HVCoIN
Home Visiting Collaborative Improvement and Innovation Network

Intimate Partner Violence

Electronic Playbook

HRSA Maternal & Child Health

EDC.ORG

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UF4MC26525, Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

HV CoIIN 2.0 Intimate Partner Violence Charter

A. What are we trying to accomplish?

Call to Action: Home visiting has a vital role in addressing intimate partner violence. The Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) designed this charter to explore and define that role by outlining the problem statement and articulating the aim, measures, changes, and expectations for the duration of the collaborative to improve outcomes for caregivers of young children who are receiving home visiting services and who are experiencing intimate partner violence (IPV). Specifically, the charter defines what is at issue; identifies how addressing IPV overlaps with the mission of home visiting; states the collaborative's proposed outcomes and SMART (Specific, Measurable, Achievable, Realistic and Timely) aim; presents primary drivers and process measures, and sets expectations for all participants.

The Centers for Disease Control and Prevention (CDC) defines IPV as "physical, sexual, or psychological harm by a current or former partner or spouse. [It] can occur among heterosexual or same-sex couples and does not require sexual intimacy" (CDC, n.d.a). According to the CDC, one in four women and one in seven men have experienced severe physical violence by an intimate partner at some point in their lifetimes (Smith et al., 2017).

Left undetected, exposure to IPV can have long-lasting adverse effects on infants and young children's growth and development. Studies have shown that mothers experiencing IPV present as less positive, spontaneous, and responsive with their infants, compromising the critical relationships a young child needs to develop (Udo et al., 2016). Unfortunately, children are often witnesses to the violence. One in fifteen children are exposed to IPV between parents or between a parent and a parent's partner (Hamby et al., 2011). During their lifetime, one in four children are exposed to at least one form of family violence. Of the children exposed to IPV, 90 percent directly witness the violence, as opposed to hearing it or experiencing it in another indirect way (Hamby et al., 2011). The effect of this exposure is significant, as research demonstrates that children who witness IPV experience poorer mental and behavioral health outcomes than those who don't (Wathen, 2013). IPV also places significant financial demands on the U.S. health care system. CDC estimates the cost of IPV in clinical and physical therapy and mental health care services at more than $8 billion (CDC, n.d. b).

Quick Facts on IPV

- The number one factor present among those who broke the cycle of abuse was empathy for self and others (Higgins et al., 1994).
- IPV is associated with adverse physical health outcomes, including chronic pain, increased risk of stroke, heart disease, diabetes, and gynecological problems (CDC, n.d. b).
- IPV disproportionately affects specific populations, including pregnant women, racial and ethnic minorities, adolescents, LGBTQ individuals, people living with HIV/AIDS, individuals living with substance use disorders, and those living in rural areas (HRSA, 2017).
- Violence during pregnancy and the postpartum period has been linked to elevated levels of a variety of emotional health problems, including depression, anxiety, post-traumatic stress disorder, and other forms of psychological distress (Martin et al., 2012).
- Some mothers who face severe stress may compensate for violent events by increased nurturing and protection of their children (Levendosky et al., 2003).
- Infants who hear or see unresolved angry conflict or witness a parent being hurt may show symptoms of PTSD, including eating problems, sleep disturbances, lack of typical responses to adults, and loss of previously acquired developmental skills (Carpenter & Stacks, 2009).
- Children's emotional recovery from exposure to IPV depends on the relationship with the nonabusive parent more than any other single factor (Bancroft, Silverman, & Ritchie, 2002).
- Strengthening the mother-child bond is a key strategy for helping children exposed to violence—a strategy that fits well with the emphasis in home visiting programs on building relationships and promoting healthy parenting skills (Bancroft, Silverman, & Ritchie, 2002).

Role of Home Visiting to Address IPV

Evidence suggests that incorporating comprehensive IPV prevention, screening, and intervention (i.e., connections with appropriate supports, including local domestic violence advocacy services organizations) into home visitation programs can help improve the trajectory for families experiencing IPV (Family Violence Prevention Fund, 2010). Yet, few programs fully integrate adequate IPV training and supervisory support into their work or build relationships with local domestic violence advocacy services organizations. Home visiting programs have a unique opportunity to reach families and to incorporate evidence-based and practice-informed strategies—what we know works—to decrease rates of IPV.

Issues related to IPV during the year before and the year after birth (the perinatal period), and all agency capacity- building efforts associated with IPV and that period, represent an important area of focus for home visiting programs for a number of reasons:

- The 2000–2003 PRAMS (Pregnancy Risk Assessment Monitoring System) data for the United States found that 3.9 percent of women experienced IPV during pregnancy.
- Risk factors associated with a higher prevalence of perinatal IPV include youth

(under the age of 20), poverty, and a relationship status of "single."
- IPV during pregnancy confers considerable risk to the mother's physical and mental health, including an increased risk of homicide and suicide.
- The impact of IPV can extend to the health of the children of the abused women, including adverse neonatal outcomes (e.g., low birth weight, small size for gestational age, and preterm birth).

The ongoing relationship between home visitors and caregivers represents an important opportunity to build relationships, connect, and collaborate with women who are at risk of IPV and to offer appropriate support and referral to other resources and services. Without this support, some of the families most in need may not receive the full benefits of these home visitation programs (Eckenrode et al., 2000).

In [insert your state here], [insert a description of the status of IPV in home visiting in your state here. If you participated in the HV CoIIN 2.0 New Topic IPV CoIIN, you could begin by summarizing the accomplishments and learning from your experiences. Then describe the gap in practice that you plan to overcome.]

Mission: Together, in HV CoIIN 2.0, we will dramatically improve not just screening women for IPV, but staff having the knowledge and confidence to effectively support families that are experiencing IPV by offering appropriate referrals based on the self-identified needs of those experiencing IPV. These referrals include community-based or local domestic violence advocacy services organizations and safer planning. [insert here the expected timeframe, based on the time between your launch date and June 2022; for example, "between January 20, 2021, and July 2022"]. Together LIAs will improve outcomes, over time, for caregivers and children who receive home visiting services and are experiencing IPV. Teams will test best practices that will lead to a significant improvement in IPV. The team has identified the following aim:

By July 2022:

90% of survivors are offered supports or services aligned with their self-identified needs and priorities.

85% of survivors who are offered supports or services receive follow-up from a home visitor.

HV CoIIN staff, faculty, and frontline home visiting teams have applied the latest evidence-based research and practice to develop an IPV Key Driver Diagram that displays the SMART aim for addressing IPV and a shared theory of how that aim will be achieved, including the primary drivers (what needs to be in place to accomplish the aim.) The primary drivers that teams will work to put in place are:

1. Competent and supported workforce to address IPV
2. Community partnerships and linkages to services

3. Ongoing universal education[1] on healthy and unhealthy relationships and screening for IPV
4. Ongoing safer planning to address survivors' priorities and decisions

The overarching **SMART AIM** and **PROCESS AIMS** for the HV Intimate Partner Violence CoIIN are:

By July 2022:

90% of survivors are offered supports or services aligned with their self-identified needs and priorities.
85% of survivors who are offered supports or services receive follow-up from a home visitor.

PROCESS AIMS & GOALS:

- 85% of home visitors engaging in reflective supervision at least once in the past month about IPV.
- 90% of caregivers provided universal education about healthy/unhealthy relationships in the past 6 months.
- 75% of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure 14).
- 80% of caregivers with identified IPV who engage in safer planning.

B. HOW WILL WE KNOW A CHANGE IS AN IMPROVEMENT?

To identify progress toward this aim, each month, the team will report on a common group of measures. Data will be graphed on run charts and shared with all HV CoIIN 2.0 participants to promote shared learning. LIAs will collect monthly data for these measures, and program staff will discuss the data to determine if the strategies being tested and implemented are moving them in the right direction. Participants will learn how to create and interpret run charts to promote the sustainability of using data for ongoing improvement efforts. Home visitors will have access to coaching that will help them increase their knowledge and develop their confidence in working with families experiencing IPV.

The selected measures reflect the processes necessary to achieve the SMART aim. These measures are outlined in the following table:

Measure #1: % of caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities.
Measure #2: % of caregivers with identified IPV offered supports or services who

[1] *Universal education* is designed for *all* families; it focuses on the characteristics of healthy and unhealthy relationships, and includes information on additional supports and services and how to access them.

receive follow-up from home visitor
Measure #3: % of home visitors engaging in reflective supervision at least once in the past month about IPV.
Measure #4: Average familiarity with community partner/s
Measure #5: Average ease of linkage to community partner/s
Measure #6: % of caregivers provided universal education about healthy relationships in the past 6 months
Measure #7: % of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure)
Measure #8: % of caregivers with identified IPV who engage in safer planning

C. WHAT CHANGES CAN WE MAKE THAT WILL LEAD TO IMPROVEMENT?

HV CoIIN 2.0 provides a "playbook" comprised of working technical documents that establish a common vision and mission, shared aims, theory, measures, and change ideas to drive improvement in services provided to families experiencing IPV. These materials were developed by HV CoIIN staff, faculty, and front-line home visiting teams who applied the latest evidence-based research and practice to draft, test and refine the *Intimate Partner Violence Key Driver Diagram* (KDD). The KDD displays our aim and our shared theory of how that aim will be achieved, including the primary drivers (i.e., what needs to be in place to accomplish the aim), change ideas (i.e., how those primary drivers might be put in place), and high-quality sample PDSAs from HV CoIIN LIA teams from the Cohort 1 for HV CoIIN's New Topic Workstream.

[Insert text here to describe how you intend local teams to learn from one another. *Sample text: Teams from participating LIAs select which of these change ideas might work in their particular contexts and design Plan-Do-Study-Act (PDSA) cycles to test those changes and drive improvement. The change package provides more detailed descriptions of the change ideas, including examples from seasoned LIA teams that tested specific change ideas and sample PDSA plans*.]

D. COLLABORATIVE EXPECTATIONS

HV CoIIN staff, faculty, and partners EDC, the Collaborative faculty, and the HV CoIIN 2.0 team will do the following:

- Provide Playbooks, which includes a draft Charter, Key Driver Diagram, Change Package with high-quality tested sample PDSAs, and measures. These will be introduced during Learning Session 1 and subsequent monthly virtual project-wide calls, and regular and ad hoc coaching.
- Offer coaching to awardee teams to support scaling and facilitate improvements in home

visiting.

- Provide communication strategies to keep *Lead the Change* participants connected to their peers across the country.
- Provide an online database that automates monthly reports to awardee leaders and local implementing agencies.
- Provide regular coaching and teaching on scale methods, content knowledge,quality improvement methods, and family leadership.

Participating awardees are expected to:

- Identify LIAs that can engage in improving the systems available to families impacted by IPV for the duration of the collaborative.
- Identify a state CQI lead or leads to provide support to local teams.
- Participate in learning sessions and monthly calls hosted by EDC.
- Develop the systems to seek and integrate feedback from parents who are survivors.
- Meet regularly (e.g., monthly) with local CQI teams to review progress (e.g., on PDSA quality reviews, data gathering, data quality) and provide coaching as needed.
- Capitalize on the learning and improvement from this focused collaborative by developing an approach for spreading the system redesign to other organizations.

Participating LIAs are expected to:

- Connect the goals of the Breakthrough Series Collaborative to a strategic initiative in the organization.
- Provide a senior leader to serve as a sponsor for the team working on the collaborative.
- Convene a CQI Team, including extending an invitation to a local domestic violence advocacy services organization.
- Set action plans for achieving the collaborative's aim.
- Perform monthly tests of changes using PDSA rapid cycle methods, and report PDSA cycles to the dashboard.
- Collect and submit data on outcome and process measures for the duration of the collaborative.
- Actively participate in learning sessions and monthly calls.
- Create a process for developing and engaging parent leaders in CQI.
- Participate in awardee-led CQI activities to review data, engage in learning, and problem-solve barriers (through in-person and virtual learning sessions, monthly calls, and one-on-one coaching calls, as needed).
- Work hard, implement change, and love your work!

E. OUR TEAM SIGNATURES

Sponsor (State/Tribal Lead/Not-for-Profit Lead):

Agency Lead(s):

Day-to-Day Supervisor(s):

Home Visitor(s):

Family Member(s):

DV Partner Agency(s):

Other:

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Home Visiting CoIIN 2.0 Intimate Partner Violence Key Driver Diagram

The Key Driver Diagram and Change Package are designed to help home visiting programs provide meaningful support to caregivers who are in coercive and/or abusive relationships (hereafter referred to as survivors). When working with someone who experiences intimate partner violence (IPV), it is important to think about what your actions mean in the context of the survivor's relationship. Consider whether what you are asking of the survivor or doing with the family is making things better, easier, worse, or harder. Our actions are not neutral if one person's decisions and well-being are not respected and if the survivor faces repercussions even for behavior that would be considered reasonable. For example, going back to school and wanting child care are reasonable actions if a survivor is in a healthy and equitable relationship—but if the survivor is experiencing coercion and/or abuse, those actions may have negative consequences. Remember that your first guiding principle is to support the survivor's right to make decisions about their relationships within the context of their own life, their culture, and their assessment of what is best for themselves and their children.

Addressing IPV in the Context of Televisits

People who are living in coercive and/or abusive relationships, as well as their children, may be experiencing increased isolation and danger caused by social distancing measures during the coronavirus pandemic. Survivors often have specific needs around safety, health, and confidentiality. We also know that people who are already more vulnerable to economic and health insecurity are facing additional challenges during this time. Staying connected—or even increasing connections—with survivors is vital.

To support privacy, **be sure to incorporate the following language into every televisit:**

- "Hi, [client's name], it's so good to hear your voice. Is this still a good time to talk? / Who is home with you today?"
- **If there are additional people present consider:** "Is there any chance you can take yourself out for a walk while we talk? If not, no worries; sometimes it's just nice to have another adult to talk with one on one, so we can focus on each other. Is there a more private room you could go to—or maybe a closet, the garage, your car, the basement, or the bathroom?"
- **If older children are present:** "Can you have someone in the house watch the kids while you and I talk? / Do the kids have a headset they can use while we are talking?"
- **"Safer planning" strategy (plan and prepare for contingencies up front):** "I know that while we are talking folks may walk into the room, or the privacy situation can change—if you ever feel uncomfortable, please feel free to change the subject, and I will follow your lead."

Intimate Partner Violence Key Driver Diagram

SMART AIM	Primary Drivers	Change Ideas
By July 2022: 90% of survivors are offered supports or services aligned with their self-identified needs and priorities. 85% of survivors who are offered supports or services receive follow-up from a home visitor.	PD1. Competent and supported workforce to address IPV	1. Address changes in home visitors' experiences and needs by providing ongoing and practice-based training to home visitors and their supervisors on evidence-informed and culturally and linguistically responsive methods, including: • Universal education on healthy/unhealthy relationships • Screening for IPV • An empathic response to IPV disclosures • "Safer planning"[1] and follow-up • Documentation and confidentiality • Referrals on related topics, including legal options for caregivers and state-mandated reporting criteria • Support for the survivor's positive parent-child interactions
		2. Offer regular group and/or 1:1 reflective supervision (internal or external) to home visitors and supervisors by a qualified provider that includes a discussion of IPV in caregivers' lives and the potential impact of the home visitor's own past or present experiences on their work with families.
		3. Have home visiting supervisors work with home visitors to develop and implement a self-care plan.
	PD2. Community partnerships and linkages to services	1. Standardize the process for home visitors to refer caregivers, with their approval, who screen positive for or disclose IPV, and clarify the relationship between the home visiting program and the community-based program that advocates for survivors of domestic violence or sexual assault.
		2. Establish regular communication (e.g., regular meetings) with a partner organization to ensure coordination of services and to build the relationship.
		1. Establish a reminder system for universal education.
		2. Create home visiting-specific safety cards, educational resources, and/or scripts to facilitate conversations about healthy and unhealthy relationships, and incorporate these cards into conversations prior to IPV screening.

[1] Comprehensive *safer planning* addresses violence and coercion, social and emotional well-being, and the basic human needs of caregivers and their children, including income, housing, health care, food, child care, and education.

	PD3. Ongoing universal education[2] on healthy and unhealthy relationships and screening for IPV	3. Integrate education on healthy and unhealthy relationships into other home visiting topics, such as maternal depression, breastfeeding, contraception, and child development.
		4. Establish guidelines and protocols for providing initial and ongoing universal education on healthy and unhealthy relationships to all families.
		5. Acknowledge and validate the caregiver's experience after a disclosure or positive screen.
		6. Develop a contingency plan for completing IPV screening after a disclosure and for caregivers who are hard to reach.
		7. Generate guidelines and protocols for IPV screening, including the timing and scheduling (i.e., periodicity[3]) of screens, the use of reliable and valid tools, and the home visitor's response to screening and client-initiated disclosures.
	PD4. Ongoing safer planning to address survivors' priorities and decisions	1. Conduct a warm referral to a community-based program or organization that advocates for survivors of domestic or sexual violence.
		2. Use conversation prompts and listening strategies to explore survivors' priorities, strengths, risks, and safer planning strategies.
		3. Conduct regular follow-ups with survivors to review and revise safer plans
		4. Integrate children's safety and well-being into comprehensive safer planning.
		5. Establish a contingency plan for safer planning for survivors who are hard to reach or whose partner is always present.
		6. Create guidelines and protocols for documenting, tracking, and receiving reminders for IPV referrals, safer planning, and follow-up (systems approach)

[2] *Universal education* is designed for *all* families; it focuses on the characteristics of healthy and unhealthy relationships, and includes information on additional supports and services and how to access them.

[3] *Periodicity* includes model and MIECHV requirements and additional screening, as needed. The guidelines should adhere to state requirements for mandatory reporting and disclosure of mandatory reporting to caregivers so that caregivers are fully informed of their choices and the potential limitations of confidentiality

Intimate Partner Violence Change Package

SMART AIM	Primary Drivers	Change Ideas	PDSA Examples
By July 2022: 90% of survivors are offered supports or services aligned with their self-identified needs and priorities. 85% of survivors who are offered supports or services receive follow-up from a home visitor	PD1. Competent and supported workforce to address IPV	1. Address changes in home visitors' experiences and needs by providing ongoing and practice-based training to home visitors and their supervisors on evidence-informed and culturally and linguistically responsive methods, including: Universal education on healthy/unhealthy relationships • Screening for IPV • An empathic response to IPV disclosures • "Safer planning"[1] and follow-up • Documentation and confidentiality • Referrals on related topics, including legal options for caregivers and state-mandated reporting criteria	IPV.PD1.C1.Example1. Training and application of attunement IPV.PD1.C1.Example2. Training with partner DV advocacy organization PV.PD1.C1.Example3. Training followed by supervision
		2. Offer regular group and/or 1:1 reflective supervision (internal or external) to home visitors and supervisors by a qualified provider that includes a discussion of IPV in caregivers' lives and the potential impact of the home visitor's own past or present experiences on their work with families.	IPV.PD1.C2. Example1. Exercise to support emotional/self-care check in supervision IPV.PD1.C2. Example2. IPV supervision reference sheets
		3. Have home visiting supervisors work with home visitors to develop and implement a self-care plan.	IPV.PD1.C3. Example1. Self-care plans IPV.PD1.C3. Example2. Mindful self-regulation
	PD2. Community partnerships and linkages to services	1. Standardize the process for home visitors to refer caregivers, with their approval, who screen positive for or disclose IPV, and clarify the relationship between the home visiting program and the community-based program that advocates for survivors of domestic violence or sexual assault.	IPV.PD2.C1.Example1. Developing an MOU IPV.PD2.C1.Example2. Creating a referral form between the DV advocacy organization and home visiting program

[1] Comprehensive *safer planning* addresses violence and coercion, social and emotional well-being, and the basic human needs of caregivers and their children, including income, housing, health care, food, child care, and education.

		2. Establish regular communication (e.g., regular meetings) with a partner organization to ensure coordination of services and to build the relationship.	IPV.PD2.C2.Example1. Engaging DV partner on CQI team
			IPV.PD2.C2.Example2. Relationship building between advocates and home visitors
	PD3. Ongoing universal education on healthy and unhealthy relationships and screening for IPV	1. Establish a reminder system for universal education.	IPV.PD3.C1.Example 1. Using client cover sheet as reminder for education
		2. Create home visiting-specific safety cards, educational resources, and/or scripts to facilitate conversations about healthy and unhealthy relationships, and incorporate these cards into conversations prior to IPV screening.	IPV.PD3.C2.Example1. Healthy Moms Happy Babies cards
			IPV.PD3.C2.Example2. Materials for ongoing education on healthy relationships
			IPV.PD3.C2.Example3. Materials for education on healthy relationships
		3. Integrate education on healthy and unhealthy relationships into other home visiting topics, such as maternal depression, breastfeeding, contraception, and child development.	IPV.PD3.C3.Example1. Integration of education on healthy/unhealthy relationships by asking about partner support
		4. Establish guidelines and protocols for providing initial and ongoing universal education on healthy and unhealthy relationships to all families.	IPV.PD3.C4.Example1. Practice guidelines for universal education
			IPV.PD3.C4.Example2. Placing educational materials in intake packets
			IPV.PD3.C4.Example3. Guidelines for providing education on healthy relationships during specific visits
		5. Acknowledge and validate the caregiver's experience after a disclosure or positive screen.	IPV.PD3.C5.Example1. Prompt for validation after a positive screen or disclosure
			IPV.PD3.C5. Example2. Posters for how to respond to a positive IPV screen
		6. Develop a contingency plan for completing IPV screening after a disclosure and for caregivers who are hard to reach.	IPV.PD3.C6.Example1. Prompt to transition from disclosure to screening

		7. Generate guidelines and protocols for IPV screening, including the timing and scheduling (i.e., periodicity[2]) of screens, the use of reliable and valid tools, and the home visitor's response to screening and client-initiated disclosures.	IPV.PD3.C7.Example1. Using a tracking tool for upcoming screenings
			IPV.PD3.C7.Example2. Home visitor receives lists of clients not yet screened for IPV
	PD4. Ongoing safer planning to address survivors' priorities and decisions	1. Conduct a warm referral to a community-based program or organization that advocates for survivors of domestic or sexual violence.	IPV.PD4.C1.Example1. Use a script to make a warm referral
			IPV.PD4.C1.Example2. Offer of support for past IPV
			IPV.PD4.C1.Example3. Add prompt to back of screening tool as reminder
		2. Use conversation prompts and listening strategies to explore survivors' priorities, strengths, risks, and safer planning strategies.	IPV.PD4.C2.Example1. Conversation -starter tips to initiate support around safer planning
			IPV.PD4.C2.Example2. Recognize and reinforce participants strengths and strategies
			IPV.PD4.C2.Example3. Home visitor engages in mindfulness exercise prior to safer planning
		3. Conduct regular follow-ups with survivors to review and revise safer plans	IPV.PD4.C3.Example1. Use prompts to follow-up with survivor
		4. Integrate children's safety and well-being into comprehensive safer planning.	IPV.PD4.C4.Example1. Validate parent- child interaction
		5. Establish a contingency plan for safer planning for survivors who are hard to reach or whose partner is always present.	IPV.PD4.C5.Example1. Contingency plans for follow-up
		6. Create guidelines and protocols for documenting, tracking, and receiving reminders for IPV referrals, safer planning, and follow-up (systems approach)	IPV.PD4.C6.Example1. Registry tool
			IPV.PD4.C6.Example2. Process map for referral process

[2] *Periodicity* includes model and MIECHV requirements and additional screening, as needed. The guidelines should adhere to state requirements for mandatory reporting and disclosure of mandatory reporting to caregivers so that caregivers are fully informed of their choices and the potential limitations of confidentiality

Intimate Partner Violence SMART Aim, Process Aims, and Measures

Intimate Partner Violence Cheat Sheet

SMART AIMS:

- 90% of survivors are offered supports or services aligned with their self-identified needs and priorities.
- 85% of survivors who are offered supports or services receive follow-up from a home visitor.

PROCESS AIMS:

- 85% of home visitors engaging in reflective supervision at least once in the past month about IPV.
- 90% of caregivers provided universal education about healthy/unhealthy relationships in the past 6 months.
- 75% of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure 14).
- 80% of caregivers with identified IPV who engage in safer planning.

Measure #1 (SMART Aim) % of survivors offered supports or services aligned with their self identified needs and priorities.

Measure #1a [Column E]

- Numerator: N of survivors with a positive screen or self-disclosure of IPV **in reporting month** offered supports or services aligned with their self-identified needs and priorities within 7 days [Column D].
- Denominator: N of survivors with a positive screen or self-disclosure of IPV **in reporting month** [Column C].

Measure #1b [Column H]

- Numerator: N of active survivors (positive screen or self-disclosure of IPV) since the start of the CoIIN offered supports or services aligned with their self-identified needs and priorities within 7 days [Column G].
- Denominator: N of active survivors (positive screen or self-disclosure of IPV) since the start of the CoIIN [Column F].

Measure #2 (SMART Aim): % of survivors who are offered supports or services receive follow-up from a home visitor.

Measure #2a [Column K]

- Numerator: N of survivors offered supports or services aligned with their self-identified needs and priorities in the 2 months prior to the reporting month, who receive follow-up from home visitor within 2 months [Column J].
- Denominator: N of survivors offered supports or services aligned with their self-identified needs and priorities in the 2 months prior to the reporting month [Column I].

Measure #2b [Column N]

- Numerator: N of survivors offered supports or services aligned with their self-identified needs and priorities more than 2 months ago, who receive follow-up from home visitor within 2 months [Column M].
- Denominator: N of survivors since the start of the CoIIN offered supports or services aligned with their self-identified needs and priorities more than 2 months ago [Column L].

The following measures were selected to reflect the processes necessary to achieve the SMART aim. They are labeled with the Primary Driver they reflect.

Measure #3 (Primary Driver 1): % of home visitors engaging in reflective supervision at least once in the past month about IPV [Column Q].

- Numerator: N of home visitors engaging in reflective supervision (1:1 or group) at least once in the past month about IPV [Column P].
- Denominator: N of home visitors [Column O].

Measure #4 (Primary Driver 2): Average rating of familiarity with other partners (Column AC).

  - Sum of scores reported by all home visitors (Column AB)/# of responses (Column AA).

Measure #5 (Primary Driver 2): Average ease of linkage to community partner(s) (Column AF).

  - Sum of scores reported by all home visitors (Column AE)/# of responses (Column AD)

Measure #6 (Primary Driver 3: % of caregivers provided universal education about healthy relationships within the past 6 months [Column T].

- Numerator: N of caregivers enrolled in home visiting at least 6 months who have been provided education on healthy relationships at least once in the past 6 months [Column R].
- Denominator: N of caregivers enrolled in home visiting *for at least 6 months* [Column S].

Measure #7 (Primary Driver 3): % of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure) [Column W].

- Numerator: N of caregivers enrolled in home visiting 6-7 months ago who have been screened for IPV using a validated tool [Column V].
- Denominator: N of caregivers enrolled in home visiting 6-7 months ago [Column U].

Measure #8 (Primary Driver 4): % of caregivers with identified IPV who engage in safer planning [Column Z].

- Numerator: N of caregivers with identified IPV who engage in safer planning with home visitor [Column Y].
- Denominator: N of caregivers with identified IPV at any point in time [Column X].

Intimate Partner Violence Data Reporting Template 2021

Data Entry Sheet

Column letters correspond to the measures, denominators, & numerators in the Cheat Sheet.

A	B	C	D	E	F	G	H
Intimate Partner Violence CoIIN Data Reporting Template 2021							
		1a			**1b**		
Month	Total N of enrolled families	# caregivers with positive screen or self-disclosure of IPV **in the reporting month**	# caregivers with identified IPV **in reporting month** offered supports or services aligned with their self-identified needs and priorities within 7 days	% caregivers with identified IPV **in reporting month** offered supports or services aligned with their self-identified needs and priorities	# active caregivers with positive screen or self-disclosure of IPV at any point in time since the start of the CoIIN	# active caregivers with identified IPV **at any point in time** offered supports or services aligned with their self-identified needs and priorities within 7 days	% caregivers with identified IPV **at any point in time** offered supports or services aligned with their self-identified needs and priorities
Feb-21				#N/A			#N/A
Mar-21				#N/A			#N/A
Apr-21				#N/A			#N/A
May-21				#N/A			#N/A
Jun-21				#N/A			#N/A
Jul-21				#N/A			#N/A
Aug-21				#N/A			#N/A
Sep-21				#N/A			#N/A

Each row represents the data for that month and year

Pink columns are calculated fields (the measure) and you will not be able to edit them.

Yellow columns are denominators of calculated fields.

Green columns are numerators for calculated fields

Gray columns are optional fields

[Find the Data Reporting Template on the HV CoIIN Website]

HV CoIIN 2.0
Intimate Partner Violence Measure Specifications

January 2021

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UF4MC26525, Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Aim	Outcome Measures
Caregivers with identified intimate partner violence[1] are offered supports or services aligned with their self-identified needs and priorities.	% of survivors are offered supports or services aligned with their self-identified needs and priorities.
Caregivers with identified intimate partner violence who are offered supports or services receive follow-up from home visitor.	% of survivors who are offered supports or services receive follow-up from a home visitor.

Primary Drivers	Process Measures
PD1. Competent and supported workforce to address IPV	• % of home visitors engaging in reflective supervision at least once in the past month about IPV.
PD2. Community partnership and linkage to services	• Average familiarity with community partner/s. • Average ease of linkage to community partner/s.
PD3. Ongoing universal education[3] on healthy and unhealthy relationships and screening for IPV	• % of caregivers provided universal education about healthy/unhealthy relationships in the past 6 months. • % of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure 14).
PD4. Ongoing "safer planning " to address the priorities and decisions of survivors[4]	• % of caregivers with identified IPV who engage in safer planning

[1] The Centers for Disease Control and Prevention (CDC) defines IPV as "physical, sexual, or psychological harm by a current or former partner or spouse. [It] can occur among heterosexual or same-sex couples and does not require sexual intimacy"

[2] Definition: Universal Education is education that is designed for all families, that focuses on the characteristics of healthy and unhealthy relationships, and that includes information and resources to access additional support or services.

[3] Definition: Comprehensive, "safer planning" addresses violence and coercion, social and emotional well-being, and basic human needs for the caregivers and their children, including such needs as income, housing, health care, food, child care, and education.

Measure #1

% of survivors are offered supports or services aligned with their self-identified needs and priorities.

Data Elements

1a. In reporting month

- *Numerator:* # of survivors (positive screen or self-disclosure of IPV) in the reporting month who are offered supports or services aligned with their self-identified needs and priorities within 7 days.
- *Denominator:* # of caregivers with positive screen or self-disclosure of IPV in the reporting month.

1b. At any point

- *Numerator:* # of **active** survivors (positive screen or self-disclosure of IPV) since the start of the CoIIN who are offered supports or services aligned with their self-identified needs and priorities within 7 days.
- *Denominator* # of **active** survivors (positive screen or self-disclosure of IPV) since the start of the CoIIN.*****

If survivor has multiple screens, only report on the most recent screen (do not count a survivor more than once)

*** Note:** the denominator for measure 1b will be a running count of clients currently enrolled in the program who have had a positive screen or disclosure since the start of the CoIIN project (Feb 2021). You do not need to include positive screens or disclosures that have occurred prior to the start of the CoIIN. Once you start tracking, clients stay in the denominator until they leave the program.

Frequency of Data Reporting

Monthly

Associated Driver

Aim

Definitions

Identified IPV

Positive IPV screen or self-disclosure for past or current IPV.
Positive IPV screen: use of a validated IPV screening instrument indicates positive result for IPV, using scoring criteria of the instrument used. If caregiver has multiple screens, only report on the most recent screen (do not count a caregiver more than once)
Self-disclosure: caregiver shares an experience with IPV at any time or outside of a positive screen.
Past IPV: An experience of IPV in a past relationship. Past IPV refers to relationship status. If a caregiver is still in a relationship with the person who previously caused the harm, it is not past IPV.
Clients who report past IPV should be included in the denominator for this measure and offered a referral to IPV supports or services. If caregivers with past IPV are not interested in services offered, they can be removed from the denominator for downstream measures (follow-up and safer planning). Additional guidance on offering supports for past IPV and for determining if a client should be included in a denominator can be found in the "Measures for Past Disclosures Document"

Offered IPV

Offer of supports or services includes:

1. Information about what services and community-based resources are available.
2. What the caregiver can expect when they call the community-based, non-profit domestic or sexual violence victim advocacy program, hotline or other community-based resource.
3. Providing the caregiver with the contact information and offering to make a telephone call together/other efforts to connect the caregiver with the service.

Supports or services aligned with their self-identified needs and priorities

Home visitor offers information/resources/support for priorities that the survivor has identified, including (but not limited to): Housing options or emergency shelter services; Legal advocacy and assistance; Crisis assistance; Support groups; Immigration related services; Child/family focused services; Faith based programs; Culturally specific programming; Child mental health services, including evidence based therapies for trauma exposure; Economic advocacy and assistance, including employment protections, public benefits, and healthcare; Counseling services to address potentially related needs such as depression or substance use.

Offer of support for self-identified needs **must** include offer of referral to community-based, non-profit domestic violence victim advocacy program, The National Domestic Violence Hotline, or to a State or County Domestic Violence Hotline.

Active survivors: survivors enrolled in the home visiting program during part or all of the reporting month. Include families that were closed during the reporting month, caregivers on creative outreach, or otherwise hard to reach potentially related needs

Measure #2

% of survivors who are offered supports or services receive follow-up from a home visitor.

Data Elements

2a. In reporting month

- *Numerator:* # of active survivors offered supports or services aligned with their self-identified needs and priorities in the 2 months prior to the reporting month who receive follow-up from home visitor within 2 months.
- *Denominator:* # of active survivors offered supports or services aligned with their self-identified needs and priorities in the 2 months prior to the reporting month .

For example, for Feb 2021 data, the denominator for this measure would be survivors who were offered a referral in December 2020. We have provided the dates associated with the numerator and denominator for this measure for each of the reporting months in the calendar calculations Appendix A. We encourage you to print this table and have it handy to facilitate data reporting each month.

Reporting Month	Caregivers offered referral in the month 2 months prior to the reporting month
	Offered referral between
Feb-21	12/1/20 – 12/31/20
Mar-21	1/1/21 – 1/31/21
Apr-21	2/1/21 – 2/28/21
May-21	3/1/21 – 3/31/21
Jun-21	4/1/21 – 4/30/21
Jul-21	5/1/21 – 5/31/21
Aug-21	6/1/21 – 6/30/21
Sept-21	7/1/21 – 7/31/21
Oct-21	8/1/21 – 8/31/21
Nov-21	9/1/21 – 9/30/21
Dec-21	10/1/21 – 10/31/21

Definitions

Follow-up

After services/supports are offered, the home visitor engages survivor in conversation about how things are going, if they have any questions, if they feel supported, if anything changed and if anything more is needed. While the intent of conversation is if the family feels supported and should not pressure the survivor to access services if they are not desired, follow-up includes the home visitor knowing the status of any referrals. We are measuring follow-up within 2 months to account for a variety of factors such as periodicity or missed visits, but home visitor should follow-up sooner as they see appropriate.

Programs could test different approaches to "follow-up," as long as the conversation makes supporting the caregiver the focus. Prompts to start the conversation could include:

- During our last visit we talked about your relationship with [insert partner]. Has anything changed? How have things been going? Anything surprise you? What's worked in the past? Do you have a new idea?
- In the past we have talked about your hopes and desires with your relationship with [insert partner]. How have things been going?
- Is there anything that you are worried about now?
- How is your partner supporting you around [insert topic]?
- Last time we talked about connecting with the local advocacy program – were any of the resources helpful? Is there anything you are wondering about? What can I help you with?

Measure #2

2b. At any point

- *Numerator:* # of active survivors since the start of the CoIIN offered supports or services aligned with their self-identified needs and priorities more than 2 months ago, who receive follow-up from home visitor within 2 months.
- *Denominator* # of active survivors since the start of the CoIIN offered supports or services aligned with their self-identified needs and priorities *more than 2 months ago.*

Reporting Month	Active Caregivers offered referral more than 2 months ago
	Offered referral between
Feb-21	12/1/2020 and 1/31/2021
Mar-21	12/1/2020 and 2/28/2021
Apr-21	12/1/2020 and 3/31/2021
May-21	12/1/2020 and 4/30/2021
Jun-21	12/1/2020 and 5/31/2021
Jul-21	12/1/2020 and 6/30/2021
Aug-21	12/1/2020 and 7/31/2021
Sept-21	12/1/2020 and 8/31/2021
Oct-21	12/1/2020 and 9/30/2021
Nov-21	12/1/2020 and 10/31/2021
Dec-21	12/1/2020 and 11/30/2021

Note:

- If a survivors (disclosed past IPV) does not accept an offer of support, they can be excluded from the denominator of this measure. Please see additional guidance on past disclosures of IPV in the Measures for Past Disclosure document *(Appendix B).*
- If a survivor is offered additional supports or services after an initial offer, they should be counted again when the next offer occurs.

Frequency of Data Reporting

Monthly

Definitions

Past IPV

An experience of IPV in a past relationship. Past IPV refers to relationship status. If a survivor is still in a relationship with the person who previously caused the harm, it is not past IPV

Primary Driver 1

Measure #3

% of home visitors engaging in reflective supervision at least once in the past month about IPV

- *Numerator:* # of home visitors engaging in reflective supervision (1:1 or group) at least once in the past month about IPV.
- *Denominator:* # of home visitors.

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 1

Definitions

Reflective supervision
A collaborative relationship that aims at creating a climate where both the client's and the home visitor's needs are being considered so that the effectiveness of the intervention is optimized. Involves the process of examining with someone else the thoughts, feelings, actions, and reactions evoked in the course of working closely with young children and their families who are experiencing intimate partner violence.

Topics related to reflective supervision about IPV could include concerns for safety, vicarious trauma, potential lack of resources available to survivors, providing universal education on healthy/unhealthy relationships, plans for safer planning with specific caregivers.

Primary Driver 2

Measures # 4 and # 5

Average familiarity with community partner/s

- Average rating of familiarity with other partners (1=little familiarity, 6=quite a bit familiarity)
    - Sum of scores reported by all home visitors/# of responses

Average ease of linkage to community partner/s

- Average ease of linkage to other partners (1=not easy, 6=very easy)
    - Sum of scores reported by all home visitors/# of responses

Data Collection
At the start of the project, local sites will be asked to identify community partners that are important to include in this work and to which they would expect to link caregivers with identified IPV. Each quarter, every home visitor would then complete a survey answering this question for each identified community partner.

Frequency
Quarterly

Associated Driver
Primary Driver 2

Reporting month	For time period between
February 2021	Dec. 2020- Feb. 2021
May 2021	Mar. -May 2021
August 2021	Jun.-Aug. 2021
November 2021	Sept.-Nov.2021
February 2022	Dec 2021-Feb. 2022
May 2022	Mar. -May 2022

Definitions

Community partner familiarity survey question
Each home visitor would be asked this question on a quarterly basis:

On a scale of 1-6, how familiar are you with the supports/services that this organization offers?

1 = "I know little about the services/supports"
2
3
4
5
6 = "I know quite a bit about the services/supports"

Community partner linkage survey question
Each home visitor would be asked this question on a quarterly basis:

On a scale of 1-6, how easy is it to link your families to this organization?

1 = "It's not easy"
2
3
4
5
6 = "It's very easy"

Primary Driver 3

Measure # 6

% of caregivers provided universal education about healthy relationships in the past 6 months

- *Numerator:* # of active caregivers enrolled in home visiting for at least 6 months who have been provided education on healthy relationships at least once in the past 6 months.
- *Denominator:* # of active caregivers enrolled in home visiting *for at least 6 months.*

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 3

Reporting Month	**Caregivers enrolled 6 or more months ago**
Jan-21	8/1/2020
Feb-21	9/1/2020
Mar-21	10/1/2020
Apr-21	11/1/2020
May-21	12/1/2020
Jun-21	1/1/2021
Jul-21	2/1/2021
Aug-21	3/1/2021
Sept-21	4/1/2021
Oct-21	5/1/2021
Nov-21	6/1/2021
Dec-21	7/1/2021

Definitions

Universal education
Ongoing education for all families that focuses on characteristics of healthy and unhealthy relationships. Education must include provision of information and resources to access additional support or services related to IPV.

Primary Driver 3

Measure # 7

% of caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool (HRSA Performance Measure)

- *Numerator:* # of active caregivers enrolled in home visiting in the month 6 months prior to the reporting month who have been screened for IPV using a validated tool.
- *Denominator:* # of active caregivers enrolled in home visiting in the month 6 months prior to the reporting month.

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 3

Reporting Month	**Caregivers enrolled 6 months prior**
	Enrolled between
Jan-21	7/1/20 – 7/31/2020
Feb-21	8/1/2020 – 8/31/2020
Mar-21	9/1/2020 – 9/30/2020
Apr-21	10/1/2020 – 10/31/2020
May-21	11/1/2020 – 11/30/2020
Jun-21	12/1/2020 – 12/31/2020
Jul-21	1/1/2021 – 1/31/2021
Aug-21	2/1/2021 – 2/28/2021
Sept-21	3/1/2021 – 3/31/2021
Oct-21	4/1/2021 – 4/30/2021
Nov-21	5/1/2021 – 5/31/2021
Dec-21	6/1/2021 – 6/30/2021

Definitions

Screened for IPV
Application of the screening tool specified by state or model curriculum.

Primary Driver 4

Measure #8

Measure

% of caregivers with identified IPV who engage in safer planning

- *Numerator:* # of active survivors who engage in safer planning with home visitor.
- *Denominator:* # of active survivors at any point in time.

*Note that if a survivor (disclosed past IPV) does not accept an offer of support, they can be excluded from the denominator of this measure. Please see additional guidance on past disclosures of IPV in the "Measures for Past Disclosures" document.

Frequency

Monthly

Associated Driver
Primary Driver 4

Definitions

Safer planning: Identifies the risks and priorities from the survivor's perspective, including their children's needs, and works collaboratively with the survivor to help them get what they want and need. The items below are key features of safer planning. The first 3 are required to meet the definition of safer planning.

- **Did I validate their experiences and thank them for sharing with me?**
- **Did I acknowledge that they are expert on their relationship and family and they get to decide what to do next?**
- **Did I ask what is the biggest worry or priority for the survivor?**
- Did I share information about local domestic violence/sexual assault advocacy programs or state or national DV hotline (chat and text options, many languages spoken by advocates)?
- Did I ask what strategies they are using or have used in the past to keep her and her children safer?
- Did we explore sources of social support?

Table 1. Calendar Calculations for Measures by Reporting Month

	Data due	Survivors-+IPV screen or disclosure this month (Measure 1a)	Active Survivors-+IPV screen or disclosure since the start of the CoIIN (Measure 1b)	Survivors offered referral in the month 2 months prior to the reporting month (Measure 2a)	Active Survivors offered referral more than 2 months ago (Measure 2b)	Caregivers enrolled 6 or more months ago (Measure 6)	Caregivers enrolled 6 months prior (Measure 7)
		+ screen or self-disclosure between the dates below	+ screen or self-disclosure after	Offered referral between	Offered referral between	Enrolled before	Enrolled between
Feb-21	3/15/21	2/1/21 -2/28/21	2/1/21	12/1/20 – 12/31/20	12/1/20 - 12/31/21	9/1/20	8/1/20 – 8/31/20
Mar-21	4/15/21	3/1/21 – 3/31/21	2/1/21	1/1/21 – 1/31/21	12/1/20 - 1/30/21	10/1/20	9/1/20 – 9/30/20
Apr-21	5/15/21	4/1/21 – 4/30/21	2/1/21	2/1/21 -2/28/21	12/1/20 – 2/28/21	11/1/20	10/1/20 – 10/31/20
May-21	6/15/21	5/1/21 – 5/31/21	2/1/21	3/1/21 – 3/31/21	12/1/20 – 3/31/21	12/1/20	11/1/20 – 11/30/20
Jun-21	7/15/21	6/1/21 – 6/30/21	2/1/21	4/1/21 – 4/30/21	12/1/20 – 4/30/21	1/1/21	12/1/20 – 12/31/21
Jul-21	8/15/21	7/1/21 – 7/31/21	2/1/21	5/1/21 – 5/31/21	12/1/20 – 5/31/21	2/1/21	1/1/21 – 1/31/21
Aug-21	9/15/21	8/1/21 – 8/31/21	2/1/21	6/1/21 – 6/30/21	12/1/20 – 6/30/21	3/1/21	2/1/21 – 2/28/21
Sept-21	10/15/21	9/1/21 – 9/30/21	2/1/21	7/1/21 – 7/31/21	12/1/20 – 7/31/21	4/1/21	3/1/21 – 3/31/21
Oct-21	11/15/21	10/1/21 – 10/31/21	2/1/21	8/1/21 – 8/31/21	12/1/20 – 8/31/21	5/1/21	4/1/21 – 4/30/21
Nov-21	12/15/21	11/1/21 – 11/30/21	2/1/21	9/1/21 – 9/30/21	12/1/20 – 9/30/21	6/1/21	5/1/21 – 5/31/21

Appendix A

IPV Data Review Guidance

January 2021

Reflecting on data is an important step in Continuous Quality Improvement; it provides both direction, motivation and opportunities for celebration. Ensuring accurate data is a crucial component of this. Below is a list of guidelines for reviewing data submitted for the HV CoIIN's Intimate Partner Violence topic area to check for data errors. All of the guidelines outlined below are meant to identify *potential* errors, in many cases there will be a perfectly good explanation for why something looks the way it does. These guidelines are also not comprehensive. If something looks off in the data but is not listed here, it is probably still worth having a conversation about. The most helpful question to ask yourself while thoroughly reviewing this data is "If the data in this column is accurate, what might I expect to see happening in the other columns?"

We recommend that you first do a general screen for all measures:

- If there are large fluctuations in any of the variables but related variables remain stable, this may be worth checking on.
- If the numbers stay exactly the same for each measure across several months, check with your team to make sure the data is being tracked/collected correctly.
- Check to make sure there is no missing data.

In the check list below, the most important data checks for teams to focus on are around Measure 1 and 2 (columns C through columns M). This is where we see the most amount of errors.

Specific measure checks:

- Column B (Total N of enrolled families)
    - Check column B to see if there is a large change from month to month, especially if column O (N home visitors) does not move in the same direction. What counts as a large change will depend on the size of the program, but for most sites a change equivalent to one home visitor caseload per 100 total enrolled women would be reason to double check (e.g. a site with 80 enrolled women wouldn't often drop to 55 in one month; a site with 150 enrolled women might increase to 170, but not often to 200).

- Column C (N caregivers with positive screen or self-disclosure of IPV in the reporting month)

- Check column C against column F (N active caregivers with positive screen or self-disclosure of IPV at any point in time since the start of the CoIIN). The number in column F should increase at the same rate as the numbers in column C unless there are caregivers with identified IPV who left the program. For example, if a team reports 5 caregivers in Column F for Jan and 2 caregivers in Column C for Feb, we expect to see 7 caregivers reported in Column F for Feb (unless any of these caregivers left the program). It is also possibly that these numbers do not match if a caregiver has had more than one screen and the new screen is negative. That client would be removed from the denominator in cumulative measure.

- Column D (N caregivers with identified IPV in reporting month offered supports or services aligned with their self-identified needs and priorities within 7 days)
  - Check column D against column G (N active caregivers with identified IPV at any point in time since the start of the CoIIN offered supports or services aligned with their self-identified needs and priorities within 7 days). The number in column G should increase at the same rate as the numbers in column D unless there are caregivers with identified IPV who left the program.

- Column I (N active caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities in the month 2 months prior to the reporting month)
  - Check column I against the data entered 2 rows higher in column D (N caregivers with identified IPV in reporting month offered supports or services aligned with their self-identified needs and priorities within 7 days). For example, when looking at the data entered in column I for August, compare it against the data entered in column D for June. We typically expect the data entered for column I to be at least what is entered in column D (from 2 months prior). Column I may be higher if an offer was made that didn't meet the criteria for an offer of support for measure 1 or if a caregiver who was already identified with IPV was provided another offer of support.
    - For further clarification on dates, please see the Calendar Calculations table on the last page of the Measure Specifications Guide (pg. 30).

- Column I (N active caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities in the month 2 months prior to the reporting month)
  - Check column I against column L (N active caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities more than 2 months ago). The number in column L should increase at the same rate as the numbers in column I unless there are caregivers with identified IPV who left the program. For example, if a team reports 2 caregivers in Column L for Jan and 2 caregivers in Column I for Feb, we expect to see 4 caregivers reported in Column L for Feb (unless any of these caregivers left the program). It is also

possibly that these numbers do not match if a caregiver has had more than one screen and the new screen is negative. That client would be removed from the denominator in cumulative measure.

- Column J (N active caregivers with identified IPV offered supports or services aligned with their self-identified needs and priorities in the month 2 months prior to the reporting month who receive follow-up from home visitor within 2 months)
    - Check column J against column M (N active caregivers with identified IPV offered supports or services aligned with their self-identified needs). The number in column M should increase at the same rate as the numbers in column J unless there are caregivers with identified IPV who left the program.

- Column R (N active caregivers enrolled in home visiting for at least 6 months)
    - Check column R against column B (Total N enrolled families). We typically expect the numbers to be close, but not the same, around 70-75% of column B. If there are large outliers, there should be an obvious explanation (e.g., the LIA just started enrolling clients when the CoIIN started).
    - Check column R against column U (N active caregivers enrolled in home visiting 6-7 months ago). The number of caregivers in column R should include all caregivers enrolled in home visiting for at least 6 months and we expect this to be higher than the number in column U. The number in column U should reflect only those caregivers who are enrolled in the 30 day window that is between 6 and 7 months ago. For further clarification on the exact days this measure includes, please see the Calendar Calculations table on the last page of the Measure Specifications Guide (pg. 30).

- Column U (N active caregivers enrolled in home visiting 6-7 months ago)
    - Check column U to see if there is any change from month to month. Since each month portrays a new 30-day window that is being measured, we expect this number to show some variety, especially if new caregivers have been added in column B (Total n families enrolled).

- Columns AC and AF (Measures 4 and 5)
    - Check column AC (Average familiarity with community partner/s) and column AF (Average ease of linkage to community partner/s). The scales of these surveys is out of 6, so we expect any number entered in these columns to be 6 or below.

Appendix B

Additional Guidance on Disclosures of Past IPV

Please see guidance below for including clients with disclosures of past IPV in the measures. We are recommending that *some* disclosures of past IPV be excluded from several measures. The table below summarizes who should be included in the denominator for all measures with a denominator of identified IPV. The flow chart below may be helpful in determining which disclosures of past IPV should be included in the denominator for measures with a denominator of identified IPV.

Time frames and Definitions:

Time frame:

There are two time frames to be considered in the measure definitions: (1) when the screen or disclosure happened (current reporting month or a previous reporting month) and (2) when IPV occurred (in a past or present relationship). For example, in the statement "disclosure of present IPV more than 3 months ago", 3 months ago refers to when the disclosure happened. Present refers to the client being in a present relationship with the person causing harm. In the statement "Disclosure of past IPV in the reporting month", "in the reporting month" refers to when the disclosure happened. Past refers to a past relationship with the person who caused harm.

Definitions:

IPV: According to the Centers for Disease Control and Prevention, IPV encompasses "physical violence, sexual violence, stalking, and psychological aggression (including coercive acts)" that occurs in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. Note that IPV encompasses more than physical or sexual abuse. Coercion may include behaviors like physical injury, psychological abuse, sexual abuse, monitoring, isolation, stalking, deprivation, intimidation, and sexual and reproductive coercion with the intent of establishing control of one partner over the other and undermining a person's decision making, autonomy and access to support and resources (i.e., healthcare, economic, WIC, HV.) Several types of IPV can occur together. IPV can vary in frequency and severity.

Positive IPV screen: use of a validated IPV screening instrument indicates positive result for IPV, using scoring criteria of the instrument used

Self-disclosure: caregiver shares an experience with IPV at any time or outside of a positive screen. Please note that IPV encompasses more than physical or sexual abuse. See full definition of IPV above.

Additional considerations and guidance around disclosures

Because of the relational foundation of home visitors with the caregivers they support, information may be shared in conversations where a home visitor may be unsure if the information shared qualifies as a disclosure. Disclosure is not the goal. The objective in these situations is to listen, offer support and stay connected to understand their experience in their relationship. Per the definition above, coercion

may include isolation, limiting decision making or access to resources, eroding a caregiver's sense of self-worth and autonomy, with the intent of establishing control of one partner over the other. The consequences that a non-abusive caregiver may be facing are unique to the people involved.

A caregiver experiencing coercion and/or abuse may face repercussions for decisions such as seeing family/friends, birth control use, family planning decisions, or having access to and managing money. Consequences could include (but are not limited to):

- taking her children away
- prohibiting breastfeeding
- restricting access to services (i.e. WIC, healthcare, behavioral health etc.)
- Impeding access to education and work
- threatening deportation
- embarrassing her at work

If you have any questions about when to include a particular situation, contact your improvement advisor for support.

Strategies for exploring if a caregiver is offering a disclosure of IPV

- All couples have disagreements, what does it look like when you and your partner disagree on a topic?
- What happens when you don't go along with your partner's plans and wishes?
- Do you feel respected in your relationship?

Past IPV

An experience of IPV in a past relationship. Past IPV refers to relationship status. If a caregiver is still in a relationship with the person who caused harm, it is not past IPV.

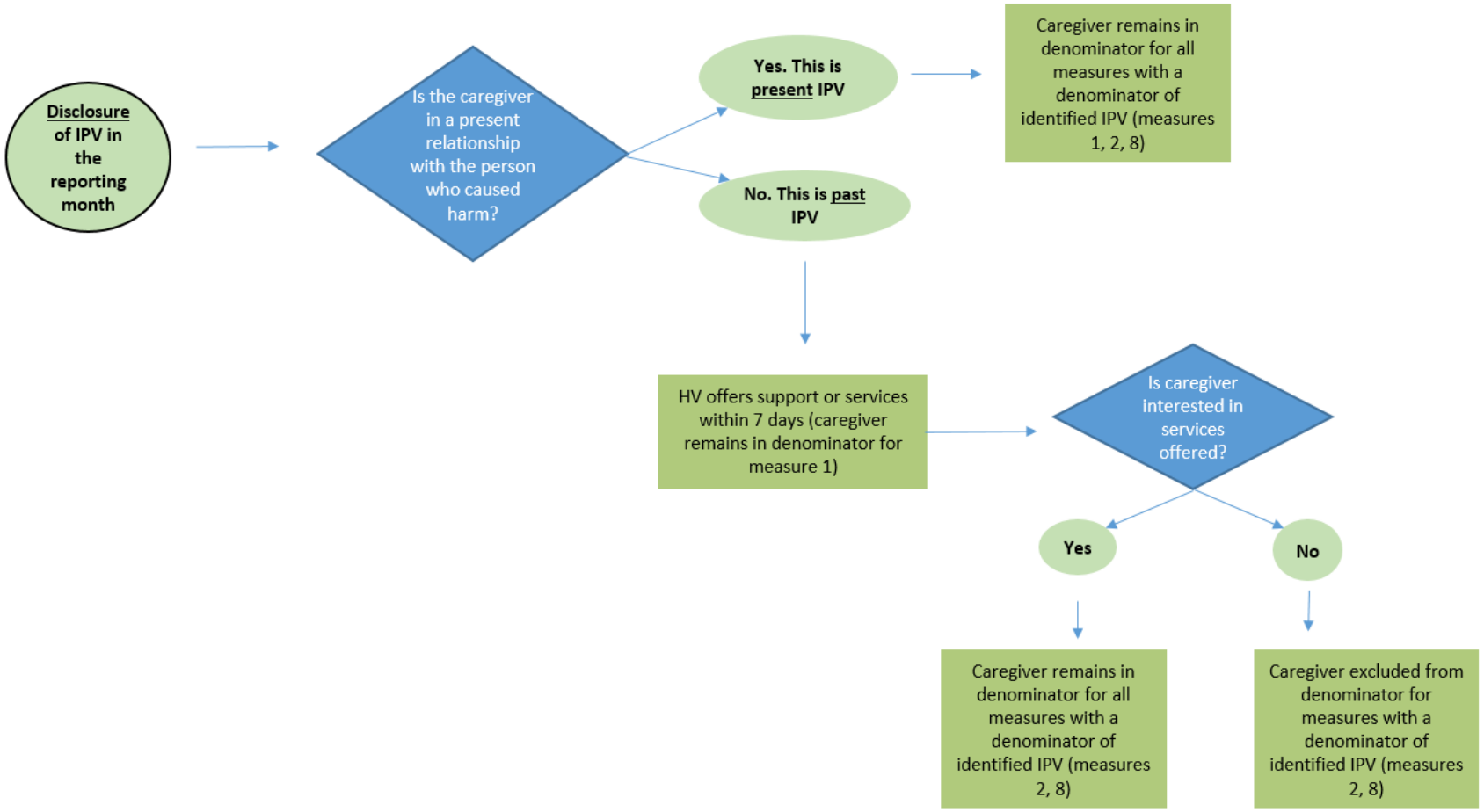
1) Does it only refer to past relationships?
    a. Yes, this only refers to past relationships. Note that many survivors may still be in contact with a person who previously caused them harm because of child visitation or other reasons.
2) What if they still have a relationship, but the person who caused the abuse is incarcerated or lives in another state?
    a. If they are still in a relationship with the person who caused the harm, it is not past IPV.
3) What if they are still living with the person, but the abuse has stopped and they no longer have concerns?
    a. If they are still in a relationship with the person who caused the harm, it is not past IPV.

Note that these are parameters for data collection ONLY. A past experience of IPV can and should inform other aspects of relationship building and home visiting services with the client.

Below are some potential strategies for offering services or re-engaging participants with a screen or disclosure of past IPV:

- "I'm glad to hear that this past relationship is no longer an issue. I just want you to know that there are resources that are always available. We give these to everyone. If anything should change, I'm here for you."
- "We know that relationships can impact health and parenting. If anything should change, I'm here for you."
- "You previously mentioned some issues with a previous relationship. I wanted to go back to that and see if you needed any additional supports."

- “We have talked about your hopes and desires in the past with your relationship with [insert partner]. How have things been going? Anything that has been surprising or something you would like to talk about?”
- “I know [insert partner] still has contact with the kids. How has that been going?”
- "I’m glad you feel safe with your ex in prison. Have you thought about how you might feel as it gets closer to his release date? We can start planning for that if and when you want to do that. We have a lot of great resources in our community that can support you when that time comes."
- "Thank you for sharing what happened in the past. You mentioned you no longer have contact with your ex. Is there any possibility that could change, or do you have any concerns he could reappear? If anything should change, we can talk about it again. Just let me know."
- Ask about specific health and parenting strategies and touch base on if and how their relationship might be impacting (either positively or negatively) those goals.


Disclosure of IPV in the reporting month
Is the caregiver in a present relationship with the person who caused harm?
Yes. This is present IPV
No. This is past IPV
Caregiver remains in denominator for all measures with a denominator of identified IPV (measures 1, 2, 8)
HV offers support or services within 7 days (caregiver remains in denominator for measure 1)
Is caregiver interested in services offered?
Yes
No
Caregiver remains in denominator for all measures with a denominator of identified IPV (measures 2, 8)
Caregiver excluded from denominator for measures with a denominator of identified IPV (measures 2, 8)

Appendix C

Intimate Partner Violence Data Frequently Asked Questions

****For all MIECHV policy and budget questions, please contact your Project Officer****

Data Reporting & Uploading

1. For agencies with multiple home visiting models, should we submit data for the models separately?
    - This decision depends on your agency and what makes the most sense for your work. For example, if you operate as one program and one team, it might make sense to submit data together. But if there are enough differences between the 2 models and you operate as 2 distinct programs, it likely makes sense to report the data separately. In HV CoIIN 1.0, all teams with different models reported the data separately. We are able to support both options but will need to know if we should create two different data entry portals for your team. If you would like help deciding which option is best for your team, please email pfinnerty@edc.org . If you are submitting data separately for each home visiting model, please email Emma McAuley (emcauley@edc.org) to discuss how you would like your team options to appear on the website.

2. Can we multi-select home visiting models when uploading data?
    - If you have multiple home visiting models represented in your data but wish to submit the data for the models together, you are able to multi-select models when you upload your data. You can find more information about how to upload your data on our "" information sheet are available on our website.

3. Will each data submission have a separate spreadsheet?
    - Each month you will fill out a new row in the same spreadsheet and will need to re-upload the HV CoIIN IPV Data Reporting Template document. For example, you will fill out February 2021 data in row 6 of the report and submit the data template via the website. When you report March 2021 data, you will fill out row 7 of the same spreadsheet, and re-upload that spreadsheet to the website with the updated information *as well as* all previously submitted data.

4. Are we submitting data for just MIECHV clients?
    - Due to the small number of caregivers screening positive or disclosing IPV, we are suggesting LIAs report data on MIECHV and non-MIECHV caregivers. However, if you have 2 completely separate work processes and data reporting systems for MIECHV and

non-MIECHV caregivers and reporting on both will cause a large burden for your site, we will leave it up to the LIA to decide if they will just report on MIECHV caregivers.

5. What document needs to be submitted and what is used for internal use?
    - The HV CoIIN IPV Data Reporting Template is the document which will be submitted monthly to the HV CoIIN 2.0 website. The IPV and Universal registries are optional tools intended for internal use within your agency. These are tools that the HV CoIIN team created to help you track individual level data, but use of this tool is optional and agencies should not submit this document.

Measure Timeframes

1. For the measures on universal education (measure 6) and safer planning (measure 8), are we reporting on our full caseload or only starting now with all new clients coming on board?
    - For measures 6 and 8), we are looking at all caregivers in your current, active caseload, not just new clients. For measure 8, this is all active clients with a positive screen or self-disclosure for IPV. For measure 6, you look at all clients who have been enrolled for at least 6 months.

2. For Measure #7 (% of caregivers enrolled in home visiting who are screened for IPV within 6 months of enrollment using a validated tool), who should we include in the denominator?
    - The denominator for this measure is caregivers enrolled in the month 6 months prior to the reporting month. Page 10 in the Measure Specification document provides Calendar Calculations for Measure 7 by Reporting Month. Here you can see that for January 2021 you would include caregivers enrolled between 7/1/20-7/31/20. For February 2021 you would include caregivers enrolled between 8/1/20-8/31/20.

3. For Measure #1a (% caregivers with identified IPV in the reporting month offered supports or services aligned with their self-identified needs and priorities), should we include in the denominator only counts of current partners or previous partners? We have been answering Column C (# of caregivers with identified IPV in reporting month) as "identified IPV in reporting month with their current partner".
    - The terms "in reporting month" and "at any time" refers to when a participant discloses IPV, not when the relationship was. So in Column C, "identified IPV in reporting month" refers to a positive screen or a disclosure happening in the reporting month, but this could be a disclosure of current or past IPV. Column F, "identified at any point in time" refers to IPV disclosures and screening which happens at any point. This is a cumulative tracking of all positive screens and disclosures.

      For example, in reporting month May 2021, Column C would be the N of caregivers who have screened positive or disclosed IPV between May 1-31 2021 (again disclosure happening in May, not that the relationship is current). Column F would be the N of

caregivers who have screened positive or disclosed IPV before May 31, 2021 (cumulative count of all your caregivers with IPV).

Data Collection Methods

1. If we are able to gather all the data on the IPV and Universal Tracking Worksheet, will we be able to answer all the questions on the HV CoIIN IPV Data Reporting Template?
    - Yes. All of the information that you need to calculate the measures can be found in the IPV and Universal Tracking forms.

2. For the questions on the IPV and Universal Tracking Worksheet related to education on healthy relationships, and safer planning – is that data on the HV CoIIN Data Reporting Template?
    - Yes. The data captured for those questions on the IPV and Universal Tracking Worksheet will be reported on the HV CoIIN Data Reporting Template. This information is related to Measure #6 (% of caregivers provided universal education about healthy relationships within the past 6 months) and Measure #8 (% of caregivers with identified IPV who engage in safer planning). For a quick guide of where to find the measures on the HV CoIIN Data Reporting Template, look at row 2 on the IPV Data Entry tab, which lists which measure each column is associated with.

3. When we go back and look at our current caseloads, if something has not been documented, does that count as a "no"?
    - If an item is not documented it should be counted as a "no". For example, if education on healthy/unhealthy relationships was not documented, that caregiver should not be counted in the numerator for Measure 6.

4. If the client is +IPV, exits NFP and then re-enrolls, should they continue entering data about the client on the form? Should they enter that client as a "new" client, in which case you might have two rows in the spreadsheet for the same client, but for different enrollment periods?
    - Once the client exits, they would no longer be included in the numerators and denominators for the measures since they are not active. If they re-enroll, the client would start to be included in the denominator again. This client can be tracked on a new row in the tracking worksheet. The client's previous row would have a closure date and entering on a new row would allow the LIA to track all the information for this enrollment cleanly.

Operational Definitions

1. If my agency has our local DV agency come to do a talk on healthy/unhealthy relationships at our monthly group connections meeting, can that count for Measure #6 (% of caregivers provided universal education about healthy relationships within the past 6 months), for those individuals who attended?
    - While we encourage these connections with your local DV agency, group sessions will not count for this measure. We advise home visitors to have individualized conversations with caregivers on healthy/unhealthy relationships.

2. Are we expected to do healthy/unhealthy relationship teaching with those who have screened positive for IPV?
    - The denominator for the healthy relationship measure (Measure 6) is all caregivers enrolled in home visiting *for at least 6 months.* Home visitors should use their discretion to know the best timing to talk about healthy/unhealthy relationships for all clients, including those with a positive screen. The span of six months gives the home visitor discretion to figure out the best time to work in healthy relationship education for each individual family.

3. Can we get further clarity on *offer* to refer to services? Does an offer mean an offer of what services are available (education), or an offer to directly call or connect them to services? Is there anywhere where an offer to services other than DV hotline or community partner are included/counted?
    - The operational definition for Offer of supports or services includes:
      1. Information about what services and community-based resources are available
      2. What the caregiver can expect when they call the community-based, nonprofit domestic or sexual violence victim advocacy program, hotline or other community based resource
      3. Providing the caregiver with the contact information and offering to make a telephone call together/other efforts to connect the caregiver with the service

      All 3 components would need to be followed to be included as an "offer". For the outcome measure, on offer to the DV partner must be included to be counted in the numerator. Other services can also be offered and there are several listed in the Measure Specifications, but the DV program must be included to be counted in numerator.

4. If a caregiver identifies several needs, does the home visitor need to offer support for each one for the caregiver to be included in the numerator?
    - No. If home visitor offers support for one of the identified needs and provides an offer of referral to the DV advocacy program, the caregiver can be included in the numerator

5. What if there isn't a specific resource for the caregiver's identified need?
    - If there is not a specific resource for the caregiver's identified needs, the home visitor should provide an offer of referral community-based, non-profit domestic violence victim

advocacy program, The National Domestic Violence Hotline or to a State or County Domestic Violence Hotline. The caregiver can be included in the numerator

HV CoIIN Resources & Tools

1. Who is my improvement advisor and how can I reach them?
    - Contact Patricia Finnerty at pfinnerty@edc.org

2. Where can I find the Calendar Calculations?
    - The Calendar Calculation is listed under each Measure throughout the IPV Measure Specifications document, as a table at the end of Measure Specifications and is a tab on the Reporting Template

3. There are several fields at the end of the data entry form that aren't yellow, green, or pink. Are those optional?
    - Those fields are automatically populated based on the data you enter, or based on the goals for measures that have been pre-set by the HV CoIIN 2.0 team. Any fields that you will need to enter data into on the IPV Data Reporting Template will be unlocked.

4. Where in the HV CoIIN Data Reporting Template do we put in the data for the measure about healthy relationships?
    - The numerator for Measure #6 is entered in Column S of the HV CoIIN Data Reporting Template. The denominator for Measure #6 is entered in Column R. The IPV Measures Cheat Sheet includes the corresponding columns in the Data reporting template for each measure. For a quick guide of where to find the measures on the HV CoIIN Data Reporting Template, look at row 2 on the IPV Data Entry tab, which lists which measure each column is associated with.

5. Who should we include on the Universal and IPV tracking worksheet?
    - As a reminder, these tracking worksheets are optional tools that LIAs can chose to utilize as a way of tracking individual caregiver information. These should not be submitted to the HV CoIIN. The tracking worksheets include:
        - (1) Universal tab which includes the information you need to know about all caregivers to calculate the measures. All current, active caregivers can be included here.
        - (2) IPV tab which includes the information you need to know about caregivers with a positive screen or self-disclosure for IPV. You should include all caregivers on your current, active caseload who have a positive screen or self-disclosure for IPV.

6. On the optional IPV & Universal Registry Tool, what does "date for second education on healthy relationships" mean? We are still working on incorporating a first healthy education interaction.

- We are recommending that education on healthy relationships happen on an ongoing basis, every 6 months. The additional columns for second and third education provide a place for LIAs to track this ongoing education.

7. Is there a directory that tells you from beginning to end on what to collect when and definitions?
    - The following resources have been developed to assist teams with data collection and reporting:
        - IPV Measures Cheat Sheet - lists all of the measures with their numerators and denominators and corresponding columns on the IPV Data Reporting Template.
        - IPV Measure Specifications – includes detailed operational definitions and data collection information, including calendar calculations.
        - IPV and Universal Tracking Worksheet – Excel document with columns for all the information you need to know from each caregiver to calculate the measures.
        - IPV Extension Registry - an updated version of the IPV registry used during IPV CoIIN specifically for the 3 month extension.
        - IPV Data Reporting Template – Excel files with data entry tabs, instructions and automated run charts.

Appendix D

HV CoIIN 2.0 COVID-19 IPV Supports

Due to this unforeseen public health crisis, HV CoIIN 2.0 staff have received requests for guidance related to best practice for screening and referral, specifically for Intimate Partner Violence and Maternal Depression with the move to virtual home visits and increased isolation.

The project has responded to these requests in several ways:

(1) Developed a memo providing general guidance from our HV CoIIN 2.0 faculty on the topics of maternal depression and intimate partner violence (IPV) in relation to our project work. This guidance is not intended to replace or supersede guidance from home visiting models or local, state, territory, or federal authorities. Find the memo here.

(2) Participated in a national MIECHV peer to peer dialogue to share the above-mentioned memo FAQs and best practice strategies and supports with the larger MIECHV community in partnership with HV-PM/CQI.

(3) Planning an additional peer learning session in collaboration with HV-ImpACT for MIECHV awardees on the topic of family violence where experts will join and provide expertise and resources related to practice implication related to the growing percentages for partner violence and child maltreatment.

(4) The HV-CoIIN 2.0 team dedicated a portion of the monthly scale peer to peer meeting to check in on the current landscape of home visiting, impact on CQI activities and implications moving forward with teams focusing on maternal depression interventions.

(5) The HV-CoIIN 2.0 team partnered with Futures without Violence to develop a national webinar presented on May 8th to an audience of over 1,000 participants representing home visiting services

(6) The HV CoIIN 2.0 IPV faculty have hosted multiple Open Office Hours for participating teams to support issues surrounding the delivery of universal education on healthy relationships and safer planning in the context on virtual home visits. Faculty will continue to provide strategies through the project newsletter and webinars through the duration of the summer

Intimate Partner Violence

According to the CDC, one in four women and one in seven men have experienced severe physical violence by an intimate partner at some point in their lifetimes[1]. Left undetected, exposure to IPV can have long-lasting negative effects on the growth and development of infants and young children[2]. IPV is a pattern of behavior that one person uses to gain power and control over the other. These behaviors can include isolation, emotional abuse, monitoring, controlling the finances and physical and sexual assault[3]. The fundamental harm of abuse is a loss of autonomy. Autonomy means freedom from external control. Evidence suggests that incorporating a comprehensive approach to IPV (i.e., connections with appropriate supports, including local domestic violence advocacy services organizations) into home visiting programs can help improve the trajectory for families experiencing violence[4]. Home visiting programs have a unique opportunity to reach families and incorporate evidence-based and practice-informed strategies—what we know works—to decrease rates of IPV. This relationship provides a safe space for families to talk about their experiences, especially during times of uncertainty.

People who are surviving violence in their relationships and families may be experiencing increased isolation and danger caused by social distancing measures during the Covid-19 pandemic. Survivors often have specific needs around safety, health and confidentiality. We also know that people who are already more vulnerable to economic and health insecurity are facing additional challenges during this unprecedented time. **At this time, staying connected or even increasing connections with caregivers experiencing violence is vital.**

Covid-19 Support

The following faculty offer guidance to your questions and concerns for families during this time of heightened stress and isolation:

- Leigh Hofheimer, Reproductive Justice lead from the Washington State Coalition against Domestic Violence
- Lisa James, Director of Health at Futures without Violence
- Rebecca Levenson, Consultant for Futures without Violence
- Allison Parish, Chief Program Officer and MIECHV Director at Florida Association of Healthy Start Coalitions Inc

We welcome you to access the recording of the IPV CoIIN Energizer call held on March 24th. (Part 1 and Parts 2 & 3) to listen to the conversation between faculty, awardees and local implementing agencies around strategies to address IPV and more specifically safer planning during the ongoing public health emergency. The strategies included in this memo are a summary of those presented during the call and aim to address the questions received from teams participating in the IPV CoIIN.

- **Strategies**
    - **Leverage Community Partners**
        - Prioritize connecting with your local DV/SA partners to understand resources available in your community given our new context
            - Find your state coalition at the National Coalition against Domestic Violence
            - Connect with Early Childhood System efforts including two-generational support partners and centralized service access points to increase your service coordination capacity to facilitate resource connections to promote protective factors. One example is connecting with your Help Me Grow network. Learn more about early childhood comprehensive systems across states here.
    - **Support Supervisors and Home Visitors to address IPV**
        - Supporting supervisors and home visitors is of paramount importance to support survivors. Home visiting programs may effectively use reflective supervision to support home visitors to care for themselves and ensure continuity of care for survivors. Supervisors should also be provided opportunity for support (i.e., peer-to-peer, mental health consultants, etc.)
            - The Supervisors Home Visitor Reference Sheet supports supervisors of home visitors working families experiencing domestic violence
            - The Home Visitor Reference Sheet supports home visitors working with families experiencing domestic Violence
            - The National Domestic Violence Hotline is available to support home visitors around the clock to obtain guidance on how to best support caregivers. Call 1-800-799-SAFE or chat with their advocates here, or text LOVEIS to 22522

Supporting Families in the Context of the Coronavirus Pandemic
Given the Coronavirus pandemic and the shift to virtual home visiting, we recognize that it is very difficult to determine caregiver safety and confidentiality for home visitors. The "shelter-in-place" recommendations can increase the risks for survivors of IPV and their children. The lack of privacy for conversations around IPV and the ability to assess the home environment now necessitates different processes. The following are strategies for consideration:

- Keep in mind the barriers to accessing reliable modes of communications
    - Follow your model developer guidance for approved mediums of communications
- When scheduling or confirming a virtual visit, encourage the caregiver to select a time when she will have access to a quiet, comfortable, and private spot where other people will not be able to overhear the conversation.
- Always Ask: “Is this a good time to talk? What is the best way to connect?”
- Be prepared to offer suggestions for gaining privacy for the conversation. For example, go outside while maintaining social distancing; take the call in their car, bathroom, garage and other private places; reschedule the chat for a more convenient time with more opportunities for privacy. Trust your intuitions about the “right time” to discuss.
- Consider coming up with a “code” word for use during your encounters. You can introduce the code word as “if you ever need me to know that you really need some extra help, but you just can’t go into all the details” – just use that word. Connect with your DV/SA partner to learn more about these strategies.
- Provide information to support and stay connected. Refer to WSCADV’s Friends and Family Guide for language to support safer planning.
- IPV Screening: At the moment there is no research indicating that virtual screenings are safe. Due to the potential risk of retaliation by an abusive partner if a caregiver discloses abuse during a screening, we encourage you to use your best practice judgement when determining whether it is appropriate or safe to screen.

We recommend that you convene as a state, local Implementing agency, community DV/SA partners and model developers’ team to arrive at a best practice that fits the needs of your community and programs. Below we have included recommendations from the experts in the field to support your conversation as you continue to deliver services across communities.

Additional Faculty Recommendations
In the absence of a screen, to promote the autonomy and safety of any potential survivor/client(s) and their children, we recommend specialized universal education on healthy relationships with a focus on educating clients on supporting friends and family who are struggling or feeling unsafe in their relationships and educating, at a minimum, about the National Domestic Violence Hotline (includes confidential chat feature, advocates speaking over 22 languages, language line access, and 24/7 days a week).

Talking about healthy and unhealthy relationships allows survivors to hear about resources and strategies to promote safety without *seeking* a disclosure of IPV. This strategy reduces the potential harm of IPV screening during virtual home visits. Sharing information universally on how to help others reduces isolation and increases understanding about virtual advocacy services that support the client's decision making and when and if to access confidential advocacy resources and supports.

Disclosure of IPV can happen *even* during universal education conversations about healthy relationships;

caregivers are the experts of their own experience. If IPV is suspected or confirmed, reducing violence and coercive behavior is the priority during this time of heightened isolation. The goal is to understand the survivor's perspective and priorities and work collaboratively with the caregiver to strengthen their safer plan, building on and adapting strategies they have used in the past, and to connect with the National Domestic Violence Hotline or local domestic violence advocacy programs for advocacy, problem-solving around safer planning and available resources including possible financial assistance. **Staying connected or even increasing connections with caregivers is vital.**

- Leaving may be a strategy, but not the only strategy. It is key to support survivors with their self-identified needs (i.e., food, housing, baby needs, etc.). Your recognition and validation of her situation is important. You can help reduce her sense of isolation and shame and encourage her to believe a better future is possible. **Staying connected or even increasing connections with caregivers is vital.**
- According to Jill Davies[5], deputy director of Greater Hartford Legal Aid, Inc. and director of the building Comprehensive Solutions to Domestic Violence Initiative staying connected can be a lifeline to a survivor[8]. Home visitors can support survivors to identify their social network in support of safer planning (i.e., is there an alternative place to stay in anticipation of shelter in place?). If you need help identifying support people in a survivor's life, take a look at the pod mapping worksheet from the Bay Area Transformative Justice Collective.
- Consider technology safety: The National Domestic Violence Hotline and RAINN - the National Sexual Assault Hotline and some state hotlines offer 24/7 online chat and text messaging in English and Spanish, along with referrals to local services and advocacy for people reaching out for the first time.
    - Managed by the Safety Net Project at the National Network to End Domestic Violence (NNEDV), TechSafety discusses technology, privacy, and safety in the context of intimate partner violence, sexual assault, and violence against women.
- **Staying connected or even increasing connections with caregivers is vital.**

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UF4MC26525, Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UF4MC26525, Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.