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CIRCULAR LETTER: DHCQ 14-11-622

TO: Hospital Chief Executive Officers, Quality and Community Benefit Officers and Risk Managers

FROM: Madeleine Biondolillo, MD, Associate Commissioner
Deborah Allwes, BS, BSN, MPH, Director, Bureau of Health Care Safety and Quality
Carlene Pavlos, MTS, Director, Bureau of Community Health and Prevention
Sheridan Haines, Executive Director, Governor's Council to Address Sexual and Domestic Violence

SUBJECT: DPH Resources to Support Hospital Care and Population Health Management for Survivors of Domestic and Sexual Violence

DATE: November 28, 2014

Background

Domestic and sexual violence[1] are public health issues that pose significant health risks to children and adults in every community across the Commonwealth. Prevalence rates are extremely high; nearly 3 in 10 women and 1 in 10 men in the US have experienced rape, physical violence and/or stalking by a partner. Nearly 1 in 2 women and 1 in 4 men in Massachusetts have experienced sexual violence victimization other than rape; more than 1 in 7 women have experienced rape[2]. Virtually all victims of such violence have contact with some medical setting – whether in a hospital as a direct result of abuse, or in primary and specialty care. Hospitals are well positioned to: 1) address the health consequences of violence; 2) connect victims with support services and after-hospital care in the community; and 3) engage with community partners in violence prevention efforts. Population health management approaches for survivors, and as prevention, by hospitals improves health outcomes and saves lives.

Guidance

The Department recognizes the critical role that community-based organizations play in responding to domestic and sexual violence. Through its Bureau of Community Health and Prevention, the Department offers expertise and technical assistance to enhance health care responses to violence and to build partnerships between health care and community-based organizations. The Department endorses The Joint Commission[3] standard relative to domestic and sexual violence: "The organization assesses the patient or resident who may be a victim of possible abuse and neglect." In addition, the Institute of Medicine[4], the American Medical Association[5] and the U.S. Preventive Services Task Force[6], have important guidance to which hospitals should refer. To further improve the health care response to domestic and sexual violence, the Massachusetts Department of Public Health issues the following guidance to all hospitals in the Commonwealth:

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[1] The term "domestic violence" includes non-physical forms of intimate partner abuse, such a verbal, emotional, financial, and other controlling behaviors intended to harm and instill fear in the victim.
[2] CDC's National Intimate Partner and Sexual Violence Survey (NISVS), MA data.
[3] The Joint Commission on the Accreditation of Healthcare Organizations, The Joint Commission Accreditation Program: Hospital, Standard PC 01.02.09, p.199.
[4] Committee on Preventive Services for Women, Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*.
[5] American Medical Association Code of Ethics: Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse.
[6] *Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults*. U.S. Preventive Services Task Force.

Recommendation 1: **Develop partnerships with community-based organizations that specialize in providing trauma-informed, post-acute services that address the complex needs of victims of domestic and sexual violence, and their families.**

A. Hospital Leadership should cultivate collaborations with community-based domestic violence and sexual violence (DV/SV) advocacy organizations. These community-based organizations (CBOs) offer services accessible to all, protect the privacy and safety of victims, and offer high quality post-hospital care.
B. Health care and CBO partnerships are critical to addressing the complex needs of DV/SV victims. Partnerships involve working together to develop clinical protocols, coordinated service delivery models, quality measures to evaluate effectiveness, training for health care providers and personnel, and community outreach/education, which is essential to prevention.
C. Successful partnerships must engage in capacity-building to ensure that the CBOs working with victims of violence have adequate supports to address the complex needs of survivors, and to respond to the potential increase in caseloads when hospitals increase identification of victims and make more referrals to CBOs. Hospitals' Community Benefit funds should be considered to support CBOs.
D. In hospitals with established on-site DV/SV programs, these should be utilized as internal consultants/experts on all DV/SV issues, including the development of partnerships with CBOs. The existence of a DV/SV program on-site does not negate or replace the hospital's benefit in developing partnerships with CBOs.

Recommendation 2: **Utilize best practices and trauma-informed approaches in the hospital when responding to victims of domestic and sexual violence.** See the Department's Statewide Health Improvement Plan (SHIP) and DPH web resources**.**

A. All hospitals should have clear and detailed written policies and/or protocols guiding assessment and responses to suspected and disclosed DV/SV among patients ***and*** employees. Policies and/or protocols should include language about how responses are trauma-informed[7] and respect victims' rights.
B. Hospitals should take active measures to ensure that responding to DV/SV is a high priority for the institution. Included in hospitals' quality improvement measures must be a plan to assess the institution's responsiveness and effectiveness in addressing DV/SV.
C. Hospitals should address the inevitable secondary trauma experienced by staff and employees in responding to DV/SV through training all hospital employees, staff, managers and senior leadership. For employees who are experiencing such violence, hospital managers should know how to connect employees to a DV/SV specialist, respect the privacy and self-determination of the individual employee, and consult with a DV/SV specialist, Human Resources, and/or in-house Security, regarding options and safety concerns.
D. All hospitals should have a system for identifying and responding to DV/SV in accordance with best practices and as appropriate for the setting/patient population. Best practices[8] include, but are not limited to: interviewing alone in a private setting; responding to disclosures in an empathic, non-judgmental manner, understanding the cultural history and context of a patient's experience, responding to immediate and ongoing safety concerns and adopting the approach of "universal education."
E. Hospital providers[9] should know how to provide a patient or employee with a supported referral to a DV/SV advocate or specialist within CBOs who can offer safety planning and comprehensive advocacy services. Providing supported referrals is not just handing a patient a phone number. It involves being knowledgeable about the community-based organization and facilitating patient's safe and coordinated access to the CBO services.

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Attached: DPH web resources

[7] *Practical Strategies for Developing Trauma-Informed Services and Organizations*, National Center on Domestic Violence, Trauma and Mental Health.
[8] *Health Cares about IPV*, Intimate Partner Violence Screening and Counseling Toolkit, National Health Resource Center on Domestic Violence.
[9] Following Chapter 260 of the Acts of 2014, the Department's Boards of Registration will be developing guidance on educational requirements of providers.