of all victims of domestic violence, whether or not symptoms are immediately apparent, is a primary starting point for an improved approach to medical practice in addressing domestic violence.^{xii} Regular, face-to-face screening of women by skilled health care providers markedly increases the identification of victims of domestic violence, as well as those who are at risk for verbal, physical, and sexual abuse.^{xiii xiv}

Screening for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence. When health care providers screen for domestic violence, victims are offered validation of their experiences and an opportunity to obtain information about safety options, improved health, potential for escalation of violence and available resources. Health care providers benefit from a better understanding of the root cause of their patients' health care problems such as chronic pain, depression, substance abuse, uncontrolled diabetes, or other related health concerns.

Providers, when they are well networked with local domestic violence and sexual assault advocacy programs, can access resources to provide the necessary referrals to essential services including safety planning, housing, and legal alternatives that are beyond the scope of the provider's capacity. Asking about domestic violence and having resources and referral materials in health settings also sends a prevention message that domestic violence is unacceptable and has serious health consequences. In asking patients about these issues that have so long been kept behind closed doors, providers expand their relationships as helpers and then take the first steps to break the cycle of violence and build a healthy community.

VI. A MODEL FOR CREATING A DOMESTIC VIOLENCE RESPONSE IN HEALTH CARE SETTINGS

While it may seem a bit overwhelming to think of establishing a program to respond to domestic violence in a clinic, hospital, or other health care setting, this model can help you get started.

In 1992, the Family Violence Prevention Fund, now Futures Without Violence (Futures), in conjunction with the Pennsylvania Coalition Against Domestic Violence (PCADV) designed a model program to strengthen a hospital response to domestic violence. It was then pilot-tested and fine-tuned in 12 hospitals in Pennsylvania and California. Over the next year, another 50 hospitals and clinics across a wide variety of medical settings (primary care, ob/gyn and women's clinics, dentistry, etc) implemented the model. Futures then worked with California's Department of Health Services to implement the program in 50 California community clinics, and as a part of this process, 800 clinical staff were trained. These projects included work with 8 Indian Health Services health care facilities, 3 tribal community clinics and many Native advocacy programs.

During the years 2002-2009, and with funding from the Indian Health Service and the Administration for Children and Families, U.S. Department of Human Services, the model was adapted for use in over 100 Indian, Tribal and Urban health care facilities and domestic violence programs across the United States.

This model approach, applicable to hospitals and clinical settings, enables the staff of a health care institution, in conjunction with local domestic violence/sexual assault programs to respond in a comprehensive manner through screening, identification, referral, documentation, and follow-up by:

- Creating an environment that prioritizes the safety of victims including respecting the confidentiality, integrity and authority of each victim over their own life choices
- Creating an environment which enhances rather than discourages the identification of abuse and its health impact
- Building the skills of health care staff so that they understand the dynamics of domestic violence; are able and willing to assess for abuse; and can effectively respond to victims and their children
- Establishing an integrated and institutionalized response to domestic violence
- Developing culturally appropriate responses and resource materials
- Evaluating, on an ongoing basis, the effectiveness of the program

- Becoming part of a coordinated response within the larger community through collaborative partnerships with local domestic violence programs and others

Essential elements of addressing domestic violence in the health care setting include the following:

- Ongoing training on domestic violence for all health care providers and allied staff of the health care system or facility
- Institutionalizing a comprehensive response to patients experiencing domestic violence through the formal adoption and implementation of protocols and policies
- The identification of victims of domestic violence through routine screening
- The provision of domestic violence services through referral to local domestic violence/sexual assault programs or services within the health care setting

VII. GETTING STARTED: ACTION STEPS

A. Setting Up a Collaborative Working Group - This means recruiting key people within the hospital or clinical setting (the setting could also include reproductive health, school health or home visitation programs), plus representatives from the local domestic violence/sexual assault programs, to ensure that policies and procedures, training, referral and services are well coordinated. It is also essential to build support within the health care institution. To accomplish this, it may be helpful for local domestic violence services to share data from their program, law enforcement, prosecution or other community services. Health care administrators may be particularly receptive to the idea by being reminded of the Joint Commission standards PC.01.02.09 on Victims of Abuse and if they are a federal health facility, the Government Performance Results Act (GPRA) requirements on domestic violence. Additionally, many professional health associations have issued guidelines on the topic including the American Medical Association (www.ama-assn.org), the American College of Obstetricians and Gynecologists (www.acog.org), the American College of Physicians (www.acponline.org), and the American Nurses Association (www.nursingworld.org).

Because of the different roles played by physicians, nurses, behavioral health staff, public health nurses, allied health, medical coders, quality assurance experts and administrators, it is crucial for this working group to be multidisciplinary. In hospitals and large clinical settings, it is also important to involve as many departments as possible. This may not happen immediately but rather gradually, as awareness spreads throughout the institution or clinical setting. An effective multidisciplinary team may include representatives from the following:

Multidisciplinary Team

- Administration
- Staff from across medical and behavioral health disciplines
- Social Services
- Pastoral Care
- Security
- Continuous Quality Improvement (CQI)
- Human Resources/Employee Assistance
- Corporate Communications
- Health Education
- Community members and domestic violence survivors
- Allied Health
- Risk Management/Quality Improvement
- Domestic Violence/Sexual Assault Advocates

It is also important to be clear about the roles and responsibilities of the health care facility and the local domestic violence/sexual assault program, particularly if the local program will be providing domestic violence services on-site in the health care setting.

A memorandum of understanding between the health care facility and local domestic violence/sexual assault program that spells out what is being agreed to—the who, where, what, when and how—should be developed. Job descriptions that outline specific responsibilities are helpful.

Also, be clear about what you want to accomplish which can include:

- Reaching victims of domestic violence who access health services: primary care; medical/surgical; women's health; emergency department; labor and delivery; behavioral health and dentistry etc.
- Improving the skills and sensitivity of hospital/clinical staff in assessing and responding to domestic violence
- Establishing/strengthening professional collaboration between domestic violence/sexual assault programs and health care organizations that may include local domestic violence programs providing services to identified victims in the health care setting

It is also important to be clear about your goals for health care providers that can include:

- Routinely screening for domestic violence and sexual assault at specific intervals
- Offering interventions/counseling to patients that support their next steps and address options for safety
- Referral of patients to domestic violence and/or sexual assault services



- Improving the health outcomes of patients experiencing domestic violence and promoting safety and patient-centered care
- Helping health care providers understand that it is not their job to "fix" domestic violence but that they can help victims by offering assistance and that success is defined by efforts to reduce isolation and offer options to improve safety

Before proceeding with the multidisciplinary team working group, an assessment should be made about the resources that are available within the health care setting (existing protocols, administrative support, potential working group members) and in the community, such as other health care entities that may be interested in partnering.

An excellent assessment tool for use in hospital settings is the Delphi Instrument for Hospital-Based Domestic Violence Programs (Agency for Healthcare Research and Quality, 2002). The tool measures nine domains of program activities including: policies and procedures; physical environment; cultural environment; training of providers; screening and safety assessment; documentation; intervention services; evaluation activities and collaboration. The tool is easy to use and can be used to provide benchmarks or objectives for program achievement, set timelines, measure and track progress over time, compare programs across sites and help determine the most critical program components to focus on. The tool can be administered before a new plan is implemented and then can be completed every six months to measure progress.

The Delphi instrument for hospitals was also adapted into the tool - Family Violence Quality Assessment Tool for Primary Care Offices. Both tools can be accessed at the National Health Resource Center on Domestic Violence website.

The team should take the time collaboratively to think about the following questions.

1. What are we (health setting and domestic violence/sexual assault programs) good at doing?
2. Who will lead the effort?
3. What is the plan?
4. How will we know if we are making a difference?
5. How will we gather information and monitor the changes?
6. How will we assess our progress and success?
7. Who will we share the information with?

Tips for Advocates - Be sure that decision-making is embedded in the working group by the health care facility. Always have an agenda for the meetings and make sure that minutes are distributed not just to the working group members but also to other key leaders to generate interest throughout the health care setting. It is very helpful to schedule the working group meetings for a full year in advance and monthly meetings are recommended, as you get started. It is often easier for health care professionals to meet during a lunch hour and providing food is always welcome.

If you need help in "selling" the idea to a health care facility, the National Health Resource Center on Domestic Violence has developed an evidence-based tool that can be helpful and is available on their website, *Making the Connection: Intimate Partner Violence and Public Health*. This PowerPoint training and education tool distills the most recent data and promising practices on the health impact of violence on maternal and child health, mental health, injury prevention, children and adolescents, and more. It includes compelling data, national resources, and program and policy recommendations along with photos and graphics to engage audiences. The tool is divided into downloadable chapters and includes a compendium listing the full citations for each chapter.

B. Developing Collaborative Relationships - Collaboration and the development of a close working relationship with the health care facility and local domestic violence/sexual assault programs is critical. It is important for advocates to learn the hierarchy, culture and language of the health care setting. Below are some terms that advocates will need to become familiar with:

- Continuous quality improvement (CQI) - the way in which health care facilities determine if their health care processes (e.g. patient safety) are working or not and tracking improvement of practice/clinic/organization operations
- Patient satisfaction - the way in which health care facilities measure their patient's satisfaction with the care they have received and health outcomes
- Utilization review - which looks at the best use of the health care facilities resources

It is also important to understand the challenges that health care professionals face in undertaking a health care response to domestic violence including: a lack of education/training on the issue; discomfort with the issue; time constraints; staff shortages and turnover.

Additionally, it is important for health care staff to learn about the impact, dynamics and appropriate response to victims of domestic violence and the services provided by the local program including: advocacy, individual counseling and support groups, legal assistance, shelter, children's programs and transitional housing. The local program may be able to provide the health care facility with experienced speakers to conduct training on domestic violence.

C. Developing Domestic Violence Policies and Protocols - Policies and protocols will minimally include: a definition of domestic violence; limits of confidentiality; screening questions and identification of who will ask them and when; interviewing strategies; safety assessment and safety planning guidelines; guidance through available options; discharge instructions; clarification of legal requirements; procedures for collection of evidence (photographs, other evidence); medical record documentation; referral processes and information; and a plan for health care staff education.

Protocols should also address confidentiality, and specifically clarify information sharing. Domestic violence/sexual assault advocates should never write in the medical record because it could lead to a breach in the state's domestic violence confidentiality privilege.

Go to <http://www.futureswithoutviolence.org/health> to review and adapt model domestic violence protocols from large hospitals, small clinics and urban programs specific to:

- Clinics
- Dental
- Employees
- Hospitals
- Primary Care
- Reproductive Health

The National Health Resource Center on Domestic Violence has also developed a *Compendium of State Statutes and Policies on Domestic Violence and Health Care*, an at-a-glance summary of state laws and regulations relevant to addressing domestic violence in health care settings. It includes new analyses and themes that reflect policy and programmatic changes made in the last decade by leaders in the fields of health care, policy and domestic/sexual violence advocacy. It also includes an introduction that provides an overview of innovative and promising practices in identified areas, as well as suggestions for amending or creating such state laws and regulations.

A synopsis of every state's domestic violence and health care state laws and regulations is included and addresses: training, screening, protocols, mandatory reporting, insurance discrimination, and other categories. The tool also identifies state earmarks for funding and public health programs specific to domestic violence, as available. The state summaries of laws and regulations are also condensed in a two-page quick chart.

It is also critical to be clear about your state's mandatory reporting law that may require the reporting of specified injuries and wounds, and suspected abuse or domestic violence for individuals being treated by hospital/healthcare professionals. Mandatory reporting laws are distinct from elder abuse, 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. It should be noted that only three states have exceptions for reporting injuries due to domestic violence injury, New Hampshire, Pennsylvania and Oklahoma.

The limits of confidentiality should always be discussed prior to doing a screening for domestic violence.

It is absolutely critical for health care providers to **ALWAYS** discuss the limits of confidentiality prior to screening and counseling for domestic or sexual violence. Providers need to be familiar with their state law and how it is implemented. Not disclosing these limits can harm the relationship between patient and provider, can be disempowering to the patients choice to disclose/not disclose abuse and may put the patient at risk for retaliation by the batterer. By disclosing the limits of confidentiality the decision making power is given to the patient about what to discuss with the provider.

Below are sample scripts for providers on how to inform patients about the limits of confidentiality. The scripts should be adapted to the specifics of your state's mandatory reporting law. Again, be aware that most mandatory state statutes apply only to hospital personnel and may not apply to private practitioners or clinics. For more information about your state statutes please see the *Compendium of State Statutes and Policies on Domestic Violence and Health Care*.^{xv}

"I'm really glad you came in today. I'm going to be asking you a lot of questions to make sure that you get what you need from today's visit. Before we 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 someone has hurt you which may require a report to the police, you are planning to hurt yourself, or you are planning on hurting someone else."

If the medical facility has a protocol that encourages/requires screening, the patient must first be informed that they may choose not to answer the screening questions. Additionally, any screening questions should only be posed when taking an oral history, rather than asking the patient to disclose such information in writing (filling out written patient history forms almost always occurs before there has been a discussion on the limits of confidentiality).

"Domestic violence is a very prevalent issue in our society that will affect approximately 25% of all women at some point in their lives. In fact, domestic violence is so prevalent that (health system) thinks it is important to give all of our female patients basic information about this issue at every contact. Even if you never need this information for yourself, chances are that you know or will know someone who could be helped by this information. In our community, (DV program name) provides a confidential phone

hotline, in-person counseling and even shelter for those who are experiencing domestic violence (give brief info and/or handout sheet). Of course, here at (health system/doctor's office) we have staff that is very sensitive to the needs of victims, and if you would like to talk to any of us, we are here to listen and support you. However, I do have to let you know that under state law, I am obligated to make a police report to (name police agency with jurisdiction over the facility), if I/we are treating someone for any injury sustained by means of violence (tailor this information to the specifics of your state law). So, if you would have any concerns about that, I would encourage you to speak with one of the domestic violence advocates/counselors at (DV program), who are able to provide confidential services and help without being required to make a police report." *(Developed by the Michigan Coalition Against Domestic and Sexual Violence)*

Additionally, there are some federal and state privacy laws that have been enacted to protect patient privacy. At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations provide a federal floor of protections. HIPAA requires providers to inform patients of health information use and disclosure practices in writing, and whenever a specific report has been made. In the case of mandatory reporting laws, this provision does not change the actual reporting from provider to the appropriate authority, but requires that providers consider the circumstances of the victim. When disclosing information about a victim, providers must promptly inform the patient (either orally or in writing) that such a report has been made or will be made.

Additional protections enacted as part of the American Recovery and Reinvestment Act of 2009 (Recovery Act) expanded upon some of the protections in the HIPAA privacy regulation. There are also myriad state laws that provide for the confidentiality of sensitive health and mental health information.

Health care facilities should ensure that their domestic violence protocols and training materials address their state reporting laws and federal regulations. For more information on privacy regulations, please go to www.futureswithoutviolence.org/health.

It is also critical for health care providers to be clear about the parameters of what the law requires to be reported and where it needs to be reported. Reporting information that is outside the parameters of what is required by the law could be a violation of HIPAA. Additionally, no state law requires that the health care facility provide access to the patient.

Universal Education

If your state has a mandatory reporting law that has not been amended, to exclude reporting domestic violence injuries, you can still work with providers to help victims stay safe and healthy. In addition to training providers on how to disclose any limits of confidentiality in their setting, especially if you have major concerns about your reporting law and the risks it might pose for patients, providers can always offer universal education about the health consequences of abuse and the resources available in the community for help.

For more information about how to train providers on disclosing limits of confidentiality or conduct universal education about domestic violence please go to www.futurewithoutviolence.org/health.

Patient safety cards, developed by the National Health Resource Center on Domestic Violence, are available for providers to use and are designed to provide information for patients on safety and safety planning, and help in recognizing how their relationship impacts their health as well as the lives of their children. The safety cards offer helpful suggestions for patients to improve their health and safety, and lists specific health problems that may be the result of chronic stress from an abusive relationship. The backside of the card refers patients to the National Hotline on Domestic Violence for further support.

Tips for Advocates - Advocates must always protect the confidentiality of domestic violence victims but it is important to figure out ways to provide feedback for health care providers who are referring patients to the local domestic violence/sexual assault program to help promote ongoing collaboration. Advocates can think about things like a thank you note for each referral or providing aggregate data on how many referrals are being received from the health facility or departments within the facility on a monthly or quarterly basis. In the same way that a primary care doctor refers a patient to a cardiologist and later receives information from the cardiologist about the results of the referral, so too should domestic violence advocates provide referring health care providers with generalized updates about new patients accessing domestic violence services.

Advocates providing on-site domestic violence services in a health care facility can also ask a battered woman to let the referring health care provider know that she was able to access domestic violence services during the next visit, if she is comfortable sharing that information.

Tips for Advocates and Health Care Providers - You do not have to reinvent the wheel! There are many excellent and specialized materials and tools that you can access through the National Health Resource Center on Domestic Violence including:

- National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings
- Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion
- Healthy Moms, Happy Babies: A Train the Trainer Curriculum on Domestic Violence, reproductive Coercion and Children Exposed
- Making the Connection: Intimate Partner Violence and Public Health
- Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health

- Business Case for Domestic Violence
- Multilingual Public Education Materials
- Training Videos
- Multidisciplinary policies and procedures
- Cultural competency information and materials specific to many communities
- Webinars

These materials include: specific guidelines/recommendations for responding to domestic violence in varying health care settings; sample scripts/questions and strategies to screen for domestic violence; what to do when patients acknowledge domestic violence or say no; interventions with victims; information on appropriate documentation; follow-up and continuity of care; quality improvement goals and implementation measures; responses for diverse populations; validated abuse assessment tools and forms; safety assessment tools and forms; discharge instructions; photo documentation and forensic evidence collection and confidentiality procedures.

D. Developing Routine, Site-Specific Domestic Violence Screening and Response - Ask these types of questions in the multidisciplinary team meetings.

1. What kind of response is best suited for the particular health care setting to best serve victims of domestic violence?
2. How can screening and counseling for domestic violence be routinely incorporated into that setting?

The answers vary by type of hospital (trauma center, community hospital), clinical or other health care setting and the availability and resources of the health care staff and local domestic violence/sexual assault programs to respond and train.

The physical layout of the health care setting should be considered as well, so that private space to screen for domestic violence can be identified. Screening and counseling may be conducted verbally or through patient-completed forms and computer responses, or both. It is essential that all victims of domestic violence leave the health care setting feeling supported and knowing that it is a safe place for them to turn for assistance.

In addition to screening for domestic violence, health care providers need to provide basic interventions and short discussions about domestic violence safety planning and referrals, even though many patients may not be ready to pursue a referral. More in-depth interventions may be carried out by other staff (such as patient advocates, case managers, social workers,

etc.), or a domestic violence advocate onsite. The multidisciplinary team can decide which of these options is best suited to the setting, often starting in one department and expanding to others.

Providing Domestic Violence Services at the Health Care Facility Site

Across the country, there are many domestic violence programs devoting significant resources to hospitals, clinics and other health facilities by providing resources to staff and providing domestic violence services on-site when a domestic violence victim has been identified and would like to receive immediate help.

In Pennsylvania, many member programs of the PA Coalition Against Domestic Violence have been providing on site advocacy services in health care settings for twenty years. In Missouri, the Bridge Program of the Rose Brooks Center provides on-site advocacy services at eight area hospitals and four community clinics in the greater Kansas Metro area.

Domestic violence advocates meet on-site with hospital or clinic patients, to provide the support and resources they may need. Patients often prefer to continue obtaining advocacy services in the health care setting and the advocates make follow up appointments with the patient. On-site group counseling may be offered at some sites. The advocates may have full time offices in the health care facility, be on site for specific days of the week when appointments can be made for patients or may respond on site on an as needed basis. In some cases, hospital staff may be trained as volunteers by the local domestic violence program to respond when the advocates are not available.

On site advocates work to integrate domestic violence awareness into the health care setting's day-to-day operations including training health care providers to recognize the signs and symptoms of domestic violence, and how to talk to patients about what may be happening at home. They also meet regularly with an assigned domestic violence task force in each facility, making sure the policies are supporting a proactive approach to domestic violence intervention.

Additionally, there are many health care facilities across the country that have hired domestic violence advocates to provide on-site services or utilize trained social workers or other trained health care staff to provide domestic violence intervention. After the initial on-site response patients are most often referred to the local domestic violence/sexual assault program for ongoing services. These models also focus on systems change through policy/procedure development and training of staff. Some sites using this model include Hartford Hospital in Connecticut, Duke University Health System in North Carolina, and Brigham and Women's Hospital in Massachusetts.

E. Developing and Institutionalizing a Staff Training Program - Providers should be trained on the dynamics of domestic violence, the health impact of abuse on victims and their children, perpetrator issues, clinical responses to victims, how to properly screen for abuse and intervene in the clinic setting, and culturally relevant resources and referral agencies in the community and neighboring areas. Interactive exercises, role-plays, and other "learner-

centered” techniques (available through the National Health Resource Center on Domestic Violence), which enable participants to practice screening and counseling, and explore personal responses to domestic violence are essential in the development of staff capacity. All staff should receive training (including physicians, nurses, social workers, clerical staff, allied health, security personnel, translators, support staff, clergy, and paramedics etc.). Training should be ongoing and periodic and part of new staff orientation.

To enhance staff training, domestic violence/sexual assault advocates and survivors should be utilized as often as possible. It is important that domestic violence advocates know the research related to health and domestic violence and existing tools that are available. A variety of materials has been developed specifically to educate providers and patients in clinic and hospital settings on domestic violence awareness and prevention and are available through the National Health Resource Center on Domestic Violence.

It is also important to create competencies and provide continuing medical education/social work etc. credits for the training. Hospitals and larger settings often have the capacity to provide such continuing education credits.

In order to adequately respond to patients and assist them in addressing violence in their lives, providers need to be aware of services provided by the local domestic violence/sexual assault program that may include legal assistance, counseling and support groups, mental health and substance abuse treatment, childcare, as well as how resources addressing language, culture, disability and LGBT (lesbian, gay, bisexual and transgender) needs in the surrounding community. This information should be collected into a referral list and made easily available to both health care providers and patients.

Tips for Advocates - When health care providers receive training on domestic violence, it can trigger their own personal experiences with abuse. The health care setting’s employees are often the first to request assistance from domestic violence advocates. Therefore, employee assistance programs and staff supervisors should be trained, and services and resource materials should be developed, so that employees who are victims of domestic violence can receive the help they may need.

Futures Without Violence is also a partner in sponsoring the Workplaces Respond to Domestic and Sexual Violence: a National Resource Center. The Center has many resources available to employers including model policies on addressing violence in the workplace and assisting employees. The Center can be accessed online: www.workplacesrespond.org.

F. Resource Material for Clinicians and Patients - The multidisciplinary team may want to develop site-specific materials to educate health care providers and patients on domestic violence awareness and prevention. The National Health Resource Center on Domestic Violence has many of these types of materials available free of charge that can be used (again, it is not necessary to re-invent the wheel). These include clinical education tools for health care providers (consensus guidelines, pocket references cards, pregnancy wheels etc.),

patient materials (posters, safety cards, referral cards, brochures) as well as videos and archived webinars.

G. Establishing Quality Assurance Mechanisms to Monitor Response - Make routine screening and appropriate responses to victims of domestic violence the targets of quality assurance reviews. This notifies health care providers that routinely screening for domestic violence is a standard of care and is not discretionary. If a baseline needs assessment has been done, ongoing quality assurance reviews can be used to engage clinicians in setting goals and addressing identified obstacles. Some sites may elect to conduct chart reviews to analyze the prevalence of domestic violence, how often screening is taking place, and whether intervention, referral and follow-up were conducted. Research shows that provider compliance with domestic violence protocols increases significantly with administrative support, including adequate staffing and training time and by offering providers tools.

Over time, the health care facility should see significant improvements in provider compliance with domestic violence protocols. However, be patient, Futures Without Violence's experience is that it takes from 3 to 5 years for a health care response to domestic violence to become institutionalized. Health care providers or administrators can be encouraged to compare their identification rates with domestic violence prevalence research to work towards improved identification goals. When a comprehensive and well-designed screening and response program is in place, identification rates often resemble national or community prevalence data.

Measuring provider skills, knowledge level and satisfaction with the program will also provide valuable information that can be used to continually improve identification rates and response to victims. Success should not be based on disclosure alone, as there are many reasons why a patient may or may not disclose abuse. Evaluating patient satisfaction and improved health and safety behaviors in addition to measuring identification rates is strongly recommended.

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