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Formerly Family Violence Prevention Fund

To: Interested Health Professionals
From: Lisa James, Director, U.S. Department of Health and Human Services' National Health Resource Center on Domestic Violence and Sally Schaeffer, Senior Public Policy Advocate, Futures Without Violence
Date: May 25, 2012
Re: Interpersonal and Domestic Violence Screening and Counseling: Understanding new Federal rules and providing resources for Health Providers

This is the first in a series of guidance memos on identifying and responding to interpersonal and domestic violence in health care settings and creating linkages with community resources for those women and adolescents experiencing abuse and neglect.

This initial memo will summarize (1) the new federal rules about insurance coverage for preventive coverage for women and adolescents who have a lifetime exposure to violence and abuse; (2) why screening for violence is so important in healthcare as violence exposure is a risk factor for health outcomes; (3) and the resources already developed and available to assist providers to identify and respond to abuse. *At the end of the memo are links to patient education resources, clinical guidelines and tools that are provided free of charge through the National Health Resource Center on Domestic Violence.*

Future memos will address the elements of a comprehensive response, other opportunities and challenges of the work, including coding and payment mechanisms, mandatory reporting and confidentiality considerations, and more information on strategies and guidelines tailored to different clinical settings, and supports for how to build a comprehensive program that partner with domestic violence agencies.

Institute of Medicine's Recommendation: Screening and counseling for interpersonal and domestic violence as preventive service for women. Screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.

Background on new Federal rules for Preventive Coverage of Interpersonal and Domestic Violence Screening and Counseling

On August 1, 2011, DHHS Secretary Sebelius issued new guidelines under the authority of the Affordable Care Act to ensure that women and adolescents receive preventive health services at no additional cost to the patient. Among the eight new preventive health services covered by this guidance was interpersonal and domestic violence screening and counseling. DHHS Secretary Sebelius based her decision on recommendations by the Institute of Medicine's (IOM) *Clinical Preventive Services for Women: Closing the Gaps* report. This IOM report recommended cost-sharing-free coverage (without co-payments or deductibles) for women and adolescent girls to be screened and counseled for interpersonal and domestic violence.

These guidelines will start to be in effect in August 2012 for new health plans and non-grandfathered plans. The guidelines also include an annual well-woman visit, a good opportunity for violence screening. By using the comprehensive annual well-woman exam to do a full screening of risk factors, including violence, it may be very effective in identifying at-risk women.

A Kaiser Family Foundation survey on employer-sponsored health insurance plans found that 44% of plans would be required to follow the new federal rules about women's preventive health coverage. The percentage

of the field covered will continue to gradually grow over time. Exchange plans will comply in 2014, and it seems clear from FAQ issued by the U.S. Department of Health and Human Services in February 2012 that preventive health services, including women's preventive health services, will be included.[1] Through this coverage and in partnership with community advocates, this is an historic opportunity to reach thousands more women and children not currently being helped.

The Institute of Medicine described interpersonal and domestic violence, including intimate partner violence and childhood abuse, as a pattern of coercive behaviors that may include progressive social isolation, deprivation, intimidation, psychological abuse, childhood physical abuse, childhood sexual abuse, sexual assault, and repeated battering and injury. These behaviors are perpetrated by someone who is or was involved in a familial or intimate relationship with the victim.

Health Consequences of Interpersonal and Domestic Violence

Interpersonal and domestic violence is common, the health effects are devastating, and the health costs are substantial. The HHS coverage requirement reflects the importance of screening for violence exposure as an essential component of quality health care delivery. The recent Centers for Disease Control and Prevention (CDC) National Intimate Partner and Sexual Violence Survey provides deeper surveillance data. The CDC survey found victims who experienced high rates of severe intimate partner violence, rape and stalking, reported long-term chronic disease and other health impacts such as Post-Traumatic Stress Disorder (PTSD) symptoms.

Some of the top line findings of the CDC survey were:

- 81% of women who experienced rape, stalking or physical violence by an intimate partner reported significant short or long term impacts related to the violence experienced in this relationship, such as PTSD symptoms and injury;[2]
- Women who had experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely than women who did not experience these forms of violence to report having asthma, diabetes, and irritable bowel syndrome;[3]
- Both men and women who experienced these forms of violence were more likely to report frequent headaches, chronic pain, and difficulty with sleeping, activity limitations, poor physical health and poor mental health than men and women who did not experience these forms of violence. [4]

Health Costs of Interpersonal and Domestic Violence

The health care costs of abuse are equally astonishing. A 2009 study of more than 3,000 women (ages 18-64) from a large health plan located in the Pacific Northwest found costs for women suffering ongoing abuse were 42 percent higher when compared with non-abused women. Women with recent non-physical abuse had annual

[1] http://cciio.cms.gov/resources/files/files2/02172012/ehb-faq-508.pdf.
[2] Centers for Disease Control and Prevention, National Intimate Partner and Sexual Violence Survey, Highlights of 2010 Findings, 2010. Available at http://www.cdc.gov/ViolencePrevention/pdf/NISVS_FactSheet-a.pdf , pg. 1.
[3] Centers for Disease Control and Prevention, National Intimate Partner and Sexual Violence Survey. 2010. Available at http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf , pg. 61-62.
[4] Ibid. pg. 62.

costs that were 33 percent higher than non-abused women.[5] Nationally, the medical cost burden of intimate partner violence against women age 18 and older within the first 12 months after victimization, range from $2.3 billion to $7 billion dollars.[6]

CDC estimates that the cost of intimate partner rape, physical assault and stalking totaled $5.8 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores. Of this total, nearly $4.1 billion are for direct medical and mental health care services and productivity losses account for nearly $1.8 billion in the United States in 1995.[7] When updated to 2003 dollars, the cost is more than $8.3 billion, and in 2012 dollars, it would be considerably more.[8]

Screening and Intervention Can Improve Health and Safety

The good news is that an intervention by a health provider has been shown to make a difference in health behaviors and outcomes. Women who talked to their health care provider about the abuse were *far more* likely to use an intervention.[9] At a 2-year follow-up, women who were screened for abuse and given a wallet-sized referral reported fewer threats of violence and assaults. A majority of the women do not have recurrent abusive relationships and health care costs go down after abuse ends.[10]

One randomized control trial found that when assessment is coupled with education, harm reduction and referrals to services, intimate partner violence can be reduced and the health status of women improved.[11] Another new randomized control trial found that a brief intervention during pregnancy can decrease partner violence victimization and related poor pregnancy outcomes. Yet another randomized control trial found that women who received a brief intervention reported fewer incidents of birth control interference and were more likely to leave relationships that were unhealthy and unsafe.[12]

Role of the Clinician in Screening and Counseling for Interpersonal and Domestic Violence

The role of the clinician should be clear and limited and include not only screening, but brief counseling as well. Health professionals can consider the following steps: ask, affirm, offer harm reduction strategies, document, and refer. Tools have already been developed to address how to ask and what to do if the answer is "yes." If yes, they need to ask specifically about forced sex – or have a separate forced sex question.

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[5] Bonomi AE, Anderson ML, Rivara FP, Thompson RS. 2009. Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research*, 44(3): 1052-67.
[6] Brown DS, Finkelstein EA, Mercy JA, 2008. Methods for Estimating Medical Expenditures Attributable to Intimate Partner Violence. *Journal of Interpersonal Violence*, 23(12): 1747-66.
[7] Costs of Intimate Partner Violence Against Women in the United States. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2003. Available at http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf.
[8] Max, W, Rice, DP, Finkelstein, E, Bardwell, R, Leadbetter, S. 2004. The Economic Toll of Intimate Partner Violence Against Women in the United States. *Violence and Victims*, 19(3) 259-272.
[9] McCloskey, L.A., Lichter, E., Williams, C., Gerber, M., Wittenberg, E., & Ganz, M. (2006). Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. Public Health Rep. 2006 Jul-Aug; 121(4): 435–444.
[10] McFarlane, Judith M.; Groff, Janet Y.; O'Brien, Jennifer A.; Watson, Kathy; 2006. Nursing Research. 55(1):52-61
[11] Tiwari, A., Leung, W., Leung, T., Humphreys, J., Parker, B., & Ho, P. (2005). A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: an International Journal of Obstetrics and Gynaecology*, 1-10.
[12] Miller E, Decker M, McCauley H, Tancredi D, Levenson R, Waldman J, Schoenwald P, Silverman J.A Family Planning Clinic Partner Violence Intervention To Reduce Risk Associated with Reproductive Coercion. *Contraception* - 01 September 2010 (10.1016/j.contraception.2010.07.013).

You can introduce the topic by saying:

- "Because domestic violence happens to so many women, we are asking *ALL* women"
- "Because domestic violence results in so many health problems for women…."

Then, a common way to ask the question is:

- "Have your partner ever hurt or threatened your?"
- "Has anyone ever made you do something sexual you did not want to?"

If providers get a positive disclosure of domestic violence, the provider can validate and support the patient. Some phrases are:

- "I am so sorry this is happening in your life, you don't deserve this."
- "It's not your fault."
- "I'm worried about your safety."

In a study with Emergency Department providers, communication behaviors associated with women disclosing domestic violence were:

- Included probing (asking 1 additional topically related question)
- Providing open-ended opportunities to talk
- Being generally responsive to patient clues (any mention of a psychosocial issues)

Tailoring assessment questions and harm reduction strategies to the clinical visit makes the screening more relevant for both patient and provider. For example, in reproductive health settings providers might begin by addressing pregnancy pressure and ability to negotiate contraception prior to follow up questions about physical violence. Accordingly, harm reduction strategies might focus on birth control options that cannot be interfered with and then referrals to local domestic violence providers for safety planning and support. Adolescent health settings would likely begin with a focus on universal education about healthy relationships for all patients and with follow-up direct assessments for those at risk or those in relationships.

Research has shown that brochure based interventions are effective and providers find that a brief intervention that uses a safety card and includes a referral to a local domestic violence or advocacy support agency is simple and effective. Providers can help patients connect with an advocate to work on a safety plan and additional services such as housing, legal advocacy and support groups/counseling. This can be done with this simple phrase:

- "if you are comfortable with this idea, I would like to call my colleague at the local program (fill in person's name) who is really an expert in what to do next and she can talk with you about supports for you and your children from her program…"

If you do not already have a relationship with a local advocate, you can provide a 'warm' referral to the National Domestic Violence Hotline (800.799.SAFE), the National Sexual Assault Hotline (800.656.HOPE), or the National Dating Violence Hotline (866.331.9474). This can be done by saying:

- "there are national confidential hotline numbers and the people who work there really care and have helped thousands of women. They are there 24/7 and can help you find local referrals too – and often can connect you by phone…"

By asking and offering support, harm reduction strategies and referrals, health care providers can significantly

improve the health and safety of victims of abuse.

Confidentiality and Reporting

It is important to discuss the limits of confidentiality prior to doing the screening. Again, scripts have been written on how to disclose limits of confidentiality with a patient before screening, and can be accessed through the resources listed at the end of this memo. Mandatory reporting requirements are different in each state and territory. Consider contacting the following entities for information and resources specific to your state/region:

- *Compendium of State Statutes and Policies on Domestic Violence and Health Care* is an at-a-glance summary of state laws and regulations relevant to addressing domestic violence in health care settings: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf.
- The domestic violence coalition in your state, which may have legal advocates or other experts that provide information and training on reporting requirements. For a complete list, go to www.nnedv.org/resources/coalitions.html.

If you need to make a report, there are several ways you can be supportive to your patient, including know your state law, inform your patient of your requirement to report, explain what is likely to happen when the report is made, asking your patient if she is willing to call an advocate to develop a safety plan in case of retaliation, and make the report with the patient.

Resources to Help Facilitate Screening and Counseling

- 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.
- AHRQ Innovations Solution: "Family Violence Prevention Program significantly improves ability to identify and facilitate treatment for patients affected by domestic violence," (profile of Kaiser Permanente Northern California's Family Violence Prevention Program) http://www.innovations.ahrq.gov/content.aspx?id=2343.
- Information on the Affordable Care Act: www.healthcare.gov/.
- Academy of Violence and Abuse's *Competencies Needed By Health Professionals for Addressing Exposure to Violence and Abuse In Patient Care:* http://bit.ly/mDis1H.

The National Health Resource Center on Domestic Violence through Futures Without Violence has safety cards that can be given to patients or placed in the practice and training resources and online learning CME modules on the overview of domestic violence, preparing your practice, primary care, and confidentiality. Training resources have also been developed on specific settings and specialties such as mental health, reproductive health, urgent care, pediatrics, adolescent health, STI/HIV, and home visitation. Finally, the Resource Center has tools to prepare your practice such as:

- National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization In Health Care Settings
- Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion
- Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed
- Safety cards for adolescent health, reproductive health, primary care and home visitation programs
- Training tools and videos
- Posters and other provider tools

- 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 at the U.S. Department of Health and Human Services. For over 16 years, the Center has provided free technical assistance and web-based and in-person training at 415.678.5500 or health@futureswithoutviolence.org.