CALIFORNIA IPV & HEALTH POLICY LEADERSHIP COHORT

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PROMOTING HEALTH ADVOCACY IN DOMESTIC VIOLENCE PROGRAMS

INTRODUCTION | Intimate partner violence[1] (IPV) directly impacts 1 in 4 women and 1 in 7 men in the US, as well as their family members, friends, and communities. IPV is a leading contributor to injuries, chronic health issues, high-risk health behaviors, and creates a significant strain on the healthcare system. Trauma-informed, evidence-based prevention and intervention strategies have proved effective in reducing the incidence and health impact of IPV. These strategies require commitment to local and state level responses led by California's domestic violence advocates, healthcare providers, policymakers, healthcare systems, and funders. As healthcare delivery systems and the policy landscape are rapidly transforming, there is an opportunity to scale successful programs, policies, and innovations across the state of California to better prevent and address IPV and improve health.

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FUTURES WITHOUT VIOLENCE

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Domestic violence (DV) advocacy programs serve as an important entry point for identifying survivor health needs and providing access to health services and preventative care. DV advocates have demonstrated that they can play a critical role in improving survivor health, providing education on health impacts of DV, and creating linkages to medical homes. Specifically, strategies for health advocacy—addressing and responding to survivor health needs within DV programs—are key to strengthening the safety net for DV survivors and improving collaboration between the health and DV fields to promote prevention, wellness, and access to trauma-informed care.

Despite the important role advocates can play in improving survivor health and wellness, many DV programs do not prioritize health advocacy in their work and oftentimes overlook their capacity for connecting survivors to a medical home. This brief outlines the value and importance of health advocacy, as well as collaboration between the health and DV fields to promote survivor health. It shares lessons and best practices from recent California-based work through the Domestic Violence and Health Care Partnership[2] (DVHCP) project and encourages continued change in practice, policy, and systems across sectors.

LESSONS FROM THE FIELD

DV programs are increasingly integrating health advocacy as a part of their core services. Strategies like formalized partnerships with health organizations, routine health assessment as part of the intake process, ongoing staff training, and referral systems with health partners are important steps in better responding to survivor health needs.

Health assessments support survivor health. Implementing a routine health assessment as part of ongoing DV support services facilitates early identification of survivor health needs and linkages to healthcare services. Furthermore, advocacy programs that address health and safety within core services are better positioned to provide whole person care to survivors. A recommended health assessment was developed and tested in the DVHCP project to assess health status, complaints, and medical coverage. It proved to be a powerful, easy-to-adopt tool for staff as they worked to promote preventative care, and provide universal education on the health impacts of violence.

> *Case Example*: In the DVHCP data pilot, survivors were assessed for both urgent and non-urgent health concerns and routinely linked to preventative care. As a result, 100% of survivors who tested positive for sexually transmitted infections were treated and completed their follow-up visit 3 months post screening. Had the assessment not been implemented in the shelter setting, these survivors' health conditions would have likely remained undetected and untreated, and worsened over time.

Survivor Stories. These stories are powerful examples of the impact health advocacy can have on survivor health outcomes. Stories like these continue to inspire and justify making health advocacy an organizational priority.

- A survivor living with type 2 diabetes was trying to self-manage her symptoms without medical care. Upon accessing DV advocacy services, she was immediately connected to a medical home, assisted with enrolling in health coverage, and assigned to a skilled physician. She was able to receive necessary medical attention, better manage living with the condition, and learned to advocate for her own health.
- Deprived of medical care by her abuser for years, a survivor feared she had been exposed to HIV and was afraid to be tested. The health advocate at the DV program she attended created seamless accessibility in linking her to needed health services, and she was finally provided the HIV education and screening she needed.

DV programs that prioritize health advocacy make a greater impact. Training DV program staff on trauma-informed health advocacy is critical to ongoing success, and must be provided when onboarding new staff and at least annually for established

The **CALIFORNIA IPV & HEALTH POLICY LEADERSHIP COHORT**, funded by Blue Shield of California Foundation (BSCF) and facilitated by Futures Without Violence, is a network comprised of a dozen local, state, and national organizations that are committed to improving health outcomes for Californians by promoting practice and policy change that addresses IPV as a health issue. The cohort is designed to bring together diverse voices to initiate, inform, and advance California-based health and IPV work to:

1. Promote shared learning and multi-sectoral collaboration among leaders in health and IPV;
2. Develop policy and practice briefs to promote application of multi-sectoral collaboration strategies that improve prevention and response to IPV and survivor health; and
3. Provide leadership in local, regional, and statewide work groups, conferences and trainings to promote and disseminate cohort-developed resources.

The briefs were co-authored by cohort members participating in 3 subgroups: Promoting Health Advocacy in Domestic Violence Programs; Addressing IPV as a Social Determinant of Health in Clinical Settings; and Integrating Community Level IPV Prevention in Community Health Assessments and Health Improvement Plans. All three briefs were developed to highlight current best and promising practices, offer relevant resources, and recommend policy changes within these focus areas.

staff as a core part of regular training. Staff must be continuously supported when implementing health advocacy and making practice, policy, and systems-level changes. Programs also learned that establishing health champions within the organization is an important part of sustaining health advocacy and overcoming staff turnover. These champions serve as the liaison between direct service staff and management, as well the voice of the organization when partnering with health programs, and participating in health and DV related community needs assessments and activities. Champions are also instrumental in tracking outcomes, challenges and successes of health advocacy services.

Lastly, programs learned that a team-based approach is necessary to achieving a sustainable health advocacy model. By engaging the whole team—direct service, facilities, administrative, and executive leadership—programs can enlist greater buy-in from staff, and health advocacy can permeate every arm of services.

Formal referral systems are effective in improving access to services. Partnerships between health and DV advocacy programs facilitate early identification of survivor health needs, which improves access to services and increases preventative healthcare utilization. By implementing care models that prioritize collaboration and integrated response, DVHCP pilot sites developed a responsive, bi-directional referral system—including clear procedures for making and receiving warm handoffs between partners—and a feedback loop to track referral outcomes. This was fundamental to implementing effective health advocacy services and it revealed that DV programs are important conduits for care—something that hadn't been captured prior to the project.

When a relationship is established between the health and DV organizations, survivors can be referred to health services seamlessly and with trust, ultimately improving referral outcomes.[3] For example, in the DVHCP project, 84% of survivors who received the health assessment were referred for health services, 51% of which completed at least one preventative healthcare visit. Without a clear policy and procedure for referrals, as well as compliant data sharing between partners on referral outcomes, this number would have been drastically lower, and the outcomes would have been unknown.

Health advocacy is viable and sustainable. Although there are some initial costs to implement components of health advocacy, once established, many programs have learned that costs are minimal, and can easily be sustained over time. Initial implementation costs may include training; staff time—including new and temporary positions—and their participation in partnership activities and other community-wide health programs; educational materials; and, software integration of health questions into electronic data systems. Programs can also leverage other funds, such as new or existing Victims of Crime Act (VOCA) funds, to support components of health advocacy, and may be able to share costs or braid funding with health partners.

Case Example: A DV advocacy program in California leveraged their relationship with a hospital in their region. Together, they created a bi-directional referral system and implemented cross-training, including health training for advocacy staff. As a result of their mutually beneficial relationship, the hospital funded the program with over $50,000 annually to support their continued collaboration and health advocacy efforts. The hospital gained full trust in the program to provide quality DV support services onsite, as well as referrals. Preventative healthcare utilization increased, and the hospital was able to document a cost savings. Ultimately, they were able to make the case for additional funding to fully support their health advocate who is co-located between the DV program and the hospital.

POLICY AND PRACTICE RECOMMENDATIONS

1. **Create and sustain cross-sector partnerships that include representation from health and IPV services sectors.** DV and healthcare organizations should continue to redefine new ways to work together to better address survivor health and safety. Through training, assessment, response and warm handoffs, partnerships can change clinical and advocacy policy and systems that promote prevention, provide comprehensive coordinated care, and support survivor health.
2. **Incorporate information on health advocacy and the health impacts of violence into all required trainings for DV advocacy staff.** DV programs can integrate ongoing health advocacy training for all staff and identify ways to include intersectional education into written policies and procedures. For example, DV programs can integrate a health module into their 40-hour training curriculum, and invite healthcare providers to present at staff meetings and in-services to train on various health topics and harm reduction strategies.
3. **Identify funding strategies that sustain health advocacy and promote preventative health among survivors**. The California Office of Emergency Services (Cal OES), the major state funder for DV programs, requires all funded agencies to have an operational agreement with community partners, including health centers. This contractual structure supports DV programs in developing strong, formal relationships with healthcare organizations.

   DV service providers can also use existing Cal OES funds to help support allowable health advocacy expenses. With strategic budgeting, a percentage of funds can be allocated to support staff time, training, and other resources needed for health advocacy services.

   Service providers should also continue to advocate for additional funding for programmatic development, particularly related to DV and healthcare integration. Explore co-location models that support partnering with health centers and hospitals, as well as other reimbursement mechanisms that can support health advocacy, such as becoming a Medi-Cal provider.[4]

4. **Integrate a health assessment into ongoing DV support services.** DV programs should make health assessment a routine practice. Health assessments should be provided to all clients walking through the door, regardless of age, gender, or orientation. Advocacy staff should have policies and procedures in place for health assessments including when and how they will happen, staff roles, guidelines for documentation in client records, and a response protocol for identified health issues.
5. **Implement bi-directional referral systems to improve access to services, as well as mechanisms for compliant data sharing between partners.** Develop, implement, and sustain a system for making warm hand-offs to health partners. Include a feedback loop procedure for follow-up and tracking referral outcomes. It's important that the feedback loop includes a protocol for compliant data sharing on referral outcomes, to optimize outcome tracking and care coordination for survivors. Without this integral piece, survivors often fall through the cracks of care at a time when they need it most in their lives. Lastly, monitor progress and success, troubleshoot challenges, and make adjustments as needed.
6. **Develop and sustain a process for data collection in order to demonstrate impact of health advocacy and justify funding.** Engage a team-based approach in data collection and clearly identify staff roles. Examine meaningful metrics for measuring desired outcomes and embed them into existing data tracking systems. Provide ongoing training and support for staff. Lastly, monitor the data routinely and document anecdotal impact (survivor stories, cost savings, and other successes).
7. **Monitor implementation of legislation AB 1863, allowing Medi-Cal billing for integrated behavioral health services.** This law, signed in 2016, when implemented, could provide additional resources for Federally Qualified Health Centers (FQHCs) to render billable onsite behavioral health services within DV advocacy programs. Specifically, it may offer an opportunity for reimbursement on services provided by licensed marriage and family therapists (LMFTs). Bill implementation was delayed until July 2018, and to date, is still pending.[5]

CONCLUSION

The negative health impact of intimate partner violence is well documented. For many survivors, entering a DV program is the first time they have had the opportunity to consider their health, and DV advocates can play an important role in creating access to much needed health services. In the current health policy landscape that prioritizes cross-sector collaboration and whole person care, DV programs are well positioned to integrate health advocacy into core services. By committing to policy and systems level change that will promote prevention and increase access to integrated care, survivor health and safety will ultimately be improved.

RESOURCES

Recommended Health Assessment Tool for DV programs | **https://dvhealthpartnerships.org/wp-content/uploads/2018/07/Recommended-Health-Assessment-Tool.pdf**

Domestic Violence Healthcare Partnerships: A toolkit for creating and sustaining cross-sector partnerships, showcases innovative strategies for health advocacy | **http://www.dvhealthpartnerships.org**

Domestic Violence and Health Care Integration: A Toolkit for Creating Sustainable Partnerships | **https://dvhealthpartnerships.org/wp-content/uploads/2017/11/WHCC-TOOLKIT.pdf**

Domestic Violence and Health Care Partnership Toolkit: Promoting Success Through Collaborative Partnerships | **https://dvhealthpartnerships.org/wp-content/uploads/2017/11/NDS-Mayview_DV-Toolkit_Final.pdf**

DV Advocates Guide to Partnering with Health Care: Models for Collaboration and Reimbursement | **https://dvhealthpartnerships.org/wp-content/uploads/2017/11/DV-Advocates-Guide-to-Partnering-with-Health-Care-Models-for-Collaboration-and-Reimbursement.pdf**

Supporting Survivor Health: Strategies for Advocates | **https://dvhealthpartnerships.org/wp-content/uploads/2017/11/Supporting-Survivor-Health-training-slides.zip**

California Partnership to End Domestic Violence: Includes a catalog of health resources for advocates | **https://www.cpedv.org/national-and-state-links**

Prevention Institute Expanding Collaborative Capacity to Prevent Domestic Violence | **www.preventioninstitute.org**

John Snow, Inc., features the Building Evidence on Domestic Violence initiative | **https://bit.ly/2uG7lVy**

Futures Without Violence: An online toolkit for DV service providers | **ipvhealth.com**

1. Intimate partner violence, also referred to as domestic violence, is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other. Learn more about the dynamics, signs, and prevalence of domestic violence at the National Coalition Against Domestic Violence website at http://www.ncadv.org/learn-more/what-is-domestic-violence
2. The Domestic Violence and Health Care Partnership project, funded by Blue Shield of California Foundation between 2014 and 2017, aimed to integrate health and domestic violence services and response across the state through intentional partnerships between healthcare and DV advocacy organizations. Visit dvhealthpartnerships.org to learn more about the project, partners, innovations and results.
3. For more information about creating referral systems and feedback loops to track referral outcomes, read DVHCP Improve Survivor Health Access: Data pilot key findings and recommendations at http://bit.ly/2QISPMb
4. Refer to Resources above for the *DV Advocates Guide to Partnering with Health Care: Models for Collaboration and Reimbursement*
5. For more information, visit http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1863