Overview of the 2023-2025 HRSA Strategy to Address Intimate Partner Violence (IPV)
July 12, 2023, 1:00-2:00 PM EST
Transcript

Helenka Ostrum: Thank you everyone for joining today's webinar Overview of the 2023 -2025 HRSA Strategy to Address Intimate Partner Violence.

Helenka Ostrum: My name is Helenka Ostrum, and I'm a public health analyst with the HRSA Office of Women's Health.

Helenka Ostrum: Please take a minute to introduce yourself in the chat with your name and organization.

Helenka Ostrum: I will now turn it over to Jessica Tytel, the Deputy Director of the HRSA Office of Women's Health.

Jessica Tytel: Thank you, Helenka. Good afternoon everyone and welcome to today's event, which is designed to provide you with an overview of the 2023-2025 HRSA Strategy to Address Intimate Partner Violence. As Helenka said my name is Jessica, Tytel and I am the

Jessica Tytel: Deputy Director of the HRSA Office of Women's Health.

Jessica Tytel: Today's event is co-hosted by three components of the Health Resources and Services Administration or HRSA:

Jessica Tytel: my office, the Office of Women's Health, along with the Bureau of Primary Health Care and the HIV/AIDS Bureau.

Jessica Tytel: This webinar is also part of the Office of Women's Health Leadership Series, which features public health experts, including HRSA grantees and stakeholders, spotlighting emerging issues and innovations in women's health across the lifespan.

Jessica Tytel: During today's event, you will first hear an overview of our new 2023-2025 HRSA Strategy to Address Intimate Partner Violence or IPV.

Jessica Tytel: This is HRSA's second agency-wide strategy to promote prevention of and response to

Jessica Tytel: IPV across HRA activities. Following that presentation, staff from the Bureau of Primary Health Care and the HIV/AIDS Bureau will discuss activities that their specific bureaus are undertaking to prevent and respond to IPV across their programs. We've set

Jessica Tytel: aside a few minutes for questions at the end, so please use the chat box to raise any questions throughout today's webinar.

Jessica Tytel: The recording and transcript will be made available on our website after today's event.

Jessica Tytel: Before we get started with today's speakers, I wanted to briefly share a bit about our agency for those of you who may be unfamiliar with our work.

Jessica Tytel: The Health Resources and Services Administration or HRSA is a component of the U.S.

Jessica Tytel: Department of Health and Human Services. We support a broad range of over 90 programs to provide health care to people who are geographically isolated and economically or medically vulnerable.

Jessica Tytel: Every year HRSA programs support tens of millions of people, including those with low-income people with HIV, pregnant people, children, parents, rural communities, transplant patients and other communities in need as well as the health workforce, health systems, and facilities that care for them.

Jessica Tytel: Within HRSA, my office, HRSA OWH,

Jessica Tytel: Leads and promotes innovative sex and gender responsive public health approaches.

Jessica Tytel: We are part of a network of women's health offices throughout the Department of Health and Human Services, and we work together with our colleagues to improve the health,

Jessica Tytel: wellness, and excuse me, and safety of women across the lifespan.

Jessica Tytel: The new IPV strategy is one of many activities that our office engages in to address

Jessica Tytel: IPV. We also develop resources, share promising practices, and promote and support research to help her supported settings prevent and respond to

Jessica Tytel: IPV and human trafficking. For today's event,

Jessica Tytel: HRSA OWH has partnered with two HRSA bureaus, first the Bureau of Primary Health Care, which funds health centers in medically underserved communities, providing access to affordable comprehensive high-quality, primary health care services for people who are

Jessica Tytel: low-income, uninsured, or face other obstacles to getting health care. And second, the HIV/AIDS Bureau, which administers the Ryan White HIV/AIDS program and plays a critical role in helping diagnose, treat, prevent, and respond as part of the ending the

Jessica Tytel: HIV epidemic in the U.S. initiative.

Jessica Tytel: Thank you all again for joining us today. I will now turn it back to Helenka, who will introduce our first speaker.

Helenka Ostrum: Thank you Jessica for that background and introduction.

Helenka Ostrum: I would like to introduce our next speaker, Steven Hayes.

Helenka Ostrum: Steven is a Public Health Analyst in the Health Resources and Services Administration in the Office of Women's Health, also called OWH.

Helenka Ostrum: He coordinates OWH activities in support of the development and implementation of the updated agency wide HRSA Strategy to Address Intimate Partner Violence.

Helenka Ostrum: Steven also provides subject matter expertise in support of federal violence

Helenka Ostrum: related activities, including the newly released U.S. National Plan to End Gender-Based Violence: Strategies for Action.

Helenka Ostrum: I'll now turn it over to Steven.

Stephen Hayes: Thank you, Helenka. And we're so excited to have the opportunity to share an overview of our renewed agency wide approach to intimate partner violence. Before I get started, I want to appreciate the contributions of many who are presenting with us here today on this webinar as well as

Stephen Hayes: participants in the audience, and many beyond that, who contributed to our development of this latest iteration strategy. I also want to acknowledge, before we get started with all of our presentations, that this is a difficult topic, and we encourage you to be patient and kind with yourself and prioritize your wellness

Stephen Hayes: if you need to step away at any time. Next slide, please.

Stephen Hayes: So, with that, mind, I'll share a little bit of how this document is structured, and what the intentions are for HRSA as an agency, and as Helenka mentioned, you're going to hear some great examples of ongoing work from different bureaus within HRSA that are

Stephen Hayes: contributing to this. But to ensure we're all working from the same definition,

Stephen Hayes: I want to start with something that's pulled from the introduction section of the document itself.

Stephen Hayes: First thing to point out here is that we'll be using Intimate Partner Violence

Stephen Hayes: and IPV for the duration of the call today. And we use the CDC definition listed here as physically and emotionally abusive behaviors by a current or former intimate partner, dating partner or spouse including physical or sexual violence, sexual coercion,

Stephen Hayes: stalking, cyber abuse and cyber stalking controlling behaviors and psychological aggression.

Stephen Hayes: We include all these terms and definitions in the language of the strategy itself.

Stephen Hayes: And today to first confirm our own terminology, and why we're using it, but also acknowledge intersections between different forms of violence.

Stephen Hayes: So other things listed here, like to domestic violence, interpersonal violence, sexual violence, or sexual assault, and human trafficking can overlap in their definitions.

Stephen Hayes: But also, as we know, unfortunately, with any public health issue, they don't exist in vacuum.

Stephen Hayes: So, if we have someone who has experienced one form of violence, the data tells us that there's a higher probability

Stephen Hayes: they have experienced another form of violence as well or could experience another form of violence in the future.

Stephen Hayes: So, moving to the next slide, talk a little bit about why it is

Stephen Hayes: That HRSA has renewed this agency

Stephen Hayes: wide approach. Next slide.

Stephen Hayes: Thank you. And starting with the renewed data that has come from our partners in the CDC,

Stephen Hayes: the National Intimate Partner and Sexual Violence Survey. Those of you who are familiar with their previous engagement in this space with an agency wide strategy, you know that we base it a lot off of 2015 data from the NIPSVS sample and we're fortunate that there's an

Stephen Hayes: updated form of that analysis from our partners and CDC. Unfortunately, the data tells us things that those of us in this field are likely not surprised by which is that prevalence continues to increase at per the sample and self-reports here in the NIPSVS data. IPV now affecting nearly half of women and

Stephen Hayes: 44% of men. And we want to acknowledge as listed on this slide, that they're disproportionate impacts across different communities.

Stephen Hayes: The real point that we use this data within HRSA for is to emphasize that first of all, that disproportionate impact exacerbates negative health outcomes that we address as an agency.

Stephen Hayes: But second, we're in a unique position to address them because of the far reaching and diversity of programs that Jessica alluded to in her introduction of the agency.

Stephen Hayes: So, if we look at the next slide, we can share a little bit of how we've been sharing this information within our internal stakeholders, and with other fellow partners and non-federal partners

Stephen Hayes: and why it's important to us. So many of us know that unfortunately, the impacts of violence can extend far beyond any sort of acute physical health issues, so they can also have chronic and exacerbate ongoing physical health

Stephen Hayes: issues. They also include a lot of behavioral health impacts that we are in a unique position to prevent or respond to.

Stephen Hayes: And when we list here also critically in the strategy, we hope that this is something that resonates with the audience, the importance of addressing, or at least acknowledging, the impact of economic outcomes and quality of life. So, one thing that we're particularly interested in emphasizing

Stephen Hayes: here is an opportunity for all of us on the call today is to identify those common risk factors that exist between violence and other important public health issues that we're in positions to begin to address.

Stephen Hayes: And we'll talk a little bit more about prevention and how we look at it across the agency.

Stephen Hayes: But we use this data point to really emphasize the importance of working here to minimize morbidity and mortality in other areas down the road.

Stephen Hayes: Thank you. Next slide. And that contributes a lot to how we talk about barriers to care.

Stephen Hayes: Because HRSA as a mission is committed to ensuring increased access to care.

Stephen Hayes: So here we list a number of reasons that we know that experiencing IPV,

Stephen Hayes: or being at risk of experiencing IPV, impacts folks' ability to seek care, whether that's because of stigma or actual literal controlling behavior, or because of the absence of availability of those services or the inadequacy of the services if you're able to access them. All

Stephen Hayes: of those present opportunities for us to better meet the needs of the folks that we serve, and they exist at the end of the individual level,

Stephen Hayes: the organizational level, the systemic level as well. And so, as we looked across the stakeholder input that we got over the better part of 18 months to contribute to what you'll see on our next slide, we made it really key that we were able to bring in all this information and begin to

Stephen Hayes: identify how we, as an agency, can crystallize our approach. And so, on the next slide.

Stephen Hayes: Thank you. We'll talk a little bit about those aims, objectives, and activities.

Stephen Hayes: So, this here is pulled from the introduction section of the strategy itself.

Stephen Hayes: And emphasizes how our focus in this area is going to be structured in the 2023 to 25 strategy.

Stephen Hayes: So, we have three core aims here, and underneath those are objectives and then activities are delineated for different bureaus and offices.

Stephen Hayes: I want to stress a couple of things here about how this is structured.

Stephen Hayes: So obviously as a federal agency, we have a lot of different constituents, both within the agency itself

Stephen Hayes: in the federal space, and obviously those recipients that we work with in the community. And a really key element of all of that is we want these aims to be approachable for everyone, the strategies about how we look at the work that we do

Stephen Hayes: as HRSA, but also how we support the work of our partners in the field, and how we can identify opportunities for collaboration with folks who might not be direct recipients as well.

Stephen Hayes: So, the first aim is really about enhancing coordination between and among HRSA, that internal look that I mentioned there, about how we can better improve our projects that focus on IPV efforts.

Stephen Hayes: The second aim about strengthening infrastructure and workforce capacity,

Stephen Hayes: this one looks at our own staff here within HRSA,

Stephen Hayes: but also, those of our recipients, and how we can encourage that sort of development.

Stephen Hayes: And finally, the third aim of promoting prevention of IPV overall.

Stephen Hayes: We're especially excited about this third aim, as it's standing as one of the three overall in our focus on prevention, and we'll talk a little bit more about those tiers of prevention when we get to that piece. Next slide please. So again, with aim one overall we're working on

Stephen Hayes: enhancing coordination between and among HRSA projects to better focus on IPV efforts.

Stephen Hayes: Next slide, please. And this has three core objectives underneath it, and they really have to do with ensuring a baseline understanding of the importance of IPV

Stephen Hayes: whether a staff member is new to HRSA or has been here for 15 years.

Stephen Hayes: We want to make sure that we're consistently sharing the information that we went over in our beginning here about how IPV impacts health, other opportunities from prevention, the cyclical and intergenerational impacts that can exist there, and how we're uniquely positioned to address those. And also

Stephen Hayes: have that has a lot to do with what services are available for us to connect to beyond what might be considered traditional, physical, or behavioral health needs.

Stephen Hayes: And so those objectives here are outlined of really how we share information across our bureaus and offices, how we structure what is available to our recipients, whether that's we have, you know, notices of funding opportunity that involve collaboration across our bureaus or if

Stephen Hayes: it's about how we report data, how it is that we make our decisions based on promising practices passed up to us by those who are working in the field.

Stephen Hayes: All of that is something that we're trying to emphasize through this aim.

Stephen Hayes: And an example of how we're accomplishing that is, in the establishment of an implementation team across the agency which has representation from all the bureaus and offices and focuses of ensuring coordination of implementation of what you'll see throughout the presentation today,

Stephen Hayes: tracking progress towards it, and ultimately working towards sustainability. Because it's critical to us,

Stephen Hayes: and one of the, I think, really great examples of sort of how HRSA continues to be a thought and action leader in this space in the federal area is ensuring that whether there is a standing strategy or not, the focus on IPV is sustained by the investments that we have in our programs and our

Stephen Hayes: internal working groups, as well. So, move to the next slide and talk a little bit about aim two, which is about strengthening infrastructure and workforce capacity to support IPV prevention and response

Stephen Hayes: services. Next slide, please. And this is broken up to recognize what we started off with on the internal HRSA look, as well as how it is that we partner with recipients and non-recipients across the country.

Stephen Hayes: And so, this is really first off, an example of how we understand our footprint existing in the diversity of programs that we have. We work in workforce capacity both in terms of training and increasing the number of available workforce. We work in service delivery in terms, of ensuring folks who might not

Stephen Hayes: have access to services because of issues with payment or medical or other sorts of barriers to care and have that access. And we also try to connect all those initiatives so that they're able to continue to work in a collaborative fashion and partner

Stephen Hayes: with our other federal entities, and work really aspiring towards the ability of having connections to all available services possible.

Stephen Hayes: And this is something that's achievable if we increase our health care and public health workforce capacity to identify need and then to support and respond to need, something that's a stated objective of the strategy.

Stephen Hayes: But something that we also have the ability to do through our standing programs and through some of that coordination we alluded to in the proceeding slide.

Stephen Hayes: A really key piece here for us is that while objective

Stephen Hayes: 2.4, for example, has a really specific focus on IPV specific care and interventions.

Stephen Hayes: We understand there are opportunities for all of us to deepen our work, to prevent and respond to IPV, regardless of whether that's the focal point of an initiative or not.

Stephen Hayes: So, a NOFO doesn't have to have IPV in the name for us to recognize

Stephen Hayes: that unfortunately, as we saw in the data slide, there's a high probability that folks that we're working with have experienced or at risk of experiencing some form of violence in their lifetimes, and given the impact that violence has, we're in position to identify ways to connect them to the supportive services

Stephen Hayes: they need, the immediate services that they need, and build from there. An example of how this work is going on, and some of our bureaus our colleagues in the Bureau of Health Workforce, have been supporting the Advanced Nursing Education Sexual Assault

Stephen Hayes: Nursing Examiners, or ANE SANE initiative which trains nurses to become sexual assault nurse examiners, inherently increasing the availability of those services.

Stephen Hayes: For the you know, these crisis services when necessary. But then also, how can we think and continue to expand that work as our colleagues and DHW

Stephen Hayes: are doing, to find ways to make connections that there is supportive care

Stephen Hayes: after that time. And so that the training is also something that is sustainable and replicable across the work that we do, whether it's HRSA supported or not.

Stephen Hayes: So, going to the next slide, please for aim 3 our focus on prevention.

Stephen Hayes: And so really promoting prevention of IPV through evidence-based programs, has been a focal point of the agency for some time, but we wanted to ensure that we included it as an aim, so that we talk about prevention in the different levels. And we'll hop to next slide if we could thanks. To

Stephen Hayes: sort of give an overview of how we're looking at this, and why this focus exists.

Stephen Hayes: So many of us are familiar with the tiers of prevention: primary being stopping something before it happened,

Stephen Hayes: secondary responding when something occurs, and tertiary making sure that we have an ability to respond to lasting impacts over time. We have a focus

Stephen Hayes: obviously with the strategy on IPV. The one thing that was apparent to us through all of our stakeholder engagement, which again included folks from the federal and non-federal space, including many of are working on the front lines as first recipients and those who are who are not recipients,

Stephen Hayes: as well, emphasize that these opportunities for preventing violence directly overlap and correlate with opportunities to prevent other negative health outcomes. Right?

Stephen Hayes: So, whenever our programs are out there in the space, and as we mentioned the last aim, even if they don't have an IPV specific focus, if we're making it possible for folks to have increased access to care as a starting point, and then make the connections from that visit whether it's in a health center or

Stephen Hayes: another HRSA supported setting to then or program to make the connections for other services and maintain the health care access they need for secondary or tertiary prevention of IPV

Stephen Hayes: or other issues. We're opening the opportunity and the door for us to continue meaningful work on this and relevant intersections. And so, on

Stephen Hayes: the next slide we'll just show out the two objectives here. Thank you.

Stephen Hayes: That describe what we're talking about in terms of what that can look like for the HRSA agency initiative.

Stephen Hayes: And so, as a starting point we have an interest on supporting upstream prevention, because, again recognizing those cyclical and intergenerational impacts of violence and how it intersects with other negative health outcomes.

Stephen Hayes: The earlier we're able to address and prevent creates obviously more positive outcomes for folks that we work with. But also, we know that the way that we provide care and the way that we encourage those that we work with to provide care has a lot to do with

Stephen Hayes: whether or not that is an effective engagement, and whether we can work towards that prevention goal, whether it's primary, secondary, or tertiary. So, if we're supporting trauma informed environments, safe and supportive settings that is going to work inherently towards this objective and

Stephen Hayes: make things more attainable for us overall. I think one thing that's exciting to us as we look across these three aims is that all of our HRSA bureaus and offices were part of the engagement and development process as well, and have had a chance to review, contribute to

Stephen Hayes: this and really set ambitious objectives for us to pursue.

Stephen Hayes: Recognizing all of those strong intersections between this public health issue and other ones in our area, but also the opportunity that we have by using, an all-of-agency approach to ensure

that we're on the same page that we're coordinating and that we're identifying opportunities to connect things that

Stephen Hayes: are out in the field and also expand our efforts where feasible.

Stephen Hayes: So, if we hop to the next slide, we'll share it kind of, and we'll close on another aspect of the work that's going on here that our office OWH, coordinated the development of, which is an Implementation Framework for HRSA-Supported Settings of Care. And so, this

Stephen Hayes: was part of our strategy development process. It also got stakeholder input from the federal and non-federal spheres and is intended to help translate some of the principles that we're working on here at HRSA in a more approachable way for the folks who are personal

Stephen Hayes: recipients out in the field. This was just released in the last couple of weeks.

Stephen Hayes: It's available on our website, and we'll drop that link in the chat.

Stephen Hayes: We're excited to give you kind of a teaser of it now, and we'll share it a lot more about it in the coming months, as well. As we hope

Stephen Hayes: you see, some of those connections of how we're doing this work within HRSA. But also, how organizations and really all of us have an opportunity to contribute to the important work here. So, if we

Stephen Hayes: the next slide. Thank you. You can see a quick overview of what's included within the implementation framework.

Stephen Hayes: And so, there are five core building blocks which each provide and reiterate the important information that we know about IPV prevalence and the impact it can have on health as well as the opportunities for prevention and response.

Stephen Hayes: And then also include a short-, medium-, and long-term steps that folks can take depending on where they are as an organization to begin to make their organization more responsive to the needs of folks in their community

Stephen Hayes: if they identify this is a priority area of focus.

Stephen Hayes: We recognize that it’s you know folks likely will not have the time to sit down and start a at block one and work through all the way to five, although we encourage it if you're able.

Stephen Hayes: So, all of the different building blocks can stand on their own and do link out to free and available evidence-based and evidence-informed resources from the federal and non-federal space to help organizations do this.

Stephen Hayes: And so, we hope to share this out in a little bit more detail on the coming months.

Stephen Hayes: It's available on our website, and we encourage feedback on it as well as you have the opportunity.

Stephen Hayes: But we hope this also reflects this important chance that we have as an agency to continue to not just work internally on our own processes, that then manifests and how we do work in the field, but provide resources to the field, to help those who are already in this space, or want to

Stephen Hayes: begin working in this space to do so in evidence informed and really inclusive, and community driven as possible, approaches as well.

Stephen Hayes: So, we're excited now to transition and share out some examples of how bureaus are already doing that, and how that's going to continue to contribute to the work that we're doing under the auspices of this strategy as we hear from our partners in the Bureau of Primary Health Care

Stephen Hayes: and the HIV/AIDS Bureau. We look forward to questions at the end of this portion, and thanks so much for the opportunity to share out this work.

Stephen Hayes: We're excited to have this renewed commitment to the issue.

Stephen Hayes: Helenka.

Helenka Ostrum: Thank you so much Steven for providing that overview of the IPV

Helenka Ostrum: Strategy. It's my pleasure to now introduce our next speakers, who are from HRSA's

Helenka Ostrum: Bureau of Primary Health Care. Captain Tracy Branch is a Physician Assistant and U.S.

Helenka Ostrum: Public Health Service Commissioned Officer, with 40 years of health care and social service experience.

Helenka Ostrum: She currently serves as the Strategic Partnership Senior Advisor within the Bureau of Primary Healthcare

Helenka Ostrum: within the Health Resources and Services Administration in Rockville, Maryland.

Helenka Ostrum: Folashade Osibanjo-Quinn is a Project Officer with the Strategic Partnerships Division and HRSA's

Helenka Ostrum: Bureau of Primary Health Care Office of Quality Improvement.

Helenka Ostrum: She oversees cooperative agreements with the national organizations focused on addressing IPV

Helenka Ostrum: and human trafficking, improving oral health access and outcomes, leveraging legal services and healthcare settings, and ensuring health centers, have a skilled workforce capable of providing high quality care and addressing the unmet health needs of their communities.

Helenka Ostrum: I'd like to now turn it over to Captain Tracy Branch and Folashade

Helenka Ostrum: Osibanjo-Quinn.

CAPT Tracy Branch: Thank you so very much. I am thrilled to see the number of states that are represented in this audience.

CAPT Tracy Branch: I thank you so much for joining today's webinar about the very important topic of intimate partner violence.

CAPT Tracy Branch: In 2017, the Bureau of Primary Health Care, wanting to support and advance the goals of the, at that point, inaugural 2017 to 2020, Strategic

CAPT Tracy Branch: HRSA Strategy to Address Intimate Partner Violence. The bureau formed a collaboration with the HRSA Office of Women's Health

CAPT Tracy Branch: and the Administration for Children and Families. With this agreement the Bureau of Primary Health Care committed over two million dollars in funding over a five-year period of time to support two demonstration projects. Apologies,

CAPT Tracy Branch: Thank you for advancing this slide. To advance two of our demonstration projects that were designed to increase

CAPT Tracy Branch: health centers staff awareness of intimate partner violence within their patient population.

CAPT Tracy Branch: The demonstration projects proved to be so effective that the Bureau Primary Health Care established a new intimate partner

CAPT Tracy Branch: violence national training and technical assistance partners cooperative agreement.

CAPT Tracy Branch: With the goal of increasing the reach of intimate partner violence technical assistance to all HRSA health centers across the U.S.

CAPT Tracy Branch: and territories. Folashade is going to be speaking with you a little bit more about the cooperative agreement

CAPT Tracy Branch: in a few minutes. But first I want to tell you more about the two demonstration projects. Next slide

CAPT Tracy Branch: please. Project Catalyst was a project that's co-funded by the Bureau of

CAPT Tracy Branch: Primary Health Care and the Administration for Children and Families.

CAPT Tracy Branch: The three-year project was actually extended an additional year, due to the start of the Covid pandemic and the closure of a number of the health centers

CAPT Tracy Branch: as a result of that.

CAPT Tracy Branch: The project was a train the trainer model that established state partnership teams that were comprised of state health departments, primary care associations, and domestic violence coalitions both at the state and local level.

CAPT Tracy Branch: The technical assistance trainer for the project was Futures Without Violence.

CAPT Tracy Branch: The partnership teams that were created received training to be able to provide intimate partner violence, technical assistance to health centers, and through the combined number of individuals trained, they would then become force multipliers in this particular project in advancing again, intimate partner violence awareness and interventions.

CAPT Tracy Branch: The primary goals of the project are to help center staff identify intimate partner violence and domestic violence

CAPT Tracy Branch: survivors within their patient population who had a need for social or medical services.

CAPT Tracy Branch: The project also was geared towards establishing formal partnerships between health centers and local domestic violence entities.

CAPT Tracy Branch: We were also wanting them to facilitate bidirectional referrals again between those health centers and domestic violence coalitions with the goal of no wrong door approaches. Whereas if someone who had a need for medical services was seen by the domestic violence coalition, they

CAPT Tracy Branch: would then refer to the health center, and vice versa.

CAPT Tracy Branch: This was one way of ensuring that not only was the patient able to obtain the health services needed, but they were also able to obtain the social supports necessary for them to recover.

CAPT Tracy Branch: The other part of our project was to evaluate the effectiveness of this particular project.

CAPT Tracy Branch: The outcomes of the project included the training of over 1,200 providers and domestic violence

CAPT Tracy Branch: prevention advocates across nine states and one territory.

CAPT Tracy Branch: We also have seen within the facilities or the health centers that were trained on this model, that 100% of them now ensure that they are seeing patients alone without their abusive partner.

CAPT Tracy Branch: This allows opportunities for them to disclose any health or social needs they need without coercion.

CAPT Tracy Branch: The second demonstration project was Survivor Health Connect.

CAPT Tracy Branch: And this project was again a collaboration between HRSA and the Administration for Children and Families and the National Domestic Hotline.

CAPT Tracy Branch: This two-year project was designed to foster collaborations between health centers and domestic violence

CAPT Tracy Branch: coalitions.

CAPT Tracy Branch: It also was geared towards informing on the services provided by the National Domestic Violence

CAPT Tracy Branch: Hotline. So that became a resource for providers

CAPT Tracy Branch: when they encountered patients who were in crisis.

CAPT Tracy Branch: The two-year project, for the most part, was incredibly informative to us

CAPT Tracy Branch: for a number of reasons. One was concurrent with the work that we were doing in terms of the technical assistance to health centers in informing them of the availability of services from the National Domestic Violence

CAPT Tracy Branch: Hotline, and conversely, informing the hotline staff of the services of health centers so that they could refer patients, or they could refer callers into the hotline to the closest health center when they identified a health need that the caller may have. So that was one of our really successful outcomes was

CAPT Tracy Branch: that cross training of resources that then resulted in again, a note to a no wrong door approach to access to health care or the ability to achieve or access social services for recovery.

CAPT Tracy Branch: Concurrent with the training that went on, there was also a survey that was conducted by the National Domestic Hotline of its callers.

CAPT Tracy Branch: Between March and August of 2021, 3,400 surveys were administered. And of the data that was collected, we found that 46% of the callers stated that they did experience an increase in frequency and intensity of intimate partner violence during the covid

CAPT Tracy Branch: Pandemic. Another 25% stated that telehealth visits were not safe for them when they were currently experiencing an intimate partner

CAPT Tracy Branch: violence situation.

CAPT Tracy Branch: We were also able to determine what some of the most more prominent barriers to health care were for our callers.

CAPT Tracy Branch: Finances, access to insurance, and childcare, having reliable transportation

CAPT Tracy Branch: were all factors that made the difference between their ability to access

CAPT Tracy Branch: health care services or not. And in a number of those situations, the abuse of partner controlled those items, or had some influence over the ability to access those particular services.

CAPT Tracy Branch: I think the most significant outcome of these two demonstration projects, which again, were limited to a five-year period, was that the data that we obtained through both of the projects really reinforce the need for continuing health center staff training and the need to establish

CAPT Tracy Branch: a long-term approach to creating a national training

CAPT Tracy Branch: and technical assistance cooperative agreement, specifically focused on intimate partner violence.

CAPT Tracy Branch: And to tell you more about that cooperative agreement,

CAPT Tracy Branch: My colleague, Folashade, will tell you about that cooperative agreement over the next few slides.

CAPT Tracy Branch: Thank you.

Folashade Osibanjo-Quinn: Thank you Tracy. In addition to the demonstration projects that Tracy mentioned the HRSA Bureau of Primary Health Care will contribute to the aims outlining the new strategy through its investment in organization

Folashade Osibanjo-Quinn: we refer to as National Training and Technical Assistance Partners or NTTAPs.

Folashade Osibanjo-Quinn: So, as I refer to NTTAPs throughout this presentation, those are our National Training and Technical Assistance Partners.

Folashade Osibanjo-Quinn: Next slide, please. HRSA recently awarded approximately 23.5 million in fiscal year 2023 to 22 national training and technical assistance partner organizations through cooperative agreements.

Folashade Osibanjo-Quinn: The NTTAPs develop, deliver, coordinate, and evaluate training, and technical assistance to existing and potential health centers

Folashade Osibanjo-Quinn: nationwide. Each NTTAP is unique and provides technical assistance tailored to a specific special and vulnerable population on topics such as IPV and human trafficking. NTTAPs are encouraged to collaborate with other HRSA supported technical assistance

Folashade Osibanjo-Quinn: providers, such as state or regional primary care associations or PCAs, as well as Health Center Controlled networks or HCCNs.

Folashade Osibanjo-Quinn: Collaboration between these various stakeholders is important in maximizing the impact of all HRSA supported training and technical assistance resources that are available to health centers.

Folashade Osibanjo-Quinn: This image on this slide highlights the connection as well as the bi-directional relationship between these entities at the federal state, regional, and local level.

Folashade Osibanjo-Quinn: Next slide, please.

Folashade Osibanjo-Quinn: We know health centers play an important role in addressing and supporting survivors of IPV and human trafficking.

Folashade Osibanjo-Quinn: And so according to the 2021 data for the Health Center Program Uniform Data System, UDS health centers served over 16,000 patients who experienced IPV and nearly 2,400 patients experiencing trafficking. And as Tracy noted, beginning in July 2020

Folashade Osibanjo-Quinn: and in alignment with the HRSA-wide IPV

Folashade Osibanjo-Quinn: Strategy, BPHC created an IPV and human trafficking NTTAP.

Folashade Osibanjo-Quinn: The current IPV and human trafficking NTTAP is known as Health Partners and IPV

Folashade Osibanjo-Quinn: and Exploitation, the logo is on the slide. They are also known as Futures Without Violence. Both Health Partners in IPV

Folashade Osibanjo-Quinn: and Exploitation, as well as our School-Based Health Alliance NTTAP type,

Folashade Osibanjo-Quinn: are the two specific NTTAPs that have received federal funding or HRSA funding specifically aimed at providing training and technical assistance to health centers

Folashade Osibanjo-Quinn: in addressing IPV. However, the two NTTAPs often collaborate with other stakeholders to develop and deliver resources for health centers.

Folashade Osibanjo-Quinn: The first three years of funding that HRSA awarded to both of these NTTAPs actually ended last month in June of 2023, and we've just begun a new three-year period of performance, which began on July first. Next slide please.

Folashade Osibanjo-Quinn: The NTTAPs, provide an array of resources, and use a number of modalities to provide resources to health centers.

Folashade Osibanjo-Quinn: And this slide really just provides a snapshot.

Folashade Osibanjo-Quinn: We have a ton of resources that can be accessed by health centers as well as other stakeholders, may be interested in the resources that help partners and IPV and Exploitation Futures as well as School-Based Health Alliance as produced in recent years. And so, while all of these resources

Folashade Osibanjo-Quinn: listed on the slide are important, I just want to highlight a few. Under publications and toolkits, I've listed here a sample health center protocol as well as a sample memorandum of understanding.

Folashade Osibanjo-Quinn: These are intended to serve as template and support resources for health centers who may be new to providing trauma informed survivors centered care and are still trying to formalize ways to connect patients with community-based services. So, I encourage you to, when you have the time, look at some of all of the resources that are provided here.

Folashade Osibanjo-Quinn: And I'm going to include at the end of my presentation include a document that, has all of the links that are provided here so that you can look at them in more detail. Next slide, please.

Folashade Osibanjo-Quinn: And so, as I mentioned, to learn more about the current and future HRSA funded IPV

Folashade Osibanjo-Quinn: and human trafficking related training and technical assistance that we are going to be providing in the coming years,

Folashade Osibanjo-Quinn: I encourage you to visit the IPV and Human Trafficking NTTAP website, healthpartnersipve.org.

Folashade Osibanjo-Quinn: We have a repository for resources that all of our 22 NTTAPs develop, and all of those resources are stored in a health center resource clearing house.

Folashade Osibanjo-Quinn: And in addition to that, I encourage you to sign up for the Primary Health Care Digest.

Folashade Osibanjo-Quinn: This is specifically a newsletter that the Bureau of Primary Healthcare releases on a weekly basis, and it includes training and technical assistance offerings that are available to current and potential health centers.

Folashade Osibanjo-Quinn: I'll now pass it over to Helenka.

Helenka Ostrum: Thank you so much to Captain Tracy Branch and Folashade Osibanjo-Quinn for that really informative presentation. Folashade will be putting into the chat a document with links that were just displayed on those slides so you can access those resources.

Helenka Ostrum: I would like now to introduce our final speaker, Dr.

Helenka Ostrum: Corliss Heath. Dr. Heath is a Health Scientist in the Division of Policy and Data at the Health Resources and Services Administration,

Helenka Ostrum: HIV/AIDS Bureau, where she leads and coordinates various collaborative projects while providing leadership, evaluation, implementation, and dissemination guidance of programs to guarantee the provision of high-quality HIV prevention, intervention care, and treatment services. Dr.

Helenka Ostrum: Heath has nearly 30 years of professional experience in public health research, with a solid track record working in nonprofit, academic, health care and clinical settings, and government organizations.

Helenka Ostrum: I'll now turn it over to Dr. Heath.

Dr. Corliss Health: Thank you, Helenka.

Dr. Corliss Health: Good afternoon, everyone. Today I'll be talking about an initiative here in the HIV/AIDS

Dr. Corliss Health: Bureau. The initiative is titled, Improving Care and Treatment Coordination for Black Women with HIV, which is also called the Black Women's First Initiative. Next slide, please.

Dr. Corliss Health: Both the vision and the mission of the HRSA HIV/AIDS Bureau are forward-looking, and acknowledges the ultimate goal of ending the HIV/AIDS epidemic in the U.S.

Dr. Corliss Health: and what HAB needs to do to get there while continuing to provide quality

Dr. Corliss Health: HIV care of the Ryan White HIV/AIDS Program

Dr. Corliss Health: that current and newly diagnosed people with HIV need. And with that being, what I want to do, is talk about one of our initiatives

Dr. Corliss Health: that incorporates HIV related, HIV and IPV-

Dr. Corliss Health: related interventions. Next slide, please.

Dr. Corliss Health: So, the Black Women's First Initiative is a four-year initiative that was funded by the Minority

Dr. Corliss Health: HIV/AIDS Fund, and HRSA HAB Bureau, Ryan HIV/AIDS Program Part F -

Dr. Corliss Health: the SPNS Program. So, the initiative supports 12 demonstrations, not sites, and a single organization which we call the ETAP, and it's to lead a multi-sided evaluation to provide, the ETAP provides multi-site evaluation, technical assistance of

Dr. Corliss Health: the demonstration sites. The purpose of this initiative is to design, implement, and evaluate the bundled interventions which we'll talk about a little bit more, but the bundle interventions are a package of two or more evidence-informed interventions that when

Dr. Corliss Health: they're into implemented together, they produce a better health outcome than when these practices are delivered separately. And that includes improved engagement, higher retention, and improved viral suppression.

Dr. Corliss Health: Next slide, please.

Dr. Corliss Health: So, with this, the Black Women's First Initiative, the funded sites span across California, Texas, Illinois, Georgia, Louisiana, New York, Pennsylvania, and North Carolina, and then our those are the 12 demonstration sites.

Dr. Corliss Health: So, we have 12 demonstration sites within those States, and then our ETAP is in the University of Massachusetts,

Dr. Corliss Health: Lowell. And that's where again, also with Boston University and AIDS United Impact Marketing.

Dr. Corliss Health: Next slide, please.

Dr. Corliss Health: So, when we're looking at the root causes to inequities in HIV care and treatment,

Dr. Corliss Health: first of all, we have to look at what often black women face in the challenges of engaging and standing here.

Dr. Corliss Health: And this is often due to competing needs of balancing their own psychosocial

Dr. Corliss Health: needs as well as family. And these challenges are further exasperated by structural factors, including racism, sexism, social status, and equitable housing, and employment opportunities.

Dr. Corliss Health: And that's just to name a few. And so, the experience of trauma and intimate partner violence severely affects black women and is also associated with worse treatment outcomes and higher transmission risk among black cisgender and transgender women with HIV. Next slide, please.

Dr. Corliss Health: And so again, we're using this definition, of bundled intervention, which came from the Encyclopedia of Health Communication.

Dr. Corliss Health: Next slide, please.

Dr. Corliss Health: So, as we look at our bundled interventions, addressing social determinants of health, such as intimate partners violence,

Dr. Corliss Health: this is one of HRSA’s objectives to improve the health and well-being of individuals and the communities in which they reside.

Dr. Corliss Health: And so, this project, not only furthers HRSA’s ending the HIV epidemic, which is a plan for America, and goals really to address and social determinants of health and reducing health disparities, but it also enhances the Office of Women's Health goals relating to

Dr. Corliss Health: improving programs and carrying out initiatives to achieve health equity for underserved women.

Dr. Corliss Health: And so, we developed this initiative in collaboration with staff from HRSA's Office of Women's Health to ensure that the program design supports interventions that are culturally relevant,

Dr. Corliss Health: culturally sensitive, inclusive, and empowering, while providing care to women who are geographically isolated, or economically and medically vulnerable.

Dr. Corliss Health: And these, what we see here. These are the intervention domains that are used within the bundles, and the number of sites that initially proposed using

Dr. Corliss Health: IPV as one of their interventions. And so, where you see the arrow, we of the six domains, the six domains here red carpet experience, stigma reduction, trauma informed care. Which in some cases, some sites choose trauma informed care separately from IPV and some use trauma informed care

Dr. Corliss Health: and conjunction with IPV. But we have actually six of the 12 demonstration sites that are actually using IPV as one of their intervention domains. Next slide, please.

Dr. Corliss Health: As Stephen talked about earlier. We also use the CDC definition of IPV.

Dr. Corliss Health: And so, we will continue on next slide please.

Dr. Corliss Health: So next we want to talk about some of the myths of IPV.

Dr. Corliss Health: And so, as we talk about this particular initiative, particularly as we are talking about using cultural relevance, being culturally sensitive to our population, the population at hand, we wanted to look at some of the myths of IPV particularly around African American women

Dr. Corliss Health: and African American communities. So, one of the, and I'm not going to talk about all the myths,

Dr. Corliss Health: but these are some of the main myths that we kind of focus on.

Dr. Corliss Health: One of the myths is that most of the time, your abusers are poor and uneducated. When in reality abusers can be wealthy, they can be poor or uneducated, or not.

Dr. Corliss Health: IPV crosses cultural and social-economic boundaries and can happen regardless of socioeconomic status or education.

Dr. Corliss Health: Myth number two, where you know, we think that people, those individuals who are being abused must also be uneducated or unsuccessful.

Dr. Corliss Health: But as we look at with number one, is a common misconception that the victims of abuse are less intelligent or have some type of personality type.

Dr. Corliss Health: Anyone can be susceptible to the manipulation of an abuser.

Dr. Corliss Health: When we look at myth number three, if you're being abused, you can just leave. Contrary to popular belief,

Dr. Corliss Health: there are many factors that contribute to a partner choosing to stay, such as fear, financial constraints, children, destroyed self-worth.

Dr. Corliss Health: It is much more difficult to leave an abusive relationship than some individuals think.

Dr. Corliss Health: So sometimes it's not that you can just leave.

Dr. Corliss Health: Sometimes we say it's safe sex, but safe sex can in terms of using a condom, can create a situation of an unsafe situation in terms of intimate partner violence. And then myth number four, IPV.

Dr. Corliss Health: is only physical abuse, and as we, if we look at the definition of intimate partner violence, we know that physical violence is usually part of the pattern of abuse. And there are other types of abuse that also include psychological manipulation, sexual abuse, financial abuse, as well as

Dr. Corliss Health: Neglect. Next slide, please.

Dr. Corliss Health: So, as we continue with this particular initiative, some of the things that we look at as we are going through this initiative.

Dr. Corliss Health: As we look at the various sites who are working and using the intimate partner violent domain is barriers to access and care.

Dr. Corliss Health: What does, what goes on in the house. So, we talk about what goes in the house, what goes on in my house stays in my house.

Dr. Corliss Health: These are some of the things, particularly as we're talking about in African American communities. These are some of the things what goes on in my house stays in my house.

Dr. Corliss Health: The cultural and religious beliefs of individuals. These are the certain things that you just don't talk about.

Dr. Corliss Health: You don't talk about abuse. You don't talk about the dynamics of abuse in one's house, you know.

Dr. Corliss Health: If abuse is going on in your house, those are just certain things that you don't talk about,

Dr. Corliss Health: Barriers to care. Also, there's the lack of transportation to safe shelter.

Dr. Corliss Health: You have some women who, if their abuser is your social transportation, then how are you,

Dr. Corliss Health: how is the individual going to get to a safe shelter?

Dr. Corliss Health: Distrust of law enforcement, the criminal justice system, and social services. And we know that mistrust or distrust of law enforcement has become a big part of within African American community. And then, as we look at lack of

Dr. Corliss Health: culturally and linguistically appropriate services. As we look at those cultural barriers between black women.

Dr. Corliss Health: And when we say black women that's across the board, because within some of our initiatives we don't just have African American women, but we also have African-born women.

Dr. Corliss Health: The lack of safe shelter, especially when it comes to transgender women.

Dr. Corliss Health: As I said within our initiative, we serve cisgender and transgender women. And so, we have some places

Dr. Corliss Health: they may have shelters for cisgender women, but they may not readily service transgender women. So that lack of safe shelter for transgender women, and then the fear that their experience will reflect on or confirm the stereotypes that that place them on their

Dr. Corliss Health: ethnicity, you know. Well, you must have done something to put yourself in this situation, or maybe it was something that you did so.

Dr. Corliss Health: These are some of the things that we have to talk about when we're talking about barriers to access and care.

Dr. Corliss Health: Next slide, please. So, in looking at our bundles in terms of intimate partner violence, these are four of the 12 sites that are actually that actually have intimate partner violence as part of their bundle. And initially, we had six sites that proposed intimate partner violence, as part of their

Dr. Corliss Health: bundle, but actually four sites are actually using intimate partner violence.

Dr. Corliss Health: And we use an implementation science approach with this particular initiative.

Dr. Corliss Health: And as with implementation science, AIDS Foundation of Chicago, intimate partner

Dr. Corliss Health: violence was not initially part of their bundle. Trauma informed care was, but it wasn't necessarily intimate partner violence. But they saw a need and they made those adaptations to their intervention, and they partnered with another organization within the community to provide the intimate partner resources

Dr. Corliss Health: to their clients. Next slide, please.

Dr. Corliss Health: So, this slide, and I tried to make it as large as I possibly could.

Dr. Corliss Health: I hope you're able to see it. But this is a slide of our final enrollment data.

Dr. Corliss Health: This is the final enrollment of our initiative.

Dr. Corliss Health: We actually ended enrollment, the end of what's this.

Dr. Corliss Health: We ended enrollment the end of June. And so, we had a total of 775 women enrolled in all the interventions, and when we say complete it, they enroll,

Dr. Corliss Health: that means that they completed baseline interviews across all 12 of the sites.

Dr. Corliss Health: We're actually in the third year, the third and final year of the project and the ETAP is currently analyzing data.

Dr. Corliss Health: In our analytics sample, the mean age of our sample is 45 years of age, and with the age ranges from 18 to 77 years. We have 80.2% of our population is cisgender and 19.2%

Dr. Corliss Health: is transgender. Next slide, please.

Dr. Corliss Health: So, when we're looking at the report on our bundled interventions.

Dr. Corliss Health: And this number is, this is based on our analytic,

Dr. Corliss Health: this is based on our analytic sample, which is n of 720 per the baseline interviews we have.

Dr. Corliss Health: You'll see here that there were 71 participants, that 71 participants across the 12 sites that were enrolled in IPV prevention. And they were 184 and they had a total of 184 encounters made

Dr. Corliss Health: post enrollment. And so, when we talk about encounters, that is, intervention encounters in terms of having encounters with case management,

Dr. Corliss Health: whether that was community health workers, whether that was support groups. Or in some form of fashion,

Dr. Corliss Health: the participants had 184, those 71 participants had 184 encounters post enrollment. Next slide, please.

Dr. Corliss Health: So, what have we learned as we talk about organizational response

Dr. Corliss Health: and IPV and HIV, in terms of these interventions?

Dr. Corliss Health: Well, first of all, organizations provide primary care services, and they have robo-service programs that includes these medical case managements.

Dr. Corliss Health: They have complex case managers and substance use conflicts, and they have intimate, intensive outpatient programs and behavior health treatment delivered through a trauma informed framework.

Dr. Corliss Health: And so, there are some of our sites that have these particular programs that have all the components to really tend to the needs of the women in our initiative.

Dr. Corliss Health: Also, we found that there are some sites who realize that you have women who are coming in, that they have a need.

Dr. Corliss Health: They are talking, about what's going on. Women who are dealing with trauma, women who are dealing with trauma, women who are in unsafe situations, and so the organizations realize that they may not have

Dr. Corliss Health: the services to be able to serve the women right there on site.

Dr. Corliss Health: So, what is going on is the organizations partner with social service organizations or clinics that can actually provide those services.

Dr. Corliss Health: They are being able to provide the IPV, or the counseling, or the medical services, so that they can actually be able to help women who are in those situations.

Dr. Corliss Health: Next slide, please.

Dr. Corliss Health: So, when we look at providing diverse leadership, the presence and programming, survivors of intimate partner violence recognize that there is a lack of diverse leadership present on staff.

Dr. Corliss Health: They know this, they can see this, and this is also recognized by the program staff.

Dr. Corliss Health: And so, the women who we are working with have identified a lack of programming geared towards communities of color and a need for staff, particularly for transgender women of color.

Dr. Corliss Health: And so, it's important that organizations advertise career opportunities so that they can bring in individuals who can actually meet the needs for black cisgender and transgender women. Also, it is important to incorporate programming activities, which include mentoring counseling social activities that

Dr. Corliss Health: are led by black women, you know that that are culturally sensitive, that speak to the needs of the population that you're actually serving, which also helps in terms of seeking that cultural, culturally relatable support group facilitation for women of color in the program. It helps when you have

Dr. Corliss Health: that for women by women. Sometimes it's not just a matter of for women by women, but sometimes you have to have for black women by black women. And with those support groups there is a general desire for support groups that allow for different stages

Dr. Corliss Health: of the healing journey. There are some women who are in different states and so this is beneficial to the overall feeling of empowerment.

Dr. Corliss Health: To take into account that survivors are not all in the same place.

Dr. Corliss Health: Everyone's not in the same place when it comes to moving on after being an IPV

Dr. Corliss Health: victim. Some people are at the victim’s stage. Some people are at the victory stage. And so, this when you're in those support groups,

Dr. Corliss Health: this can help be achieved when you have, if you don't have just closed in groups, but have groups at different stages.

Dr. Corliss Health: Next slide, please.

Dr. Corliss Health: Also, it's important to have capacity training for staff, and this comes through incorporating training from the top down and not just from the bottom up. Because one of the things that we learned that when inequities exist, perceived supervision knowledge often decenters, devalues,

Dr. Corliss Health: or delegitimizes the experiences of the client.

Dr. Corliss Health: So, staff training is not just for the staff who are working with the clients.

Dr. Corliss Health: Training is also for those who are at the top that are making the decisions, because it's important, for they for the decision makers to have a realistic view.

Dr. Corliss Health: Excuse me of what is going on because it also helps them to have buy-in to the programs. Next slide, please.

Dr. Corliss Health: When working with the communities of color, we are going to be,

Dr. Corliss Health: sometimes we're going to be dealing with multi-generational trauma and so it's important to be sensitive to the way people move through the world when trying to help them.

Dr. Corliss Health: And it's important that we tread lightly and watch and listen.

Dr. Corliss Health: You know, acknowledge individuals where they are. Advocates who apply the lens, that they have often successfully provides support and assistance to survivors of domestic violence. For individuals who have gone through the experience, one can help validate the

Dr. Corliss Health: experiences of the survivor instead of further stigmatizing them.

Dr. Corliss Health: And so, these are some of the individual and interventionist responses that we have seen.

Dr. Corliss Health: You know that we suggest understanding, having an understanding and a meaning of what individuals have gone through, recognizing and value the diversity of black cisgender and transgender black women increasingly a capacity to explore the multiple ways to connect to your clients

Dr. Corliss Health: And just understanding that everyone has a story. Next slide,

Dr. Corliss Health: Please. And also, and I think this is my last slide, things to consider.

Dr. Corliss Health: Healing for black IPV survivors is not supported by a one size

Dr. Corliss Health: fits all service, you know. It's important to understand that black women do not function as a monolith. Always considered one's historical trauma, and its impact on interventions for black women, build on their strengths. Everyone has a story

Dr. Corliss Health: as I stated before, and all stories are not the same. And also, when you're actually providing those services incorporate a budget for resources for IPV survivors.

Dr. Corliss Health: And these are some of the things that you can incorporate in your budget.

Dr. Corliss Health: Next slide.

Dr. Corliss Health: And that's it. Thank you.

Helenka Ostrum: Thank you so much, Dr. Heath, for that wonderful presentation.

Helenka Ostrum: Her contact information is on that screen if you have any questions. I know we are right at time, but I want to call everyone's attention to a few things that were placed in the chat.

Helenka Ostrum: Stephen has added the link to where the webinar recording and the transcript will be posted, in addition to where you can find the IPV Strategy.

Helenka Ostrum: And that Implementation Framework link too.

Helenka Ostrum: And I'll pose just one question to the group.

Helenka Ostrum: I know there are a lot of other HRSA and federal resources related to IPV

Helenka Ostrum: available. If you want, for our speakers, you can put them in the chat or feel free to unmute. And also want to call the attention that the White House recently released the first ever National Plan to End Gender-Based Violence: Strategies for Action. Would any of our

Helenka Ostrum: speakers be able to elaborate more on HRSA's initiatives that are included in that plan?

Helenka Ostrum: And again, you can feel free to go to the chat or unmute.

Stephen Hayes: I'll take a first crack at it

Stephen Hayes: if that's all right Helenka and others please pop in. I just put the link to the strategy Helenka mentioned in the chat here.

Stephen Hayes: So, the White House Gender Policy Council has been engaged with all the federal space and nonfederal as well

Stephen Hayes: in an effort to stand up the National Plan to End Gender-Based Violence: Strategies for Action, and HRSA is called out in a couple of places. First, our Maternal, Infant, and Early Childhood Home Visiting Program, or MIECHV, which many of you are familiar with from our Maternal Child and Health Bureau. And

Stephen Hayes: they are included as having, you know, they provide evidence-based home visiting services to at-risk pregnant women and parents to prevent child abuse, neglect, and other inverse childhood experiences, all of which are risk factors for IPV and other forms of gender-based violence.

Stephen Hayes: They also acknowledge what our colleagues, from the Bureau of Primary Health Care today shared on the Health Partners on IPV

Stephen Hayes: and Exploitation website, which I'm also putting in the chat.

Stephen Hayes: And finally, the strategy document itself. But it's encouraging to see this all of government approach sort of mapped to what we're, we've been working as an agency to do for some time with an agency wide approach.

Stephen Hayes: So, we're excited to be part of that work and HRSA is represented on the Implementation Interagency Working Group, as they're calling it, in support of the White House's plan.

Stephen Hayes: But we thank everybody for the opportunity to share out a little bit about our work, and some great comments in the chat.

Stephen Hayes: Great questions as well. Anybody wants to reach out, I've also included my email in there.

Helenka Ostrum: Thank you, Stephen. I'm going to go to our last slide where you can learn more about HRSA.

Helenka Ostrum: Can also sign up for HRSA eNews on the website as well.

Helenka Ostrum: Thank you all for your time today. We look forward to seeing you at our next webinar.

END OF TRANSCRIPT