



THE HRSA STRATEGY TO ADDRESS INTIMATE PARTNER VIOLENCE 2017-2020 SUMMARY REPORT

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FOREWORD

MESSAGE FROM THE ACTING ADMINISTRATOR

Intimate partner violence (IPV) is a serious public health issue in the United States. According to the Centers for Disease Control and Prevention (CDC), IPV includes sexual violence, stalking, physical violence, and psychological aggression by an intimate partner. About one in four women and nearly one in ten men in the U.S. experience IPV in their lifetime; millions of people nationwide are impacted every day. Beyond the immediate harms caused by IPV, it can also have additional serious physical and psychological health consequences for individuals, their loved ones, and their communities.

The Health Resources and Services Administration (HRSA) is at the forefront of improving the health and well-being of people throughout the U.S., especially those who are geographically isolated, economically or medically vulnerable. HRSA's mission is to improve health outcomes and achieve health equity through access to quality services, a skilled workforce, and innovative, high-value programs. HRSA's wide breadth of public health and health care programs uniquely positions the agency to address IPV. One out of eleven U.S. residents receive their primary care through a HRSA-funded health center; over half of people with HIV receive care through the Ryan White HIV/AIDS program, and more than 50 million mothers and children rely on services provided through HRSA-supported maternal and child health programs.

In January 2017, HRSA continued its role as a leader of public health practice by beginning implementation of *The HRSA Strategy to Address Intimate Partner Violence* ("the Strategy"). This was the first of its kind agency-wide Strategy identifying key activities to be carried out across HRSA to improve the agency's capacity to prevent and respond to IPV and its impacts on health. The HRSA Office of Women's Health (OWH) coordinated the development, implementation, and sustainability of Strategy activities and key elements through extensive collaboration with every HRSA Bureau and Office throughout the process. As of December 2020, all 27 of the Strategy's key activities have been completed with several recurring.

The Strategy's successful implementation demonstrates HRSA's commitment to coordinating across the agency on a critical public health issue, and is a model for future efforts. The extraordinary contributions of HRSA Bureaus and Offices are part of the agency's ongoing commitment to sustainable efforts to build health equity.

I am proud to lead an agency committed to addressing the impact of IPV across multiple health care and public health programs. I encourage you to read this Summary Report to learn more about how HRSA addressed IPV through the 2017-2020 Strategy implementation period, and how it will continue to do so in coming years. Together we will continue to achieve our vision of "Healthy Communities, Healthy People."

Diana Espinosa
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EXECUTIVE SUMMARY

Background

Intimate partner violence (IPV) is a serious yet preventable public health issue. According to the Centers for Disease Control and Prevention (CDC), IPV encompasses “physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner.” In addition, approximately one in five women and one in seven men have experienced severe physical violence by an intimate partner at some point in their lifetimes. IPV often has complex and severe impacts on the physical and mental well-being of those who experience it – as well as on children, friends, extended families, and their communities. IPV disproportionately affects many populations served by HRSA’s programs, particularly pregnant women, adolescents, racial/ethnic minorities, people with HIV, LGBTQ+ individuals, individuals living with disabilities, individuals with substance use disorders, and individuals living in rural areas.

The Strategy

Beginning in 2016, the HRSA [Office of Women's Health](#) (OWH) led development and implementation of [The HRSA Strategy to Address Intimate Partner Violence](#) (“the Strategy”). Prior to the Strategy’s implementation, HRSA had only two programs and one pilot project specifically addressing IPV in its portfolio. In response to this opportunity, HRSA OWH engaged with leadership and staff from across HRSA’s bureaus and offices to strengthen existing programs and strategically address relevant gaps through an iterative year-long process. The resulting Strategy nested 27 key activities under four overarching priorities:

1. **Train** the nation’s health care and public health workforce to address IPV at the community and health systems levels
2. Develop **partnerships** to raise awareness about IPV within HRSA and HHS
3. Increase **access** to quality IPV-informed health care services across all populations
4. Address **gaps** in knowledge about IPV risks, impacts, and interventions

After several engagements with key HRSA and external stakeholders, the Strategy officially began in January 2017 and carried through December 2020.

Results

All 27 key activities identified in the Strategy were implemented by December 2020, with many recurring. Additional programs and policies not described in the Strategy’s 27 key activities were also developed and implemented. The Strategy’s sustainable elements, which include IPV-related standard language to include in HRSA’s Notice of Funding Opportunities, support for the [The National Health Network on Intimate Partner Violence and Human Trafficking](#), and recurring trainings and distribution of materials across HRSA networks, reflect a commitment to addressing a critical public health issue through an equitable focus on violence prevention and response and intersecting supportive services. HRSA attained this success even in the midst of the COVID-19 pandemic and [HRSA’s extensive activities responding](#) to COVID-19. COVID-19 also exacerbated certain conditions [contributing to violence](#), further highlighting the importance of HRSA’s sustained commitment to address IPV.

Implications

The Strategy’s agency-wide approach reflects a recognition of IPV’s far-reaching impacts on health and HRSA’s distinctive position to prevent and respond to its occurrence. The whole-of-agency approach strengthened HRSA’s existing internal collaborations and developed critical new collaborations that will continue to further HRSA’s commitment on IPV and other health issues. OWH’s engagement with key stakeholders throughout the planning and implementation process and the development of additional collaborative spaces on IPV, ranging from IPV-focused workgroups within HRSA and across its 10 regions to targeted funding opportunities, helped nurture these collaborations.

The successes of the Strategy reflect the feasibility of an agency-wide approach as possible, practical, and effective. This suggests an expanded focus on violence prevention and response is possible within HRSA and with interested partners. Employing sustainable program and policy changes across Strategy activities encourages the maintenance of equitable responses to critical public health issues and other emerging priorities. The completion of all key Strategy activities on schedule, the expansion of related efforts not described in the Strategy itself, and the sustained focus throughout the COVID-19 pandemic carry valuable lessons for other agency-wide efforts at HRSA and beyond.

BACKGROUND

Intimate partner violence (IPV) is a serious yet preventable public health issue. According to the Centers for Disease Control and Prevention (CDC), IPV encompasses “physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner,” and approximately one in five women and one in seven men have experienced severe physical violence by an intimate partner at some point in their lifetimes. IPV affects millions of women, men, and children, and can have complex and severe impacts on the physical and mental well-being of survivors – as well as on children, friends, extended family, and their communities. IPV disproportionately affects specific populations, including many of those served by HRSA’s programs, such as pregnant women, adolescents, racial/ethnic minorities, people with HIV/AIDS, LGBTQ+ individuals, individuals living with disabilities, individuals with behavioral health and substance use disorders, and individuals living in rural areas.

Strategy Development

The Health Resources and Services Administration (HRSA) is well-positioned to respond to IPV through its programs serving individuals who are geographically isolated, economically or medically vulnerable. In response to this pressing concern, the HRSA Office of Women’s Health (OWH) launched an agency-wide initiative, [The HRSA Strategy to Address Intimate Partner Violence](#). The first-of-its-kind Strategy was implemented between January 2017 and December 2020 using an innovative model to focus on this critical social determinant of health through agency-wide collaborative action.

The Strategy is the result of a year-long process where leadership from across HRSA’s bureaus and offices collaborated to strengthen existing programs and strategically address gaps that address IPV. This engagement led to a practical and actionable Strategy describing available IPV-related educational tools, trainings, and technical assistance resources to support public health professionals, health care providers, and health care settings to better serve individuals and communities impacted by IPV. The Strategy provided a framework for HRSA to address IPV and outlined concrete actions that each bureau and office would take both individually and collaboratively, as well as in partnership with other federal agencies and grantees. Strategy objectives were organized within four priorities describing how HRSA’s employees and programs can address IPV:

- ▶ **Train** the nation’s health care and public health workforce to address IPV at the community and health systems levels
- ▶ Develop **partnerships** to raise awareness about IPV within HRSA and HHS
- ▶ Increase **access** to quality IPV-informed health care services across all populations
- ▶ Address **gaps** in knowledge about IPV risks, impacts, and interventions

Strategy Implementation

Prior to the Strategy, there were only two HRSA programs and one pilot project that specifically addressed IPV. Three guiding principles informed Strategy priorities, activities and intended outcomes:

1. A comprehensive, evidence-informed, coordinated community and health systems-level response to IPV is needed
2. Collaboration within HRSA and with other HHS agencies is essential for bringing about sustainable change at all levels of the health care system
3. Culturally relevant and trauma-informed practices for IPV are at the heart of the Strategy



These three guiding principles reflect a commitment to a comprehensive and equitable response to IPV. This focus led to the identification of 27 key activities across 10 strategic objectives. Strategy activities were implemented across three phases between 2017 and 2020:

- ▶ Year 1 (2017-2018): Raise awareness to achieve agency-wide buy-in while continuing to identify, develop, and enhance activities
- ▶ Year 2 (2018-2019): Implement project work plans and establish initial metrics and descriptive tracking systems
- ▶ Year 3 (2019-2020): Work to strengthen metrics and conduct evaluations where feasible, and plan for sustainability

Tracking Strategy Progress and Results

As part of HRSA's commitment to accomplishing the Strategy's key activities, OWH coordinated regular information exchange and check-ins with key representatives from HRSA bureaus and offices. These representatives served as primary points of contact for the Strategy, in-house consultants on IPV, and tracked their respective organization's progress towards key activities described in the Strategy. Their commitment to supporting and furthering Strategy activities in addition to their regular duties ensured successful accomplishment of Strategy objectives.

These key representatives also fostered and led additional gains on addressing IPV through the creation of working groups on IPV within their program area. These efforts at expanding regular information exchange and planning on IPV-related topics encouraged adoption of practices recommended by the Strategy, most notably diffusion of the [IPV Health Providers Toolkit](#), [CUES Safety Cards](#), and CDC's [Preventing Intimate Partner Violence fact sheet](#). Bureaus and Offices also included standardized slides describing Strategy activities in presentation decks across various programs and identified areas for additional focus on IPV outside of those initially described in the Strategy.

[The HRSA Strategy to Address Intimate Partner Violence - 2017-2018 Progress Report](#) provides extensive detail regarding the Strategy's initial implementation and tracking process. The report reflected broad initial success in meeting Strategy objectives through 2018; fifty-nine percent of the 27 key activities were already completed and/or recurring, and in progress items were on track for completion before December 2020. Progress tracking over the course of 2019 and 2020 reflected completion of all pending activities even as the effects of the COVID-19 pandemic response began in 2020. While COVID-19 response took precedence across HHS, HRSA was able to maintain a thoughtful focus on addressing IPV in spite of a natural shift in priorities toward frontline pandemic response.

In 2020, the HRSA Office of Planning, Analysis and Evaluation (OPAE) conducted a process evaluation of the Strategy. OPAE used a review of key Strategy documents and key informant interviews to develop an internal evaluation report identifying key successes, challenges, and lessons.

Key Activities and Beyond

The Strategy has also resulted in gains extending beyond quantitative tracking and the completion of key activities. These gains reflect HRSA's existing and growing understanding of, and commitment to, addressing IPV and its critical impacts on health across HRSA. This commitment is rooted in HRSA's history of equitably serving those most in need through accessible and responsive services. Baseline understanding of IPV's prevalence and impact on health is greater across the agency than at the Strategy's outset, as is an interest in preventing and responding to violence in all its forms. The inequities highlighted by the disproportionate distribution of burdens resulting from COVID-19 has further emphasized the need for supportive services for those served by HRSA programs.

KEY ACCOMPLISHMENTS BY STRATEGY PRIORITY

HRSA OWH partnered with key staff from every bureau and office to successfully implement the Strategy. The success of this first-of-its-kind agency-wide strategy reflects the passion for innovation and service shared by team members and partners in HRSA and HRSA-supported settings of care.

All 27 key activities were accomplished on schedule with both recurring and ongoing activities. More than half of the Strategy's key activities recurred at least once between 2017 and 2020. Critically, several key activities are expected to recur in 2021 and beyond. This section highlights particular successes under each Strategy Priority Area.

TRAIN THE NATION'S HEALTH CARE AND PUBLIC HEALTH WORKFORCE TO ADDRESS IPV AT THE COMMUNITY AND HEALTH SYSTEMS LEVELS

IPV Health Partners Toolkit

The [IPV Health Partners Toolkit](#) is a central resource featured throughout the Strategy. Dissemination efforts on the part of nine HRSA bureaus and offices led to more than 13,000 toolkit page views in the first two years of the Strategy alone, of which more than 70 percent were unique. Disseminated content was tailored to be responsive to unique requirements of specific settings of care, including rural providers, and to consider the needs of special populations. Extensive circulation of these evidence-based IPV-related resources including the toolkit resulted from broad grantee-facing engagements. Links to the toolkit were also provided via bureau and office standing slide decks, high-visibility websites and newsletters, and external and internal briefing materials. For example, the Bureau of Health Workforce shared these evidence-based IPV-related resources with its 20 [Advanced Nursing Education-Sexual Assault Nurse Examiner \(ANE-SANE\)](#) grantees who work to increase the number of registered nurses, advanced practice registered nurses, and forensic nurses trained and certified to conduct sexual assault nurse examinations, and through events like its 2019 town hall webinar featuring health workforce resources to address the impact of IPV across the lifespan. The toolkit remains available and is one of the key sustainable elements of the Strategy.

OWH's engagement with the Agency for Healthcare Research and Quality (AHRQ) resulted in the Strategy and toolkit being included as resources in the U.S. Preventive Services Task Force's (USPSTF) 2018 [Final Recommendation Statement for Screening for IPV, Elder Abuse, and Abuse of Vulnerable Adults](#). The USPSTF recommended clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.

National Ryan White Conference on HIV Care and Treatment

Beginning in 2018, the intersection of IPV and HIV has been a featured topic in presentations at the HIV/AIDS Bureau's (HAB) National Ryan White Conference on HIV Care and Treatment (National Conference). The [2020 National Conference](#) included a sustained focus on IPV extended across three related sessions presented as part of an *Intimate Partner Violence Institute*. These three associated sessions built upon each other's learning objectives to provide evidence-based, patient-centered, and equitable information for the diverse practitioners and community servers participating in the National Conference. These sessions focused on exploring the intersection between IPV and HIV, leveraging Ryan White HIV/AIDS Program (RWHAP) funding streams in trauma-informed systems of care, and cultural competency and organizational readiness in addressing IPV which all offered continuing education units for participants. In addition to these associated presentations, the 2020 National Conference included an additional session and two posters specifically focusing on the intersection and impact of violence for people with HIV.

Federal Office of Rural Health Policy Rural Health Information Hub IPV Resources

The Federal Office of Rural Health Policy (FORHP) facilitated the addition of more than two dozen new IPV resources and special features to the [Rural Health Information \(RHI\) Hub](#). Resources include topics such as [Domestic and Intimate Partner Violence: Some Do's and Don'ts for Health Providers](#), [The Ruralness of Domestic and Intimate Partner Violence: prevalence, Provider Knowledge Gaps, and Healthcare Costs](#), [Indigenous People and Domestic Violence: Who's Bringing Solutions](#), and the [IPV Health Partners Toolkit](#). The RHI Hub continues to regularly update resources on the platform that help those serving rural residents plan, develop, learn, and connect or facilitate information exchange and other information resources.

DEVELOP PARTNERSHIPS TO RAISE AWARENESS ABOUT IPV WITHIN HRSA AND HHS

OWH Project Catalyst

[Project Catalyst](#) helps improve responses and advance policy for IPV and human trafficking in HRSA-funded health centers and domestic violence programs. State teams include leaders from state Primary Care Associations (PCA), state health departments, and state domestic violence coalitions and were supported through collaboration between the Administration for Children and Families (ACF), the HRSA Bureau of Primary Health Care (BPHC), and OWH. These state teams use training curricula, health care provider resources, patient education materials, and quality improvement tools to form partnerships between health centers and domestic violence programs; make new policy level changes across the health care delivery system; train health centers to educate all patients; and engage at least 50% of the HRSA-funded health centers in their state or territory. Completed follow-up assessments reflect health centers' implementation of seeing patients alone policies, a key practice to provide privacy and confidentiality for survivors. 95% of trained providers reported an increased understanding about the impact of IPV and human trafficking on health. Three months after training, providers reported they were almost three times more likely to refer patients to their domestic violence agency partners.

In addition to the work accomplished through state teams in their own states, *Project Catalyst* provides a model of effective efforts in each of the Strategy's four priority areas that are replicable across communities in the U.S., particularly those that are home to HRSA-supported settings of care. Learnings from the *Project Catalyst* experience are reflected in focus areas of the BPHC's [The National Health Network on Intimate Partner Violence and Human Trafficking](#), led by [Futures Without Violence](#), which expands upon *Project Catalyst* work by offering training and technical assistance to health centers and PCAs.

Notice of Funding Opportunity IPV-related Language

The Office of Federal Assistance Management (OFAM) collaborated with OWH to develop language about addressing IPV and other critical social determinants of health across all HRSA-funded activities regardless of their primary focus area. Several bureaus and offices have adopted this language in their Notice of Funding Opportunities for Fiscal Year 2021 and have indicated they intend to continue including the language in subsequent years. Additional details regarding this key accomplishment and its sustainability are available in the Sustainability Section of this report. This complete language is included in Appendix A.

Office of Global Health International Visitors Leadership Program Presentations

In collaboration with the U.S. Department of State, the HRSA Office of Global Health (OGH) leads International Visitors Leadership Program (IVLP) meetings at HRSA. The IVLP is the Department of State's premier professional exchange program bringing together current and emerging leaders with American counterparts in short-term exchange programs. OWH presented HRSA's IPV portfolio and related resources to international visitors from more than 21 countries over the course of the Strategy's implementation providing opportunities for valuable bidirectional learning.

INCREASE ACCESS TO QUALITY IPV-INFORMED HEALTH CARE SERVICES ACROSS ALL POPULATIONS

Maternal, Infant and Early Childhood Visiting Program IPV Screening Rates

The Maternal and Child Health Bureau's (MCHB) Maternal, Infant and Early Childhood Visiting (MIECHV) Program demonstrated improvement in the delivery of IPV-related services for economically disadvantaged and geographically isolated communities. Initial 2017 data for newly-implemented MIECHV national IPV screening performance measure demonstrated a baseline screening rate of 74 percent. The most recently available data from 2018 reflected a strong increase to 81.9 percent showing consistent progress towards the best practice of universal screening in a nationwide program.

Home Visiting Collaborative Improvement and Innovation Network 2.0

The HRSA MCHB Home Visiting Collaborative Improvement and Innovation Network ([HV CoIIN 2.0](#)) brings together MIECHV Program awardees and local home visiting service agencies to engage in dialogue and take action through collaborative learning, rapid testing for improvement, sharing of best practices, scaling of tested interventions, and building quality improvement capacity. The HV CoIIN 2.0 has leveraged its engagement and partnership-building expertise to bring critical attention to IPV across participating MIECHV home visiting programs. Six MIECHV awardees (MA, MI, MN, OR, SC & WA) and 18 Local Implementing Agencies (LIAs) engaged in a 15-month Learning Collaborative achieving sustained shifts in the baseline median (median of the first six data points) for the following outcome and process aims:

- ▶ *Outcome:* Percent of caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities: 75 percent from baseline of 70 percent
- ▶ *Outcome:* Percent of caregivers with identified IPV offered supports or services who receive follow-up from home visitor: 80 percent from baseline of 70 percent
- ▶ *Primary Driver 1:* Competent, supported, and trauma-informed workforce to address IPV
 - Percent of home visitors trained in basic competencies in IPV: 94 percent from baseline of 62 percent
 - Percent of home visitors engaging in reflective supervision at least once in the past month about IPV: 85 percent from baseline of 79 percent
- ▶ *Primary Driver 3:* Safe and respectful conversations on healthy relationships and screening for IPV
 - Percent of caregivers provided universal education about healthy relationships within the past six months: 58 percent from baseline of 41 percent
- ▶ *Primary Driver 4:* Comprehensive, fluid, individually tailored, and highly collaborative safer planning and follow-up
 - Percent of caregivers with identified IPV who engage in safer planning: 63 percent from baseline of 52 percent

The third cohort of HV CoIIN 2.0 awardees began their work in February 2021 and will continue work through June 2022.

Ryan White HIV/AIDS Program Special Projects of National Significance

The RWHAP funds Special Projects of National Significance (SPNS) to identify and implement evidence-informed interventions. The Evidence-Informed Interventions to Improve Health Outcomes among people with HIV ([e2i](#)) has successfully implemented interventions at more than 26 sites nationwide, six of which implemented interventions addressing trauma, including that resulting from IPV, among people with HIV. This work reflects the program's commitment to assessing the role of evidence-based interventions addressing trauma on seroprevalence, access to care, and other outcomes for people with HIV.

ADDRESS GAPS IN KNOWLEDGE ABOUT IPV RISKS, IMPACTS, AND INTERVENTIONS

OWH Commentary

In January 2020, OWH staff co-authored a commentary, [Galvanizing an Agency-wide Approach: The HRSA Strategy to Address Intimate Partner Violence](#), which was published in *Public Health Reports*. The commentary succinctly describes IPV's prevalence and effects on health and HRSA's position to address and prevent it. It also provides detail regarding key actions and foundational efforts from the Strategy's development and implementation. In addition to providing a replicable evidence-based case for addressing IPV, the commentary summarizes practical learnings related to developing and generating buy-in for an agency-wide strategy while framing the public health implications of these takeaways.

U.S. Preventive Services Task Force IPV Screening Recommendation

OWH's engagement with the AHRQ resulted in the Strategy and IPV Health Provider Toolkit being included as resources in the USPSTF's 2018 *Final Recommendation Statement on Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening*. The USPSTF's *Final Recommendation Statement* recommended that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services. The inclusion of the Strategy and toolkit in the USPSTF's endorsement reflected a positive shift in clinical recommendations by reaching beyond screening alone and emphasizing provision of and referral to services as a key element of the recommendation. USPSTF's inclusion of the Strategy in its references is a long-term sustainable action. It also reflects how important changes in practice around IPV beyond those specifically described within the formal document was a valuable result of the Strategy's implementation, and led to the adoption of practices in line with its four priority areas beyond HRSA. Such broader changes, while not necessarily specifically identified at the Strategy's outset, are reflective of HRSA's broader commitment to equity across its public health activities.

Data Brief on Adverse Childhood Experiences

In June 2020, MCHB's Division of Epidemiology published a [2017-2018 Data Brief](#) on Adverse Childhood Experiences (ACEs). ACEs are stressful and potentially traumatic events that occur during childhood, including experiencing or observing violence, which can result in chronic toxic stress without mitigating or buffering support. There is a consistently strong relationship between an increasing number of ACEs and poor health outcomes in adults, making their prevention of particular interest to MCHB. The brief summarized data from the National Survey of Children's Health (NSCH) and highlighted the percentage of children 0-17 years with two or more parent-reported ACEs. One in three children had experienced at least one parent-reported ACE in their lifetime. Reports of ACEs varied significantly by race/ethnicity and household income. The data brief reflects a commitment to identifying inequities and deploying data to articulate emerging priorities.

Analysis of Federal Regulatory and State Policy Initiatives Related to IPV

OPAE led several key analyses regarding existing interventions and policies that support or hinder service provision to individuals impacted by IPV. These included regular updates to HRSA staff regarding health system financing changes and state policy initiatives related to IPV, domestic violence, and human trafficking. These included fact sheets regarding Medicaid and IPV Coverage, and other critical health financing analyses. In May 2018, the Office of Legislation also provided support to OWH in preparation for a congressional staff briefing entitled [Health Solutions to Children and Families Affected by Trauma and Abuse](#) which was sponsored by the National Health Collaborative on Violence and Abuse. Additionally, OPAE authored a blog in observance of 2020 Domestic Violence Awareness Month entitled *Domestic Violence Awareness Month: Combating Intimate Partner Violence in the Era of COVID-19* which described lessons from previous disasters, crises, and their impact on IPV and provided additional context around the COVID-19 pandemic.

Office of Regional Operations Activities

The Office of Regional Operations (ORO), through its 10 regional offices, increased stakeholder knowledge of the Strategy through more than 60 large-scale events, webinars, summits, and newsletters. ORO engaged over 10,000 stakeholders from diverse backgrounds and organizations including HRSA grantees, State and Local Government, Federal Agencies, Faith-based and Community-Based Organizations, and Tribal Entities. Some highlights include:

- ▶ In August 2020, ORO Region 10-Seattle hosted an Alaskan two-day virtual forum focused on the intersections between IPV and human trafficking in the American Indian and Alaskan Native (AI/AN) populations leading to development of a Labor and Delivery Human Trafficking Protocol in an Alaska Health Center. Recordings are available for [Day 1](#): aGErQCx5 (Password) and [Day 2](#): PqtiP3U3 (Password)
- ▶ In May 2020, ORO Region 9-San Francisco hosted a webinar with Futures Without Violence, OWH, and ACF entitled "Sheltering in Place, Violence, and the Healthcare Response". The webinar provided best practices and resources to healthcare providers and their community partners to respond to domestic violence, support victims experiencing abuse, and promote resiliency in children during the COVID-19 pandemic. The webinar reached more than 1,000 attendees and was featured in several HRSA and National Association of Community Health Centers [newsletters](#)
- ▶ In October 2019, OWH and ORO (Region 2-New York; Region 3-Philadelphia; Region 5-Chicago) hosted a webinar commemorating Domestic Violence Awareness Month. The webinar highlighted state-level efforts to address IPV and provided strategies for implementing trauma-informed care in health settings. 185 participants joined the webinar and 89 percent of poll respondents found the webinar useful to their organization with 99 percent indicating they would recommend the webinar to a peer

Office of Civil Rights, Diversity and Inclusion Violence Training

The Office of Civil Rights, Diversity and Inclusion (OCRDI) leads HRSA efforts to build a culture of fairness, diversity, and inclusion to improve health and achieve health equity. Recognizing IPV as a critical barrier to this mission, OCRDI incorporated HRSA's Workplace Violence Prevention Policy into its ongoing *Preventing Sexual Harassment in the Federal Workplace* training offered to all bureau and office managers and supervisors. From 2019-2020, OCRDI provided six employee-focused trainings to HRSA staff, both at headquarters and across HRSA's regional offices. During this timeframe, OCRDI also provided a separate supervisor/manager-focused training to eleven of HRSA's bureaus and offices. This inclusion of violence-related materials in workplace trainings is critical to achieving a truly agency-wide focus as it helps ensure HRSA itself becomes a safe an environment for all.

OPAE Strategy Evaluation

OPAE conducted a process evaluation of the Strategy's implementation across HRSA. This was informed by background research into the development process in the form of reviews of key Strategy documents and materials, and key informant interviews conducted with representatives from across HRSA. The evaluation provided valuable information regarding achieving Strategy buy-in and uptake, fidelity to original Strategy objectives, identifying key activities related to IPV not delineated in the Strategy, and opportunities for deepened or expanded focus across HRSA. Recommendations for continued implementation and integration included improving agency NOFOs to address Strategy priorities, and enhancing communication about the Strategy to internal and external constituencies. Participants reported the IPV Toolkit and educational materials were excellent resources for communicating the Strategy. Further recommendations included developing a systematic approach to successfully communicate effective messages and data about IPV while highlighting HRSA's efforts.

IMPLICATIONS & SUSTAINABILITY

The Strategy brought an unprecedented agency-wide focus on a critical public health issue present across HRSA's expansive portfolio. The Strategy demonstrated that lasting engagement around planning, implementation, tracking, and sustainability was possible for an effort of its scale and that HRSA is uniquely positioned to address IPV and violence in all of its forms. This impact is visible through the 100% completion rate of all 27 key activities identified in the Strategy and the recurrence of several of those activities. Further, the Strategy coincided with the development and implementation of additional HRSA efforts on IPV that were not delineated in the Strategy but recognize the importance of preventing and addressing IPV across HRSA programs. This section identifies sustainable achievements and the implications of those activities in an effort to further sustain and institutionalize these gains and spark opportunities for building upon and expanding them. In addition to describing IPV-related gains and lessons, this section identifies valuable takeaways regarding an agency-wide strategy model of potential interest to other HRSA bureaus and offices.

Continued Agency-wide Commitment

The National Health Network on Intimate Partner Violence and Human Trafficking

BPHC has funded [The National Health Network on Intimate Partner Violence and Human Trafficking](#) ("the Network"), a National Training and Technical Assistance Partner (NTTAP) for BPHC-supported health centers. The Network began its work on July 1, 2020 and will continue to serve as the BPHC NTTAP for IPV through June 2023. The Network offers health centers training on trauma-informed services, building partnerships, policy development, and the integration of processes designed to promote prevention and referrals to supportive services for individuals at risk for, experiencing, or surviving IPV and human trafficking.

The Network represents an ongoing commitment to identifying, addressing, and where possible preventing IPV and human trafficking across the Health Center Program. The Network addresses all four priority areas and synthesizes several activities supported by the Strategy into an enduring and far-reaching training and technical assistance partner. Futures Without Violence have stressed the importance of maintaining a focus on IPV and other forms of violence in the midst of the COVID-19 pandemic. Completed webinars include [Intimate Partner Violence/Human Trafficking: Building Partnerships Between Community Health Centers and Domestic Violence Advocacy Programs](#), [Improving Health Outcomes Through Violence Prevention: Promising Strategies from Community Health Centers](#), and [Supporting LGBTQIA+ Youth Who Have Experienced Trafficking](#).

The Network provides an opportunity to further expand awareness of IPV across HRSA-funded health centers and their partners, while encouraging the adoption of evidence-based approaches to identifying and addressing IPV through strategies such as the [CUES](#) intervention and further update of the [IPV Health Provider Toolkit](#). The Network is also reflective of HRSA's commitment to respond to various forms of violence and make referrals to supportive services.

Notice of Funding Opportunity IPV Language

OFAM is a key partner in sustaining the impact of the Strategy. Recognizing the importance for an agency-wide approach to IPV, OFAM worked with OWH to develop form language to include in the FY 2021 NOFO template distributed to all HRSA bureaus and offices awarding grant opportunities. The NOFO language highlighted IPV's prevalence, preventability, and impact on health outcomes. Inclusion of the language in several NOFOs reflects increased awareness of IPV's impact on various HRSA priorities. MCHB included the language in all of its FY 2021 NOFOs deepening their clear commitment to addressing IPV across its programs. This language is included in Appendix B.

Inclusion of this language in the FY 2021 NOFO template reflects recognition of IPV's prevalence and impacts on health outcomes, a critical step in reducing its incidence and impacts. Further, the precedent

of including language regarding IPV, in this case in the context of critical social determinants of health, can serve as a basis for emphasizing increased awareness and focus on IPV and other forms of violence in subsequent NOFOs and the work that results from their award and grantees' work. Several bureaus and offices have indicated they intend to continue to include language regarding IPV in subsequent years. This policy change is consistent with all four Strategy priorities because of the HRSA's reach.

Improving Care and Treatment Coordination; Focusing on Black Women with HIV

As noted earlier, HAB has elevated the voices of individuals experiencing violence and the importance of addressing IPV across RWHAP activities in settings such as the annual *National Ryan White Conference on HIV Care and Treatment* and the [Part F Special Projects of National Significance \(SPNS\) Program](#), which supports the development of innovative models of HIV care and treatment. In addition to these efforts, HAB awarded the *Improving Care and Treatment Coordination – Focusing on Black Women with HIV* ([Evaluation and Technical Assistance Provider](#) (ETAP) and [Project Sites](#)) notice of funding opportunity in FY 2020. HAB is funding 12 demonstration sites in addition at up to \$360,000 per site and \$1 million to the ETAP. The project's period of performance extends from September 1, 2020 through August 31, 2023.

One of the initiative's six goals specifically includes "interventions for IPV, physical and sexual violence, or other behavioral health needs (e.g. provider and/or organizational training on IPV, physical and sexual violence prevention, or behavioral health and care coordination with other community-based services)." In addition to requiring this focus on IPV from grantees, HAB is also able to promote standardized evidence-based policies and practices across participating demonstration sites because of its partnership with an ETAP working in partnership across all 12 distinct sites.

HRSA-supported activities carried out through HAB's *Improving Care and Treatment Coordination – Focusing on Black Women with HIV* provide a model for further activities addressing violence in their efforts to equitably address various health priorities. HAB's funding opportunity created a space for organizations to develop new or expand existing activities accounting for the impact of violence on HIV care outcomes. By doing so with diverse sites across the country, and through a partnership with an evaluator and technical assistance provider, HAB creates the opportunity to share and implement best practices and promising policies across diverse settings. The multiyear commitment also makes it more feasible to measure uptake and promote a shift towards accounting for and addressing IPV and other forms of violence across future funding opportunities as well.

Sustaining a Focus on Intimate Partner Violence

The successes of the Strategy have been recognized by Congress through HRSA's FY 2021 appropriation which includes report language requiring no less than \$1,500,000 be committed to the HRSA Strategy, an increase of \$500,000 over the FY 2020 enacted level. Congress further emphasizes support for "training, technical assistance, and resource development to assist public health and health care professionals to better serve individuals and communities impacted by intimate partner violence." HRSA is committed to continuing to support training and technical assistance efforts such as the [National Health Network on Intimate Partner Violence and Human Trafficking](#), and other key gains of the Strategy described in this report. Additional activities specifically focusing on accounting for and addressing IPV at an agency level are also planned.

The Agency-wide Strategy Model

In addition to the programmatic and policy gains from accomplishing all 27 key activities described in the Strategy, ensuring recurrence and sustainability for several of those activities, and expanding HRSA's

capacity to account for and address IPV, the Strategy experience provides lessons regarding the development and implementation of an agency-wide Strategy. Key takeaways and promising practices regarding the development, implementation, and sustainability of an agency-wide strategy are applicable to additional HRSA efforts, as well as potentially those of other HHS agencies. These experiences regarding achieving buy-in and uptake, and institutionalizing change intended by the Strategy are summarized here.

Achieving Buy-In and Uptake

While the Strategy reflects HRSA's current understanding and prioritization of accounting for and addressing IPV across activity areas, HRSA faced different levels of situational awareness about IPV at the starting point for Strategy development. OWH used data, strategy summits, and the establishment of key partnerships to develop the necessary awareness and buy-in to facilitate the Strategy's collaborative development and wide uptake.

Data

In 2015, [new data](#) from the National Intimate Partner and Sexual Violence Survey (NISVS) indicated a high prevalence of IPV nationwide (approximately one-in-four women and one-in-ten men). The availability of the latest national-level sample data point provided the opportunity to begin critical conversations regarding awareness of and/or existing efforts to address IPV across HRSA's activities. Further, [research](#) from Futures Without Violence indicated women who talked to their health care provider about abuse were four times more likely to use an intervention and 2.6 times more likely to exit the abusive relationship. This clear connection between prevalence and the effectiveness of interventions emphasized the importance and feasibility of addressing IPV across HRSA's activities. In addition to available sample data, various HRSA stakeholders and HRSA-supported settings of care reported their own experience serving individuals experiencing IPV and shared existing approaches and gaps. Together, this helped foreground the issue where it might otherwise have not yet been recognized.

Strategy Summits

In order to ensure Strategy development was an inclusive and participatory process for all HRSA bureaus and offices, OWH coordinated more than half a dozen strategy summits before Strategy implementation. These strategy summits brought together HRSA leadership and staff to better understand awareness of IPV's impact on health outcomes, identify existing or planned efforts to specifically account for and address IPV in HRSA programming and policies, and determine priority areas and strategic opportunities for prioritization in the implementation of a final strategy. This model reflected OWH's vision for an inclusive, agency-wide approach that built upon existing priorities and identified and prioritized gaps to address on an accelerated timeline. Strategy summits were continued on a quarterly and then annual basis during Strategy implementation which created the opportunity for HRSA stakeholders to share challenges, successes, and opportunities and ensured the Strategy was dynamic and responsive.

Key Partnerships: Champions, Ambassadors, and Tracking Leads

The breadth of the Strategy's priority areas and key activities required a broad team of committed HRSA stakeholders from ideation through its completion. The collaboration facilitated through Strategy champions, ambassadors, and tracking leads are of note for potential replication in other agency-wide efforts. Champions, ambassadors, and tracking leads were key HRSA leadership and staff who served as advocates and central points of contacts for their bureaus and offices on Strategy implementation while also contributing directly to the Strategy's extension through their participation in summits and other planning activities, these key contacts served as in-unit consultants and ideates to facilitate the expansion and deepening of bureau and office activities. Strategies of a similar scale and scope should consider working through and with equivalent key contacts as possible.

OPPORTUNITIES AND NEXT STEPS

The Strategy's success provides informative takeaways for future activities related to IPV, and for additional efforts to develop health and other supportive services centered on equity. Violence – in all its forms – continues to harm individuals, families, and communities, in many cases disproportionately and in conjunction with other social determinants and vulnerabilities, such as substance use, other chronic conditions, and economic precarity. Some opportunities to build upon the Strategy's accomplishments and sustainable elements are described in this section.

Within HRSA

The Agency-Wide Strategy Model

In addition to its success in expanding and deepening HRSA's focus on a critical public health issue through the four priority areas and their associated key activities, the Strategy provides an example of how coordinated agency-wide efforts using the Strategy format are possible, practical, and effective. This experience can inform additional formal, coordinated, agency-wide, and action-oriented strategies. Longer-term health priorities such as addressing health equity, preventing ACEs, managing chronic conditions, or improving childhood nutrition may benefit from the lessons learned and key elements of the Strategy experience, particularly with regards to priority identification and articulation, achieving buy-in, and tracking progress. These perspectives come from HRSA's strong history of effectively leveraging its expertise and coordinating abilities, as demonstrated most recently and visibly by its [COVID-19 Response](#).

IPV and Other Forms of Violence

IPV is one of many forms of [Interpersonal Violence](#) which includes violence between individuals and is itself subdivided into family violence, IPV, and community violence. [Child maltreatment](#), [elder abuse](#), [youth violence](#), and assault by strangers are examples of additional forms of interpersonal violence that carry similar public health impacts to those of IPV. Several evidence-based efforts, such as CDC's [Connecting the Dots](#)' cross-cutting approach, to address these diverse forms of violence are deployed by diverse stakeholders nationwide, which may benefit from additional coordination and information sharing. The Strategy provides a set of approaches and model for coordination and information sharing that could be beneficial for groups to leverage as part of expanded efforts promote health equity's complex and overlapping components and prevent and address other forms of violence.

Substance Use and Mental Health

Even before the COVID-19's pandemic's negative impacts on mental health and substance use, an epidemic of substance use already impacted millions. According to the [National Survey on Drug Use and Health](#), 19.7 million adults in the U.S. lived with substance use disorder in 2017, and 8.5 million adults suffered from both a mental health disorder and a substance use disorder. In August 2020, the CDC's [Morbidity and Mortality Weekly Report](#) indicated that adults in the U.S. reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.

Existing data such as CDC's [Youth Risk Behavior Survey \(YRBS\)](#) illustrate the bidirectional association between experience of violence and mental health risks. Additional research describes intersections between substance use and violence, which further exacerbate negative health impacts. Substance use coercion (SUC) is an example of one of these intersections, as described in an October 2020 [Assistant Secretary for Planning and Evaluation and Family Youth Services Bureau Policy Brief](#). SUC occurs when perpetrators of IPV undermine and control their partners through substance-use related tactics and actively keep them from meeting treatment and recovery goals. A [survey of National Domestic Violence](#)



[Hotline callers](#) revealed 43 percent of respondents had experienced at least one form of SUC. The Strategy can also serve as a model for a comprehensive and equitable approach to COVID-19 pandemic recovery of which behavioral health is a critical piece. Takeaways from the Strategy experience provide examples of how agencies can bring coordinated and comprehensive evidence-informed approaches recognizing the intersections between substance use and violence to improve factors contributing to both.

Beyond HRSA

Partnering to Prevent and Respond to Violence

The successes of the Strategy lay a solid foundation for partnering with entities outside of HRSA to further expand a Federal focus on violence prevention and response. HRSA's reach and mission-driven nature makes it an especially appealing and effective partner. CDC's [Violence Prevention Portfolio](#) includes several examples for such collaboration, as does the Department of Justice's [Office for Victims of Crime](#). Lasting impacts on violence benefit from complementary policies and services coordinated at the Federal level in collaboration with local partners. Leveraging the extensive networks of various HHS and non-HHS agencies creates a powerful opportunity to expand and share the gains of the Strategy with various partners and address violence's continued impact on individuals and communities nationwide.

Partnerships for Health Equity

According to the CDC, [health equity](#) is when everyone has the opportunity to be as healthy as possible. Expanding health equity leads to positive outcomes in health and other areas. The COVID-19 pandemic further illustrated and exacerbated existing [racial and ethnic health disparities](#), especially in key social determinants of health such as:

- ▶ Neighborhood and Physical Environment
- ▶ Health and Healthcare
- ▶ Occupation and Job Conditions
- ▶ Income and Wealth
- ▶ Education

CDC also [indicates](#) "community- and faith-based organizations, employers, healthcare systems and providers, public health agencies, policy makers, and others all play a key part in promoting fair access to health," reflecting the importance of bringing a focus to health equity across all sectors. The internal partnerships modeled by the Strategy can be scaled and replicated to focus on the critical components of health equity across agencies throughout HHS and beyond. The diverse focus areas, systems, and constituencies involved in addressing these critical elements of health equity may benefit from a descriptive and coordinated approach in the model of the Strategy that builds upon existing partnerships between HRSA and other Federal entities.

Moving Forward

Because of the Strategy's focus on sustainability, HRSA continues several key programmatic gains as part of its regular activities. Adjustments in standard operations and increased awareness of and attention to IPV also continue to provide new opportunities to more effectively prevent and respond to IPV across HRSA's wide-reaching programs and within the agency itself. OWH will continue to encourage this focus on the prevention and awareness of violence in its own activities, as well as those of its awardees and other partners. Immediate next steps include continued support for [The National Health Network on Intimate Partner Violence and Human Trafficking](#), BPHC's support for the [Survivor Health Connection Project](#), and new activities promoting violence prevention and response in HRSA-supported settings of care building upon the those in the Strategy.

APPENDIX A – HRSA STRATEGY TO ADDRESS IPV LIST OF KEY ACTIVITIES

The HRSA Strategy to Address IPV was made up of four priority areas. A total of 27 key activities were nested under these four priority areas and are listed here. By December 2020, all activities were implemented across HRSA with many recurring.

| Priority | Strategic Objectives | Activities |
|--|---|---|
| 1. TRAIN THE NATION’S HEALTH CARE AND PUBLIC HEALTH WORKFORCE TO ADDRESS IPV AT THE COMMUNITY AND HEALTH SYSTEMS LEVELS | 1.1: Create or adapt a range of culturally competent, evidence-based, and trauma-informed educational materials and TA on IPV for health care and public health professionals in the field | Build the evidence base for IPV practices and resources for rural populations Provide technical expertise to develop culturally and linguistically competent IPV educational resources for various health care providers Lead outreach to key oral health stakeholders, including federal and non-federal partners, to collaborate on mechanisms to better address IPV in oral health care settings |
| | 1.2: Expand IPV TA and training opportunities for the health care workforce through HRSA B/O’s national and regional grant programs and training networks | Facilitate access to health workforce training on IPV through HRSA’s existing networks Integrate IPV content into existing national training programs that prepare clinicians to comprehensively address the health needs of people living with HIV/AIDS Disseminate IPV training and TA materials via HRSA’s National Hansen’s Disease Program to its national network of health care providers Disseminate the IPV Health Partners Toolkit and other IPV educational resources to existing networks Work with stakeholders to implement the updated 2016 Women’s Preventive Services recommendations supporting IPV screening and counseling Provide IPV informational resources to minority-serving colleges and universities Extend the reach of HRSA’s IPV-related materials and approaches to other countries |

KEY ACTIVITIES TABLE

| Priority | Strategic Objectives | Activities |
|---|--|---|
| 2. DEVELOP PARTNERSHIPS TO RAISE AWARENESS ABOUT IPV WITHIN HRSA AND HHS | 2.1: Leverage existing mechanisms to promote awareness of IPV as a public health issue among HRSA employees | <p>Continue agency-wide coordination for IPV-related activities</p> <p>Raise awareness among HRSA employees about IPV and the impacts on socially disadvantaged and underserved populations</p> <p>Educate HHS regional employees throughout the country about HRSA’s commitment to the issue of IPV and health</p> |
| | 2.2: Establish within- HRSA and interagency partnerships on IPV | <p>Add an IPV component to the SAMHSA- HRSA Center for Integrated Health Solutions (CIHS)</p> <p>Partner with other agencies on topics that directly relate to IPV</p> |
| 3. INCREASE ACCESS TO QUALITY IPV-INFORMED HEALTH CARE SERVICES ACROSS ALL POPULATIONS | 3.1: Highlight the importance of IPV as a topic that HRSA grantees can propose to address | <p>Incorporate text related to IPV as appropriate in federal assistance planning tools, such as a Notice of Funding Opportunity (NOFO)</p> <p>Engage in bi-directional dialogue about IPV with current HRSA grantees</p> |
| | 3.2: Increase awareness of IPV among HRSA’s key external stakeholders | <p>Leverage existing networks to engage external stakeholders about IPV as a social determinant of health</p> |
| | 3.3: Improve the delivery of IPV-related services for economically disadvantaged and geographically isolated communities | <p>Improve IPV screening, referral, and health-related outcomes for families</p> <p>Explore present and future MCH program collaborations around improving screening, referral, and health-related outcomes for families impacted by IPV</p> |
| | 3.4: Establish a model of collaboration among federal, state, and local health care leaders to strengthen systems of care for IPV | <p>Scale implementation of IPV training through a new HRSA-funded State Leadership Model for improving health outcomes through violence prevention</p> |

KEY ACTIVITIES TABLE

| Priority | Strategic Objectives | Activities |
|--|--|---|
| <p>4. ADDRESS GAPS IN KNOWLEDGE ABOUT IPV RISKS, IMPACTS, AND INTERVENTIONS</p> | <p>4.1: Contribute to the evidence base on the risk factors and impacts of IPV</p> | <p>Explore analyses of national data sources (e.g., the National Survey on Children’s Health), with a focus on children who witness IPV</p> <p>Build the evidence base for interventions that address trauma among people living with HIV/AIDS (PLWHA)</p> |
| | <p>4.2: Support the continuous review and evaluation of federal IPV-related activities and legislative priorities</p> | <p>Share ongoing updates to HRSA-wide inventories focused on IPV that relate to HHS priorities, such as veteran’s health, behavioral health, and opioid use, to identify intersectional opportunities on IPV-related topics</p> <p>Maintain and share an inventory of grant activities that highlight the intersection of maternal and child health and IPV</p> <p>Conduct analysis of federal regulatory and state policy initiatives related to IPV to assess their impact on safety net populations</p> <p>Provide coordination and TA to Bureaus and Offices in developing metrics and tracking mechanisms as they begin to implement, monitor, and evaluate IPV-related activities</p> |

APPENDIX B – NOTICE OF FUNDING OPPORTUNITY IPV LANGUAGE

Option 1 – General Social Determinants of Health Language

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.¹ Community and intimate partner violence are among these factors that can disproportionality affect underserved communities.

IPV describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse, and can have both direct and indirect effects on individual, family and community health.² Applicants are encouraged to consider the impact of Intimate partner violence (IPV) on the target audience, and as relevant, propose and integrate evidence-informed activities into their projects that mitigate this impact.

Collectively, activities will allow programs to better align with priority areas for the Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA), including investments in the integration of behavioral health and primary care.

Option 2 – IPV-specific Language

Intimate partner violence (IPV) describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse, and can have both direct and indirect effects on individual, family and community health.² In 2017, HRSA launched the [HRSA Strategy to Address IPV](#), a whole of agency effort to address this critical social determinant of health through agency-wide collaborative action.

The Strategy includes four priority areas including (1) Training the nation’s health workforce, (2) Building partnerships to raise awareness, (3) Increasing access to quality care, (4) and addressing gaps in knowledge about IPV risks, impacts, and interventions.

Applicants are strongly encouraged to consider one or more of these priority areas, as relevant, in the development and measurement of their (program, study, network, center etc.).

Option 3 – Concise SDOH Language

SDOH include factors like socioeconomic status, neighborhood and physical environment, social support networks, and community and intimate partner violence. SDOH affect a wide range of health, functioning, and quality-of-life outcomes and risks.³ Addressing SDOH, such as violence, is a HRSA objective to improve health and well-being of individuals and the communities in which they reside.

Optional Resources

Other resources that reference IPV and that may provide helpful background include:

- ▶ Healthy People 2020, IVP-39 <https://www.healthypeople.gov/node/3497/data-details>
- ▶ The U.S. Preventive Services Task Force IPV Screening *Final Recommendation Statement 2018: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults*: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening1>
- ▶ The HRSA-Supported Women's Preventive Services Guidelines: <https://www.hrsa.gov/womens-guidelines/index.html>

¹ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

² <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>

³ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

APPENDIX C – LIST OF ACRONYMS

ACRONYMS

| | |
|---------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ACF | Administration for Children and Families |
| BHW | Bureau of Health Workforce |
| BPHC | Bureau of Primary Health Care |
| CDC | Centers for Disease Control and Prevention |
| CIHS | SAMHSA-HRSA Center for Integrated Health Solutions |
| CoIINs | Collaborative Improvement & Innovation Networks |
| E2i | Evidence Informed Interventions to Improve Health Outcomes among People Living with HIV |
| FORHP | Federal Office of Rural Health Policy |
| FY | Fiscal Year |
| HAB | HIV/AIDS Bureau |
| HHS | United States Department of Health and Human Services |
| HIV | Human Immunodeficiency Virus |
| HRSA | Health Resources and Services Administration |
| IPV | Intimate Partner Violence |
| IVLP | International Visitors Leadership Program |
| LGBTQ+ | Lesbian, Gay, Bisexual, Transgender, Queer/Questioning |
| MCHB | Maternal and Child Health Bureau |
| MIECHV | Maternal, Infant, and Early Childhood Home Visiting Program |
| NISVS | National Intimate Partner and Sexual Violence Survey |
| NOFO | Notice of Funding Opportunity |
| OCRDI | Office of Civil Rights, Diversity, and Inclusion |
| OFAM | Office of Federal Assistance Management |
| OGH | Office of Global Health |
| OPAE | Office of Planning, Analysis, and Evaluation |
| ORO | Office of Regional Operations |
| OWH | Office of Women’s Health |
| RHI Hub | Rural Health Information Hub |
| RWHAP | Ryan White HIV/AIDS Program |