2023-2025

HRSA Strategy to Address Intimate Partner Violence

HRSA
Health Resources & Services Administration

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Acronyms

ACRONYM	DEFINITION
BHW	Bureau of Health Workforce
BPHC	Bureau of Primary Healthcare
CDC	Centers for Disease Control and Prevention
CRCC	Civil Rights Coordination & Compliance
DV	Domestic Violence
FORHP	Federal Office of Rural Health Policy
HAB	HIV/AIDS Bureau
HRSA	Health Resources & Services Administration
IEA	Office of Intergovernmental and External Affairs
IPV	Intimate Partner Violence
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MCHB	Maternal and Child Health Bureau
NISVS	National Intimate Partner and Sexual Violence Survey
NOFO	Notice of Funding Opportunity
NTTAP	National Training and Technical Assistance Partners
OCRDI	Office of Civil Rights, Diversity, and Inclusion
OFAM	Office of Federal Assistance Management
OPAE	Office of Planning, Analysis, and Evaluation
OSHI	Office of Special Health Initiatives
OWH	Office of Women's Health
PTSD	Post-Traumatic Stress Disorder
SANE	Sexual Assault Nurse Examiner
SDOH	Social Determinants of Health
SME	Subject Matter Expert
T/TA	Training and Technical Assistance

Note on Language

Intimate partner violence (IPV) includes physically and emotionally abusive behaviors by a current or former intimate partner, dating partner, or spouse. These behaviors may include physical or sexual violence, sexual coercion, stalking, cyber abuse and cyberstalking, controlling behaviors, and psychological aggression.[1-6] The Health Resources and Services Administration (HRSA) recognizes that IPV is a form of *gender-based violence*, which consists of harmful acts directed at an individual based on their gender.[7] IPV may intersect with various other forms of and experiences with violence within relationships, families, households, or communities, including domestic, interpersonal, and sexual violence and human trafficking.

Domestic violence (DV) is a consistent effort of one intimate partner to maintain power and control over another through emotional abuse, financial control, intimidation, physical assault, battery, sexual assault, or other abusive behavior.[i,8] While people often use "DV" and "IPV" interchangeably, this 2023-2025 Framework primarily uses the term "IPV," except when referring to organizations that use the term "DV."

Interpersonal violence describes "the intentional use of physical force or power against other persons, and encompasses child abuse, community violence (e.g., among individuals who are not related, but may know each other), family violence (e.g., violence within or between family members), and domestic and intimate partner violence (e.g., violence between current or former partners)."[9,10] *Sexual violence*, or *sexual assault*, is any nonconsensual sexual act proscribed by federal, tribal, or state law, including when an individual lacks capacity to consent (e.g., sexual harassment, rape, sexual exploitation, and unwanted sexual contact).[11,12] *Human trafficking* describes an individual performing labor or engaging in commercial sex by force, fraud, or coercion and relates to IPV in the overlapping patterns of behavior employed by both traffickers and people who use violence against intimate partners.[13]

The 2023-2025 Strategy recognizes the intersections between IPV and these other forms of violence that impact individuals and communities served by HRSA-supported settings of care. It underscores that preventing and addressing IPV requires recognizing and addressing these other forms of violence that increase the risk for and impacts of IPV. The Strategy also focuses on the experience of IPV from adolescence to adulthood. While child abuse and elder abuse are important issues that also intersect with IPV, they are beyond the scope of this Framework.

This 2023-2025 Strategy uses "people who have experienced violence" and "people who use violence" rather than "survivor" or "victim" and "perpetrator," respectively. This language acknowledges the dynamic nature of violence, in that people who experience violence may use violence themselves and vice versa.

[i] For more information on what constitutes abusive behavior, see https://ncadv.org/learn-more/what-is-domestic-violence/abusive-partner-signs.

Foreword

The Health Resources and Services Administration (HRSA) is dedicated to reducing disparities in health care outcomes and providing health care to the nation's highest need communities. We serve people who are geographically isolated and those who have been historically underserved, including people with low incomes, people with HIV, those who are pregnant, rural communities, transplant patients, new parents and their infants and children, and other communities in need. Intimate partner violence is a serious public health issue, and preventing and responding to it is important across all of the communities that we serve.

HRSA implemented its original ***Strategy to Address Intimate Partner Violence*** between 2017 and 2020. As noted in the ***2021 Summary Report***, HRSA completed all 27 key activities of the 2017-2020 Strategy, including:

- Launching ***Project Catalyst***, which trained 1,200 health care providers and advocates;
- Incorporating benchmarks into the Home Visiting Collaborative Improvement and Innovation Network 2.0; and
- Incorporating standard language on the impact of intimate partner violence in HRSA notices of funding opportunities.

This updated 2023-2025 Strategy builds upon these prior successes and provides actionable activities to realize three aims. Its development centered on the needs and priorities of people and communities who have experienced or are at risk of experiencing intimate partner violence. The three aims are to:

(1) **Enhance coordination** between and among HRSA projects to better focus intimate partner violence efforts;

(2) **Strengthen infrastructure and workforce capacity** to support intimate partner violence prevention and response services; and

(3) **Promote prevention of intimate partner violence** through evidence-based programs.

I am grateful to HRSA's staff for their continued leadership of this important work.

Working together, we can make a meaningful difference and advance the work of preventing intimate partner violence once and for all.

Carole Johnson
Administrator
Health Resources and Services Administration

Executive Summary

The Health Resources and Services Administration (HRSA) serves those most in need, including 30 million people at health centers in historically underserved communities, more than 58 million pregnant women, infants, and children, 3.6 million infants—nearly every infant in America—and more than 576,000 people with HIV.[14] The 2023-2025 Strategy is HRSA's plan for how it will address intimate partner violence (IPV) prevention and response within its programs and assist HRSA-supported settings in preventing and responding to IPV.

IPV includes physically and emotionally abusive behaviors by a current or former intimate partner, dating partner, or spouse, which intersects with multiple forms of abuse and violence (see Note on Language). These behaviors extend beyond instances of physical or sexual violence and include controlling behaviors, manipulation, coercion, stalking, and psychological aggression. These behaviors can impact physical and behavioral health, substance use, economic security, and quality of life.[1,2]

IPV will affect nearly one in two people in their lifetimes, with slightly more trans/non-binary individuals (54%)[15] experiencing IPV than cis-gendered women or men (46%[1] and 44%[1], respectively). The percentage of individuals who experience IPV also differs by race and ethnicity, sexual orientation, gender identify, and age.

HRSA developed its initial *2017-2020 Strategy to Address Intimate Partner Violence* to inform efforts to respond effectively to IPV in the health care and public health sectors. The 2023-2025 Strategy builds on the earlier Strategy to continue efforts to identify partnerships, address barriers, strengthen existing programs, and create new activities preventing and responding to IPV.

HRSA serves the nation's highest need communities, including people who are geographically isolated and those who have been historically underserved, including people with low incomes, people with HIV, those who are pregnant, rural communities, transplant patients, new parents and their infants and children, and other communities in need. IPV often affects many people in these communities and the health workforce that cares for them. Thus, HRSA is well positioned to prevent and respond to IPV.

To develop the 2023-2025 Strategy, HRSA conducted a literature review and engaged with external subject matter experts and key staff from HRSA's Bureaus and Offices. This process led to an evidence-informed roadmap to strengthen HRSA's systems-level approach to prevent and address IPV.

The Strategy consists of the following aims, each describing how HRSA Bureaus and Offices can prevent and address IPV:

- Aim 1: **Enhance coordination** between and among HRSA projects to better focus IPV efforts
- Aim 2: **Strengthen infrastructure and workforce capacity** to support IPV prevention and response services
- Aim 3: **Promote prevention of IPV** through evidence-based programs

Introduction

The Health Resources and Services Administration (HRSA) developed its initial ***2017-2020 Strategy to Address Intimate Partner Violence*** to support agency-wide efforts to effectively respond to intimate partner violence (IPV) in the health care and public health sectors. The 2023-2025 Strategy builds on the success of the 2017-2020 Strategy and will guide continued efforts to identify partnerships, address barriers to accessing and delivering care, strengthen existing programs, and create new initiatives to prevent and respond to IPV.

HRSA's extensive portfolio of projects, programs, and partners that deliver public health and health care programs and services (referred to throughout this document as "HRSA-supported settings") uniquely position the agency to address IPV. HRSA-supported settings include safety net settings such as health centers, rural health clinics, school-based clinics, and critical access hospitals.

IPV as a Public Health Issue

IPV is a major public health issue that affects millions of individuals and families in the United States.

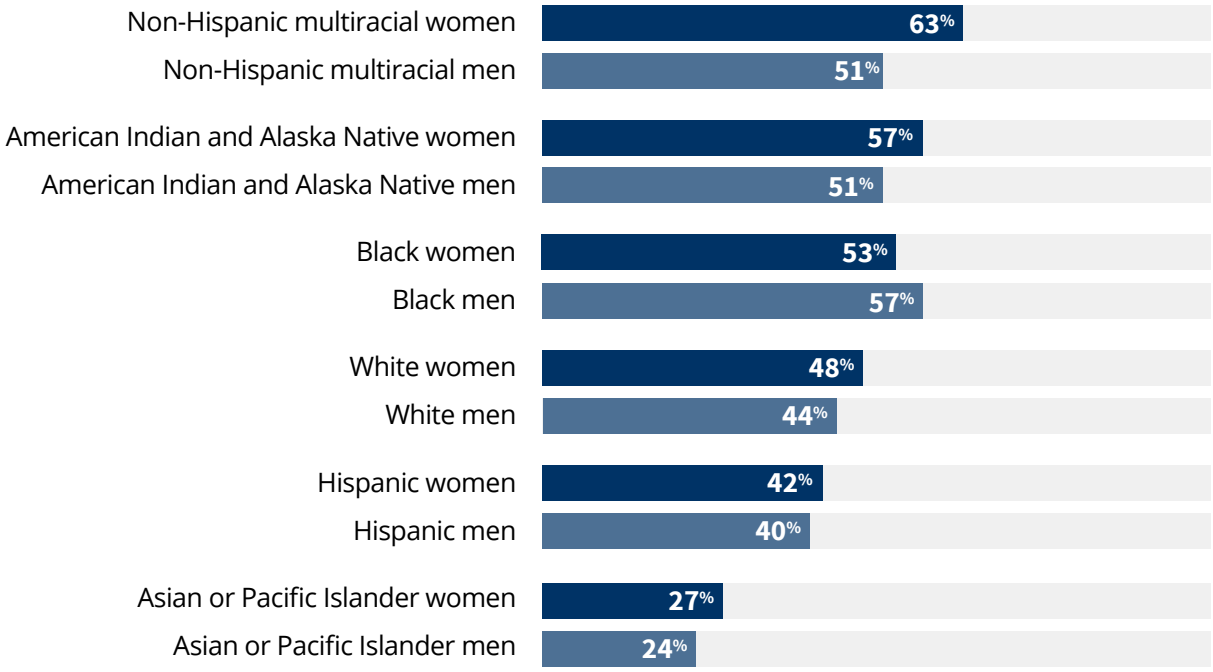
Who Experiences IPV?

IPV affects nearly half of women and 44% of men.[1] Nearly two-thirds (61%) of bisexual women[16-18] and over half (54%) of trans/non-binary individuals[15,19] report experiences of IPV. A majority of individuals first experience IPV before age 25.[1]

Various other communities are also disproportionately affected by IPV, including:

- People with disabilities[20,21]
- People living in rural areas[22]
- Young people ages 12 to 18[23,24]
- Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) communities[15-19,25]
- People who are pregnant[26]
  - The risk of homicide is 35% greater for pregnant and postpartum women[27] and nearly half of pregnancy-related homicides are associated with IPV.[28]
- People with HIV[29-33]
- Individuals who use substances[34]
  - 40-60% of IPV incidence include substance use[34]
- Racial and ethnically minoritized communities[1] (see Exhibit 1)

Exhibit 1: IPV Prevalence Among Adults, by Race, Ethnicity, and Gender*



Data source: Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

*The National Intimate Partner and Sexual Violence Survey does not break out prevalence by race and ethnicity *and* gender identity or sexual orientation.

While research studies tend to consider and report on categories like age, race, sexual orientation, and gender identity separately, individuals can identify with and experience membership in multiple categories simultaneously. There is also less research available about experiences of IPV among highly specific groups (e.g., rural bisexual women; non-binary white individuals living with disabilities).

Experiencing IPV has many negative health outcomes and risk behaviors, which can have lasting effects on individuals and their families.[1] Research shows that the myriad impacts of violence can persist throughout the lifespan[35,36] and affect an individual's:

Physical health, e.g., reproductive, cardiovascular, gastrointestinal, nervous system conditions, and traumatic brain injury.[37,38]

Behavioral health, e.g., Post-Traumatic Stress Disorder (PTSD), depression, and suicidal ideation,[39,40] use of alcohol and other substances as coping mechanisms, substance use disorder,[41-45] and high-risk sexual behaviors.[46]

Economic outcomes, e.g., diminished access to opportunities, absenteeism, reduced workplace productivity, and lost earnings.[47,48]

Quality of life, e.g., decreased sense of safety, school or work attendance, and needing to access advocate services.[33]

The consequences of IPV extend beyond the people who experience violence themselves; IPV also affects children in the household, friends, extended family, and even employers.[ii, 49-53] Despite the prevalence of IPV across many populations, people experiencing violence may not seek or receive care for various reasons, including individual, organizational, socio-cultural and structural circumstances or barriers.

Individual

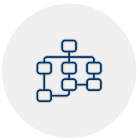
- Fear for personal and children's safety due to disclosure implications, confidentiality, and privacy concerns[54-58]
- Shame and embarrassment from stigma and fear of judgment[54-56,58]
- Lack of awareness about available resources or if experiences are IPV[58]

Organizational

- Service and medical provider bias and stigma[54-56,59]
- Limited availability of or constraints with IPV services, such as lack of privacy[60]
- The impact of public health emergencies on processes and capacity, which can increase challenges in providing universal screening and IPV response and magnify inequities[61]

Socio-cultural

- Language barriers, which can limit communication with providers[58,62]
- Cultural norms, which can contribute to stigma regarding IPV and seeking services[58,62]
- Immigration and refugee status, which can hinder ability or willingness to access care or disclose experiences of violence[58,62-65]



Structural

- Systemic inequities and structural discrimination that create unwelcoming or unreceptive health care and service environments, which may lead to distrust[58,66]
- Limitations in health care access or ability to seek care due to unequal resource distribution for people with lower socioeconomic status (e.g., income, educational attainment, poverty)[67]
- Social and geographic isolation, which reduces time or resources available to seek care[22,54,58]
- Policies that limit access to services[58]

[ii] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines secondary trauma, also known as vicarious trauma, as "trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., health care providers, peer counselors, first responders, clergy, intake workers)."[52]

The Strategy

The Strategy advances HRSA's mission through the three aims and corresponding objectives and activities. The Strategy also complements related national public health initiatives (see Appendix A).

2023-2025 Strategy Aims

Aim 1:

Enhance coordination between and among HRSA projects to better focus IPV efforts

Aim 2:

Strengthen infrastructure and workforce capacity to support IPV prevention and response services

Aim 3:

Promote prevention of IPV through evidence-based programs

An equitable and community-driven approach drives the 2023-2025 Strategy

In alignment with HRSA's commitment to achieving health equity, the Strategy centers the needs and priorities of people who have experienced or are at risk of experiencing IPV. Equity-focused efforts aim to break cycles of violence by addressing violence itself and the social determinants of health (SDOH; i.e., the conditions and environments that impact health and quality of life outcomes)[68] that can be root causes of violence. Programs, policies, and services that improve living conditions and SDOH can be violence prevention strategies in and of themselves.

Equitable approaches also acknowledge the diverse identities and contexts of individuals and communities to inform the design and delivery of IPV prevention and response programming. The relevant identities of each person who experiences or is at risk for experiencing IPV may compound the effects of structural violence and trauma experienced in their daily lives. These include the violence of racism, sexism, classism, ableism, and other forms of discrimination based on religion, sexual orientation, and immigration status. The socioeconomic, geographic, and cultural contexts in which individuals experience violence also influence how they speak about violence, access services, and respond to treatment.

HRSA Bureaus and Offices should consider seeking input from the individuals and communities they serve, wherever possible, when developing, funding, implementing, and evaluating programs and services to prevent and respond to IPV. Engaging individuals with lived experiences of violence ensures a stronger understanding of community priorities, assets, and challenges. In addition, governmental entities, direct service providers, and other community-based organizations striving to improve the living conditions of the communities HRSA serves are critical partners in this work. Culturally responsive care and using a health equity lens also reduces disparities experienced by populations disproportionately impacted by IPV.[69]

Programs that incorporate this type of equitable and community-driven approach are more nuanced, effective, and tailored for the communities they serve. This cross-cutting approach underlies all three aims of the Strategy.

HRSA will implement the activities described in the following pages in three phases between 2023-2025:

YEAR 1

(2023)
Increase awareness of the 2023-2025 HRSA Strategy

YEAR 2

(2024)
Implement activities supporting objectives

YEAR 3

(2025)
Monitor progress and identify opportunities for sustainability

Aims, Objectives, and Activities

The 2023-2025 Strategy identifies three aims grounded in an equitable and community-driven approach to preventing and responding to IPV that the HRSA Bureaus and Offices will prioritize through strategic objectives and key activities:

AIM 1

Enhance coordination between and among HRSA projects to better focus IPV efforts

AIM 2

Strengthen infrastructure and workforce capacity to support IPV prevention and response services

AIM 3

Promote prevention of IPV through evidence-based programs

AIM 1

Enhance coordination between and among HRSA projects to better focus IPV efforts

Ongoing coordination of efforts within HRSA is key to raising and maintaining awareness about IPV and its effects on health and equipping HRSA Bureaus and Offices to assist HRSA-supported settings to prevent and respond to IPV. An internal HRSA Implementation Team will coordinate implementation of the Strategy and align activities across HRSA Bureaus and Offices, including identifying trainings for HRSA staff, activities to increase awareness of IPV, and subject matter experts (SMEs). The Implementation Team will also disseminate and share approaches and promising practices across HRSA and in coordination with other federal agencies.

Objective 1.1:

Promote communication and collaboration across HRSA on efforts to prevent and respond to IPV.

Objective 1.2:

Increase HRSA staff knowledge to support IPV prevention and response within HRSA-supported settings.

Objective 1.3:

Leverage data to drive decision-making to improve IPV prevention efforts and access to IPV-specific care.

Objective 1.1:

Promote communication and collaboration across HRSA on efforts to prevent and respond to IPV.

ACTIVITY 1.1.1 | Establish a HRSA Implementation Team to coordinate implementation of the Strategy, align activities across HRSA Bureaus and Offices, and ensure HRSA is on track to meet the Strategy aims.

Key Collaborators: Office of Women's Health (OWH), Office of Special Health Initiatives (OSHI), Office of Planning, Analysis, and Evaluation (OPAE)

Action Items:

- Leverage Implementation Team with representation from across HRSA Bureaus and Offices to monitor progress toward Strategy objectives.
- Identify emerging opportunities for collaboration and coordination across HRSA.
- Increase buy-in across HRSA leadership and staff.
- Encourage HRSA activities that increase opportunities for information exchange and collaboration on activities related to preventing and responding to IPV.
- As possible, consult with the U.S. Department of Health and Human Services and other partners with relevant equities.

Results:

- Increased partnerships between HRSA Bureaus and Offices to prevent and respond to IPV that leverage each partner's existing resources and competencies.
- Increased opportunities for activities related to preventing and responding to IPV in HRSA-supported settings.

ACTIVITY 1.1.2 | Maintain and disseminate a roster of internal (e.g., HRSA staff) and external (e.g., academics, researchers, community advocates) SMEs who can support HRSA in implementing IPV programs and capacity-building efforts.

Key Collaborators: Implementation Team

Action Item:

- Build a roster of internal and external IPV SMEs and create sustainable processes for HRSA to update and access rosters.

Results:

- Increased integration of internal and external SME perspectives throughout activities in HRSA and HRSA-supported settings.
- Increased accessing of rosters of internal and external SMEs.

Objective 1.2:

Increase HRSA staff knowledge to support IPV prevention and response within HRSA-supported settings.

ACTIVITY 1.2.1 | Expand capacity among HRSA staff to facilitate implementation of IPV prevention and response programs within HRSA-supported settings. Building on the success of the 2017-2020 Strategy, the Implementation Team will contribute to HRSA staff training on how to support HRSA-supported settings and the communities they serve in preventing and responding to IPV and associated SDOH.

Key Collaborators: Implementation Team

Action Item:

- Leverage existing trainings that reflect best practices in adult learning.
- Identify or develop trainings showcasing promising practices.
- As possible, incorporate practice-based learning opportunities and dynamic approaches (e.g., roleplay) into trainings to identify and respond to IPV.

Results:

- Increased number of trainings offered to HRSA staff and leadership that build knowledge around IPV and its impacts.
- Increased number of HRSA staff who have completed trainings about IPV.
- Increased capacity to identify opportunities to prevent and respond to IPV across HRSA activities.

Objective 1.3:

Leverage data to drive decision-making to improve IPV prevention efforts and access to IPV-specific care.

ACTIVITY 1.3.1 | Continue to build the evidence base for practices that prevent and respond to IPV. Program evaluation and research can expand upon existing and generate new evidence on programs and approaches that demonstrate success and promote necessary continuous quality improvement efforts.

Key Collaborators: HRSA-wide, Bureau of Primary Health Care (BPHC), Office of Intergovernmental and External Affairs (IEA), OPAE, Federal Office of Rural Health Policy (FORHP)

Action Items:

- Consolidate and disseminate existing evaluation resources to standardize outcome evaluations across HRSA-supported settings.
- Use implementation science approaches to understand barriers and facilitators to implementation.
- Integration of data and evidence to inform decisions related to IPV prevention and response activities and ongoing quality improvement efforts.

Results:

- Integration of data and evidence to inform decisions related to IPV prevention and response activities and ongoing quality improvement efforts.

ACTIVITY 1.3.2 | Strengthen HRSA's data and analysis mechanism(s) to drive decision-making to prevent and respond to IPV while ensuring privacy. HRSA-supported settings and other entities can use data to inform IPV-related programs, services, and policies.

Key Collaborators: HRSA-wide, BPHC, IEA, OPAE, FORHP

Action Items:

- Provide training and technical assistance (T/TA) to HRSA-supported settings on strengthening IPV-related and SDOH data collection mechanisms and using these data to inform IPV-related programs, services, and policies.
- Encourage ongoing data collection of IPV-related measures (e.g., consistently collecting information on numbers of screenings conducted, patient education conducted, referrals made).
- Support the development and reporting of IPV-related measures and SDOH.

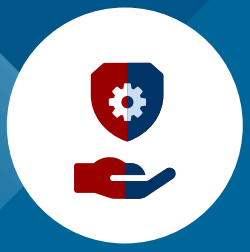
Results:

- Increased number of T/TA engagements with HRSA-supported settings to improve data collection.
- Increased number of staff in HRSA-supported settings who are involved in tracking program implementation and outcome metrics in decision-making.

Activity in Action: Using Data Across HRSA Bureaus and Offices

The Maternal and Child Health Bureau (MCHB)-funded Maternal, Infant, and Early Childhood Home Visiting programs report on two performance IPV indicators (percent of primary caregivers screened for IPV with a validated tool within six months of enrollment, and percent who get referral information to enroll in home visiting with a positive IPV screen from a validated tool).[70] HRSA provides programs with additional information about IPV screening and referral measures and tools in Maternal, Infant, and Early Childhood Home Visiting performance measure FAQs.

BPHC's Uniform Data System includes data on the number of visits for patients who have experienced IPV and human trafficking, determined through the following IPV screening measures: 20e Human trafficking (T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, z04.82, Z62.813, Z91.42) and 20f Intimate partner violence (T74.11, T74.21, T74.31, Z69.11).[71]



AIM 2

Strengthen infrastructure and workforce capacity to support IPV prevention and response services

HRSA can bolster the capacity of HRSA-supported setting workforce and infrastructure (e.g., technology, communication and collaboration systems, data collection systems, grant-writing, management) to effectively implement IPV programs by providing program design guidance, building and strengthening intersectional partnerships, and encouraging training. Training is essential to support trauma-informed and culturally responsive care, eliminate bias in care delivery, and enhance practical skills and knowledge.

Trauma-informed approach:
All people at all levels of the organization or system "***realize*** the widespread impact of trauma and understands potential paths for recovery; ***recognize*** the signs and symptoms of trauma; ***respond*** by fully integrating knowledge about trauma into policies, procedures, and practices, and actively ***resist*** re-traumatization."[72] It also aligns with the following five principles: Safety, trustworthiness & transparency, peer support, collaboration & mutuality, and empowerment, voice, & control.[72]

Culturally responsive care:
Integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.[73]

Objective 2.1:

Increase health care and public health workforce capacity to support IPV prevention and response and understanding of factors that can contribute to violence.

Objective 2.2:

Encourage HRSA-supported settings to incorporate IPV prevention and response activities into existing and new programs to expand implementation capacity.

Objective 2.3:

Promote development and strengthening of local partnerships and referral networks within HRSA-supported settings to prevent and respond to IPV.

Objective 2.4:

Improve access to IPV-specific care and interventions.

Objective 2.1:

Increase health care and public health workforce capacity to support IPV prevention and response and understanding of factors that can contribute to violence.

ACTIVITY 2.1.1 | Encourage incorporation of IPV education and training into HRSA-supported settings' existing programs, tools, frameworks, and capacity-building initiatives (e.g., T/TA programs and learning collaboratives).

Key Collaborators: HRSA-wide

Action Items:

- Identify ongoing and upcoming capacity-building initiatives and programs.
- Determine opportunities to include IPV prevention and response education into new and existing learning activities.

Results:

- Increased integration of IPV prevention and response-related content into new and existing HRSA training programs or stand-alone T/TA programs.

Activity in Action: Promoting IPV Education and Training Across HRSA-supported Settings

MCHB has several activities incorporating IPV education and training into HRSA-supported setting initiatives, including the Home Visiting Collaborative Improvement and Innovation Network 2.0. Through this learning collaborative, participants and local home visiting service agencies use continuous quality improvement methods to improve screening of women for IPV. These efforts increase home visitor staff knowledge and confidence to support those experiencing IPV through referrals to domestic violence (DV) advocacy services based on their self-identified needs.

ACTIVITY 2.1.2 | Increase HRSA staff knowledge and capacity to provide T/TA to HRSA-supported settings on how to adapt and tailor IPV strategies to fit their local contexts and needs.

Key Collaborators: HRSA-wide

Action Items:

- Identify IPV-related training needs of different HRSA-supported settings.
- Connect HRSA-supported settings to relevant IPV-related T/TA.

Results:

- Increased number of T/TA engagements between HRSA and HRSA-supported setting staff to increase knowledge and capacity to implement IPV prevention and response activities in their settings of care.

Activity in Action: National Training and Technical Assistance Partners (NTTAPs)

BPHC funds 22 NTTAPs, each providing free T/TA and subject matter expertise to existing and potential health center grantees and look-alikes. All T/TA activities proposed by NTTAPs align with the seven domains in the Health Center Excellence Framework and help health centers improve their performance. HRSA-supported health centers can contact the NTTAPs directly or connect with their project officers for more information.

- Health Partners on IPV + Exploitation NTTAP provides HRSA-supported health centers with T/TA to increase trauma-informed service delivery, support partnerships and policy development, and improve health center workflows by increasing identification and referral of people who are experiencing or have experienced IPV and/or human trafficking.

ACTIVITY 2.1.3 | Provide T/TA to HRSA-supported settings on federal civil rights laws and their application to IPV prevention and response programs.

Key Collaborators: Office of Civil Rights, Diversity, and Inclusion (OCRDI), Implementation Team

Action Items:

- Identify the civil rights-related training needs of HRSA-supported settings.
- Create a resource that integrates civil rights, nondiscrimination, and IPV-related information.
- Provide training and T/TA to HRSA-supported settings about potential implications of federal civil rights laws on delivering services related to IPV.

Results:

- Increased number of trainings for staff in HRSA-supported settings on the implication of federal civil rights laws on delivering services related to IPV.
- Increased number of staff in HRSA-supported settings who receive training on federal civil rights laws and their potential impact on providing services related to IPV.

Activity in Action: OCRDI's Civil Rights Coordination & Compliance (CRCC) Section

OCRDI's CRCC Section takes a preventive and education-based approach to assisting HRSA-funded recipients to comply with their federal civil rights obligations. OCRDI CRCC's services include the provision of T/TA and development of plain language informational resources on emerging and nuanced civil rights issues and inequities as they relate to access to health.

Objective 2.2:

Encourage HRSA-supported settings to incorporate IPV prevention and response activities into existing and new programs to expand implementation capacity.

ACTIVITY 2.2.1 | Ensure HRSA Notices of Funding Opportunities (NOFOs) encourage consideration of IPV and intersecting risk factors, as possible.

Key Collaborators: Office of Federal Assistance Management (OFAM), Implementation Team, HRSA-wide

Action Items:

- Update NOFO template language to include information on IPV and intersecting risk factors where appropriate.

Results:

- Increased number of funding opportunities that include IPV prevention and response activities as allowable costs.

Objective 2.3:

Promote development and strengthening of local partnerships and referral networks within HRSA-supported settings to prevent and respond to IPV.

ACTIVITY 2.3.1 | Encourage HRSA-supported settings to partner with other health and human service providers to collaborate on programs and initiatives preventing and responding to IPV. Interprofessional collaborations address multiple co-occurring care concerns for individuals experiencing or at risk of experiencing IPV and increase collaborations that can facilitate primary prevention activities (e.g., education in school and community settings).

Key Collaborators: OFAM, OWH, IEA, Implementation Team

Action Items:

- Include opportunities for partnerships that address IPV and other SDOH within NOFOs, where appropriate.
- Develop, curate, and disseminate template memoranda of understanding, data use agreements, and other T/TA materials that HRSA-supported settings can use to facilitate formal partnerships.
- Encourage HRSA-supported settings' use of templates.

Results:

- Increased number of memoranda of understanding, data use agreements, and other templates available to promote and facilitate partnerships.
- Increased number of opportunities to introduce IPV-responsive partnerships and referral networks into HRSA funding proposals.

Activity in Action: Academic-Practice Partnerships

Bureau of Health Workforce (BHW) Advanced Nursing Education - Sexual Assault Nurse Examiner (SANE) grantees develop academic-practice partnerships as part of their funding requirements, including collaboration with HRSA-supported health centers and critical shortage facilities. These partnerships promote collaboration and the recruitment of diverse participants and trainees and provide opportunities to integrate trauma-informed, evidence-based sexual assault and DV services.

Objective 2.4:

Improve access to IPV-specific care and interventions.

ACTIVITY 2.4.1 | Enhance T/TA and guidance specific to telehealth services for IPV to reduce barriers to accessing care.

Key Collaborators: Office for the Advancement of Telehealth, Implementation Team

Action Items:

- Identify and disseminate promising practices to increase options for virtual connections between patients and staff in communities.
- Update and disseminate guidance around telehealth policies, procedures, and best practices for implementation.

Results:

- Increase IPV resources available for patients and providers, including resources on Telehealth.HHS.gov.

ACTIVITY 2.4.2 | Support adoption of new ways of providing services in the community—and expand existing ones—to meet people "where they are."

HRSA-supported settings can increase access to care by diversifying care locations (e.g., mobile vans, providing IPV services in other social service settings such as Family Justice Centers).

Key Collaborators: Implementation Team

Action Items:

- Identify and disseminate innovative strategies for HRSA-supported settings to consider using to connect with patients.
- Identify and disseminate promising practices, policies, procedures, and best practices for implementing innovative care delivery practices.

Results:

- Expanded care delivery options within HRSA-supported settings will reduce barriers to accessing care.

ACTIVITY 2.4.3 | Promote the development and use of interdisciplinary, coordinated care teams to provide appropriate, specialized IPV care. Coordinated care, one-stop-shop models, and approaches that facilitate rapid connection to specialty care decrease barriers to linking to care and remaining retained in that care.

Key Collaborators: Implementation Team

Action Items:

- Encourage the inclusion of diverse staff (e.g., providers, advocates, community health workers, *promotores de salud*, health navigators, doulas, midwives, peers, and extension workers) and an array of expertise across disciplines (e.g., primary care, behavioral health, ancillary supports) in care delivery at HRSA-supported settings.
- Encourage integration and co-location of social and medical services to support wraparound, holistic care for individuals experiencing IPV.
- Encourage coordination among care teams, including secure information exchange and providing warm referrals to ensure safe and effective care.[74]

Results:

- Sustain focus on integration and coordinated care across HRSA NOFOs.
- Increased number of T/TA engagements that encourage integration and coordinated care.

ACTIVITY 2.4.4 | Create a HRSA-wide inventory and support implementation of IPV screening processes to identify and address factors contributing to IPV (including SDOH) and specifically screen for IPV.[75,76] Disclosure-driven practices such as screening can be most supportive of people experiencing IPV when they are culturally responsive, acknowledge barriers to disclosing experiences of IPV, and are conducted by trusted providers in private, one-to-one settings.

Key Collaborators: Implementation Team

Action Items:

- Identify evidence-informed screening tools (such as those compiled by the Agency for Healthcare Research and Quality),[77] complementary protocols, referral networks, training, processes, and other resources most appropriate for HRSA-supported settings and the populations they serve.
- Disseminate screening resources to HRSA-supported settings to inform their work with their grantees, awardees, recipients, and subrecipients.

Action Items Continued:

- Provide T/TA to HRSA-supported settings on how and when to use the screening tools and how to respond if an individual's screening indicates an experience of IPV.

Results:

- Increased number of T/TA engagements to support implementation of screenings.
- Increased number of HRSA-supported settings offering universal IPV screening.

AIM 3

Promote prevention of **IPV** through evidence-based programs

HRSA's vision for preventing and responding to IPV includes prevention activities[78] across diverse settings, with evidence-based programs to address the complexities and challenges of serving individuals who are at risk for experiencing IPV.

Three kinds of public health prevention strategies, primary, secondary, and tertiary, can address risk for IPV and its co-occurrence with other epidemics like HIV/AIDS, substance use disorder, and mental illness.[iii,iv,v]

Primary Prevention: Preventing IPV before it happens

Secondary Prevention: Immediately responding when IPV occurs

Tertiary Prevention: Responding to IPV's lasting impacts over time

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Objective 3.1:

Support implementation of upstream primary prevention approaches that promote healthy relationships.

Objective 3.2:

Encourage establishment of safe and supportive settings promoting secondary and tertiary prevention approaches to IPV and its impacts.

Objective 3.1:

Support implementation of upstream primary prevention approaches that promote healthy relationships.

ACTIVITY 3.1.1 | Curate an inventory of IPV primary prevention strategies and approaches (e.g., school-based initiatives and bystander intervention), resources, and programs appropriate to HRSA-supported settings to facilitate rapid uptake and implementation within HRSA-supported settings (modeled after the Centers for Disease Control and Prevention (CDC) Technical Package on Primary Prevention).

Key Collaborators: Implementation Team

Action Items:

- Identify and disseminate evidence-informed primary prevention programs and approaches most appropriate for HRSA-supported settings and the populations they serve, including populations that have traditionally been underserved or experienced discrimination.
- Connect HRSA-supported settings with T/TA providers and SMEs for implementation support as necessary.
- Encourage HRSA-supported settings to establish partnerships with schools, school-based health centers, afterschool and youth programs, and community-based settings to implement primary prevention activities.

Results:

- Increased number of T/TA engagements to support implementation of prevention programs.
- Increased use of evidence-informed, culturally, and linguistically appropriate trauma-informed IPV training resources (e.g., curricula, toolkits, experts) within HRSA-supported settings.

Activity in Action: Support of Primary Prevention Across HRSA Bureaus and Offices

The HIV/AIDS Bureau (HAB) and BPHC provided funding support to Futures Without Violence and IPV Health Partners to develop the IPV Toolkit. The toolkit is available on the AIDS Education and Training Centers National Coordinating Resource Center and on the BPHC-funded Health Center Resource Clearinghouse. As part of its National HIV Curriculum, the HAB-funded AIDS Education and Training Centers integrate curriculum on gender-based violence.

HAB maintains an inventory of evidence-based programs and a best-practices compilation repository on TargetHIV.org.

ACTIVITY 3.1.2 | Promote the use of universal education within HRSA-supported settings. HRSA-supported settings can implement universal education to provide consistent information as standard practice to all patients, including adolescents, about available supportive services, should they need them, in addition to implementing screening when feasible and appropriate during a patient-provider interaction.

Key Collaborators: Implementation Team

Action Items:

- Identify existing universal education materials and gaps in materials, to inform T/TA.
- Disseminate universal education materials to HRSA colleagues to inform their work with their grantees, awardees, recipients, and subrecipients.
- Provide information and T/TA to HRSA-supported care settings to increase use of universal education.

Results:

- Increased number of HRSA-supported settings using universal education tools and implementation strategies.

Activity in Action: Universal Education in Select Health Centers

A cohort of HRSA-supported health centers utilized a protocol developed by BPHC's IPV NTTAP, Health Partners on IPV + Exploitation, to engage patients through universal education approaches on Exploitation, Human Trafficking, DV, and IPV. This initiative enabled HRSA-supported health centers to provide trauma-informed, person-centered care; intervention with clinical and case management services; and formalized ways to connect patients with community-based services that provide resources for DV, employment assistance, housing, food, civil legal aid, and other basic needs.

Objective 3.2:

Encourage establishment of safe and supportive settings promoting secondary and tertiary prevention approaches to responding to IPV.

ACTIVITY 3.2.1 | Promote policies and procedures that encourage HRSA-supported settings to provide trauma-informed, culturally responsive services to people who have experienced violence. People experiencing violence may also face stigma, challenges with SDOH, and other lived experiences and obstacles that may affect their ability to seek care and services. Trauma-informed care and related policies and procedures enable HRSA-supported settings to respond effectively and sensitively to the trauma of experiencing violence and challenges with intersecting needs. Training all staff to understand and implement a trauma-informed approach ensures "no wrong door" to care.

Key Collaborators: Implementation Team

Action Items:

- Identify new and existing training opportunities on the integration of trauma-informed care and culturally responsive practices into care delivery for all staff in HRSA-supported settings.
- Identify and disseminate model trauma-informed and culturally responsive policies and practices that HRSA-supported settings could adapt and adopt.

Results:

- Increased integration of trauma-informed, culturally responsive policies and procedures within HRSA and HRSA-supported settings.

Activity in Action: Promote Trauma-informed Care Across HRSA Bureaus and Offices

Trauma-informed care will be the focus of one of three HAB Part D Communities of Practice set to launch in fiscal year 2023. The Communities of Practice will increase delivery of programs that are evidence-informed or have emerging levels of evidence that enhance patient outcomes; increase the skill level of the HIV workforce providing care and treatment to women, infants, children, and youth; and involve partner collaboration for dissemination of best practices.

One of BHW Advanced Nursing Education - SANE Program goals is cultivating an environment conducive to SANE training and practice through partnerships and T/TA consultation. Grantees work with local and national partners to reduce barriers to SANE training and practice and incorporate these services into the standard health care workflow. The goal of SANE training is to enable examiners to effectively evaluate and address survivors' health concerns, minimize trauma, and promote healing during and after their exam, and detect, collect, preserve, and document physical evidence related to the assault for potential use by the legal system.

ACTIVITY 3.2.2 | Extend trauma-informed and culturally responsive resources and approaches to staff in HRSA-supported settings. HRSA-supported setting staff themselves may need access to supportive services and human resource practices (e.g., clinical supervision, time off for behavioral health care).

Key Collaborators: Implementation Team

Action Items:

- Support the implementation of policies and procedures for staff in HRSA-supported settings to address their own violence exposure or risks and to reduce the potential for secondary trauma.[79-84]

Results:

- Increased access to workforce resources among staff at HRSA-supported settings.

Conclusion

HRSA is uniquely positioned to address IPV's lasting impacts on health care needs and access. Building on the success of the 2017-2020 Strategy, the 2023-2025 Strategy focuses on the activities HRSA can undertake to strengthen efforts to increase knowledge of IPV and its impacts and support IPV prevention and response within HRSA-supported settings.

Through the Strategy's three aims and their related objectives and activities, HRSA will identify opportunities to respond to and address the intersections between violence, SDOH, structural and systemic discrimination, and critical public health issues. The Strategy's aims, objectives, and activities outline how to coordinate implementation and align activities, process metrics, and plan for sustainability that help prevent and respond to IPV across HRSA activities. An agency-wide approach recognizes the diversity of HRSA's activities and the varying needs of the populations and communities served in HRSA-supported settings. Completing the Strategy's activities and meeting its objectives is part of HRSA's ongoing commitment to taking actionable steps to achieve health equity and improve public health, improve access to quality health services, foster a health workforce and infrastructure able to address current and emerging needs, and optimize and strengthen HRSA operations and program engagement.

Appendix A: Related National Initiatives

The 2023-2025 Strategy complements related national initiatives, including:

- The National Strategy on Gender Equity and Equality, which includes eliminating gender-based violence.
- Healthy People 2030, which includes reducing IPV as a Health Behavior objective.
- The goals and activities of the Administration for Children and Families, including the Family Violence Prevention & Services Resource Centers and the Missing and Murdered Native Americans: A Public Health Framework for Action (2020); the National Health Resource Center on Domestic Violence; the Stop Observe Ask Respond to Human Trafficking Health and Wellness Training; and the National Human Trafficking Training and Technical Assistance Center.
- The Indian Health Services' existing portfolio of initiatives to address IPV.
- Centers for Disease Control and Prevention seminal surveillance work via the National Intimate Partner and Sexual Violence Survey (NISVS) and the 2017 Preventing Intimate Partner Violence Across the Lifespan technical package for states and communities.
- The White House Blueprint for Addressing the Maternal Health Crisis, which includes goals for addressing violence against pregnant and postpartum individuals.
- The Department of Health and Human Services Roadmap for Behavioral Health Integration, which aims to provide care for individuals who have experienced IPV.
- The White House Task Force to Address Online Harassment and Abuse, which will address the disproportionate effect on women, girls, people of color, and lesbian, gay, bisexual, transgender, queer, and intersex individuals.

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