Volume 9 No. 2

endabuse
FAMILY VIOLENCE PREVENTION FUND

Summer 2002

HEALTHALERT

STRENGTHENING THE HEALTH CARE SYSTEM'S RESPONSE TO DOMESTIC VIOLENCE

THE BUSINESS CASE FOR DOMESTIC VIOLENCE PROGRAMS

Patricia R. Salber, MD, MBA | *Co-founder and Co-President, Physicians for a Violence-free Society*

Health care today is big business accounting for approximately 1/7 of the US economy. For the past several years, public and private purchasers of health care have been facing double-digit increases in health care costs at the same time that the rest of the economy is stagnant. Increasingly, even insured patients are paying more out-of-pocket for their health care—sharing the cost of insurance premiums, medications and services. As costs continue to escalate, some purchasers are forced to drop coverage, adding to the already unacceptable number of uninsured in this country. It is no wonder, then, that health care decision-makers are focused on reigning in costs and questioning the value of any proposed new programs or services.

Patricia R. Salber, MD, MBA

In the current climate, it is important that advocates for domestic violence (DV) programs understand the impact that these programs will have on both cost and quality of medical outcomes. The medical literature has documented that domestic violence has a significant financial impact on health systems' cost of delivering care.(1)(2) Victims of abuse are at higher risk for injury, chronic physical and mental health problems, are often seen repeatedly without resolution of complaints, and even undergo unproductive testing if the underlying cause of symptoms --domestic violence -- is not recognized. Further, children who are co-victims or exposed to partner violence experience both short and long-term health effects that require medical attention as well.(3)

Routine screening of women and adolescent girls for domestic violence victimization has been documented to improve identification rates.(4)(5) When coupled with a systematic approach to providing information, support and referral to domestic violence experts, it is expected that outcomes, such as improved safety, physical and mental health will be achieved. Because of this, healthcare decision-makers should consider implementing domestic violence programs. The 31% lifetime prevalence of domestic violence(6) is greater than that of breast cancer or cervical cancer—conditions that are routinely screened for in clinical practice. Because of the prevalence and the extensive health consequences and related costs to the health care system, developing a DV response program makes sense from a clinical, financial and ethical perspective.

The Business Case for Domestic Violence Programs in Health Settings:

Over the last decade health care providers and victim advocates have developed, tested and implemented effective clinical tools and training programs to better equip health systems to identify domestic violence. Some of these approaches have been reported in the peer-reviewed medical literature. As a result, it is now possible to systematically analyze the costs and benefits (both clinical and financial) of implementing a domestic violence program in a health care setting. This type of analysis is known as a business case. It is important to emphasize that a business case captures not only dollars saved as a result of the program, but also clinical and

Continue on page 2

We Want To Hear From You - Fill Out The Family Violence Prevention Fund Survey Page 5

Health Cares About Domestic Violence Day October 9, 2002 Page 7

Have You Registered For The National Conference on Health Care and Domestic Violence? Page 8

societal benefits that accrue to patients, family, and the community. If a health care decision maker is faced with choosing between two programs each of which is going to cost say, $30,000 to implement, they are likely to weigh the benefits of both and choose the one that brings the most benefit to the most people, all other things being equal. Because of the connection between abuse and other devastating and costly chronic health problems, domestic violence interventions can have significant benefits.

- *Why Implementing Programs to Respond to Domestic Violence is a Good Investment:*

- The magnitude of the need. DV is common. It impacts not only the victim, but also her children and her abuser. Health effects are wide reaching, ranging from severe injury to chronic health problems, lower preventative health behaviors, increased injurious health behaviors, significant mental health impact and aggravation of other medical conditions when compliance with a medical regimen is interrupted. This translates into more significant costs spent to treat victims (e.g., victims of DV cost one health plan $1775 more per year than non-victims[1].) Health care utilization, including use of mental health services is increased in women experiencing domestic violence compared to women who are not abused.[2][7] Looking at one related health issue alone, victims delivering low-birth weight babies, one can see a potential for improving outcomes and cutting costs through early intervention and health education (see inset, page 3).

- Interventions efficiently and effectively address the issue. In the case of DV prevention programs, there is peer-reviewed literature as well as expert opinion that routine screening increases identification of "at risk" individuals[3][4] and this can be the first critical step towards intervention. Successful models and materials for these programs already exist and are readily available. There is evidence that being asked about DV by a health care practitioner provides validation and may plant the seed for positive change[8] and screening, combined with validation, has been documented to be beneficial to the health and safety of victims.[9]

- Experts, Patients, and Purchasers Support DV programs: Programs to respond to DV are required by accreditation bodies, requested by purchasers and supported by professional health associations as well as patients. National health care organizations that have issued policy recommendations supporting routine DV screening and intervention include the: AMA, ANA, APA, ACOG, AAP, and most recently, the Institute of Medicine recommends comprehensive research and education in their report, "Confronting Chronic Neglect" on the training needs of health care professionals on abuse.[10] The Joint Commission on the Accreditation of Health Care Organizations requires accredited facilities to have policies in place to identify domestic violence and respond. Purchasers such the National Business Coalition on Health, include domestic violence screening and response as component of quality care. In numerous studies, patients overwhelmingly support screening for abuse.[11]

- Failure to implement the program may lead to unsatisfactory outcomes. The medical literature is replete with information on how the status quo has failed DV victims and their families. It is known that such individuals are seen by health professionals multiple times and often undergo unnecessary evaluations and testing because providers rarely ask about family violence or determine it's impact on the patients health. All too many patients leave the health setting without receiving any information about abuse and services to help them protect themselves and prevent future injury. The cycle continues as children with adverse childhood experiences, including witnessing domestic violence grow up to have significantly higher risk of smoking, alcoholism, substance abuse, obesity, depression and health problems relating to those problems such

> **"If a health care decision maker is faced with choosing between two programs each of which is going to cost say, $30,000 to implement, they are likely to weigh the benefits of both and choose the one that brings the most benefit to the most people, all other things being equal. „**

endabuse
FAMILY VIOLENCE PREVENTION FUND

e Family Violence Prevention Fund (FVPF) is a national non-profit organization focusing domestic violence prevention, education and public policy reform. Founded in 1980, the PF has developed pioneering strategies to address the problem of domestic violence in justice, health care, child welfare, workplace and communication fields.

National Health Initiative on Domestic Violence Staff

Debbie Lee, Director of Health
Lisa James, Anna Marjavi, Fran Navarro, Erika Rodriguez, Rebecca Whiteman and Parry Wu

Health Alert Editor: Fran Navarro
Design and Layout: Aisha Hamilton

This publication was funded by the U.S. Department of Health and Human Services and the Conrad N. Hilton Foundation.

as chronic obstructive pulmonary disease, hepatitis, heart disease, depression, and suicide.(12) Without help, the health of abused patients continues to deteriorate and costs continue to rise exponentially over generations. Finally, as responses to DV becomes the standard of care, health care organizations may be held liable for not identifying and responding appropriately to patients.(13)

> **"The alternative to implementing a program is the status quo - which isn't acceptable from an ethical, clinical or financial perspective."**

- A methodology for evaluating the costs to implement the program is available. Costs vary depending on setting and intensity of intimate partner response programs, but by in large are small compared to costs of doing nothing. In order to help understand the financial implications of a DV program, PVS (Physicians for a Violence-free Society) and the FVPF have developed an Excel spreadsheet that prompts the user to estimate personnel, equipment, and other resources needed to carry out programs based on the elements of successful model programs across the country. *(See table on page 4 for more information.)*

- Further research needed. While we know that on-site patient advocates generally improve health outcomes in other prevention programs,(14) a critical piece of information that is currently unavailable in the field is documentation that DV programs result in saving all or part of the additional dollars spent when a victim goes unidentified. Because of this, it may be prudent to build an evaluation component into the program and/or start by implementing it as a pilot.

- Implementing DV programs makes sense: Domestic violence programs increase identification and provide validation to the victim thus offering unparalleled opportunities for early intervention and prevention - as well as opportunities to manage the extensive host of chronic health problems that victims of abuse suffer from. Based on the financial analysis one can develop using the new return on investment tool, in many, if not most, cases it will be possible to demonstrate a positive financial return on investment.

The alternative to implementing a program is the status quo – which isn't acceptable from an ethical, clinical or financial perspective. Without specific domestic violence programs, health care costs related to failure to identify and address domestic violence early and often will continue now and into the future. Most importantly, at the end of the day, health care organizations exist to serve their patients and their communities. With domestic violence impacting such a significant percentage of patients, it is clear that DV programs fit into the social mission of health systems and are simply the right thing to do.

What to consider when meeting with health care leaders:

Often advocates for domestic violence programs including staff and/or managers from hospitals, health plans and clinics want to find ways to make the argument to CEO's and CFO's that identifying and helping victims of abuse is good business. Understanding a few key elements of the business of healthcare can be helpful when approaching decision makers about implementing programs to improve the response of the health care system to DV. The following issues should be considered when advocating for change:

- Health care resources are finite – Health care organizations, whether health plans, medical groups, community clinics or doctors' offices – can only spend what someone else is willing to pay. It is a simple truth, but is often forgotten because of the third party (i.e., insurance) payment mechanisms that predominate in this country.

- Health care decision makers face multiple, often competing demands. They must make decisions about resource allocation that bring the most value to patients, payers, purchasers, and society as a whole.

- There are more good ideas than there are dollars to pay for them. In any given year, a decision maker may have to decide between implementing an DV prevention program and a program to increase immunization levels in children or a program to increase the rate of screening

Continue on page 4

Consider This...

- 240,000 pregnant women are abused annually.(1)
- 10.7% of abused women deliver low birth weight (lbw) babies. (2)
- The average cost of lbw delivery is $50,300 (3)
- The average cost for term deliveries is $3,355 (3)
- We are currently spending approxamently $1,291,704,000 on lbw babies delivered to victims of DV compared to $86,156,400 we would spend if these were term deliveries.

By identifying victims of domestic violence who are at higher risk for delivering lbw babies and providing targeted health care education, intervention and promotion of early access to prenatal care, we have the potential to save $46,945 per patient, or over 1 billion nationally *on this health issue alone*.

1. *Center for Disease Control and Prevention, The Atlanta Journal and Constitution, 1994.*

2. *Parker, B., McFarlane, J., Soeken, K., Abuse during pregnancy: Effects on maternal complication and birth weight in adult and teenage women, Obstetrics and Gynecology, Vol. 844, No. 3, September 1994.*

3. *Agency for Health Care Policy and Research, Center for Organization and Delivery Studies, Healthcare Cost and Utiliztion Project. Hospital Inpatient Statistics, 1996.*

ANNUAL HEALTH CARE COSTS	
Demographics/Target Population	**Year 1**
Estimated Members/Patients Seen Per Year	25,000
Estimated # of Patients Experiencing DV	
Estimated # of Identified without Training	30
Estimated # Identified with Training	750
Estimated Providers/Personnel Trained	
Total Physicians:	30
Time to Attend Training	$6,000
Total Licensed Health Care Professionals:	70
Time to Attend Training	$5,250
Total Other Health Center Staff:	100
Time to Attend Training	$4,500
Administrative Costs	
Training	
Training the Trainer Costs	$415
Internal Training	$720
Training and Program Implementation	$975
Personnel	
Program Manager	$4,000
Onsite DV Expert	$50,000
IT Support	$0
Administrative Assistance	$1,500
Quality/Outcomes Evaluator	$3,000
Other Administrative Costs	$2,600
TOTALINVESTMENTCOST	$78,960
Breakeven Analysis	
Estimated cost reduction after health and safety is improved	$450
Cumulative Savings in Health Care:	
If 25% of Identified Victims Improve Health & Safety	$81,000
If 50% of Identified Victims Improve Health & Safety	$162,000
Cumulative Investment Costs	$78,960
Cumulative Program Savings	
25% - moderately aggressive program	$2,040
50% - aggressive program	$83,040

for colon cancer. Therefore presenting the clinical, ethical, and financial benefits for domestic violence programs is critical.

- DV prevention programs are most efficiently implemented in systems of care (e.g., medical groups, IPAs, HMOs, clinics and hospitals etc.) where allied health professionals and others in the system can facilitate and/or support the clinician's involvement by providing easy access to needed expertise and follow-up. Presentation to leaders should highlight the role about potential programs of ancillary providers and community based organizations when talking with decision-makers in healthcare systems.

Because of concessions they face competing demands and we must help decision makers understand the business case for domestic violence programs. In order to optimally position DV prevention as a health care priority for health systems, it is important that the value of such programs are analyzed in a systematic way and presented using the language that health care decision-makers understand. There is a compelling business case for these programs in the health care setting that can be articulated and new materials are available that can help advocates for change make the business case to health care decision-makers.

Refrences on page 7

Dr. Patricia R. Salber, MD, MBA, is the co-founder and President of Physicians for a Violence-free Society. She is a Permanente Medical Group emergency physician and is currently serving as the Medical Director, Managed Care, Health Care Initiatives, for General Motors Corporation. She co-authored one of the first texts on Domestic Violence written specifically for physicians, The Physicians Guide to Domestic Violence. She is board certified in Internal Medicine and Emergency Medicine and has completed a Pew Fellowship in Health Policy. She has written and lectured widely on domestic violence and violence prevention in the health care setting.

The Return on Investment Tool is accompanied by a detailed guidebook to help users make the best estimates of costs in their own unique circumstances as well as a scripted PowerPoint business case presentation. These will be available in October via the PVS website (www.pvs.org) and FVPF website (www.endabuse.org) or by calling 888-Rx-ABUSE.

Set up an education program on domestic violence in your health care setting.

endabuse
FAMILY VIOLENCE PREVENTION FUND

Visit the Family Violence Prevention Fund online at www.endabuse.org/health for patient education materials, health practitioner tools and health resource packets to get started!

www.endabuse.org/health

HEALTH CENTER SURVEY

Answer our Survey and receive COMPLIMENTARY materials!

Since 1994, the Center has provided materials and technical assistance to more than 20,000 providers and individuals interested in health care's response to domestic violence. As part of our efforts to better address these requests, we would like to solicit your feedback. Please take a few minutes to complete this short questionnaire and return it to us as soon as possible.

The first 100 responses will receive COMPLIMENTARY copies of our new Pediatric Posters and our new screening tool for health care providers. Everyone will receive complimentary Health Care and Domestic Violence posters and safety cards.

If you would like to receive these items, please complete the contact information. Survey results are for research purposes only, are confidential, and will not be matched to Health Resource Center database files. Return survey in envelope provided.

Name or Initials: _____

Organization (where applicable): _____

Address: _____

City:/State:/Zip: _____

Email: _____

☐ Yes! Please send me updates at this email address. I know I can unsubscribe at any time.

1 Professional Area(s): *Please check appropriate box(es):*

Health Care Provider	Health Care Administrator	Academic	Domestic Violence Advocate/Provider
☐ Physician	☐ Private Hospital	☐ Student	☐ Shelter Worker specify _____
☐ Nurse	☐ Public Hospital	☐ Researcher	☐ Counselor
☐ NP	☐ HMO	☐ Faculty	☐ DV Agency Worker specify
☐ PA	☐ Clinic	☐ Other _____	☐ Other _____ specify _____
☐ Social Worker	☐ Public Health Department		
☐ Non-licensed personnel	☐ Other _____		
☐ Other _____			

2 Usage Information: Please check appropriate box(es)

How many times have you requested assistance from the Health Resource Center?	When did you receive assistance? If more than once, please refer to the most recent experience for this survey.	How did you contact the Health Resource Center?
☐ 0-1	☐ 2002	☐ 888-Rx-ABUSE
☐ 2-3	☐ 2001	☐ 415-252-8900 (General line)
☐ 4-5	☐ 2000	☐ 800-595-4889 (TTY)
☐ More than 5	☐ Before 2000	☐ Regular mail
☐ Don't know	☐ I have never received assistance	☐ Email
	☐ Don't know	☐ At a conference _____ specify _____
		☐ Don't know

3 How helpful was the Health Resource Center? *Please check*

☐ Very helpful ☐ Helpful ☐ Not very helpful ☐ Not helpful at all ☐ Don't know

4 Did you speak (or exchange emails/voicemails) with a staff member of the Health Resource Center? *Please check.*

☐ Yes (Please complete Question 5) ☐ No (Please go to question 6)

5 Usage Information: *Please check appropriate box(es):*

Ability of staff member to address your questions or refer you appropriately	Politeness/Demeanor of staff member	How long after leaving your initial message were you contacted?
☐ Above Average	☐ Very considerate	☐ 0-2 working days
☐ Average	☐ Considerate	☐ 3-5 working days
☐ Below average	☐ Inconsiderate	☐ 6-10 working days
☐ Poor	☐ Very inconsiderate	☐ More than 10 days
☐ Don't know	☐ Don't know	☐ N/A– I reached them directly
		☐ Don't know

HEALTH CENTER SURVEY

6 The Health Resource Center has a number of packets and other materials available at no cost. Please answer the following questions about these items:

Item Name	Are you aware that item is available? *Please check.*	Have you ever requested item? *Please check.*	If YES: How well did the material(s) meet your needs? *Please circle.* Not well / Average / Very well
General Information on the Health Care Response to Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Primary Care Response to Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Mandatory Reporting of Domestic Violence by Health Care Providers	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Emergency Department Response to Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Screening Patients for Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Nursing Response to Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Responding to Diversity	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Battering During Pregnancy	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Domestic Violence Health Care Protocols	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Workplace Response to Domestic Violence in Health Care Orgs	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Responding to Domestic Violence in Lesbian, Gay, Transgender, and Bisexual Communities	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Teen Dating Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Health Care and Domestic Violence Day Organizing Packet	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Two Day Training	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Mandatory Reporting of Domestic Violence by Health Care Providers	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Health Privacy Principles for Protecting Victims of Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Coding and Documentation of Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Other Item (Please Specify):	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5

7 Are you satisfied with the delivery time of your requested materials? ☐ Yes ☐ No ☐ Don't know/Never requested materials

8 Do you feel you will request free items from the Health Resource Center in the future? ☐ Yes ☐ No ☐ Don't know

9 The Health Resource center has a number of training and educational items available for purchase (at cost). Please answer the following questions abouth these items:

Item Name	Are you aware that item is available? *Please check.*	Have you ever purchased item? *Please check.*	If YES: How well did the material(s) meet your needs? *Please circle.* Not well / Average / Very well
Training & Resource Manual	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Screening Guidelines	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Patient Safety Cards	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Pregnancy Wheel	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Practitioner's Reference Card (laminated)	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5
Public Education Materials (posters, buttons)	☐ Yes ☐ No	☐ Yes ☐ No	1 2 3 4 5

10 How would you characterize the costs of items from the Health Resource Center?
☐ Inexpensive ☐ Moderate ☐ Expensive ☐ Don't know

11 Do you feel you will purchase items from the Health Resource Center in the future?
☐ Yes ☐ No ☐ Don't know

12 Have you utilized materials from the Health Resource Center in a language other than English? (Please note that some of our materials come in Spanish, Russian, Vietnamese and Chinese)
☐ Yes ☐ No ☐ Don't know

13 I feel the Quality/Usefulness of information in the Health Alert is:
☐ Very Useful ☐ Useful ☐ Not very useful ☐ Not useful at all

14 Are you interested in resources that cover the following topics?
Public Education and Awareness ☐ Yes ☐ No
Workplace Response to DV ☐ Yes ☐ No
Battered Immigrant Women ☐ Yes ☐ No
Training Judges and Courts ☐ Yes ☐ No

15 Please check this box if you have answered yes to any of the above and would like to receive a catalog of materials.
☐ Yes! I have completed the contact information at the beginning of this survey.

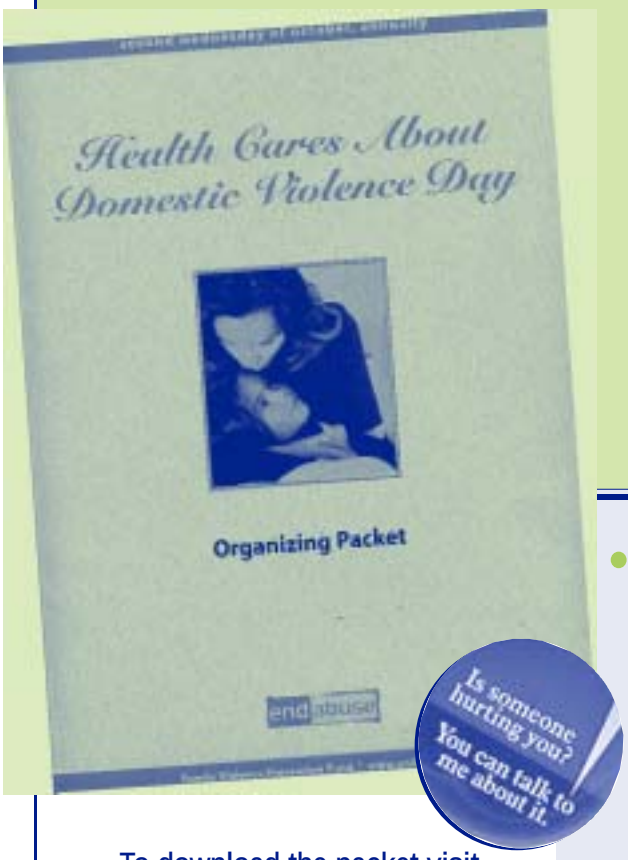
16 Please list areas you would like to see the Health Resource Center address in order to improve health care's response to domestic violence as well as any suggestions or comments regarding the Center or any of your survey answers:

_____
_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU !

YOUR INPUTIS VITALIN OUR EFFORTS TO IMPROVE HEALTH CARE'S RESPONSE TO BATTERED INDIVIDUALS.

For Health Resource Center Reference (NOTto be filled out by respondent)
Survey Number: _____



Health Cares About Domestic Violence Day is October 9th!

Join health care professionals, domestic violence advocates and concerned citizens by getting the message out that domestic violence is a health issue!

The Family Violence Prevention Fund's fourth annual Health Cares About Domestic Violence Day takes place October 9, 2002.

An Organizing Packet is now available on-line and in hard copy to assist your planning.

FREE!

- **THE ORGANIZING PACKET INCLUDES:**
  - National clinical guidelines on how to screen for domestic violence.
  - Free patient & provider educational tools: English & Spanish buttons, patient safety cards & two free posters.
  - Three "Dear Provider" postcards you can send to your personal primary care providers to encourage that they begin routine screening for domestic violence.
  - Organizing ideas for October 9th activities and more.

To download the packet visit
www.endabuse.org/hcadvd
or request that a FREE copy be mailed to you by calling
(888) Rx-ABUSE, TTY (800) 595-4889

Reference:

1. Wisner C, Gilmer T, Saltzman L, Zink T. Intimate Partner Violence Against Women: Do Victims Cost Health plans More? The Journal of Family Practice, 48 (6), June 1999.
2. Bergman B, Brismar B. A 5-year Follow-up Study of 117 Battered Women. American J of Public Health, 81(11), Nov. 1991.
3. Dube SR, Anda RF, Felitti VJ, Edwards VJ et al. Exposure to abuse, neglect, and household dysfunction among adults who witnesses intimate partner violence as children: implications for health and social services. Violence and Victims, 17(1), Feb 2002.
4. Wilst WH, McFarlane J. The Effectiveness of an Abuse Assessment Protocol in Public Health Prenatal Clinics. American J of Public Health, 89(8); Aug 1999.
5. Koziol-McLain J, Coates CJ, Lowenstein SR. Predictive Validity of a Screen for Partner Violence Against Women. American J of Preventive Medicine, 21(2); Aug. 2001.
6. The Commonwealth Fund, Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health, May 1999.
7. Gleason WJ, Mental disorders in battered women: an empirical study, Violence and Victims, 8(1), 1993.
8. Gerbert B, Abercrombie P, Caspers N, et al. How Health Care Providers Help Battered Women: the Survivor's Perspective. Women and Health, 29(3), 1999.
9. McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. Journal of Obstetrical, Gynecological and Neonatal Nursing, January 1998.
10. American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence. Archive of Family Medicine 1992; 139-47. American Nurses Association. Position Statement on Physical Violence Against Women. Washington D.C. American Nurses Association: 1994; American Psychological Association. Report of the American Psychological Association Presidential Task Force on Violence and the Family. Washington DC: American Psychological Association. American Academy of Pediatricians. The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women: 1998; American College of Obstetricians and Gynecologists: Technical Bulletin. 1989; Confronting Chronic Neglect: The Training Needs of Health Care Professionals on Family Violence. National Academy Press 2101 Constitution, N.W. Washington D.C. 20418.
11. Caralis P, Musialowski R. Women's Experiences with Domestic Violence and Their Attitudes and Expectations Regarding Medical Care of Abuse Victims. South Medical Journal, 90:1075-1080, 1997.; McCauley J, Yurk R, Jenckes M, Ford D. Inside 'Pandora's Box': Abused Women's Experiences with Clinicians and Health Services. Archives of Internal Medicine, 13:549-555, 1998.; Friedman L, Samet J, Roberts M, Hudlin M, Hans P. Inquiry About Victimization Experiences: A Survey of Patient Preferences and Physician Practices. Archives of Internal Medicine, 152:1186-1190, 1992.; Rodriguez M, Quiroga SS, Bauer H. Breaking the Silence: Battered Women's Perspectives on Medical Care. Archives of Family Medicine, 5:153-158, 1996.
12. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. American J of Preventive Medicine, 14 (4), 1998.
13. Cranstoun, Jennifer Brown. A New Trend for Healthcare Professional who Treat Victims of Domestic Violence. Journal of Health Law. Voume 33, Number 4, 629-655, Fall 2000. Kringen Vs.. Boslough and St. Vincent Hospital and Health Care Center, Inc. A Montana Corporation. Montana Thirteenth Judicial District Court, Yellowstone County. 07.26/96.
14. Liebert, Mary Ann. Journal of Women's Health and Gender-based Medicine. Volume 9, Number 2, 2000.

2002 National Conference

On Health Care And Domestic Violence

Register Early — Space is Limited

The National Health Resource Center on Domestic Violence, a program of the Family Violence Prevention Fund, is collaborating with leading medical associations and government agencies to sponsor the 2002 National Conference on Health Care and Domestic Violence. This biennial conference is designed for all health care professionals, domestic violence advocates and providers, health care administrators and organizations, health policy makers and students to provide a discussion of the most current research and innovative clinical responses to domestic violence and will include:

- cutting-edge research and responses to domestic violence for victims, perpetrators, and their children
- innovative practices, programs, and partnerships between health systems, providers, government, and domestic violence experts;
- culturally relevant intervention strategies.
- pre-conference workshops on September 26.

SEPTEMBER
27-28
2002
Atlanta, GA

endabuse
FAMILY VIOLENCE PREVENTION FUND
www.endabuse.org

The conference schedule, pre-conference workshop information and online registration is available at www.endabuse.org/conference.

To request a registration brochure, please call 888-Rx-ABUSE (792-2873), 888-595-4889 (TTY).

---

383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
health@endabuse.org
www.endabuse.org

FAMILY VIOLENCE PREVENTION FUND
endabuse

Non-Profit Organization
U.S. Postage
PAID
Permit No. 2788
San Francisco, CA