The Health Care Response to Domestic Violence:

Information for Health Care Providers

Nearly **one-third** of American women, 31%, report being physically or sexually abused by a husband or boyfriend at some point in their lives.[14]

Domestic violence is a serious public health problem.
Be prepared to respond.

Screen. Document. Refer.

Maryland Health Care Coalition Against Domestic Violence

Health care providers may encounter a number of barriers to recognizing and treating victims of domestic violence. These may include: a lack of awareness among many health care providers, the notion that it is not a health provider's place to intervene, a tendency to blame the victim, disbelief because the abuser is present and seems concerned, and simply not knowing how to assess and provide appropriate intervention. However, health care providers can and must play a critical role in recognizing and protecting the victims of domestic violence.

This guide for health care providers conveys important information related to addressing domestic violence in your health care facility.

Table of Contents

Prepare Your Hospital or Health Care Facility

Be prepared to respond to your patients.

Contact your local domestic violence service provider prior to seeing any victim to learn what services they offer and find out if they can send an advocate to your office.

- Have a private space available for interviewing patients.
- Have brochures and other materials available to place in waiting rooms and in bathrooms. Consider options for giving resources to patients when it may not be safe for them to leave with the office with brochures.
- Offer your patient a phone to call a domestic violence hotline and create a safety plan.
- Schedule a follow-up appointment with your patient.
- Educate your office staff by coordinating to have domestic violence experts present at staff meetings and grand rounds.

What is Domestic Violence?

Domestic Violence is a ***pattern of coercive behavior*** characterized by the domination of one person over another, usually in the context of a current or a former intimate relationship. Victims may experience physical, sexual, emotional, medical and financial abuse. Domestic violence can occur in all relationships regardless of sexual orientation. Victims are found in all socio-economic levels, educational, racial and age groups.

- Approximately 85% of victimizations by intimate partners were against women and 15% percent of victimizations were against men.[11]
- Nearly one-third of American women, 31%, report being physically or sexually abused by a husband or boyfriend at some point in their lives.[14]
- Some groups may be at a greater risk for abuse, such as pregnant women and people with disabilities.
- Domestic violence also contributes to a number of chronic health problems, including depression, alcohol and substance abuse, sexually transmitted diseases and often limits the ability of women to manage other chronic illnesses such as diabetes and hypertension.[4]

Screening for Domestic Violence in a Medical Setting

Screen Every Patient. Every Visit.

Beyond being aware of the indicators for abuse, health care providers are urged to screen universally by asking direct questions or by providing a written questionnaire. Any questions related to abuse should only be asked in **private and alone,** so that the patient may answer freely and confidentially.

Normalize screening questions by saying, "Since abuse is so common, I ask all of my patients the following questions." Also, instead of asking, "Are you a victim of domestic violence?" rather use these questions:

- ***"Are you afraid of or are you being threatened by a current or former partner?"***
- ***"Within the past year, have you been hit, slapped, kicked, forced into sexual activity, bitten, strangled or otherwise physically hurt by a current or former partner?"***

Does the patient have any injuries, marks, pain or behavior that could be due to abuse or an assault?

In addition to asking screen questions, look for and document indicators of abuse: injury-related, medical, treatment-related, physical and emotional indicators.

Next Steps:
Patient Screens Positive

"I'm concerned about your safety."

"You don't deserve this abuse. It's not your fault."

"Violence tends to continue and often becomes worse."

"There is help available."

Screening is Education

Advocate and Empower Your Patients

- Share your concern for patient's safety and health
- Protect patient's privacy and confidentiality
- Promote access to community services
- Schedule a follow up appointment
- Respect autonomy
- Believe and validate experiences
- Acknowledge injustice
- Be patient, it may take time for the victims to act. Leaving is a process, not an event.

Things to say if patient denies abuse, but you still suspect abuse

- *"I've seen injuries like this before and often they've been caused by someone. Did someone do this to you?"*
- *"If you were to answer "yes," I would not call the police."**
- *"If this is happening to you, there is help available."*
- *"I'm concerned about your safety."*

Injuries can still be documented in the patient's medical chart. Also, you can give the patient domestic violence resources and encourage her or him to call their local hotline.

**In most states. Check state laws regarding reporting requirements.*

Injury Related Indicators of Abuse

37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.[10]

- Injuries that are unexplained, poorly explained, or with unlikely explanations
- Bruises, especially clusters, "restraint" bruises on wrist or ankle, or bruises in unlikely locations
- Defensive injuries, such as injuries to forearm, back, or hands as victim attempts protective measures
- Patterned injuries, such as belt marks or implement imprint
- Covering up injuries with make-up or sunglasses
- Swelling, sprains, dislocations, pain, burns
- Injuries in different stages of healing
- Human bite marks
- Injuries during pregnancy

- Central injuries, specifically to the face, head, chest, breasts, abdomen, genital areas

Medical Related Indicators of Abuse

- Headaches, stomach aches, GI problems, somatic complaints
- STDs, genital or anal pain, bruising, bleeding
- Under-medicated, overdose, self-medication
- Malnutrition
- Poor hygiene, fatigue
- Pregnancy complications
- Complaints of acute or chronic pain without tissue injury

- Evidence of strangulation, which may include:*
    - loss of consciousness
    - voice changes
    - petechiae
    - reported loss of urine or bowel
    - confusion
    - pain or difficulty swallowing

**In some cases strangulation can be documented with forensic technology. Check with your local Sexual Assault Forensic Exam (SAFE) Center for details.*

Emotional Indicators of Abuse

- Shows discomfort when discussing possibility of abuse
- Seems fearful of partner
- Patient appears to be embarrassed, ashamed, frightened, disoriented or depressed
- Excessive distress over a minor injury or little emotion over a serious injury
- Is unusually quiet, jumpy, or nervous
- Has a limited attention span during assessment
- Hyper-vigilance among victim or abusive partner

Treatment Indicators

- Non-compliance with treatment
- "Doctor shopping"
- Pattern of lateness or missed appointments
- Delayed treatment

Pregnancy

1 in 12 pregnant women are abused.[6]

- About 324,000 pregnant women are battered by their intimate partners.[6]
- Abuse may be as common for pregnant women as gestational diabetes or preeclampsia, conditions for which pregnant women are routinely screened.[9]
- Abuse is four times more likely if the pregnancy is unwanted.[7]
- Increased risk may be the result of the partner's jealousy and resentment towards the unborn child[2]; partner's increased feelings of insecurity and possessiveness during the pregnancy; and/or women's reduced physical and emotional availability during pregnancy.[1]

More than One at Risk

In Maryland, homicide was the leading cause of death for all pregnancy-related deaths from 1993-2008; 63% of these deaths were perpetrated by a current or former intimate partner.[15]

Homicide is the second leading cause of traumatic death for pregnant and recently pregnant women in the U.S., accounting for 31 percent of maternal injury deaths.[3] Domestic violence during pregnancy is a focused attack that puts two lives at risk.

High Risk Indicators during Pregnancy

Abused women are twice as likely to begin prenatal care in the third trimester.[8]

- Injury and bruises to face, neck, chest, breasts, abdomen, or genitals
- HIV or frequent sexually transmitted infections (STIs)
- Delayed or no prenatal care
- Pre-term labor
- Depression
- Tobacco, alcohol or substance abuse

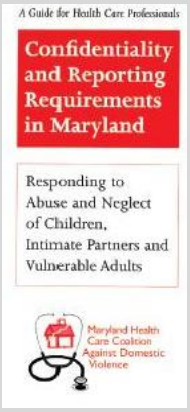
Assessment during Pregnancy

Reproductive health visits are an important point of contact for domestic violence screening. Health visits offer a chance to continually observe a woman's behavior during each trimester and postpartum.

- Abusers may limit or sabotage birth control and force sex resulting in unwanted pregnancy.
- Abusers may use pregnancy and children as a way to control and trap their victims
- Women experiencing abuse during pregnancy are 40-60% more likely than non-abused women to report:[13]
  - High blood pressure
  - Vaginal bleeding
  - Severe nausea
  - Kidney or urinary tract infections
  - Hospitalizations during pregnancy
  - Preterm delivery
  - Low birth weight
  - Miscarriage

As recommended by the American College of Obstetrics and Gynecologists (ACOG), assessment during pregnancy should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup.

Reporting and Confidentiality in Maryland



Your patient's confidentiality is an important priority. Do not contact the police without the victim's consent.* Contacting the police without the victim's consent may place the patient in a higher level of danger. Inform the patients that they can contact the local police or State's Attorney's office to request that charges be filed against the abuser. Victims may also file for a protective order.

**Refer to specific state laws regarding confidentiality and reporting.*

Documentation

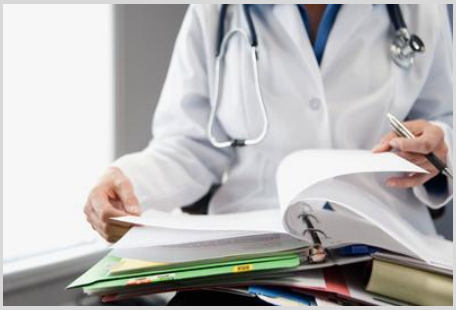
Accurate documentation provides several benefits: continuity of care, legal evidence collection, justification for specific clinical recommendations, reimbursement for services, protection from malpractice claims and improved understanding of the impact of domestic violence.[12]

Health care providers should document findings in the confidential medical record. Well written documentation lessens likelihood of a physician's need to testify. Documentation allows victims to produce evidence for court, even if months or years later. Documentation is often an underutilized, but highly beneficial resource for victims.

- Record patient's account of how injury was inflicted and by whom (in quotes preferred).
- Avoid judgmental words (e.g. "alleged" assault). Use "patient reports…" instead of "patient alleged…" and "patient states" rather than "patient claims."
- Document clinical observation: Record size, location, appearance, color of injury or marks. (May state, "injury consistent with patient's account" without definitely attesting to how the injury was received).
- Document patient's report of pain.
- Use photo documentation of injuries and/or body maps.
- Record contact with Sexual Assault Forensic Examiners (SAFE), police, courts, and other agencies.

Diagnosis and Coding

Documentation and coding of domestic violence can positively affect reimbursement for domestic violence screening, identification, assessment, care and follow-up. Improved documentation and coding will thus ultimately improve health services for victims.[12]



- Medical record documentation of domestic violence is recommended[5] but it is not routinely or properly done.
- Proper coding of injuries and symptoms related to abuse may be important in court proceedings.
- Be aware that coding may become known to the abuser, particularly if the victim is on the same insurance. Check with the victim to discuss safety concerns.
- ICD-9 CM Codes[16] related to adult domestic violence:[12]
    - **Adult Maltreatment and Abuse codes** (Adult Physical Abuse code 995.81 is the primary code that identifies each recorded incidence of domestic violence)
    - **E-codes** (Used as modifier codes that provide information as to when and where the abuse happened, to whom or by whom, and how)
    - **History Codes and Counseling, V-codes** (Provides information about the history of abuse or the need for counseling as a result of domestic violence)
    - **Injury or Abuse codes** (Records the underlying condition for which hospitalization is necessary)

**For more information about coding and documentation of domestic violence and specific codes, please refer to "Coding and Documentation of Domestic Violence" (see reference). The transition from ICD-9 to ICD-10 codes is mandated to occur by October 1, 2013 for organizations subject to the Health Insurance Portability and Accountability Act (HIPAA).*

Brochures and Information

Maryland Resources

Access the following websites to print and/or order educational materials.

Maryland Health Care Coalition Against Domestic Violence
http://www.healthymaryland.org/domestic-violence-coaliton.php

Maryland Network Against Domestic Violence
www.mnadv.org

Maryland Coalition Against Sexual Assault
www.mcasa.org

National Resources

Futures Without Violence
www.endabuse.org

National Coalition Against Domestic Violence
www.ncadv.org

National Network to End Domestic Violence
www.nnedv.org

National Resource Center on Domestic Violence
www.nrcdv.org

Maryland Hospital-based Domestic Violence Programs

The Abuse and Domestic Violence Program
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401
(443) 481-1209
Coordinator: Rae Leonard

Domestic Violence Program (DOVE)
Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133
(410) 496-7555
Coordinator: Audrey Bergin

Domestic Violence and Sexual Assault Center at Dimensions Healthcare
Prince George's Hospital Center
3001 Hospital Drive, Suite 3000
Cheverly, MD 20785
(301) 618-3154
Coordinator: Karalyn Mulligan, (301) 618-3060

Family Violence Program
Sinai Hospital
2401 W. Belvedere Avenue
Baltimore, MD 21215
(410) 601-8692
Coordinator: Beth Huber

Family Violence Response Program
Mercy Medical Center
301 St. Paul Place
Baltimore, MD 21202
(410) 332-9470
Coordinator: Colleen Moore

The GBMC Domestic Violence Program
Greater Baltimore Medical Center
6701 North Charles Street
Towson, MD 21204
(443) 849-3323
Coordinator: Sally Hess

Contact Information

This guide only provides brief recommendations and may not cover every situation. For additional questions or information, please contact us:

Maryland Health Care Coalition Against Domestic Violence
1211 Cathedral Street
Baltimore, MD 21201
Phone: 410-539-0872
Email: dvcoalition@medchi.org
Website: http://www.healthymaryland.org/domestic-violence-coalition.php

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