

A Guide to Sustaining Public Health Partnerships to Prevent and Address Violence Against Women **Written by Nancy Durborow for Futures Without Violence**

Overview

For over two decades, health providers and advocates, such as Futures Without Violence, formerly Family Violence Prevention Fund, have promoted routine assessment for violence and abuse and effective responses to victims in health care settings. Most professional medical organizations recommend assessing for violence and abuse such as the American Medical Association, the American College of Obstetrics and Gynecology, the American Nurses Association, the American Academy of Pediatrics and the American College of Emergency Physicians.

Domestic and sexual violence is a critical health care problem and one of *the most significant* social determinants of health for women and girls. The prevalence of this issue is enormous; nearly one-third of women in the United States report being physically or sexually abused by a husband or boyfriend some time in their lives. The Centers for Disease Control and Prevention (CDC) conservatively estimates that intimate partner violence costs the health care system \$8.3 billion annually from direct injuries and services.

Health settings provide an early entry point to help victims and provide anticipatory guidance when providers see women and their children for medical care, including annual visits. However, health care providers can only be a partner in helping women and their families if they know how to detect violence and abuse and provide victims with referrals and support.

Few states have enacted state statutes requiring domestic or sexual violence health care protocols, or screening/assessment requirements for health care providers and facilities. For example, just fifteen states have enacted laws requiring training on domestic violence for health care providers, and the requirements vary greatly.

This guide seeks to link Project Connect grantees to resources, training materials, and a check list of steps involved in policy/organizational change. Building on previous presentations, it includes highlights of federal opportunities for sustainable partnerships between the health sector and domestic and sexual violence advocates. Finally, a few examples of states that have created innovative strategies and improved data collection and monitoring are profiled.

Federal Policy Opportunities

Women's Health Amendment and Coverage for IPV Screening and Counseling - On August 1, 2011, the U.S. Department of Health and Human Services (DHHS) Secretary Sebelius adopted all of the women's preventive health services recommended by the Institute of Medicine's *Clinical Preventive Services for Women: Closing the Gaps*. This decision included cost-sharing-free coverage (without co-payments or deductibles) for women and adolescent girls to 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. Starting in August 2012, this provision will affect new health plans and non-grandfathered plans. A recent Kaiser Family Foundation survey on employer-sponsored health insurance plans found that 44% would be required to follow this decision. The percentage of the field covered will continue to gradually grow over time.

Already, 23% of covered workers were in plans that have changed their cost-sharing for preventive services in response to the ACA's provision, and 31% were in plans that changed which preventive services are covered.



(Kaiser Family Foundation Employer Health Benefits Annual Survey, 2011). The new overall focus on preventive health in the Affordable Care Act is already changing the private insurance market. Through this coverage and with training and education of health care providers, this is an historic opportunity to reach thousands more women and children not currently being helped. Advocates can contact private insurers now and ask them to follow Secretary Sebelius' decision and include coverage for intimate partner violence and domestic violence screening and counseling and work with them before August 2012 to train providers on services available to them in their community.

Prohibition on Pre-Existing Condition Exclusion Based on Violence and Abuse History - Beginning on January 1, 2014, insurance companies are prohibited from refusing to sell coverage or renew policies because of an individual's pre-existing conditions, which could be defined as broadly as cancer or domestic violence. Also, in the individual and small group market, it eliminates the ability of insurance companies to charge higher rates due to gender or health status. Before this protection passed into law, seven states allowed insurers to deny health coverage to survivors, and only 22 states had enacted adequate domestic violence insurance discrimination protections.

Maternal, Infant, and Early Childhood Visitation - The Affordable Care Act included provisions to support America's Healthy Futures Act, a \$1.5 billion dollar, five-year national initiative to support maternal infant and early childhood home visitation programs to States, tribes, and territories. In addition to providing funds to support these services, the legislation also included new benchmark requirements for States. One such benchmark requires home visitation programs to measure a reduction in "crime or domestic violence." At least 40 states and territories are currently implementing a range of home visitation models through over 70 distinct programs. Federal investments in maternal and infant health home visiting programs are authorized in the Title V Maternal and Child Health Services Block Grant legislation and many states and territories currently use MCH Block Grant funds to support and leverage additional funds for home visiting programs. It is worth noting that the U.S. Senate Appropriations Committee recently voted to cut \$50 million to the Title V Maternal and Child Health Block Services Grant. The impact of this proposed cut on America's Healthy Futures Act is unclear.

Preventing Teen Pregnancy - Research has shown a clear link that unintended pregnancies increase women and girls' risk for violence, and in reverse measure, violence increases women and girls' risk for unintended pregnancies. The DHHS Office of Adolescent Health and the Administration for Children and Families fund over 80 different grant programs aimed at preventing teen pregnancy, in particular among those youth most at risk. The most recent funding opportunity announced was the set-aside for tribes and tribal organizations under the Personal Responsibility Education Program. With the clear connections between violence and unintended adolescent pregnancy, and the evidence that shows that asking about violence and reproductive coercion can decrease risk for unintended pregnancy and improve risk, working with these programs is critical.

Recent legislation, the Communities of Color Teen Pregnancy Prevention bill, was introduced in Congress as the first first-ever policy approach that combines teen dating violence prevention and teen pregnancy prevention in communities of color. It recognizes the role coercion and violence plays in unintended pregnancy, and invests in getting young people of color the information and skills they need to build healthy relationships. It further addresses the need among racial or ethnic minority and immigrant communities for culturally appropriate information and education on issues of reproductive and sexual health.

Elements of Coordinated Response between Public Health Leaders and Advocates

In order to take full advantage of the opportunity to position violence and abuse as a public health care issue, public health officials who do not have expertise in this area need consultation on the impact of domestic and sexual violence on health and how to assess and respond in specific settings; resource materials; training programs; and model policies and procedures that can help develop a framework for moving toward a comprehensive health care response to violence and abuse on a state level. This creates an opportunity for key public health leaders and violence and abuse advocates to build a sustained effort to collaboratively respond to violence and abuse. It also creates opportunities for promoting education for patients accessing those public health services about the connection between domestic and sexual violence and their health.

It is important to acknowledge that prevention terminology and tools developed by public health practitioners may not be a perfect fit for violence and abuse advocates. Public health has its roots in science and medicine and consequently places considerable emphasis on empirical evidence and structure. Public health and violence and abuse practitioners may have different philosophies and missions, and often use different terminology that can be confusing or even conflicting. Nevertheless, both of these fields have strong underpinnings in social equity. Advocates are dedicated to ending social injustices against women. Public health professionals are committed to reducing health disparities which can include the barriers to good health created by violence and abuse.

On a statewide level, build partnerships between public health providers and violence and abuse partners by organizing a meeting between professional health associations, department of health leadership, policy makers and advocates for victims of violence and abuse to find out who the champions might be and propose joint initiatives that include a comprehensive action plan to create sustainable changes in the public health response to violence and abuse and expand research and data collection to health practice and policy.

The key to success is building leadership and forging new relationships between public health professionals and advocates for victims of violence who each bring strengths and expertise to the table. It is important to take the time to learn about and understand each other's work. The vision is to integrate practices for addressing violence and abuse into existing programs and not creating new programs. This type of an integrated approach can maximize existing resources and improve the quality of services for patients who have experienced violence and abuse.

When undertaking systems and policy change, take the time collaboratively to think about the following questions:

- What are we (public health system and violence and abuse programs) good at doing?
- Who will lead the effort?
- What is the plan?
- How do we know/will we know if we are making a difference?
- How will we gather information and monitor the changes?
- How will we make sense of this?
- Who will we share the information with?

State public health departments are emerging as the newest allies in the effort to respond to and prevent violence and abuse. Their emphasis on prevention of health care problems, addressing health disparities, the relationship of prevention to cost containment, and the attention being paid to women's health combine to

present a golden opportunity to explore with public health officials what a reformed health care system might mean in terms of prevention, reduction and treatment of violence and abuse.

Creating Policy and Systems Change

Policy and systems change is a core element of intervening and responding to violence and abuse in public health care settings. It is a critical pathway to creating a health care environment that supports routine assessment for violence and abuse, with a focus on early identification of all victims of violence and abuse whether or not symptoms are immediately apparent, and is a primary starting point for an improved public health approach to medical practice for violence and abuse. Regular, face-to-face assessment of women by skilled health care providers markedly increases the identification of victims of violence and abuse as well as those who are at risk for verbal, physical, and sexual abuse. (McFarlane J, Christoffel K, Bateman L, Miller V, Bullock L. (1991). Assessing for abuse: self-report versus nurse interview. *Public Health Nursing*. Vol. 8, 242-250. Koziol-McLain, J. Coates, C., and Lowenstein, S. (2001). Predictive validity of a screen for partner violence against women, *American Journal of Preventative Medicine*, 21 (2), 93-100.)

When victims or children exposed to violence and abuse are identified early, providers may be able to break the isolation and coordinate with violence and abuse advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality. (Saltzman LE, Salmi, LR, Branche, CM, Bolen, JC. (1997) Public health screening for intimate violence. *Violence Against Women*. Vol. 3, 319-331.)

Talking with patients about violence and abuse provides a valuable opportunity for providers to learn about their experiences with abuse. Battered women report that one of the most important aspects of their interactions with a physician was being listened to about the abuse. (Hamberger LK, Ambuel B, Marbella A, Donze J. (1998). Physician interaction with battered women: the women's perspective. *Archives of Family Medicine*. Vol. 7, 575-582.)

It is also important to note that research shows that provider compliance with violence and abuse protocols increases significantly with administrative support, including adequate staffing and training time and by offering provider tools to assist with assessment. Over time, systems with these supports in place see significant improvements in provider compliance with violence and abuse protocols.

In order to make real and lasting progress, practices and programs must become institutionalized, first through changes in policies and then by changes in system practices. The new practices required through policy change reinforce a change in norms and behavior which in turn leads to ongoing support for the policy and the practice. While policy change is an essential component of systems change, it is not by itself, enough to realize institutionalization of new programs and practices to identify and intervene with violence and abuse in public health settings. To accomplish change in public health systems, policy change must be a critical component in a strategy that includes implementation support, monitoring of adherence to the policy and evaluation that improves practice over time.

Core Elements

This approach supports public health care systems and providers to respond in a comprehensive manner to violence and abuse (i.e., through assessment, 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 discussion about abuse and its health impact
- Building the skills of public health care staff so that they understand the dynamics of violence and abuse; are able and willing to assess for abuse; and can effectively respond to victims and their children
- Establishing an integrated and institutionalized response to violence and abuse
- 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 violence and abuse programs and others

Successful Public Health Violence and Abuse Policy Reform Initiatives

Public health departments and budgets are always strained but can reap major benefits by integrating a coordinated response to violence and abuse into existing programs. Examples of health policy reforms in state public health departments include:

- Altering the state contracting process to include requirements for training, assessment and interventions for violence and abuse as elements of the contract
- Surveying survivors of abuse to ask what role they think public health care providers should play in violence and abuse prevention and intervention
- Adding questions about violence and abuse to state health surveys such as the Behavioral Risk Factor Surveillance Survey (BRFSS) and Pregnancy Risk Assessment Monitoring System (PRAMS)
- Changing death certificate requirements so that homicide rates for pregnant women can be tracked

The following are domestic and sexual violence and public health care collaborations with state specific examples.

California: FFACT is California's state funded (federal match) family planning service provision program, supporting the reproductive health care needs of women and men at 200% of the poverty level and below—this program serves 1.6 million women in California each year. FFACT is recognized not only for their successful reduction and prevention of teen pregnancy, but also for billions in cost savings associated with the reduction and prevention of pregnancy. FFACT has co-branded the FWV reproductive coercion cards in Spanish and English as well as our posters and provide them for free as part of their catalog of tools for providers. All 3,200 FFACT providers in the state received a letter providing an overview research on the connection between violence and reproductive health, a description of new materials available in the catalog and received examples of the cards. This was followed up by disseminating copies of Reproductive Health Guidelines, new provider education video vignettes demonstrating how to assess and intervene for reproductive coercion as part of routine care. Marking the largest statewide initiative on reproductive coercion to date—and opening the door for the some 1.6 million women FFACT patients to learn about reproduction, domestic violence and how to get support and help for both of these issues.

Florida:



Since 2003, the Florida Department of Health (FDOH) has issued written guidelines for intimate partner violence screening for the more than 400,000 clients served annually. Currently, screening occurs throughout several FDOH programs, including Family Planning, HIV, and Healthy Start. The screenings can occur at several points, including initial visits of female clients ages 14 and over (and all pregnant females), annual checkups, periodic health assessments, when the client indicates a new relationship, when the health professional suspects signs of violence, or if medical symptoms characteristic of chronic violence are present. The guidelines were developed as a collaborative project between the Florida Coalition Against Violence and Abuse, violence and abuse experts, FDOH central office and county health departments.

Massachusetts:

In Massachusetts, the Violence and Abuse Screening Care, Referral, and Information Project (DV SCRIP) was created to improve the quality of care provided to women and children served within the state funded maternal and child health programs. To achieve this improvement of care goal, the state incorporated intimate partner violence screening, identification, protocols and referrals into their existing work. The DV SCRIP training has also been used to train staff of the state's Early Intervention Partnership Programs and the home visitation program.

New Hampshire:

In New Hampshire the Governor's Commission on Domestic and Sexual Violence developed a statewide violence and abuse protocol for all health care providers on the identification and treatment of adult victims of violence and abuse. Additionally, recommendations to assess for and collect data regarding family violence were integrated into the state's Prevention Guidelines. Issued with the help of the highest public health official in the state, these guidelines are utilized in all primary care settings throughout the state.

West Virginia:

The West Virginia Coalition Against Violence and abuse partnered with the West Virginia Bureau for Behavioral Health and Health Facilities to provide statewide training on violence and abuse for behavioral health and substance abuse providers. They are now partnering with the home visitation programs to train home visitors statewide and are exploring partnerships with the school based health associations to train school based health programs on how to identify and respond to domestic violence.

Virginia:

Since 2007, the Virginia Home Visiting Consortium (HVC), a collaborative of 10 home visiting programs in five state and two private agencies, has been developing a continuum of home visiting services with the goal of having the family's needs rather than the program model determine the intensity and duration of services. The member home visiting programs have agreed to screen for substance abuse, depression and intimate partner violence. An advisory team assisted in the development of Virginia's *Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age*. The tool asks "Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled, or made to feel afraid?" If a woman responds yes, then the home visitor will support her in accessing appropriate community resources and developing a safety plan. The screening and follow-up actions are part of the state's benchmarks under the new federal Maternal, Infant and Early Childhood Home Visiting grant. The benchmark improvement will be defined by increased referrals among women who identified for the presence of violence and abuse and an increase in the safety plans developed. Training sessions on lifetime exposure to violence and contraceptive sabotage have been provided free to home visitors across the state. Virginia will be following up this year with additional training on the Risk Screen tool and development of community resources.

Training, Education, Evaluation, and Policy Resources

General Resources:

- Institute of Medicine's *Clinical Preventive Services for Women: Closing the Gaps* report: www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.
- AMCHP's home visitation resources: www.amchp.org.
- Delphi Instrument for Hospital Based Violence and Abuse Programs (assessment tool for evaluation of hospital-based violence and abuse programs): www.ahrq.gov/research/domesticviol/dvtool.htm. An adaptation for primary care offices was done by Futures Without Violence.
- Information on the Affordable Care Act: www.healthcare.gov/.

Sample of resources provided by the National Health Resource Center on Domestic Violence and Futures Without Violence:

- National Consensus Guidelines on Identifying and Responding to Violence and abuse Victimization in Health Care Settings (Family Violence Prevention Fund, 2004)
- National Health Care Standards Campaign on Family Violence: Model Practices from 15 States (2004)
- Building Violence and Abuse Health Care Responses: A Promising Practices Report from Indian Country (Family Violence Prevention Fund, 2010).
- Reproductive Health and Partner Violence Guidelines: An Intergrated Response to Intimate Partner Violence and Reproductive Coercion (Family Violence Prevention Fund, 2010)
- Compendium of State Statutes and Policies on Violence and Abuse and Health Care (Family Violence Prevention Fund, 2010)
- Realizing the Promise of Home Visitation: Addressing Domestic Violence and Child Maltreatment (Family Violence Prevention Fund in partnership with the National Child Abuse Coalition and Safe Start Center, with sponsorship from the Avon Foundation for Women, 2010)
- Engaging With Federal Policy to Better Address Violence Against Women (Family Violence Prevention Fund in partnership with The California Endowment, 2010)
- Mandatory Reporting of Violence and Abuse to Law Enforcement by Health Care Providers: A Guide for Advocates Working to Respond to or Amend Reporting Laws on Domestic Violence (Futures Without Violence, 2011)
- Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed (Futures Without Violence, 2011)
- Patient Safety cards and posters are available for multiple settings and programs

To access these materials or if you need technical assistance, please contact the National Health Resource Center on Domestic Violence, funded by the Family Violence Prevention and Services Program. The Center provides free technical assistance at:

http://www.futureswithoutviolence.org/section/our_work/health/_ta_submission, or by phone 415.678.5500 or email: health@futureswithoutviolence.org.



Appendix A Potential Steps in Policy Change

Policy change requires intentional strategy based on local/state circumstances and knowledge balanced with the flexibility to reassess and revise strategy and policy over time. Policy change can move forward quickly based on current circumstances, leaders or unanticipated opportunities, such as federal health care reform or funding opportunities. It may also be delayed by the loss of a leader or new priorities such as a state budget crisis.

The development of a strategy to create policy change should include the input of key health care leaders (both public health and private providers) and domestic and sexual violence advocates who believe in the importance of institutionalizing a comprehensive response to violence and abuse in public health settings. Prior to developing a comprehensive plan to initiate and sustain policy change, consider the following:

1. Assessment of existing public health policies on violence and abuse: Review public health policies that may be in place by reviewing which core elements are in place and determining if the policy needs to be revised. Determine when the existing policy was adopted and the strategies used to have it implemented, and if the leaders involved in adoption of the policy are still working in the public health system. Determine who will be the leader(s) and what the plan will be to change policy.
2. Identify or develop champions inside the public health system: Request meetings with policymakers (Secretary of Health or the equivalent department in your state, legislative chairs of public health and welfare committees), public health administrators (reproductive and sexual health; HIV/AIDS; maternal and child health and perinatal; breast feeding and nutritional supplements; child and adolescent health; injury and violence prevention; mental health and substance abuse; and, home visitation) and others to determine their views about the importance of policy adoption and their priorities. Find a way to link and meet their priorities to addressing violence and abuse in the public health system through research and existing tools. If there are identified leaders, ask for their assessment of the best approach to take. Use the new DHHS recommendations on screening as leverage!
3. Gather relevant research: Establish that routine assessment and intervention with violence and abuse can provide primary, secondary and tertiary interventions and prevent further injury and mortality.

In addition to relevant national data, do your homework in your own state by surveying domestic and sexual violence programs and health care colleagues in your state. The questions can determine if there are successful health care responses to violence and abuse programs/projects. Invite them to be a part of the team or to provide support in approaching public health officials.

Also, include in your research and incorporate into your plan, information and response to your state's statute related to health care reporting of injuries and suspected domestic or sexual violence to law enforcement. Most U.S. states have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, and suspected abuse and a few states specifically lift up violence and abuse for individuals being treated by a health care professional. 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: (1) states that require reporting of injuries caused by weapons; (2) states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; (3) states that specifically address reporting in violence and abuse cases; and (4) states that have no general mandatory reporting laws.

4. Develop a case for change: Create compelling information that supports the need for policy change by identifying how improving the public health response to violence and abuse can improve health care outcomes for victims and their children. In addition to the relevant research you gathered, also seek out anecdotal information and personal stories about how an appropriate health care response made a difference in the victim's life and helped them and their children be safe.

Look at what has been done in other states to make the case that even with limited resources, policy and systems change can be made. Violence and abuse protocols and information from public health entities initiatives are available from the National Health Resource Center on Domestic Violence.

5. Identify key constituents: Organize health care providers, health care professional organizations, violence and abuse advocates and survivors of violence and abuse in support of policy change and addressing violence and abuse in the public health arena. Ask them to speak to or write letters of support to public health leaders.

6. Map out the steps in your strategy: Who are the key decision makers? What is the right timing for policy change/adoption? What is a realistic time table given that public health programs are often housed in bureaucracies that may move slowly? What can advocates do to increase momentum and the urgency or timeliness of accomplishing policy change? Should the media be used and how?

7. Scan for opportunities: Pay attention to federal health reform requirements and state and research funding opportunities. Do your homework on federal public health regulations and state regulations that govern public health programs. Become familiar with the new National Prevention Strategy and Healthy People 2020, both released by Secretary Sebelius.

8. Evaluate progress: Measure the success of each step you have mapped out including identification of leaders, development of a plan and successful implementation of policy change. Remember that policy change takes time and may not happen in a year; a three to five year implementation plan may be more realistic.

9. Implementation support: Continue the momentum after policy adoption to cheer and support implementation. Develop a plan for media attention and outreach for positive changes and determine who will be the spokespersons. Report positive changes and results of training public health administrators through patient stories.

10. Monitor what happens: With your public health partners establish an annual review of policy change implementation based on data collection and reporting. Evaluation tools are available. Share any successes or challenges with the Project Connect team!

**Appendix B
Health Policy Opportunities Worksheet¹**

Objective: Identify next steps to institutionalize and sustain prevention and intervention of domestic and sexual violence in the upcoming year through policy change.

List one identified policy opportunity here:

Key Elements:

- 1) Identify a specific policy objective;
- 2) Consider political will and feasibility of your objective: (At present, is this policy objective feasible? If not, what are the challenges (timing, resources, resistance from public officials, etc.)?)

Key Elements:

- 1) Frame the need for change;
 - 2) Back-up idea with research (health impact of DV/SA, cost savings, personal testimonials, etc.)
- How can we “frame” the issue to convince state/federal policymakers that this issue is important?

Key Elements:

- 1) Identify key influencers;
- 2) Develop partners and supporters;
- 3) Understand resistance

Who are the potential policy champions/partners that can help us advance this policy with decision makers or influencers of decision makers? What additional partnerships might we need to cultivate?

Key Elements:

- 1) Ensure implementation is planned and achievable; and
- 2) Plan to evaluate policy impact and disseminate results

Who will be responsible for implementing the policy? (Is there training, resources required?)

Who is responsible for monitoring or enforcing the policy, once it is implemented?

ⁱ Adapted from Prevention Institute Worksheet, www.preventioninstitute.org

