Integrating Intimate Partner Violence Advocacy in Health Care Services and Benefits

Prepared in Partnership by:
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Introduction to Domestic and Intimate Partner Violence

Intimate Partner Violence (IPV), also known as Domestic Violence (DV), is a pattern of assaultive and coercive behaviors. The behaviors often escalate over time. Common IPV tactics, used in a variety of combinations, may include: progressive isolation, stalking, deprivation, intimidation, threats, financial abuse, psychological abuse, reproductive coercion, sexual assault, and inflicted physical injury. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.[1]

IPV occurs on a magnitude that providers, policymakers, and insurers cannot afford to ignore. Data show 35.6% of women and 28.5% of men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[2] Additionally, about one in four (24.3%) women have experienced severe physical violence by an intimate partner.[3] The problem is no less prevalent in Oregon – "[i]n 2013, 34 Oregonians were killed in 26 separate domestic violence incidents; 27 victims and 7 perpetrators were killed, and another 9 victims survived murder attempts, including a child under the age of 6."[4] In 2015, 60 Oregonians were killed in domestic violence incidents. While people of any gender can experience violence, and people of any gender can perpetrate violence, women are disproportionately impacted. The Oregon Women's Foundation (OWF) 2016 "Count Her In" report on the state of women and girls in Oregon included violence against women as one of the "Eight That Can't Wait" indicators for the health and wellbeing of Oregonian women and girls. The OWF Violence Against Women policy brief states that this is a racial equity and public health issue that policy makers must address in order to improve health outcomes and reduce

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[1] Family Violence Prevention Fund. Preventing Domestic Violence: Clinical Guidelines on Routine Screening. San Francisco, CA: Family Violence Prevention Fund. 1999.

[2] Centers for Disease Control and Prevention. National Intimate Partner and Sexual Violence Survey (2010) at page 2. http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[3] *Id.*

[4] Oregon Coalition Against Domestic and Sexual Violence (2014). Fatal domestic violence in Oregon: Demographics related to victims, perpetrators and incidents. http://ocadsv.org/sites/default/files/ocadsv_fataldv2013.pdf.

health care costs. IPV costs the state $50 million a year in medical expenses and lost productivity in the work place.[5]

In addition to the immediate risk IPV poses to the survivor's health and well-being, studies have shown an association between IPV and a wide range of chronic health conditions such as heart attacks, high cholesterol, cancer, diabetes, respiratory conditions, and neuromuscular conditions.[6] Women who experience intimate partner violence also experience higher instances of stress and anxiety disorders, are more likely to suffer from depression and substance abuse, and are at a greater risk of unintended or unwanted pregnancy than those women with no history of abuse.[7] IPV often has more than one victim. Children who witness violence in their home can also suffer mental and physical health consequences as a result. The Adverse Childhood Experiences (ACEs) study includes witnessing IPV as one of ten ACEs. Researchers Anda and Felitti found that ACEs occur in clusters, meaning where there is one ACE there is an 87% chance there will be at least a second. There's a 95% probability that a child growing up with IPV will be exposed to at least one other ACE.[8] This means addressing IPV can reduce ACEs in children. Children exposed to IPV can suffer from impaired cognitive and sensory growth. Multiple studies document that compared to non-exposed children, children exposed to IPV are more likely to develop asthma, become obese, and experience frequent infections. Later in life, they are at greater risk

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[5] Women's Foundation of Oregon. (2017). *Count Her In: A Report About Women and Girls in Oregon.* Retrieved from Women's Foundation of Oregon website: https://womensfoundationoforegon.org/count-her-in.

[6] National Center on Domestic Violence, Trauma & Mental Health. Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions, & Chronic Illness (2014) at pages 4-6. http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf.

[7] World Health Organization. Understanding and Addressing Violence Against Women: Health Consequences. http://apps.who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf.

[8] Dube, S.R., et al., "Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: Implications for health and social services." *Violence and Victims* 17(1) (2001): 3-17. NCBI. Web. 7 July 2017.

for substance abuse, juvenile pregnancy, and criminal behavior than those raised in homes without violence.[9]

As touched on earlier, the financial burden of IPV should also be noted. In the United States "[c]osts of intimate partner violence (IPV) against women alone in 1995 exceeded an estimated $5.8 billion. These costs included nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity."[10] To look at individual patients, other studies showed "health care costs associated with each incident of domestic violence were $948 in cases where women were the victims… [and overall] health care costs were significantly higher for women who were victims of domestic violence."[11]

The Role of the Community-Based Advocate

Community-based advocates are trained professionals specializing in confidential, trauma-informed services for survivors of IPV and sexual violence. They work from a social justice and equity lens, providing a broad range of essential services to survivors and their families. They offer support, information, safety planning, referrals, assistance with protective orders, trauma informed system navigation and accompaniment, including connections to legal, medical, and community resources. Community-based advocacy programs generally offer a mix of emergency safe housing and long term shelter while connecting survivors to employment services and financial supports through WIC, SNAP, DHS TANF and TADV grants, food banks and meal sites thereby addressing a variety of social determinants of health. Advocates individualize services to each survivor's resources and needs in order to increase safety, self-efficacy, and to reduce chronic toxic stress and other effects of trauma exposure. On a systems level, advocates and their community-based programs offer provider education

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[9] Behind Closed Doors: The Impact of Domestic Violence on Children. https://www.unicef.org/protection/files/BehindClosedDoors.pdf.

[10] Intimate Partner Violence: Consequences. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html.

[11] Corporate Alliance to End Partner Violence. Financial Costs. http://www.caepv.org/getinfo/facts_stats.php?factsec=2.

and support through training and consultation on policies and practices that impact survivors.

Erin Widener-Richardson, a community-based advocate from Tillamook County Women’s Resource Center, provides advocacy services in the Columbia Pacific CCO region and described advocates as ‘masters of flexibility’ – there is no “typical day.” In the community setting, an advocate might begin her day away from the office at the courthouse, providing accompaniment support services to a survivor during legal proceedings. Then she might return to the office for an appointment with another client to support them with safety planning, then follow up on a referral from a clinician who has identified a patient they suspect may be experiencing reproductive coercions as part of IPV.

The Tillamook Safer Futures Program in collaboration with Portland State University conducted an evaluation of the project and designed the Advocate Tracking Tool (ATT) to evaluate how advocates spend their time with clients. The ATT was used for data collection from October 2016 through March 2017. TCWRC advocate, Erin Widener-Richardson completed a total of 374 forms with 64 unique clients over a six-month period. The tool tracked client demographics, meeting location, duration, and content. It also tracked referral pathways, both how clients were connected to the advocate and where the advocate referred the client for additional services.

The ATT findings demonstrate how advocates are providing services that support increased health and safety of survivors. It found that while the meetings ranged from under 30 minutes to more than two hours, the majority of the advocate meetings lasted for 30-60 minutes, two to four times longer than the average medical appointment visit. The advocate often provided multiple services during a single contact; the majority of contacts occurred in person at the health clinic, at the advocacy center, or over the phone. Safety planning is a process and a key feature of advocacy services that took place in 309 of the 374 contacts with clients. Safety planning includes an assessment of recent and potential future events followed by strategizing for harm reduction and risk mitigation. The safety planning process involves education for the client on the dynamics and various tactics of IPV along with a menu of options so that the client determines a safety plan the best suites them. Advocates provide assistance related to management of anxiety and depression, and skill building for trauma recovery that are helpful both in and out of meetings with the advocate. The advocate addressed insurance coverage, reproductive and sexual health, pregnancy options and birth plans, breast feeding support and parenting education among other health needs. The ATT findings confirmed that in addition to addressing safety concerns and planning, the advocate provided resources and referrals to address a wide variety of physical health and social determinants of health concerns in the context of how IPV is impacting each client and their family. The wrap around services advocates provide for this vulnerable patient population and their children are key to improving health outcomes and increasing patient self-efficacy.

Advocates in Oregon must complete a minimum of 40 hours of training covering historic and social contexts of IPV, dynamics of intimate partner violence, sexual violence and stalking; oppression and equity; trauma and vicarious trauma effects; effects on children exposed to violence; advocacy skills; crisis response; safety planning; overview of courts and victims' rights; protective orders; and advocate confidentiality and privilege.[12] Additionally, to maintain their certification and advocate privilege (discussed later in “Confidentiality”), they must be mentored and work as an employee or volunteer of a qualified victim’s services program. Over the last two decades, the role of community-based advocates has expanded due to the necessity for their services and the success of their efforts. IPV advocates play a valuable role in both educating survivors of IPV about the social and health impacts of their experience, about their rights as survivors, and in helping them effectively plan for their futures. Going forward, community-based advocates should be recognized as vital assets and partners in health care delivery.

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[12] http://www.doj.state.or.us/victims/pdf/137-085_text_advocate_certification.pdf

Community-based Advocacy and Trauma-Informed Care

A relatively recent development in the delivery of health care and social services is the idea of trauma-informed approaches to client interactions. Trauma-informed care is founded on six principles (safety, trustworthiness, peer support, collaboration, empowerment, and cultural/historical/gender issues) and aims to:

> *Realize* the widespread impact of trauma and understand potential paths for recovery; *recognize* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; *respond* by fully integrating knowledge about trauma into policies, procedures, and practices; and seek to actively resist *re-traumatization*.[13]

Most community-based advocacy organizations have decades of experience providing trauma-informed care to survivors and their families as they are focused on serving a specific, trauma exposed population. Futures Without Violence created a tip sheet in 2011 to further assist advocates in delivering trauma-informed services to their clients.[14]

Though CCOs, providers, and policy-makers are rightly concerned with using trauma-informed approaches in the delivery of mental and physical health care, in considering the volume of patients who are impacted by IPV and the health care fields lack of training and confidence in addressing IPV, recruiting community-based advocates to address the specific needs of this patient population is efficient and follows the lead of other community systems as outlined below.

Community-Based Advocates

The Oregon Department of Justice annually received $1 million from 2013- July 2017 in federal Pregnancy Assistance Funds (PAF) from the US Department of Health and Human Services, Office of Adolescent Health. Oregon's PAF grant, called “Safer

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[13] SAMHSA. *Trauma-Informed Approach and Trauma-Specific Interventions.* https://www.samhsa.gov/nctic/trauma-interventions.

[14] CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES: A Trauma-Informed Approach to Domestic Violence Advocacy. http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Tipsheet_TI-DV-Advocacy_NCDVTMH_Aug2011.pdf.

Futures Project," integrates advocates in health care and child welfare settings with a focus population of pregnant and newly parenting women who are victims of IPV. The five Safer Futures Health Care Cohort project sites are located in partner public health departments, federally qualified health centers, and clinics in Grants Pass, The Dalles, Portland, Roseburg and Tillamook, OR. "Oregon's DHS recognizes co-located advocates in the child welfare system as national best practice."[15] This paper focuses on the benefits of placing community-based advocates in health care clinics.

The community-based model of care physically places DV advocates in primary care clinics, thereby allowing them to integrate with the health care team. Advocates are provided a private space to meet with survivors. In some partnership models they are HIPPA trained and granted access to EHR systems, allowing advocates to receive provider referrals electronically in order to coordinate care. The advocates work with physicians, nurses, and other office staff to provide universal education on how relationships affect health and are available to offer services to survivors.

There are many advantages to the integrated model of community-based advocates in health care settings. Integrated advocates provide support to providers in discussing IPV to increase their understanding and confidence in addressing IPV, and integration facilitates referrals between providers and advocates. Health care settings provide a unique opportunity for identification and intervention of IPV.[16] Having IPV advocates in the building, ready to be introduced by the physician, can ease the transition between the office visit and the conversation with the advocate. Patients trust their providers' referrals, and advocate confidentiality as outlined in the federal Violence Against Women Act (VAWA) provides an additional level of protection of survivors' sensitive information. In the State of Oregon, advocates have privilege and can therefore reduce an important barrier for survivors seeking treatment: fear of the

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[15] Working Together: A Desk Guide. Domestic Violence Advocates Co-Located at DHS. http://www.oregon.gov/dhs/abuse/domestic/Documents/working-together-guide-for-domestic-violence-advocates.pdf.

[16] ASPE. Screening for Domestic Violence in Health Care Settings. https://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings.

unintended consequences a mandatory report could have on their safety or their ability to continue parenting their children. Additionally, the advocates' placement in the clinic reduces barriers to access and increases supportive services related to the social determinants of health. Survivors can discreetly meet with community-based advocates with less stigma, hassle, or risk of seeking them out in a shelter or separate office setting. For providers, community-based advocates increase provider efficiency by reducing time-costs of addressing IPV in tight workflows while still meeting critical needs. Finally, this model facilitates collaboration between advocates, survivors, and providers. Ultimately, this should lead to improved services for patients who have experienced abuse, improved health outcomes for survivors, and the opportunity to gather higher quality data for researchers and policy-makers.

The Business Case for Funding Community-based Advocacy for IPV Survivors

As mentioned in the introduction, intimate partner violence results in staggering costs to the US health care system and economy as a whole. Understandably, administrators, funders, and providers might be wary of implementing innovative, confidential, community-based advocacy models with limited data on improved health outcomes and cost savings. However, even though the integrated model programs are still comparatively in their infancy, most experts agree that in addition to being ethically sound, funding domestic violence advocacy programs generates a noticeable return on investment. [17]

In one study, a hospital-based domestic violence intervention program reduced health care costs by at least 20%. In another, a systems model approach to IPV screening and intervention was associated with increased member satisfaction scores,

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[17] The Business Case for Intimate Partner Violence Intervention Programs in the Health Care Settings. https://www.futureswithoutviolence.org/the-business-case-for-domestic-violence-programs-in-health-care-settings/.

which could lead to increased membership retention. The comprehensive elements of the program were also associated with improved provider satisfaction.[18]

Physicians for a Violence-Free Society and the Family Violence Prevention Fund have developed a return-on-investment Excel spreadsheet that can be used to measure the potential health care cost savings due to integrating community-based IPV advocacy programs against the cost of intervention on an annual basis. In the various hypotheticals given in their training materials, a low-cost program in a rural health setting with one physician and two mid-level clinicians with a panel of 25,000 patients eligible to be screened per year would save around $38,000 if the program were aggressively implemented.[19]

Funding Sources

It is important to develop sustainable, easily navigable funding sources for IPV advocates in order to ensure three things: first, that the advocates have the resources to aid survivors; second, that the advocates do not waste valuable time in flux between (or searching for) different funding sources; and third, to provide continuity of care within the clinic setting and for survivors in need of advocacy services.

Traditional Grant and Appropriated Funding

As mentioned above, Oregon recently used its Safer Futures (PAF) grant to support community-based advocates in health care settings, as well as other domestic violence programs. “The PAF is a $25 million competitive grant program that funds states and Tribal entities so they can provide a seamless network of support services to expectant and parenting teens, women, fathers, and their families.”[20] Competitive grants like these support federal programs established by the Violence

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[18] McCaw, Et. al. Beyond Screening for Domestic Violence: a Systems Model Approach in a Managed Care Setting, 2001. https://www.ncbi.nlm.nih.gov/pubmed/11567836.

[19] The Business Case for Intimate Partner Violence Intervention Programs in the Health Care Settings: Guidebook to the Return on Investment tool. http://citeseerx.ist.psu.edu/viewdoc/download?rep=rep1&type=pdf&doi=10.1.1.194.8618.

[20] Pregnancy Assistance Fund Program. https://www.hhs.gov/ash/oah/oah-initiatives/paf_program/.

Against Women Act (VAWA) programs, the Family Violence Prevention and Services Act (FVPSA) and the Victims of Crime Act (VOCA) Fund to create and support comprehensive responses to the needs of victims of domestic violence.[21] Finally, various city, county, and state funds can be used to provide services for DV advocates. For example, Community Wellness Investment Funds (CWIF) through Columbia Pacific CCO (CPCCO) were used to expand the partnership model from Tillamook County into Clatsop and Columbia Counties to create continuity in care models throughout CPCCO's service region.

The benefits of this grant and appropriated funding is that the programs are numerous and relatively readily available. As the money is appropriated by agencies or the legislature, the various funding streams are difficult to dissolve and more stable than relying entirely on private grants or charitable donations.

Unfortunately, these program funding streams also have pitfalls. First, in times of economic instability, sequestration and other reductions in governmental spending can drastically reduce funding for the programs. Second, grant applications are complicated and time-consuming. Some programs find it necessary to hire grant-writers to ensure they have the best shot at receiving awards. Others are forced to reduce staff or suspend advocacy services while waiting for grants to be renewed or new opportunities to arise. Finally, grants and governmental program dollars are usually issued with inflexible, prescriptive terms. It can be difficult for programs to administer the integrated community-based program model within the confines of the requirements, yet valuable time and effort must be expended to ensure compliance lest the funding be revoked. All of these pitfalls make continuity of partnerships between advocacy and health care challenging to maintain. This means health care providers experience less support for a vulnerable patient population and survivors experience reduced access to vital services.

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[21] NNEDV. Funding and Appropriations. http://nnedv.org/policy/issues/funding.html.

Partnerships with Insurers

Since IPV has been established as pervasive and costly, and budding evidence shows advocacy programs can be effective at reducing costs and improving health services to survivors as well as survivor health outcomes, it is in the best interests of insurers to find a way to support community-based IPV programs.

CCOs are in a unique position to be able to justify funding IPV advocates. CCO budgets allow for local flexibility, including services and supports that may not meet the definition of "medically necessary" but could eventually help satisfy the triple aim of reducing costs, improving care, and improving outcomes.[22] Columbia Pacific CCO's innovative partnership through the previously mentioned CWIF grant helped the Tillamook County Women's Resource Center, a PAF funded Safer Futures site, to expand capacity-building of advocacy and health partnerships to Clatsop and Columbia Counties. For example, in Clatsop County 20 medical providers or students and 8 advocates were trained on the intersection of advocacy and health care. In Columbia County, 15 medical providers were given the same training. Project evaluations showed an increase in understanding of the intersections of health and IPV among both primary care providers and advocates, as well as increased comfort in addressing the topic. This demonstrates that community-based advocates and health care partnerships are an area of potential impact in positive outcomes. However, this potential may be crippled by the previously discussed funding challenges.

It stands to reason that a larger grant stream or dedicated program fund from the CCO to maintain community-based advocates within the service area would be superior to government grants or private charity. The CCO would be in the position to monitor the program and interact with the advocates, bypassing some of the "inflexibility" present in other types of grants. The CCO would also be well-positioned to increase information gathering to track the efficacy of the collaboration, and better measure a return on investment. The CCO's knowledge of and presence in the community would

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[22] Coordinated Care Organizations 101. https://www.oregon.gov/oha/Transformation-Center/Documents/CCO-101_Mohr-Peterson.pdf.

lend itself well to addressing issues alongside advocates, instead of reacting from afar. Additionally, partnerships with CCOs improve a primary prevention response where providers give education on healthy relationships to patients who might otherwise not receive information or referrals to improve relationship health and safety.

The current political and financial landscape presents potential threats and opportunities. The very concept of “flex dollars” is dependent upon the current Section 1115 Medicaid demonstration waiver, and CCOs have been shy to implement flex dollar services. Additionally, global cuts to Medicaid and other welfare services might force CCOs to re-evaluate spending on innovation and instead focus on bolstering traditional health services. Currently, domestic violence counseling is a core service reimbursable on the Oregon Health Plan, however only licensed clinicians can bill for this service under a mental health diagnosis. Capacity for billing may be expanded in the future based on the 2017 legislative passing of HB 2304, which states:

> SECTION 9. (1) The Attorney General and the Director of the Oregon Health Authority, or their designees, shall develop and implement a plan for incorporating advocates for domestic and sexual violence survivors into the workforce of traditional health workers under ORS 414.665 to increase access by medical assistance recipients to services provided by the advocates.
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> (2) In developing the plan described in subsection (1) of this section, the Attorney General and the director, or their designees, shall consult and collaborate with coordinated care organizations, as defined in ORS 414.025, the Oregon Coalition Against Domestic and Sexual Violence and other groups that advocate for survivors of intimate partner violence.

In support of the integration of IPV into health care outlined above, a report by Health Management Associates titled “Reimbursement for Domestic Violence Advocacy Services Provided to Members of Oregon’s Coordinated Care Organizations” prepared for The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) outlines potential strategies for advocate service reimbursement without reliance on medical providers[23]. While Medicaid funding faces potential cuts, recognition of the work of community-based advocates as health workers and pathways for payment to advocates for their unique services and expertise are now part of Oregon's statewide planning.

Social Enterprise and Private Funding

Private funding sources are notoriously fickle. Reliance upon philanthropies or social benefit organizations for grants or gifts requires relationship maintenance, steady interest, and economic incentives. Additionally, it is unclear how proposed changes to the US tax code might affect charitable giving. On one hand, a “simplification” of the code that eliminates other major deductions could result in an increase in donations. On the other, a cap on total itemized deductions and a consolidation of tax brackets might reduce the value of charitable deductions, leading (usually high income) earners to rethink making donations at all. It is probably not feasible for community-based IPV advocates to rely on the sustainability of private funding streams, especially considering the long-term stability needed to effectively serve survivors.

Considerations and Barriers to Integrating Intimate Partner and Domestic Violence Advocacy with Health Care

Confidentiality and Privilege

In June 2015, Governor Brown signed HB 3476 into law. HB 3746, codified at ORS 40.264 (Rule 507), requires that advocates maintain the confidentiality of their clients, as well as creates statutory privilege for communications between survivors of IPV and sexual assault and certified advocates.[24] A major benefit provided by this law guaranteeing absolute testimonial privilege is that advocates can provide upfront assurance for survivors that anything they discuss will be kept confidential. The survivor governs sharing of their personal information and can access services without fearing

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[23] Health Management Associates (2016). Reimbursement for Domestic Violence Advocacy Services Provided to Members of Oregon’s Coordinated Care Organizations. https://www.ocadsv.org/sites/default/files/resource_pub/Final_report_for_OCADSV_with_Ex_Sum.pdf.

[24] ORS 40.264. https://www.oregonlaws.org/ors/40.264.

potential unintended consequences. Such assurances can help victims feel secure enough to discuss the range of abusive tactics and threats committed against them. This strict confidentiality is meant to restrict the flow of the information to enhance safety for the survivor and any dependents. Keeping in mind that when a survivor chooses to leave lethality is at its highest, the confidentiality status of an advocate therefore allows them to assist survivors in creating meaningful safety plans for themselves and any dependents, and to continually update these potentially lifesaving safety plans.

This is contrasted with confidentiality of physicians and other mandated reporters in health care. It is known and recognized that limitations in provider confidentiality via mandated reporting plays an important role in the social services safety net. Additionally, HIPPA confidentiality is designed to encourage sharing of information for continuity of care among providers. Physicians in Oregon are required to report IPV of adult patients when it is known or suspected that a physical injury was caused by deadly or dangerous weapons or if they suspect a serious injury was inflicted on the patient by non-accidental means per OR 146.750. However, if the physician (or other mandated reporter) suspects abuse or neglect of a child, they must report their suspicions to the Oregon Department of Human Services or law enforcement.[25] This elevates the importance of the IPV advocate and underlines the convenience of having a community-based advocate integrated in the health care team. Without the presence or availability of an advocate who does not have mandatory reporting status, survivors who are also mothers might be reluctant to disclose their experiences to a clinician, even if they are properly screened. In cases where clinicians do need to make a report, advocates' role in the clinic allow for trauma informed mandatory reporting, providing patients with advocacy support to address safety planning.

Advocate privilege also begets the responsibility of confidentiality. Advocates are prevented from disclosing "[c]onfidential communications made by the victim to a certified advocate in the course of safety planning, counseling, support, or advocacy

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[25] Mandatory reporting. https://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx.

services…" without the permission of the victim.[26] This confidentiality requirement mimics that of the Violence Against Women Act, which prohibits sharing personally identifying information about victims without informed, written, reasonably time-limited consent. The VAWA confidentiality provisions apply to any program grantee or sub grantee funded by the act.[27] Additionally, community-based advocates are trained on the differences between their VAWA confidentiality and HIPAA confidentiality and privacy requirements.[28]

These confidentiality provisions are in place to protect the privacy and safety of survivors. However, they may cause challenges to information-sharing or data collection. Electronic Health Records (EHR) designed around HIPAA confidentiality might not conform to ORS or VAWA standards. Therefore an advocate would not be able to use the EHR to schedule or track client visits or to congregate data without violating survivor confidentiality. Advocates, providers, administrators, and payers should thoroughly examine privacy, privilege, and confidentiality requirements and create pathways for problem solving when implementing these programs.[29]

Liability

Some providers have expressed concern about their own professional liability after they refer a survivor to an IPV advocate. These fears are not unfounded – the seeming ease of a potential litigant to establish proximate cause and foreseeability against providers in negligence suits is well-established and daunting, even when the patient has been out of the care of the physician for an extended period of time.[30] Providers might balk at the idea of a referral to an advocate with absolute confidentiality,

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[26] ORS 40.264(2)(a). https://www.oregonlaws.org/ors/40.264.

[27] VAWA Confidentiality. http://nnedv.org/policy/issues/vawaconfidentiality.html.

[28] Health Information Privacy. https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/.

[29] Health Privacy Principles for Protecting Victims of Domestic Violence. http://www.healthcaresaboutipv.org/health-care/health-privacy-principles-for-protecting-victims-of-domestic-violence/.

[30] The Physician's Guide to Medical Malpractice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1291321/.

especially if they have no working relationship with the advocate or are unfamiliar with their mission and purpose.

However, this fear is almost undoubtedly outweighed by the concern that increasingly, not implementing programs will open up a provider or health care facility to malpractice suits. A hospital in Billings, Montana, settled a professional negligence lawsuit brought by an IPV victim for failure to evaluate, diagnose and intervene appropriately in order to ensure the patient's safety.[31] Since routine IPV screening combined with targeted referrals to a qualified IPV advocate is more widely becoming the standard of care, having a community-based IPV advocate may help protect individual providers and systems from future civil liability as the advocate increases provider understanding of IPV and the clinic capacity to more effectively treat survivors. Additionally, because the community-based model, such as Safer Futures, depends on strong working relationships between advocates and providers, there is no problem of a referral to an unknown advocate.

Disinterested Providers

While the support from the medical community for evidence-based practice and trauma-informed care has arguably never been higher, implementing effective IPV screening and care has been uncharacteristically difficult. Lack of appointment time and general discomfort with the subject are the two most noted provider barriers. Anecdotes of providers apologizing to clients for having to ask questions that "people like you obviously don't have to worry about" or being openly hostile during IPV trainings are unsettlingly common. There are also providers who avoid screening for intimate partner violence altogether, as indicated by findings in a national systemic sample of 2400 physicians in specialties likely to initially encounter abused women that "physicians

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[31] Medical Providers' Guide To Managing the Care of Domestic Violence Patients Within a Cultural Context. http://ecald.com/Portals/49/Docs/Publications/Medical%20Providers%20Guide.pdf

screened a median of only 10% . . . of female patients. Ten percent reported they never screen for domestic violence; only 6% screen all their patients."[32]

Provider noncompliance is attributable to a multitude of causes. The first issue is that, "like anybody else, doctors avoid things they may have discomfort doing."[33] One way to combat provider discomfort is to provide training and tools to facilitate effective screening and collaboration with the IPV advocate. Futures Without Violence offers a provider training that normalizes talking about IPV first by framing it squarely in the context of trauma informed services and second by teaching them to speak generally to patients about how relationships affect health. The training and card tool teaches providers to practice universal education with all patients; discussing dynamics that indicate if a relationship is healthy or unhealthy. The training coaches providers on how to discuss the topic sensitively, and present all patients with resource options so patients can use the information to help themselves or friend or family member.

The next issue is a lack of time. Providers are rushed and though there are ways to bill for domestic violence screening and counseling post-ACA[34], physicians still cite being in a hurry as one of the most pervasive reasons they forget to screen for IPV. Fortunately, it is not out of line to consider training other members of the care delivery team to screen for IPV. A 2013 study found that front office staff could effectively deliver clinical tobacco intervention.[35] Therefore, it might be an efficient use of time and resources to explore training assistants or other staff to screen for IPV and facilitate a team approach to screening and referrals to the advocate so that the burden does not fall entirely on the primary care provider.

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[32] Elliot, Et. Al. *Barriers to Screening for Domestic Violence.* J Gen Intern Med 2002. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495014/.

[33] Marcus, Erin M.D. Screening for Abuse May Be Key to Ending It. NYT Health 2008. http://www.nytimes.com/2008/05/20/health/20abus.html.

[34] Recommended Preventive Medicine Service Codes To Record Screening and Brief Counseling of Domestic and Interpersonal Violence. http://www.healthcaresaboutipv.org/wp-content/blogs.dir/3/files/2013/11/Preventive-Medicine-Service-Codes.pdf.

[35] Front Office Staff Can Improve Clinical Tobacco Intervention. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3828111/.

Unfortunately, some providers are opposed to the idea of having a community-based advocate in their clinics. Here, the only option might be a top-down approach from administrators, as well as payers (i.e., health plans), mandating that IPV advocates be included in the care team and that IPV screenings be prioritized as highly as any other preventive service or medical treatment.

Finally, some providers simply may not know IPV is so prevalent, and therefore underestimate the value of their collaboration with advocates. Again, education and affirmation from administrators about the role and significance of IPV screening and advocacy should go a long way toward ensuring that all survivors experience a welcoming forum that meets their needs by addressing the impact of trauma.

Conclusion

Thanks to advances in policy, health care research and delivery, and the work of advocates and communities alike, the United States is finally beginning to take note of the true cost of domestic violence. Oregon is a leader in this development. However, the same ignorance and fear that hid knowledge of IPV’s prevalence for so long still threatens to keep survivors and their families from receiving the health care and social support they deserve.

Community-based IPV advocates, especially those integrated in health centers, have the unique opportunity to interact with members of the community and health care providers in a place survivors of abuse will present for treatment. In these collaborative environments, it makes fiscal and customer service sense that advocates be integrated into care teams in order to reduce survivor re-traumatization and to provide easy access to care and guidance.

In order to facilitate this arrangement, stable sources of funding must be secured for advocates. Reliance on competitive grants and gifts requires redundancy and effort, which adds unneeded burden to organizations whose success depends on steadiness and long-term presence. Reliance on these grants can also create inconsistency in the availability of survivor services. Creative solutions are especially possible in progressive places like Oregon. Policy-makers, administrators, and payers should explore ways to sustainably fund these life-saving, cost-saving and outcome-improving programs.