Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care

Fourth Edition

Produced by:

FUTURES WITHOUT VIOLENCE®

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With heartfelt dedication to victims and survivors of domestic and sexual violence. We hope this Compendium helps promote effective policies and regulations to support the health, healing, and wellness of survivors.

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www.FuturesWithoutViolence.org

Everyone has the right to live free of violence. Futures Without Violence works to prevent and end violence against women and children around the world.

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About the National Health Resource Center on Domestic Violence

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting-edge advocacy and sophisticated technical assistance. The Center offers a wealth of free culturally competent materials that are appropriate for a variety of public and private health professions, settings and departments.

For free technical assistance, and educational materials:

Visit: **www.FuturesWithoutViolence.org/health**

Online Toolkit: **www.ipvhealth.org**
Online Toolkit for community health centers: **www.ipvhealthpartners.org**

Call (Monday-Friday; 9am-5pm PST): 415-678-5500
TTY: 866-678-8901

Email: **health@FuturesWithoutViolence.org**

Introduction and Methodology

For more than two decades, Futures Without Violence and the National Health Resource Center on Domestic Violence through its publications, practices, educational programs, and outreach efforts, have promoted prevention and early intervention for domestic violence victims seeking care in health care settings. During the past twenty years, there has been a growing recognition among health care professionals that domestic violence, also known as intimate partner violence, is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse.

In 2001, Futures produced the first State by State Legislative Report Card on Health Care Laws and Domestic Violence. Following in 2010, Futures produced this Compendium of State Statutes and Policies on Domestic Violence and Health Care that updated and replaced the earlier publication. The third edition was (2013) newly titled: Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care, and included a new chapter: Tribal Codes on Domestic Violence and Promising Programs in Indian Country. This fourth edition continues to provide the most recent updates to state and territory laws, statutes, and policies; updated summaries for state public health work; a revised section on tribal codes on domestic violence; and a new section on trauma-informed mandatory reporting.

The Compendium is an at-a-glance summary of state and U.S. territory laws, regulations, and other activities relevant to addressing domestic violence in health care settings. It includes analyses and themes that reflect policy and programmatic changes made in the last two decades by leaders in the fields of health care, policy and domestic/sexual violence advocacy. FUTURES invited staff from every state and territory department of health and/domestic violence coalition to review their respective summary and provide feedback; the Compendium reflects these comments. While some states/territories reported on sexual assault policies and programs, this compendium is not an exhaustive review of health policies and programs that relate to sexual assault. Additionally, policies change quickly and may have changed since we invited feedback from the field. If there has been a change or an omission on our part please let us know by emailing health@futureswithoutviolence.org. Relevant state and territory laws were researched to ensure correct citations through both state legislative web pages and LexisNexus.

The Compendium includes state and territory-specific summaries of policy that addresses the following areas: domestic violence fatality review; mandatory reporting of domestic violence to law enforcement by health care providers; insurance discrimination against victims of domestic violence; health care protocols addressing domestic violence; screening for domestic violence by health care professionals and training on domestic violence for health care professionals. Additional information is provided where available on state or territory public health programs, and funding opportunities.

While state or territory law is an important component of addressing domestic violence in the health care system, it is important to note that throughout the U.S. many collaborations with state or territory domestic violence coalitions, public health professionals, health care providers, managed care

providers and local communities have undertaken new and exciting projects that are also providing critical support, safety and hope to domestic violence victims receiving health care services. A number of those state local activities are highlighted in the summaries.

Domestic Violence Fatality Review

Fatality Review Teams

Given the high death toll stemming from domestic violence, many states and local municipalities have established Domestic Violence Fatality Review teams and projects. Participants on Domestic Violence Fatality Review Teams are multi-disciplinary and often come from a broad array of professions, including: government officials; public health professionals; law enforcement; health care providers including mental health professionals; domestic violence advocates; coroners; medical examiners; forensic pathologists and others. A Fatality Review Team evaluates cases of fatal and near fatal domestic violence homicides, and sometimes suicide, to identify trends and patterns associated with domestic violence fatalities. These Teams also make recommendations for domestic violence prevention, intervention, and investigation efforts and often monitor the implementation of those recommendations.

The fatality review process assumes that the circumstances of untimely deaths are likely to be repeated and that detailed examinations can lead to important insights regarding risks, intervention, and prevention efforts. The process rests on the premise that in-depth analysis of a small number of cases can provide a window into system response problems, which may affect a larger number of people. The goal is a focused, multidisciplinary examination into the circumstances surrounding a fatal incident for insight into how future deaths may be prevented through strengthening system-level responses.

State Laws

It is important to point out that many state domestic/sexual violence coalitions, state governments and local municipalities have established Domestic Violence Fatality Review Teams without legislative direction. There are currently 31 states and Washington, DC, that have enacted this type of legislation. The state laws vary in the scope of coverage (local, regional or state level); appointed members; the range of recommendations; and resources including funding.

The Compendium lists each state with its corresponding fatality review law, and brief summaries of the laws. However, it is important to review the text of the entire law to understand authority, scope of practice, make-up of Fatality Review Team Members and available resources.

Mandatory Reporting of Domestic Violence to Law Enforcement by Health Care Providers

Reporting Abuse of Adults

Most U.S. states have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, and very few have mandated reporting laws specific to suspected abuse or

domestic violence for individuals being treated by a health care professional. Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse and child abuse reporting laws, in that the individuals to be protected are not limited to a specific group, but pertain to all individuals to whom specific health care professionals provide treatment or medical care, or those who come before the health care facility. The laws vary from state-to-state, but generally fall into four categories: states that require reporting of injuries caused by weapons; states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; states that specifically address reporting in domestic violence cases; and states that have no general mandatory reporting laws.

Implications for Victims of Domestic Violence

With the increasing awareness about domestic violence as a health care issue, attention has turned to how health care providers can best assist their patients through identification, documentation, intervention and referral. Unfortunately, applying mandatory criminal injury reporting laws to domestic violence cases is most often not helpful to domestic violence victims. Research indicates that the most critical elements of providing domestic violence victims with quality health care responses include offering ongoing and supportive access to medical care, addressing safety issues, and guiding patients through available options.

The goals potentially served by mandatory reporting include enhancing patient safety, improving health care providers' response to domestic violence, holding batterers accountable, and improving domestic violence data collection and documentation. However, upon closer examination it becomes apparent that mandatory reporting does not necessarily accomplish these goals.

In addressing mandatory reporting laws that include reporting of domestic violence, health care professionals and advocates should consider the following principles in determining if their state's law needs to be amended.

Enhancing Patient Safety and Increasing Access to Health Care Services

For some victims of domestic violence calling the police invokes retribution by their batterers. Criminal justice intervention is not always the best or safest response for victims who may fear that law enforcement reports made by medical personnel will place them in greater danger. Consequently, domestic violence victims may have no choice but to withhold information from their health care providers regarding the origin of their injuries, or avoid seeking medical attention entirely.

Improving Health Care Provider Responses to Domestic Violence Victims

Removing the requirement to report can allow domestic violence victims to be more candid about their injuries, allowing health care providers to make informed judgments about medical treatment and follow-up care. Mandatory reporting laws can be amended to require that health care providers offer referrals to trained domestic and sexual violence service agencies, helping to ensure that domestic violence victims are given access to a wide range of services geared toward meeting their specific needs. Domestic/sexual violence advocates work with victims to address needs related to emergency shelter/housing, protection/restraining orders, children, finances, emotional/spiritual support, and safety planning/next steps. By helping to connect patients to community and onsite domestic violence advocates, safety is enhanced.

Preserving Patient Autonomy and Control of the Decision-Making Process

Batterers use a myriad of tactics to obtain and assert control, often making their victims feel powerless over their lives. Mandatory reporting further limits victims control over their own lives. Removing mandatory reporting requirements can help empower victims of domestic violence to make decisions that they feel are best for themselves based on their knowledge and experience. It can help victims gain control over their lives and health care options and honors their agency and voice to determine what they want for themselves.

Protecting Patient Confidentiality

For many victims isolated by their abuser from their friends, family and social services, health care providers may be the only professionals to whom they have safe access. Mandatory reporting of domestic violence related injuries interferes with the confidential nature of the provider-patient relationship and can undermine victims' trust in health care providers.

Recognizing the Value of Informed Consent in Health Care Environments

In the health care system, competent and informed patients determine the course of action that is in their best interest. Mandatory reporting of domestic violence related injuries negates patients' ability to make critical life decisions, raises serious ethical issues, and compromises the integrity of the provider's relationship with a patient. Removing reporting requirements corrects this inconsistency by ensuring domestic violence victims make informed decisions for themselves.

Advocating for Victims of Domestic Violence

It is important that health care providers and domestic violence advocates understand their state or territory's domestic violence reporting law. In order to maximize patient input regarding law enforcement action, providers and advocates should also familiarize themselves with how their local law enforcement agency responds to such reports. Becoming familiar with such procedures will allow the provider and advocate to better assist the patient in safety planning, and in knowing what to expect. Mandated reporting responsibilities should always be discussed with patients seeking care prior to assessing for domestic violence. See section below on harm reduction for mandatory reporting.

Additionally, Federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations require providers to inform patients of health information use and disclosure practices in writing, and whenever a specific report has been made. Health care facilities should ensure that their domestic violence protocols and training materials address their state reporting laws and federal regulations. Read more about the HIPPA privacy rule for further information.

Harm Reduction for Mandatory Reporting

In the event that a mandated report for domestic violence needs to be made, follow the guidance below to increase the patient's safety and minimize harm. Ensure that you:

1. Always discuss the limits of confidentiality with the patient, regardless of whether or not you anticipate any conversation about domestic violence. Your patient/client has the right to make an informed decision about whether they choose to disclose information about their relationship.
2. When a report must be made, explain to the patient why it is being made, where it will go, who

will see the report, and what will happen next.

3. Talk through common fears and concerns survivors have about making a report, especially around immigration status and child abuse reporting.
4. Offer the patient the opportunity to be included in every step of the process (if they would like to be). This includes filling out the report with the patient, and calling the report in with the patient is in the room.
5. Offer to make a warm referral to a domestic violence advocate for safety planning and additional support.
6. Follow up with the patient during their next visit.

Download a brochure for patients or clients that offers trauma-informed recommendations for survivors about how to best advocate for their needs with health care providers, how trauma can affect the body during a visit, and tips for wellness.

U.S. State and Territory Laws

The Compendium lists each U.S. state and territory with its corresponding mandatory reporting law, and brief summaries of the laws. However, it is important to review the text of the entire law to understand things such as the specific health care providers required to report, under what conditions and definitions and penalties. It should be noted that only two states have laws that specifically require mandated reporting of DV specifically (not just injuries) to law enforcement and that five states have exceptions for reporting injuries due to domestic violence. New Hampshire's statute excuses a person from reporting if the victim is over 18, has been the victim of a sexual assault offense or abuse (defined in RSA 173-B:1), and objects to the release of any information to law enforcement. However, this exception does not apply if the victim of sexual assault or abuse is also being treated for a gunshot wound or other serious bodily injury. Oklahoma's statute does not require reporting domestic abuse if the victim is over age 18 and is not incapacitated, unless the victim requests that the report be made orally or in writing. In all cases what is reported to be domestic abuse shall clearly and legibly be documented by the health care provider and any treatment provided. Pennsylvania's statute states that failure to report such injuries when the act caused bodily injury (defined in § 2301) is not an offense if the victim is an adult; the injury was inflicted by an individual who is the current or former spouse or sexual or intimate partner; has been living as a spouse or who shares biological parenthood; the victim has been informed of the physician's duty to report and that report cannot be made without the victim's consent; the victim does not consent to the report; and the victim has been provided with a referral to the appropriate victim service agency. Tennessee's statute excuses health care practitioners from reporting if the person is 18 years of age or older; objects to the release of any identifying information to law enforcement officials; and is a victim of a sexual assault offense or domestic abuse (defined in § 36-3-601). The exception does not apply and the injuries shall be reported if the injuries incurred by the sexual assault or domestic abuse victim are considered by the treating healthcare professional to be life threatening, or the victim is being treated for injuries inflicted by strangulation, a knife, pistol, gun, or other deadly weapon. Colorado's statute provides an exception for reporting if the injuries are resulting from domestic violence and if the victim is at least 18 and does not wish the injury to be reported. This exception does not apply if the injury is from a firearm, knife, ice pick, or other sharp object.

Kentucky, North Dakota, and Washington also require that victims of domestic violence be given educational information related to support services. Kentucky's statute states that professionals (including health professionals) must provide the victim with educational materials on domestic violence support services if the professional has cause to believe the patient has experienced domestic or dating violence. North Dakota's statute requires that health professionals provide victims with information on support services when a report on domestic or sexual violence has been made. Washington's statute requires that hospitals inform the patient of resources to ensure their safety if the patient has stated that their bullet, gunshot, or stab wound was the result of domestic violence.

Insurance Discrimination Against Victims of Domestic Violence[1]

History

Information that insurance practices negatively affect victims of domestic violence first came to light in 1994 when two insurance companies denied health, life and disability insurance to a Pennsylvania woman based on information in her medical records that her husband had abused her. As domestic violence advocates soon discovered, her experience was not an isolated instance.

Further examination revealed the common and widespread practice of underwriting on the basis of domestic violence as well as other practices that negatively impact victims of domestic violence. Such discrimination occurs in all lines of insurance—health, life, disability, and property and casualty (i.e., homeowners, personal automobile, and commercial property and automobile). These practices can result in cancellation of insurance, claims exclusions and denials, application of intentional act exclusions to innocent co-insureds, rating surcharges, adverse actions against third parties associated with victims of domestic violence, and disclosures that place victims at risk. These actions by the insurance industry and employers who self-insure health and other coverage for their workforce, deny victims the life necessities that only insurance can provide; undermine available protection and assistance; and perpetuate inaccurate perceptions about domestic violence.

In 1994, no law prohibited insurers from taking domestic violence into account in determining whom to insure, what to insure, and how much to charge. This prompted victim advocates, legislators, and state insurance regulators to work together to gather information on the scope of the problem and develop legislative solutions. The National Association of Insurance Commissioners (NAIC) developed comprehensive model legislation to prohibit this discrimination in all lines of insurance. The model bills define essential terms and specific prohibited actions; recommend development of protocols for insurance company employees to follow to protect the safety and privacy of victims; and address enforcement. Omitted from the models, however, was any protection for third parties or organizations that have been harmed by insurance practices which take into account their association with victims of abuse.

1 Information regarding insurance discrimination was compiled from material developed by Nancy Durborow when she was the Health Projects Manager for the PA Coalition Against Domestic Violence and Terry Fromson, Esq., Managing Attorney, Women's Law Project, Philadelphia. See more in the document "Insurance Discrimination Against Victims of Domestic Violence": https://www.futureswithoutviolence.org/insurance-discrimination-against-victims-of-domestic-violence/ (updates provided by Nancy Durborow and Terry Fromson in 2018).

For more information on insurance discrimination, please see this 31-page report, **"Insurance Discrimination Against Victims of Domestic Violence."** The report highlights the discriminatory practices of some insurance companies that penalize domestic violence victims who seek coverage and the recent changes to state and federal law.

State Laws

Since 1994, 45 states and the District of Columbia have adopted some form of legislation prohibiting insurance discrimination against victims of domestic violence. State laws provide a significant bar to insurance discrimination against victims of abuse and an important and potentially sole remedy for its victims. These laws were adopted over a span of years during which the information about the types of insurance practices that affect victims was continuously rising and the period in which the NAIC model laws were evolving. As a result, state laws vary widely in scope of coverage, including types of insurance to which they apply, types of practices prohibited, and remedies provided. Protecting victims' confidentiality is addressed in less than half of the state laws.

For example, only 26 states and the District of Columbia have laws covering all four types of insurance (health, life, accident or disability, and property and casualty), seven states and the District of Columbia cover three types of insurance, seven states cover two types, and five states cover only one type. Property is the type of insurance least regulated with respect to domestic violence, with 27 states prohibiting such discrimination. Thirty-three states prohibit such discrimination in accident or disability insurance; 39 states and the District of Columbia prohibit such discrimination in life insurance. Health insurance is the most covered insurance with 45 states and the District of Columbia prohibiting discrimination against domestic violence victims in health insurance.

The Need for a Federal Remedy

Despite the repeated introduction of comprehensive federal legislation in this arena, Congress has taken action in this area only with regard to health insurance. The first federal law addressing this problem is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which prohibits discrimination against victims of abuse primarily in group health plans. States have adopted legislation to implement these federal requirements. In 2010, the adoption of the Patient Protection and Affordable Care Act has provided the most comprehensive protection for victims of domestic violence in health insurance. The Affordable Care Act prohibits preexisting condition exclusions and premium rate discrimination, and guarantees availability and renewability of insurance. It also specifically prohibits eligibility rules based on, among other factors, "[e]vidence of insurability (including conditions arising out of acts of domestic violence)." Health insurers are not allowed to deny coverage, refuse to continue coverage, or exclude a condition from coverage based on domestic violence. The Act also prohibits requiring payment of a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factors. Comprehensive federal protection for victims of domestic abuse subjected to discrimination in other lines of insurance has yet to be enacted.

A federal law is important not only for comprehensive coverage for all lines of insurance but also for uniformity of protection. When victims of abuse flee to escape domestic violence, they often go as far away as they can for their safety, frequently crossing state lines. In addition, insurance is an economic resource and often is a critical factor in having the financial resources to flee, including

providing health care and other necessities to her children and herself. Protection from insurance discrimination in every state is critical.

The Compendium summarizes each state and territory's insurance anti-discrimination law (as applicable); which types of insurance are covered; and brief summaries of the laws. However, it is important to review the text of the entire law to understand things such as the definition of abuse victim used, if a private right of action is permitted and enforcement mechanisms.

Protocols, Screening and Training Statutes

Very few states or U.S. territories have enacted state statutes requiring domestic violence health care protocols, or screening requirements for health care providers/facilities. Just nineteen states and one U.S. territory—Puerto Rico, enacted laws requiring training on domestic violence for health care providers, and the requirements greatly vary.

However, as noted previously there are many exciting domestic violence and health care changes occurring throughout the country and in U.S. territories with or without legislation. A selection of state statues that do address protocols, training, and screening are highlighted below.

Protocols

In Alaska, a law mandates that the Alaska Council on Domestic Violence and Sexual Assault consult with the State Department of Health and Social Services to produce standards and procedures for the delivery of services by health care providers to domestic violence victims. The Department of Health and Social Services is then required to make a notice of the rights of domestic violence victims and services for support available to health facilities.

Training

In 2015, Massachusetts passed a new law that the boards of registration in medicine, nursing, physician assistants, nursing home administrators, social workers, psychologists, and allied mental health and human services require training and education on domestic and sexual violence. This training is to include a wide range of topics, including the health effects of domestic and sexual violence, the effect of witnessing abuse on children, the additional challenges experienced by marginalized communities, and the pathology of offenders.

Screening

Since 1995 in California, clinics[2] have been required to have written policies and procedures for routine screening of patients for domestic violence. See section below on universal education for more information and guidance on addressing domestic violence in health care settings, without relying on a disclosure to share resources.

2 "Clinic" is defined as "an organized outpatient health facility that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and that may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility." (Cal Health & Saf. Code §1200)

Universal Education on Domestic Violence in Health Settings

While some states and territories have instituted policies to establish screening for domestic violence in health settings, screening alone can limit the number of survivors that will be reached, and also does not provide an opportunity for prevention. By initiating a conversation and offering resources on healthy relationships and domestic violence with all patients, providers are not dependent on a disclosure to ensure that the patient receives critical information about domestic violence and its impact on health. In addition to serving as intervention for someone who may be currently experiencing violence but chooses not to disclose, a universal education approach also serves as prevention for patients who have not initiated relationships, or who share the information with family and friends.

In the event that there are already screening questions on domestic violence that providers are required to ask, these can still be asked as direct follow up questions following universal education. Universal education should be done using a trauma-informed approach, by talking to patients about the limits of confidentiality in the event of a disclosure, and ending with a warm referral (if the patient indicates they would like this) and resources for support.

A helpful acronym for remembering the universal education approach is **CUES:**

C: Confidentiality

Know your state/territory's reporting requirements and share any limits of confidentiality with your patients before discussing domestic and sexual violence. Always see patients alone for at least part of the visit. It is unsafe to discuss relationships if their partner, friend, or family member is with them.

UE: Universal Education and Empowerment

Give each patient two Safety Cards to start the conversation about healthy relationships, those that are not healthy, and how they can affect their health. Normalizing this conversation as a health issue is crucial.

S: Support

Though disclosure of violence is not the goal of CUES, it will happen. Know how to support someone who says "yes, this happened to me." Make a warm referral to your local domestic violence partner agency or the National Domestic Violence Hotline (on the back of all Safety Cards) and document support provided in order to follow up the patient at their next visit. Offer health promotion strategies and a care plan that takes surviving abuse into consideration.

Read more about **CUES** on **www.ipvhealth.org** and for community health centers, please visit: **www.IPVHealthPartners.org.**

Tribal Codes on Domestic Violence and Promising Programs in Indian Country

Introduction

What is Indian Country?

Indian Country is land either within an Indian reservation or federal trust (land technically owned by the federal government but held in trust for a tribe or tribal member). For most purposes, Indian Country can be categorized by Reservations,[3] Informal Reservations,[4] Dependent Indian Communities,[5] Allotments,[6] and Special Designations.[7]

Federally Recognized Tribes and Population

There are more than 550 federally recognized Tribes in the U.S. According to the 2010 Census, 5.2 million people in the U.S. or 1.7% of the total U.S. population identified as American Indian and Alaska Native, either alone or in combination with one or more other races. Of this total, 2.9 million were American Indian and Alaska Native only, and 2.3 million were American Indian and Alaska Native in combination with one or more other races.

Jurisdictional Complexities in Indian Country

There are many jurisdictional complexities and limitations to achieve justice for victims of crime in Indian Country. While Tribes are sovereign and maintain a government to government relationship with the U.S., Tribal authority to criminally prosecute and hold perpetrators accountable for sexual and domestic violence crimes committed in Indian Country has been severely restricted. The confusing division of authority among tribal, federal, and state governments results in a jurisdictional maze that is complicated by the lack of tribal courts' criminal jurisdiction over non-Indians, the practical impact of Public Law 280,[8] and other limitations on tribal criminal jurisdiction. The difficulty of determining jurisdiction, and provisions for concurrent jurisdiction of certain cases, can cause con-

3 (18 USC 1151(a).

4 If a reservation has been disestablished or if the legal existence of a reservation is not clear, remaining trust lands that have been set aside for Indian use are still Indian country (Oklahoma Tax Commission v. Chickasaw Nation, 515 US 450 and Oklahoma Tax Commission v. Sac & Fox Nation, 508 US 114).

5 (18 USC 1151(b).

6 (18 USC 1151(c).

7 Congress can specifically designate that certain lands are Indian country for jurisdictional purposes even if those lands might not fall within one of the categories mentioned above. An example of this is Santa Fe Indian School in Santa Fe, New Mexico (Public Law 106-568, section 824(c)).

8 Public Law 280 is a federal statute enacted by Congress in 1953. It enabled states to assume criminal, as well as civil, jurisdiction in matters involving Indians as litigants on reservation land. Previous to the enactment of Public Law 280, these matters were dealt with in either tribal and/or federal court.

flict and confusion for law enforcement, prosecution, courts, service providers, and crime victims in Indian Country.[9]

To help address these disparities, the Tribal Law and Order Act of 2010 (TLOA) was passed to help the U.S. Federal Government better address the unique public safety challenges that confront tribal communities. The Act allows tribal courts to increase prison sentences for offenders in criminal cases, which were previously very limited. Part of the purpose of the Act was the recognition of high rates of domestic and sexual violence against women in tribes, and includes a strong emphasis on decreasing violence against women in Native communities. In its effort to do so, a four-year Bureau of Prisons Pilot Project was launched with TLOA, which allowed someone convicted of a violent crime in a tribal court to be imprisoned through the Bureau of Prisons.[10] This pilot provided service programs for offenders in preparation for re-entry into the community, including: job training, education, counseling, and anger management.[11]

The 2013 reauthorization of the Violence Against Women Act also contains provisions to address the high rates of violence against women in Native communities. In particular, the reauthorization allows non-Indians to be tried in tribal courts if they commit domestic violence, dating violence, or if they violate a protection order. Prior to this, it was not possible for non-Indians to be tried in tribal courts.

Public Law 280 or PL 280 was a transfer of legal authority/jurisdiction from the federal government by Congress to state governments in six states (California, Minnesota, Nebraska, Oregon, Wisconsin, and Alaska) that could not refuse jurisdiction. This transfer gave extensive criminal and civil jurisdiction over tribal lands within those states to the state governments. PL 280 moved Federal criminal jurisdiction over offenses involving Indians in Indian Country to the states mentioned above, and gave other states the option to also assume such jurisdiction in the future. Criminal laws in those states therefore became effective over Indians who were either in or out of Indian Country. However, PL 280 did not provide any financial support to the states for these new responsibilities. Under PL 280, about 28% of the reservation-based tribal population and 28% of all federally recognized tribes in the contiguous 48 states, as well as 70% of all federally recognized tribes including all Alaska Natives and their villages, are covered.[13]

9 Valencia-Weber, G., and C. P. Zuni, "Domestic Violence and Tribal Protection of Indigenous Women in the United States." St. John's Law Review 69:69 (1995): 16.

10 https://www.justice.gov/opa/pr/bureau-prisons-implements-key-provision-tribal-law-and-order-act-pilot-program-incarcerate

11 https://www.bop.gov/inmates/custody_and_care/tribal_offenders.jsp

12 https://www.tribal-institute.org/lists/title_ix.htm

13 Goldberg, Carole, and Valdez Singleton, Heather. Research in Brief: Public Law 280 and Law Enforcement in Indian Country – Research Priorities. Dec. 2005. National Institute of Justice. Accessed 4/19/2010. Link: https://www.ncjrs.gov/pdffiles1/nij/209839.pdf

Domestic Violence Fatality Review

Understanding how fatality reviews are conducted in Indian Country is complex since each federally recognized tribe is a sovereign nation and may establish different protocols, if any at all. Many of the fatality review protocols that state and counties have developed include components specific to team membership, record retrieval, report writing, and inclusion of local members. These requirements may differ in tribal and federal environments. For example, statutes that allow for the procurement of state and local data reports are not the same in a federal and tribal environment. Law enforcement, probation, and medical reports all must be obtained through a federal source.[14]

Montana established the first Native American Domestic Violence Fatality Review team in 2014, focusing on domestic violence fatalities with a Native American perpetrator and/or victim, both on and off reservations.[15] Due to the requirement that law enforcement, probation, and medical reports be obtained through a federal source, the committee found it necessary for federal law enforcement or criminal justice employees to be part of a team undertaking reviews. Such federal agencies might include the FBI, Bureau of Indian Affairs (BIA), Bureau of Alcohol, Tobacco, Firearms, and Explosives (BATF), U.S. Attorney's Office USAO), federal Victim Services and/or the Office of Federal Probation.

As a result of the fatality review collaboration between state, county, and tribal agencies in Montana, a "Hope Card" was developed that distilled the key elements of an Order of Protection on a portable card for victims. The card was initiated by a BIA agent working on the Crow Reservation and was originally offered as part of the Tribe's Purple Feather Campaign, focusing more broadly on domestic violence. If it was not for the collective collaboration between these agencies the resourceful Hope Card would not have been possible.[16] Montana's Native American Domestic Violence Fatality Review team has been recognized nationally for its work.[17]

Missing and Murdered Indigenous Women and Activism

The rates of domestic and sexual violence among indigenous women is much higher than the national rates--more than 4 in 5 indigenous women have experienced violence. Additionally, there are alarmingly high numbers of indigenous women that have been murdered or have gone missing, in large part as a result of domestic violence. Inadequate law enforcement in tribal communities and insufficient federal protections make it especially difficult to prevent and respond to these crimes.[18] A number of indigenous women's organizations have been working on prevention and response efforts, including the Indian Law Resource Center and the National Indigenous Women's Resource Cen-

14 Matthew, Dale. Domestic Violence Fatality Review in Indian Country. Fatality Review Bulletin, Spring 2010.

15 Matthew, Dale. Domestic Violence Fatality Review in Indian Country. Fatality Review Bulletin, Spring 2010.

16 Matthew, Dale. Montana Domestic Violence Fatality Review Commissions, Montana Department of Justice. August 2017. http://ndvfri.org/download/montana-statewide-annual-report-2017/?wpdmdl=1432&ind=B7el3gZpUGyWg5jJ-FfgIEJ0HcXD2fOSC-bOegwBVVhgB8waOfFfDOiblH3oYsUf0V3PrwkPIpqvwyUxjC2iM6w

17 https://indianlaw.org/safewomen; http://www.niwrc.org/sites/default/files/documents/Resources/Toolkit_MissingAndMurdered.pdf

18 https://indianlaw.org/safewomen

ter. The Safe Women, Strong Nations Project from the Indian Law Resource Center works towards ending violence against AI/AN women by raising awareness at the federal level, working to restore tribal criminal authority, and working with tribes and organizations on violence prevention.[19] The National Indigenous Women's Resource Center has created a toolkit protocol for taking action when a woman is missing.[20] A number of federal and state laws have also been proposed to help address this issue, including Savanna's Act, which would expand tribes' access to federal crimes databases and would establish a protocol for cases of murdered and missing indigenous women.[21]

Domestic and Sexual Violence Health Care Policies

Model protocols on domestic and sexual violence for health care systems are readily available for review and adaptation. In 2016, the Indian Health Service (IHS) released a national domestic violence protocol as part of its "Indian Health Manual" to establish a uniform standard of care for all domestic violence victims seeking clinical services at IHS health care facilities.[22] The "Indian Health Manual" also establishes a uniform standard of care for sexual assault victims at IHS health care facilities, revised in 2018.[23] Policies at IHS health care facilities have been developed in order to ensure the victim's care is culturally sensitive, patient-centered, and that all of their needs are addressed in addition to a coordinated community response. The policies are also important because they may aid (as evidence) in the criminal justice system. The Indian Health Service/Administration for Children and Families Domestic Violence Pilot Project (2002-2009) supported Urban/Tribal and federal clinics and hospitals to establish domestic violence protocols and conduct routine assessment for abuse.

A standard protocol should include a definition of domestic violence and sexual assault, information on the universal education brochure based approach (to be done privately), the limits of confidentiality, safety planning and connection to a local tribal or community based DV advocacy organization, and a plan for ongoing staff training and support.

Please see our safety cards for American Indian/Alaska Native Communities:

- **We Are Sacred (Reproductive Health Safety Card)**
- **Women are Sacred (General Health Safety Card)**
- **We are Worthy (Alaska Native Safety Card)**

19 http://www.niwrc.org/sites/default/files/documents/Resources/Toolkit_MissingAndMurdered.pdf

20 https://www.apnews.com/9bdd5fdd0604497a8d628d7395828c0a

21 https://www.ihs.gov/ihm/pc/part-3/p3c31/#3-31

22 https://www.ihs.gov/ihm/pc/part-3/p3c29/

23 https://www.ihs.gov/ihm/pc/part-3/p3c29/

Mandatory Reporting of Domestic Violence to Law Enforcement by Heath Care Providers in Indian Country

In the U.S., states maintain authority to set the reporting requirements for health care providers who provide care to victims (or suspected victims) of domestic violence; there is no federal law with such regulations. As sovereign nations, tribes can assert jurisdiction in criminal and civil actions involving assaults against Native women[24] and namely through the development of domestic violence, or sexual assault tribal laws. Such laws may reflect traditional values to support the safety of individuals and families, as well as identifying how state or federal laws might apply in their community.[25] Tribal laws could also include components specific to health care responses. Currently, tribal codes and/or laws that mandate that health care providers working in Indian Country report domestic violence to law enforcement have not been identified. (Similarly, only two out of the fifty U.S. states have mandatory reporting laws specific to health care providers). Recent data suggest that health care providers in Indian Country have the unique and critical opportunity to conduct early identification and primary prevention of abuse. Routine assessments for domestic violence and sexual assault combined with community partnerships have produced promising results.

Child Abuse Reporting Laws

Reporting laws in regards to children in Indian Country are more developed than those for intimate partner violence. In 1990, Congress passed the Crime Control Act.[26] Part of the act mandated that professionals report child abuse that happens on federal land (i.e., reservations) or in federal facilities.[27] Much like standard reporting procedures, personnel[28] with knowledge or reasonable suspicion that a child was abused in Indian Country, or that actions are being taken or will be taken that would result in the abuse of a child in Indian Country must immediately report such abuse or action to local child protective services or local law enforcement.[29] In every federally operated (or contracted) facility, and on all federal lands, a standard written reporting form, with instructions, shall be disseminated to all the mandated reporter groups. Use of the form is encouraged, but should not take the place of telephone and oral reports. All reports that are received will be promptly investigated, and whenever appropriate, shall be conducted jointly by social services, law enforcement personnel, with a view toward avoiding unnecessary multiple interviews with the child.[30] Upon receipt of the report, local law enforcement or social services will notify the Federal Bureau of Investigation if the abuse involves an Indian child or if the alleged abuser is Indian.

24 Tribal Legal Code Resource: Domestic Violence Laws (Guide for Drafting or Revising Victim-Centered Tribal Laws Against Domestic Violence), Tribal Law and Policy Institute, February 2015 http://www.tribal-institute.org/download/Amended%2520Domestic_Violence_Code_Resource_2015.pdf

25 Ibid.

26 Victims of Child Abuse Act, 42 U.S.C. § 13021 (2003).

27 42 U.S.C. § 13031(a) (2003).

28 Health Care Personnel including physicians, surgeons, dentists, podiatrists, chiropractors, nurses, dental hygienists, optometrists, medical examiners, emergency medical technicians, paramedics and any person employed in the mental health profession.

29 P.L. 101-630; 18 U.S.C.

30 P.L. 101-647; 18 U.S.C.

The Indian Child Welfare Act Summary[31]

Reporting child abuse to authorities has been a contested issue for Native communities because of the history of child removal to non-Native adoptive families and boarding schools, among other reasons. Native communities worked to keep children removed from abusive homes in Indian Country and to determine child welfare decisions. This led to the passage of the Indian Child Welfare Act (ICWA) in 1978. The intent of Congress under ICWA was to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). ICWA sets federal requirements that apply to state child custody proceedings involving an Indian child who is a member of or eligible for membership in a federally recognized tribe.

The Indian Child Welfare Act, 25 U.S.C. § 1901 et. seq., recognizes that there is a government to government relationship between the United States and Tribes. This law, passed in 1978, affirms that special political relationship, and is not based on race or ethnic factors. Responding to reports that 25-35% of Indian children nationwide (as high as 50-75% in some states) had been removed from their families and placed at a rate of nearly 90% in non-Indian homes; Congress found that there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children. Congress also determined that states often failed to recognize the essential tribal relations of Indian people and the cultural and social standards prevailing in Indian communities and families. Congress declared that it is the policy of this nation to protect the best interest of Indian children and to promote the stability and security of Indian Tribes and families by the establishments of minimum federal standards for the removal of Indian children from their families and the placement of such children in foster or adoptive homes which will reflect the unique values of Indian culture.

Purpose of the Indian Child Welfare Act:

To protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by the establishment of minimum federal standards for the removal of Indian children and placement of such children in homes which will reflect the unique values of Indian culture (25 U.S.C. § 1902).

- ICWA regulates States regarding the handling of child abuse and neglect and adoption cases involving Native children- State courts, State Child Protection agencies, and adoption agencies;
- ICWA sets minimum standards for the handling of these cases;
- ICWA affirms the rights of Tribal Courts to adjudicate child abuse and neglect and adoption cases involving children on the reservation;
- ICWA establishes a preference for Tribal courts to adjudicate child abuse and neglect cases in situations of concurrent jurisdiction; and
- ICWA affirms and supports Tribal jurisdiction in child welfare proceedings.

31 Content from this section was adapted from the Tribal Law and Policy Institute's "The Indian Child Welfare Act Summary" http://nc.casaforchildren.org/files/public/community/programs/Tribal/indian-child-welfare-act-summary.pdf

Promising Practices and Federally-funded Tribal Programs

In 2010 the Indian Health Service (IHS) launched their Domestic Violence Prevention Initiative (DVPI) by a nationally coordinated demonstration program addressing domestic violence and sexual assault in American Indian and Alaska Native communities.[32] IHS works in partnership with Tribes to bring resources together to provide access to services for survivors. DVPI now supports 83 projects on a five year funding cycle, providing funds to tribes, tribal organizations, Urban Indian Organizations, and IHS federal facilities. Their core goals are to:

- Build a coordinated community response to support survivors of domestic and sexual violence;
- Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services;
- Promote trauma-informed services for survivors and their families;
- Offer health care provider and community education on domestic violence and sexual violence;
- Respond to the health care needs of survivors;
- Incorporate culturally appropriate practices and/or faith-based services for survivors

The Office on Violence Against Women (OVW) currently administers 25 grant programs authorized by the Violence Against Women Act of 1994 and subsequent legislation. These grant programs are designed to develop the nation's capacity to reduce domestic violence, dating violence, sexual assault, and stalking by strengthening services to victims and holding offenders accountable for their actions. The Grants to Indian Tribal Governments Program (Tribal Governments Program), authorized by Title IX of the Violence Against Women Act of 2005 (VAWA 2005), is designed to enhance the ability of tribes to respond to violent crimes against Indian women, enhance victim safety, and develop education and prevention strategies.

OVW's Tribal Governments Program awards funds to develop and enhance effective plans for tribal governments to respond to violence committed against Indian women; strengthen the tribal criminal justice system; improve services available to help Indian women who are victims of violence; create community education and prevention campaigns; address the needs of children who witness domestic violence; provide supervised visitation and safe exchange programs; provide transitional housing assistance; and provide legal advice and representation to survivors of violence who need assistance with legal issues caused by the abuse or the violence they suffered. In Fiscal Year 2018, the Tribal Governments Program funded 55 American Indian Tribes, Alaska Native villages, and other tribal designees totaling approximately $35 million.[33]

Family Violence Prevention & Services (FVPSA) is the primary Federal funding stream dedicated to provide immediate shelter and supportive services for victims of family violence, domestic violence or dating violence and their dependents.[34] FVPSA appropriates 10% of funds for grants to Native

32 Information in this paragraph was adapted from: https://www.ihs.gov/dvpi/aboutdvpi/

33 Information in this paragraph was adapted from: https://www.justice.gov/ovw/tribal-affairs

34 https://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/programs/tribes

American tribes.[35] All federally recognized Tribes are eligible for FVPSA formula-based funding.

FVPSA also provides funding for training and technical assistance centers dedicated to Native American communities.[36] The National Indigenous Women's Resource Center (NIWRC) is a national resource center focused on policy, research, public education, and training and technical assistance. The StrongHearts Native Helpline is the first national hotline for domestic violence for Native Americans. In 2018, the Alaska Native Women's Center was created as a state resource center to improve domestic violence services to Alaska Native survivors. There are also a number of domestic violence coalitions specifically for Native American survivors of violence: **www.niwrc.org/tribal-coalitions.**

Finally, between 2010-2013, seven native health sites and fourteen states were selected to participate in Project Connect, a national initiative that helped establish partnerships between public health programs and domestic and sexual violence advocates to effectively identify and refer victims of abuse. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees. Project Connect was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The participating Native health sites were Little Traverse Bay Band of Odawa Indians (Michigan), Nooksack Tribal Health Clinic (Washington), Passamaquoddy Health Center (Maine), The Queen's Medical Center (Hawaii), Washoe Tribe of Nevada and California (Nevada), the Kima:w Medical Center, and Southern Indian Health Council. For more information on Project Connect visit: **www.futureswithoutviolence.org/health/project-connect/**

Futures Without Violence, formerly Family Violence Prevention Fund, in partnership with faculty from Sacred Circle and Mending the Sacred Hoop Technical Assistance Project, worked with more than 100 Indian, Tribal and Urban health care facilities as well as DV advocacy programs across the United States to improve the health system response to domestic violence. This community partnership has resulted in the training of thousands of health care providers and community advocates, identified and empowered national experts, instituted sustainable DV response programs in hospitals and clinics, developed model policies and tools to better address abuse and prevent violence, and dramatically increased screening for DV. The complete report, Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report, can be found at **www.futureswithoutviolence.org/health.**

Organizations and Resources of Interest

The following organizations offer useful resources from model codes, training, technical assistance and Native American specific resource/outreach materials.

Tribal Law and Policy Institute
www.tribal-institute.org

The Tribal Law and Policy Institute is a Native American owned and operated non-profit corporation organized to design and deliver education, research, training, and technical assistance programs

35 https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_tribaldvservices_071818_508.pdf

36 Information in this paragraph was adapted from: https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_tribaldvservices_071818_508.pdf

which promote the enhancement of justice in Indian Country and the health, well-being, and culture of Native peoples, including the following:

- On-Site Training
- Tribal Court Development
- Tribal Court Review Services
- Tribal Code Drafting and Revision (Check Out: Tribal Legal Code Resource: Domestic Violence Laws, Guide for Drafting or Revising Victim Centered Tribal Laws Against Domestic Violence
- Grant and Proposal Writing
- Tribal Court Website Development

Mending the Sacred Hoop
www.mshoop.org

Mending the Sacred Hoop seeks to restore safety and integrity to Native women by assisting Native Sovereign Nations in strengthening their response to domestic violence and sexual assault. They work to improve the safety of Native women who experience battering, dating violence, sexual assault, and stalking by assisting tribes with training, technical assistance and resource materials that specifically address violence against American Indian/Alaska Native women, including training, technical assistance, and resource development.

National Indian Health Board
www.nihb.org

The National Indian Health Board is a non-profit organization that works to strengthen tribal health systems by providing services such as: advocacy, research, policy formation and analysis, training and technical assistance, and project management.

(**Check out** regular newsletters and digests on health issues in Indian country: **www.nihb.org/communications/nihb_publications.php)**

Futures Without Violence
www.futureswithoutviolence.org

For more than three decades, Futures Without Violence has worked to end violence against women and children around the world. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, Futures has continued to break new ground by reaching new audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers and others address violence.

Check Out:

- Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report. In partnership with faculty from Sacred Circle and Mending the Sacred Hoop, Futures worked with more than 100 Indian, Tribal and Urban health care facilities as well as domestic violence (DV) advocacy programs across the United States to improve the health system response to domestic violence.

- Safety Cards
- AI/AN Posters

Minnesota Indian Women's Resource Center
www.miwrc.org

The Minnesota Indian Women's Resource Center (MIWRC) is a non-profit organization that provides a comprehensive set of gender and culturally based services for American Indian women and their families. Located in the Philips neighborhood of Minneapolis and founded in 1984, MIWRC provides a broad range of programs designed to educate and empower American Indian women, their families and the surrounding community.

Check Out:

- Shattered Hearts Report, The Commercial Sexual Exploitation of American Indian Women & Girls in Minnesota. The topic of this report is the commercial sexual exploitation of American Indian women and girls in Minnesota, including but not limited to sex trafficking.

National Indigenous Women's Resource Center
www.niwrc.org

The National Indigenous Women's Resource Center (NIWRC) is a Native nonprofit organization that seeks to enhance the capacity of American Indian and Alaska Native (Native) tribes, Native Hawaiians, and Tribal and Native Hawaiian organizations to respond to domestic violence through technical assistance, education, public awareness and policy development.

Alaska Native Women's Resource Center
www.aknwrc.org

The Alaska Native Women's Resource Center (AKNWRC) is state resource center to improve domestic violence services to Alaska Native survivors, through training, policy advocacy, and public awareness. It is dedicated to strengthening local, tribal government's responses through community organizing efforts advocating for the safety of women and children in their communities and homes, especially against domestic and sexual abuse and violence.

StrongHearts Native Helpline
www.strongheartshelpline.org

The StrongHearts Native Helpline is the first domestic violence hotline for Native American survivors of violence. The helpline was created as a collaboration between the National Indigenous Women's Resource Center and the National Domestic Violence Hotline, in order to better meet the needs of Native American survivors. The confidential, anonymous hotline is available Monday through Friday, from 9:00am-5:30pmCST: 1-844-7NATIVE.

Also see the tribal domestic violence coalitions for more resources and technical assistance:
www.niwrc.org/tribal-coalitions

Quick Chart: State and Territory Statutes and Policies on Domestic Violence and Health Care

State	Fatality	Insurance	Reporting	Protocols	Screening	Training
Alabama	X	X	X			X
Alaska	X	X	X	X		X
Arizona	X	X	X			
Arkansas		X	X			
California	X	X	X	X	X	X
Colorado	X	X	X			X
Connecticut		X	X			X
Delaware	X	X	X			
Florida	X	X	X			X
Georgia		X	X			
Hawaii	X	X	X			
Idaho			X			
Illinois		X	X	X		
Indiana	X	X	X			
Iowa	X	X	X	X		
Kansas	X	X				
Kentucky	X	X	X	X		X
Louisiana		X	X			
Maine	X	X	X			X
Maryland	X	X	X			
Massachusetts		X	X			X
Michigan	X	X	X	X		X
Minnesota	X	X	X			X
Mississippi		X	X			
Missouri		X	X			
Montana	X	X	X			
Nebraska		X	X			
Nevada	X	X	X			
New Hampshire	X	X	X	X		X
New Jersey	X	X	X			X

State and Territory Statutes and Policies on Domestic Violence and Health Care (Cont.)

State	Fatality	Insurance	Reporting	Protocols	Screening	Training
New Mexico	X	X				
New York	X	X	X	X	X	X
North Carolina		**	X			
North Dakota	X	X	X			
Ohio		X	X	X		X
Oklahoma	X	X	X	X		X
Oregon	X	X	X	X		
Pennsylvania		X	X	X	X	X
Rhode Island		X	X			
South Carolina	X	**	X			X
South Dakota		X	X			
Tennessee	X	X	***			X
Texas	X	X	X	X	X	
Utah		X	X			
Vermont	X		X	X		
Virginia	X	X	X		X	
Washington	X	X	X			X
Washington, DC	X	X	X			
West Virginia		X	X	X		X
Wisconsin		X	X			
Wyoming		**				
American Samoa				X	X	
Guam				X		
Mariana Islands				X		
Puerto Rico				X		X
Virgin Islands						

** These states (SC, NC and WY) maintain insurance discrimination statutes that apply only to group health insurance.

*** TN just has statistical reporting.

ALABAMA

Statutes Addressing

Fatality Review: Code of Ala. §§ 30-9-1 and 30-9-2 allows a domestic violence fatality review team to be established on the local, regional, or state level to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. Such teams should consist of the coroner or county medical examiner, domestic violence advocates, and any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

Insurance Discrimination: Code of Ala. § 10A-20-6.16(a)(2) applies to health, life, disability and property insurance for special purpose entities. Code of Ala. § 27-55-2 applies to insurance that is not associated with special purpose entities. They state that no insurer in Alabama may deny, refuse to issue, renew, reissue, cancel, or otherwise terminate, restrict, or exclude coverage on an insurance policy or health benefit plan; exclude or limit coverage for a loss, deny benefits, or deny a claim; add a premium differential to an insurance policy or health benefit plan; terminate health coverage for a subject of abuse, where the subject of abuse does not qualify for coverage under COBRA because coverage originally was issued in the name of the abuser; on the basis of an applicant's or insured's abuse status, or on the basis of any association, relationship, or assistance to a subject of abuse. The statute for general and commercial insurers is slightly different, in that it allows general polices that may result in disproportionate impact on victims of domestic violence, however there cannot be any targeted policies.

Mandatory Reporting: Code of Ala § 22-11C-5 requires the reporting of all head and spinal injuries treated by medical practitioners to the State Health Officer.

Protocols: None.

Screening: None.

Training: Code of Ala § 30-6-[1-13] establish the Alabama Coalition Against Domestic Violence, which is tasked with establishing education, training, research and evaluation standards regarding domestic violence.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

ALABAMA (Cont.)

Public Health Responses

The Alabama Department of Public Health's Rape Prevention and Education Program Manager serves on the Council on Violence Against Women hosted by the Alabama Coalition Against Domestic Violence. The Council has representatives from multiple disciplines working to develop strategies to prevent domestic violence, including amending the Alabama State Plan on Violence Against Women to include primary prevention policies and protocols.

ALASKA

Statutes Addressing

Fatality Review: Alaska Stat. § 18.66.400 allows the commissioner of public safety to establish domestic violence fatality review teams in areas of the state, and municipalities to establish domestic violence fatality review teams in their municipality. Membership may include representatives from the office of the chief medical examiner and other domestic violence advocates. These meetings are closed to the public, and all information is presumed confidential unless released as part of a public report.

Insurance Discrimination: Alaska Stat. § 21.36.430 applies to health, life, disability and property insurance. It requires that no insurers in Alaska can refuse to issue or renew coverage, limit the scope of insurance coverage, cancel an existing policy, deny a covered claim, or increase the premium on an insurance policy if the refusal, cancellation, the denial, or increase results only from the fact that the person was a victim of domestic violence or a provider of services to victims of domestic violence.

Mandatory Reporting: Alaska Stat. § 08.64.369 requires health care professionals (not including practitioners of religious healing) to report specific types of burns, gunshot wounds, non-accidental wounds caused by knives, axes or other sharp pointed instruments, as well as any other non-accidental injuries likely to cause death to local law enforcement agencies.

Protocols: Alaska Stat. § 18.66.300 mandates that the AK Council on Domestic Violence and Sexual Assault consult with the State Department of Health and Social Services to produce standards and procedures for the delivery of services by health care providers to domestic violence victims. The Department of Health and Social Service shall make available to those facilities a written notice of the rights of victims of domestic violence and the services available to them.

Screening: None.

Training: Alaska Stat. § 18.66.310 provides for continuing domestic violence education for all public employees who are required by law to report child abuse under §47.17.020 (includes practitioners of the healing arts). Such education must include the nature, extent, and causes of domestic violence, procedures designed to promote the safety of the victim and other household members, resources available to victims and perpetrators of domestic violence, and the lethality of domestic violence.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

ALASKA (Cont.)

Public Health Responses

The Alaska Rape Prevention and Education (RPE) Program, funded by CDC, works with DVSA coalitions, education institutions, rape crisis centers, community organizations, and other entities to strengthen sexual violence prevention systems throughout Alaska. It aims to prevent sexual violence perpetration and victimization before it begins. The RPE Program also supports the Alaska Prevention Summit, a bi-annual conference providing community level staff with sexual violence prevention skills, and works to develop strategic planning and evaluation to improve community and societal level prevention efforts.

The Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. ANDVSA was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

ARIZONA

Statutes Addressing

Fatality Review: A.R.S. § 41-198 creates fatal or near fatal domestic violence review teams in political subdivisions of the state. These reviews happen after any criminal proceedings are completed, and are closed to the public. The review teams are composed of a law enforcement representative, a court representative, a representative from the prosecutor's office, a representative of a local domestic violence prevention program, a victim of domestic violence, a representative of a county or state public health agency, a representative from the county medical examiner's office, a representative of a statewide domestic violence coalition. In cases where a child was involved in some manner, then a representative from Child Protection Services will also participate.

Insurance Discrimination: A.R.S. § 20-448G-L applies to health, life, disability and property insurance. It requires that no insurers in Arizona deny a claim incurred or deny, refuse, refuse to renew, restrict, cancel, exclude or limit coverage or charge a different rate for the same coverage solely on the basis that the insured or proposed insured is or has been a victim of domestic violence or is an entity or individual that provides counseling, shelter, protection or other services to victims of domestic violence.

Mandatory Reporting: A.R.S. § 13-3806 requires physicians, surgeons, nurses or hospital attendants called upon to treat any person for gunshot wounds, knife wounds or other material injuries which may have resulted from a fight, brawl, robbery, or other illegal or unlawful act, to immediately notify local law enforcement.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Arizona Department of Health Services (ADHS) funds nine rural and urban domestic violence shelters and their supportive services, including an additional five community based organizations that provide domestic violence supportive services, training and/or prevention programs. One program staffs a full-time, bi-lingual Spanish and English Victim Patient Advocate dedicated to their community health center. The Victim Patient Advocate is a supportive team member of the medical staff that provides expertise in the intersection of health care and domestic violence services. The ADHS also funds child and adolescent related domestic violence programs and activities.

ARIZONA (Cont.)

Other ADHS programs are also actively involved in identifying, supporting and referring victims of intimate partner violence to appropriate services. Health Start, an ADHS home visitation program, implemented policy regarding screening home visitation clients at 3 months of enrollment for reproductive coercion and domestic violence in 2015. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) screens primary caregivers for intimate partner violence within 6 months of enrollment.

Arizona was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project, health care providers statewide were trained to assess for, and respond to, domestic and sexual violence in clinical settings. In addition, training requirements and formal partnerships with local domestic violence programs were added to Title V and Title X contracts.

Arizona is one of four states participating in the Providers, Advocates, and Technology for Health and Safety (PATHS) Project, partnering with the Johns Hopkins School of Nursing, the University of Pittsburgh, the Office on Women's Health, and Futures Without Violence. A leadership team is working with 3 sites to utilize the CUES universal education intervention, using the MyPlan safety decision aid, for supporting survivors of domestic violence and sexual assault, and to promote healthy relationships.

ARKANSAS

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: ARK. Code Ann. § 23-66-206(14)(G)(i) applies to health, life, disability and property insurance. It prohibits insurers in Arkansas from refusing to insure or continue to insure an individual or risks solely because of the individual's race, color, creed national origin, citizenship, status as a victim of domestic abuse, or sex abuse.

Mandatory Reporting: ARK. Code Ann. §12-12-602 requires all physicians, surgeons, hospitals, druggists, or other persons or entities that render first aid treatment to report to the county sheriff if they treat or receive in the hospital a case of a knife or gunshot wound when the knife or gunshot wound appears to have been intentionally inflicted; or burn wound that could reasonably be connected to criminal activity that is:

- A second or third degree burn to five percent (5%) or more of a person's body; or
- A burn to a person's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

Arkansas was one of five states that participated in *Project Catalyst: Statewide Transformation on Health and Intimate Partner Violence (2017-2018).* A leadership team consisting of the Arkansas Department of Health, the Community Health Center Association of Arkansas, and the Arkansas Domestic Violence Coalition, promoted policies and practices that support ongoing integration of intimate partner violence (IPV) and human trafficking (HT) responses into community health centers and domestic violence programs statewide. The leadership team offered training and technical assistance to five community health centers and five domestic violence advocacy programs that partnered with one another on trauma-informed practice transformation and made significant inroads into the implementation of an action plan to train and engage at least 50% of the HRSA-funded health centers across AR. In their effort to spread this work throughout Arkansas, the leadership team began working to establish the Project Catalyst 3.5 hour training curriculum as an established training for all health center and DV program staff, and created a new EHR smartform on IPV and HT for health centers across Arkansas. Additionally, the leadership team developed a

ARKANSAS (Cont.)

stakeholders group with diverse members to help strengthen their work—the group developed a resource directory with contact info, resources, sample policies, and legislation related to Project Catalyst. Learn more about Project Catalyst and to download the training curricula and tools, visit **www.ipvhealthpartners.org.**

Moreover, collaboration efforts exist between domestic violence statewide organizations, the Arkansas Commission on Child Abuse, Rape, Domestic Violence, and the Arkansas Department of Health. These collaborations will develop and implement statewide plans for addressing violence throughout the state of Arkansas.

CALIFORNIA

Statutes Addressing

Fatality Review:

Cal Pen Code § 11163 allows counties to establish interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides. The review team shall include coroners and medical examiners, county health department staff who deal with domestic violence victims' health issues and medical personnel with expertise in domestic violence abuse.

Insurance Discrimination:

Cal. Health & Safety Code § 1374.75, Cal. Ins. Code §§ 675, 675.5, 676.9, 10144.2, 10144.3; Cal. Fam. Code § 6211 applies to health, life, disability and property insurance. It requires that no insurer in California can deny, refuse to accept an application, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic violence.

Mandatory Reporting:

Cal. Penal Code §§11160 and 11161 require that any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or clinic or other facility operated by a local or state public health department, is required to make a report to local law enforcement if he or she provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is suffering from any wound or other physical injury that is the result of assaultive or abusive conduct as defined, including sexual assault; or any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.

Cal Pen Code § 13823.11 states that the minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault shall include notification to law enforcement authorities.

Protocols:

Cal. Health & Saf. Code § 1233.5 requires that policies and procedures adopted by clinic boards, as shall include documenting in the medical record patient injuries or illnesses attributable to spousal or partner abuse, and providing to patients who exhibit signs of spousal or partner abuse a current referral list of private and public community agencies that provide, or arrange for, the evaluation, counseling, and care of persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local battered women's shelters, legal services, and information about temporary restraining orders.

Cal. Health & Saf. Code § 1259.5 requires that the policies and procedures adopted by general acute care hospitals, acute psychiatric hospitals, special hospitals, psychiatric health facilities, and chemical dependency recovery hospitals, include documenting injuries attributable to spousal or partner abuse, advising patients who exhibit signs of such abuse of crisis intervention services available through the facility or the community, and providing them with a referral list, to be updated periodically, of private and public community agencies that provide, or arrange for, evaluation of and care for

CALIFORNIA (Cont.)

persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local battered women's shelters, legal services, and information about temporary restraining orders.

Cal Pen Code § 13823.5 requires the agency or agencies designated by the Director of Finance to establish a protocol for the examination and treatment of victims of sexual assault and attempted sexual assault, and the collection and preservation of evidence. The protocol shall contain recommended methods for meeting the standards specified in § 13823.11.

Cal Pen Code § 11161.2(b) requires the agency or agencies designated by the Director of Finance pursuant to § 13820, in cooperation with the State Department of Health Services, to establish medical forensic forms, instructions, and examination protocol for victims of domestic violence using as a model the form and guidelines developed pursuant to § 13823.5. The form should include a place for notation concerning taking a patient history of domestic violence, performance of the physical examination for evidence of domestic violence and a complete documentation of medical forensic exam findings.

Screening:

Cal. Health & Saf. Code § 1233.5 requires a licensed clinic board ("clinic" defined in § 1200 and 1200.1) and its medical director to establish and adopt written policies and procedures to screen patients for purposes of detecting spousal or partner abuse.

Cal. Health & Saf. Code § 1259.5 requires general acute care hospitals, acute psychiatric hospitals, special hospitals, psychiatric health facilities, and chemical dependency recovery hospitals to establish written policies and procedures to screen patients routinely for the purpose of detecting spousal or partner abuse and provide education for appropriate hospital staff about the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.

Training:

Cal. Bus. & Prof. Code §2191(h) directs the Division of Medical Licensing to consider providing a continuing education course on screening for signs exhibited by abused women.

Cal. Bus. & Prof. Code §2196.5 requires the state board to periodically disseminate information and educational material regarding the detection and treatment of spousal or partner abuse to each licensed physician and surgeon and to each general acute care hospital in the state.

Cal. Bus. & Prof. Code § 2091.2 requires all applicants for medical licensure prove that they have received instruction and coursework in spousal or partner abuse detection and treatment.

Cal. Pen. Code §13823.93 establishes one hospital-based training center to train medical personnel on how to perform medical evidentiary examinations for victims of child abuse or neglect, sexual assault, and domestic violence. The training will be available for medical personnel as well as law enforcement and the courts throughout the state and must meet numerous conditions and standards.

CALIFORNIA (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The California Department of Public Health (CDPH) has released the first in a series of reports focused on violence. *Preventing Violence in California Volume 1: The Role of Public Health* provides a broad overview of the complex topic of violence prevention. The purpose of this report is to strengthen the understanding of the governmental public health role in violence prevention, to better address the connections among the different forms of violence, shape future funding initiatives and guide collaborative efforts with partners across the state.

The California Partnership to End Domestic Violence (CPEDV) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. CPEDV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

COLORADO

Statutes Addressing

Fatality Review: C.R.S. 24-31-702 establishes a domestic violence fatality review team was established to examine data collected by review teams during the preceding year; Identify measures to help prevent domestic violence fatalities and near-death incidents; (c) Establish uniform methods for collecting, analyzing, and storing data relating to domestic violence fatalities and near-death incidents; and (d) Make annual policy recommendations concerning domestic violence to the general assembly. Members of the domestic violence fatality review team shall include a domestic violence advocate, a medical professional with forensic experience, a law enforcement representative, a criminal defense attorney, two domestic violence survivors, among others.

Insurance Discrimination: C.R.S. §§ 10-3-1104.8 applies to health, life, disability and property insurance. It prohibits insurers in Colorado from denying, refusing to issue, refusing to renew, refusing to reissue, canceling, or otherwise terminating an insurance policy or restricting coverage; adding any surcharge or rating factor to a premium of an insurance policy solely because of that person's domestic abuse status.

Mandatory Reporting: C.R.S. § 12-36-135 requires physicians, nurses and other health care providers as defined in 12-36-106 to report attending to or treating any wounds believed to be intentionally inflicted on a person or any other injury that the physician has reason to believe involves a criminal act to local police, except for injuries resulting from domestic violence if the victim is at least eighteen years of age and indicates their preference that the injury not be reported and if the injury is not from a firearm, knife, ice pick, or other sharp object. CRS 12-36-135 (VI) states that if a licensee has reason to believe that an injury resulted from domestic violence, then, regardless of whether the licensee reports the injury to law enforcement, the licensee shall either refer the victim to a victim's advocate, as defined in section 13-90-107(1)(k)(II), or provide the victim with information concerning services available to victims of abuse.

Protocols: None.

Screening: None.

Training: C.R.S. §§ 26-7.5-101 and 26-7.5-103 encourage the development of domestic abuse programs by units of local government which shall provide educational programs for both the community at large and specialized groups, such as medical personnel and law enforcement.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

COLORADO (Cont.)

Public Health Responses

Colorado is one of three states/territories participating in Project Catalyst Phase II: State and Territory-Wide Transformation on Health, Intimate Partner Violence, and Human Trafficking (2018-2019), focused on fostering intimate partner violence, human trafficking, and health leadership and collaboration at the U.S. state/territory level to improve the health and safety outcomes for survivors of IPV and human trafficking and to promote prevention. The leadership team consists of leaders from Violence Free Colorado, The Colorado Community Health Network, and the Colorado Department of Human Services.

CONNECTICUT

Statutes Addressing

Fatality Review: There is no state statute pertaining to domestic violence fatality review. However, the Connecticut Coalition Against DV does lead the CT Domestic Violence Fatality Review Task Force and Department of Public Health is a member. A synopsis can be found here - **www.ctcadv.org/projects-initiatives/fatality-review/.**

Insurance Discrimination: Conn. Gen. Stat. § 38a-816 (18), 38a-469 applies to health insurance. It prohibits health insurers in Connecticut from refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because such individual has been a victim of family violence.

Mandatory Reporting: Conn. Gen. Stat. § 19a-490f requires all hospitals, outpatient clinics and surgical facilities to report treatment of any injuries resulting from the discharge of a firearm to local police departments, or a stab wound that is a serious physical injury likely caused by a knife or other sharp or pointed instrument.

Protocols: None.

Screening: None.

Training: Conn. Gen. Stat. § 20-10b requires all medical and surgical professionals seeking license renewal to complete a continuing education program which must include at least one hour of education or training relating to domestic violence. A licensee applying for first time renewal or those not engaged in active professional practice of any form are exempt.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: The Connecticut Coalition Against DV receives a grant from DSS for a Health Professional Outreach Project, which provides substantial amounts of training and technical assistance for healthcare providers. A synopsis can be found here - **www.ctcadv.org/projects-initiatives/health-professional-outreach/.**

Public Health Responses

In 2016 the Connecticut Coalition Against DV established a partnership with Connecticut Children's Medical Center to form the Children's Center on Family Violence. The Center's activities are focused on facilitating dissemination of existing evidence-based practices in child-serving sectors, developing and evaluating best practices and sharing learnings with the field, and educating & training stakeholders. A portion of this work is targeted specifically to healthcare providers. Here is a link to the available publications - **ctccfv.org/resource-library/**

CONNECTICUT (Cont.)

Connecticut was one of five states that participated in *Project Catalyst: Statewide Transformation on Health and Intimate Partner Violence (2017-2018).* A leadership team consisting of the Connecticut Department of Health, the Community Health Center Association of Connecticut, and the Connecticut Coalition Against Domestic Violence, promoted policies and practices that support ongoing integration of intimate partner violence (IPV) and human trafficking (HT) responses into community health centers and domestic violence programs statewide. The leadership team offered training and technical assistance to five community health centers and five domestic violence advocacy programs that partnered with one another on trauma-informed practice transformation and made significant inroads into the implementation of an action plan to train and engage at least 50% of the HRSA-funded health centers across Connecticut. In their effort to spread this work throughout Connecticut, the leadership team worked to establish the Project Catalyst 3.5 hour curriculum as an available training to any interested Connecticut health center or work group in the state. Learn more about Project Catalyst and to download the training curricula and tools, visit **www.ipvhealthpartners.org.**

DELAWARE

Statutes Addressing

Fatality Review: 13 Del. C. § 2105 allows the Domestic Violence Coordinating Council to investigate and review all deaths and near deaths that occur as a result of domestic violence through a Fatal Incident Review Team. Membership shall include the Director of the Division of Substance Abuse and Mental Health and other domestic violence advocates.

Insurance Discrimination: 18 Del. C. §§ 2302(3), (5), 2304(24)-(25), 3340 applies to health, life, disability and property insurance. It requires that no insurers in Delaware deny, refuse to issue, refuse to renew, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage; add any surcharge or rating factor to a premium of an insurance policy; exclude or limit coverage for losses or deny a claim; because that individual is, has been or may be the subject of abuse or seeks, has sought or should have sought, medical or psychological treatment for abuse, protection from abuse or shelter from abuse; because of an individual's history of, status as, or potential to be subject to abuse; or for losses incurred by an insured as a result of abuse or the potential for abuse.

Mandatory Reporting: 24 Del. C. § 1762 requires all persons certified to practice medicine who attend to or treats stab wounds, poisonings (other than accidental), or firearm injuries to report to local policing authorities.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: The Criminal Justice Council manages public funding received from the Victims of Crime Act of 1984 (VOCA); the Family Violence Prevention and Services Grant Program; the Violence Against Women Act ("VAWA"), to include the Sexual Assault Services Program (SASP) and STOP (Services, Training, Officers, and Prosecutors) Violence Against Women Formula Grant.

The Domestic Violence Fund

As defined in § 3132 (b) of Title 16 the Delaware State Code, "the fee charged for each certified copy of a marriage license/certificate shall be $25, except that upon production of a valid military identification card, active members of the military and their spouses shall be exempt from paying such fee. This fee shall be collected by the Bureau of Vital Statistics or the Clerk of the Peace, whichever agency issues the certified copy. Each Clerk of the Peace and the Bureau of Vital Statistics shall file a semi-annual report of the fees collected with the Department of Revenue and shall deposit $15 from each fee for a certified marriage license/certificate copy into the Domestic Violence Fund, to be

DELAWARE (Cont.)

administered by the Criminal Justice Council."

And further defined in § 8704 (10) of Title 11, the CJC must "allocate funds resulting from the certified copy fees for marriage license/certificates, pursuant to § 3132(b) of Title 16. Moneys resulting from the copy fees shall constitute The Domestic Violence Fund."

The intent of these funds is to increase and enhance the domestic violence services statewide. Priority consideration will be given to those programs detailing services statewide, or collaborations between agencies in all three counties to ensure services are equitably distributed and available to victims.

Prevent Child Abuse Delaware, SOAR, La Esperanza, Contactlifeline, and the YWCA Delaware – Sexual Abuse Response Center all receive state funds toward services and prevention of sexual assault, domestic violence and child abuse. These funds total almost $200,000. In addition Delaware receives numerous federal grants for the same purpose to include the Center for Disease Control and Prevention (CDC) Rape Prevention and Education grant.

The above agencies are a few of those who receive state funds that are specifically earmarked for domestic violence and abuse services, however, there are numerous agencies who receive state funds and a portion of their services include counseling and general abuse recovery services. They include but are not limited to: Children & Families First, La Red, One Village Alliance, Inc., Planned Parenthood of DE, Westside, Kingswood Community Center, Health, Inc. - Family Medical, Jewish Family Service of Delaware, Peoples Place, Brandywine Counseling, Inc., Brandywine Community Resource Council, CAMP Rehoboth, Salvation Army- Statewide Crisis Alleviation, Victims' Voices Heard, Inc., and West End Neighborhood House.

Others: None.

Public Health Responses

The Delaware Coalition Against Domestic Violence (DCADV) has partnered with the Office of Women's Health and other stakeholders to develop and implement a statewide plan to prevent intimate partner violence.

The Division of Public Health, Office of Women's Health receives the Center for Disease Control and Prevention's Rape Prevention and Education (RPE) grant. The Division of Public Health works with DCADV and Jewish Family Services to carry out the objectives of this grant. Additionally, Delaware's Division of Public Health holds an annual statewide conference on the primary prevention of IPV and sexual violence in collaboration with DCADV, Jewish Family Services and the Sexual Assault Network of Delaware.

In 2013, Delaware was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Con-

DELAWARE (Cont.)

nect 2.0 was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The Project Connect 2.0 work in Delaware was led by the Delaware Coalition Against Domestic Violence, in partnership with the Delaware Division of Public Health, to develop state policies to require universal education on healthy relationships, targeted assessment for reproductive coercion and adolescent relationship abuse for sexually active young women, and partnership with local advocacy organizations for school and community-based adolescent health settings. In addition, providers from five clinic sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

The Delaware Coalition Against Domestic Violence (DCADV) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. DCADV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

FLORIDA

Statutes Addressing

Fatality Review: Fla. Stat. § 741.316 allows for establishment of domestic violence fatality review teams at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. Membership must include a representative from the Office of the Medical Examiner and other victim's services.

Insurance Discrimination: Fla. Stat. § 626.9541 (1)(g)(3)(e) applies to health, life, disability, automobile, managed care and property and casualty insurance. It prevents all insurers in Florida from refusing to issue, reissue, or renew a policy, refusing to pay a claim, cancel or otherwise terminate a policy, or increasing rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim, sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member. The statute allows restrictions that target conditions that may have been caused by domestic violence, but does not allow companies to consider the abuse as a causing factor.

Mandatory Reporting: Fla. Stat. § 790.24 requires any physician, nurse, or employee thereof and any employee of a hospital, sanitarium, clinic, or nursing home who knowingly treats or is requested to treat any person suffering from a gunshot wound or life threatening injury indicating an act of violence shall report immediately to the sheriff's department. Willful failure to report is punishable as a misdemeanor.

Fla. Stat. § 877.155 requires any person who treats, or is requested to treat, second or third degree burns affecting 10% or more of the body, to report such treatment to the sheriff's department if they determine the burns were caused by a flammable substance and if they suspect the injury is a result of violence or other unlawful activity.

Protocols: None.

Screening: None.

Training: Fla. Stat. § 456.031 mandates a two-hour continuing education course on domestic violence as part of every third biennial re-licensure or recertification for physicians, nurses, dental care providers, licensed clinical social workers, mental health professionals and other health care providers.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

FLORIDA (Cont.)

Public Health Responses

The Florida Coalition Against Domestic Violence (FCADV) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. FCADV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

GEORGIA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: O.C.G.A. § 33-6-4 (b)(15) applies to health, life, disability and property insurance. It requires that all insurers in Georgia cannot deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or that such person knows or has reason to know the applicant or insured may be a victim of family violence; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence.

Mandatory Reporting: O.C.G.A. § 31-7-9 requires that physicians, registered nurses, security personnel and other personnel employed by a medical facility whose employment duties involve the care and treatment of patients therein, with cause to believe that a patient has had physical injury or injuries inflicted upon him by nonaccidental means to report, or cause reports to be made, to local law enforcement.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None

Public Health Responses

Georgia has been conducting domestic violence fatality reviews since January 2004. This statewide initiative reviews deaths and near deaths that occur in the context of intimate partner violence and makes recommendations for systemic change. A detailed summary of the findings and recommendations are published in an annual report that is widely used to educate and train those who have a role in ending domestic violence and related deaths.

Georgia was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project nearly 1,000 health care providers were trained to assess for,

GEORGIA (Cont.)

and respond to, domestic and sexual violence in clinical settings. The Georgia Coalition Against Domestic Violence and Georgia Department of Health partnered to write a chapter on domestic violence screening and intervention for inclusion in the family planning nurses' manual. In addition, Georgia added questions about reproductive coercion to PRAMS, and the Department of Health is considering adding questions to other statewide surveillance systems (BRFSS, YBRS, etc.).

HAWAII

Statutes Addressing

Fatality Review: HRS §321-471 to §321-476 Allows the Department of Health to conduct multidisciplinary and multiagency reviews of domestic violence fatalities, near-deaths, and suicides to reduce the incidence of preventable intimate partner homicides.

Insurance Discrimination: Haw. Rev. Stat. Ann. §§ 431:10-217.5, 432:1-101.6, 432:2-103.5, 432D-27 applies to health, life disability and property insurance. It provides that all insurers in Hawaii cannot deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

Mandatory Reporting: H.R.S. § 453-14 requires every physician, osteopathic physician, physician assistant, and surgeon attending or treating attending who's treating knife wounds and injuries caused by a firearm that would seriously maim, produce death, or have rendered the injured person unconscious, caused by the use of violence or sustained in a suspicious or unusual manner to report the case to the local chief of police.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Department of Health, in partnership with 3 other state agencies (the Department of the Attorney General, the Judiciary, and the Department of Human Services) has developed and is implementing continuous statewide training for state and county employees who may encounter domestic violence survivors in the course of their work. The goal is to provide these government employees with a greater understanding and knowledge of the dynamics of domestic violence, its impact, and available resources.

IDAHO

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: None.

Mandatory Reporting: Idaho Code § 39-1390 requires any person operating a hospital or other medical treatment facility, or any physician, resident on a hospital staff, intern, physician assistant, nurse or emergency medical technician to report to law enforcement authorities treatment or request for treatment of any person whom they believe to have received an injury inflicted by means of a firearm, or, an injury indicating that the person may have been a victim of a criminal offense.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Idaho Council on Domestic Violence and Victim Assistance (ICDVVA) is a state agency under the Governor's office. The ICDVVA funds programs that serve victims of crime and assists victims through legislation, advocacy, training, and public awareness. The ICDVVA also funds four child abuse advocacy centers. The ICDVVA holds an annual "Two Days in June Conference" that provides training to individuals who work in domestic violence fields. Training at the conference includes the following topics: working with victims of different cultural backgrounds; mental health issues and drug abuse; victims with disabilities; elderly and teen victims; and health-related issues.

The Idaho Coalition Against Domestic and Sexual Violence (ICADSV) was one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Focus grant from the Center for Disease Control and Prevention (CDC). From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

In 2013, Idaho was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided

IDAHO (Cont.)

technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Connect 2.0 was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The Project Connect 2.0 work in Idaho was led by the Idaho Coalition Against Domestic and Sexual Violence, in partnership with the Idaho Department of Health and Welfare to develop state policies to require universal education on healthy relationships, targeted assessment for reproductive coercion and adolescent relationship abuse for sexually active young women, and partnership with local advocacy organizations for school and community-based adolescent health settings. In addition, providers from five clinic sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

Idaho was one of five states participating in *Project Catalyst: Statewide Transformation on Health and Intimate Partner Violence (2017-2018).* A leadership team consisting of the Idaho Department of Health, the Idaho Primary Care Association, and the Idaho Coalition Against Sexual and Domestic Violence, promoted policies and practices that support ongoing integration of intimate partner violence (IPV) and human trafficking (HT) responses into community health centers and domestic violence programs statewide. The state leadership team offered training and technical assistance to five community health centers and five domestic violence advocacy programs that partnered with one another on trauma-informed practice transformation and made significant inroads into the implementation of an action plan to train and engage at least 50% of the HRSA-funded health centers across Idaho. In their efforts to spread this work throughout Idaho, the leadership team established a stakeholders group of diverse community leaders to help inform their strategies and approaches. Stakeholder members included: a representative from the Shoshonne-Bannock Tribe Domestic Violence Program; a community leader involved with engaging men programs, batterer's intervention programs, and HIV testing programs; and a representative from the Idaho Community Council, the largest organization in the state that serves the Latinx community. Lastly, the leadership team plans to use the Project Catalyst curriculum to train Title X-funded clinics throughout Idaho. Learn more about Project Catalyst and to download the training curricula and tools, visit **www.ipvhealthpartners.org.**

ILLINOIS

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: 215 ILCS 5/155.22a-b, 5Ill. applies to health, life, disability and property insurance. It requires that no insurer in Illinois can deny, refuse to issue, refuse to renew, refuse to reissue or otherwise terminate an insurance policy or restrict coverage on an individual because that individual has or has been the subject of abuse, or because that individual seeks or has sought medical or psychological treatment for abuse or protection or shelter from abuse or sought protection or shelter from abuse.

Mandatory Reporting: 20 ILCS 2630/3.2 requires any person conducting or operating a medical facility, or any physician or nurse, to report treatment of injuries to local law enforcement when it reasonably appears that the person requesting treatment has suffered from an injury caused by the discharge of a firearm or sustained in the commission of, or as the victim of, a criminal offense.

Protocols: 750 ILCS 60/401 provides that any person who is licensed, certified, or otherwise authorized by the state to administer health care in the ordinary course of business or practice of a profession, shall offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse.

77 Ill. Adm. Code 250.1035 provides that hospitals licensed under the Hospital Licensing Act shall have policies regarding the identification of possible victims of abuse, and any policies regarding possible victims of alleged or suspected abuse or neglect shall address patients' special needs relative to the patient assessment process, including consent, evidence collection, notification and release of information to authorities, and referrals to community agencies.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: The Illinois Coalition Against Domestic Violence provides federal pass-through dollars to a small number of domestic violence programs to have advocates present in the emergency department of key large cities. The advocates provide on-site, confidential counseling and help to victims of domestic violence in the ERs.

Others: Since 2002 the Illinois Violence Prevention Authority has provided between $200,000--$400,000 per year for grants to a statewide initiative and local communities focused on improving health care prevention and response efforts to domestic, elder and sexual violence. Since that time a total of 16 communities and one large urban hospital have

ILLINOIS (Cont.)

received this funding through a program named Illinois Health Cares (See below for further description of Illinois Health Cares).

Public Health Responses

The Illinois Health Cares (IHC) grant program, co-sponsored by the Illinois Department of Public Health and the Illinois Violence Prevention Authority, seeks to improve the health care response to domestic/sexual violence and elder abuse. Funded sites strive to: develop a local partnership representing hospitals, clinics, health departments, and other health care providers as well as local violence prevention service providers; provide system-wide education for health care providers and institutions on the health care response to domestic/sexual violence and elder abuse; increase public understanding of these issues as critical health problems for which help can be sought through health care providers; improve the clinical response to these forms of violence; and increase the statewide capacity of health care systems to respond to domestic/sexual violence and elder abuse. Eligible grantees are public health departments or domestic/sexual violence and elder abuse service providers. A small scale evaluation of the IHC project has shown improvement in policies, practices, and facility environments at participating institutions in funded sites, as well as an increase in training for staff and greater collaboration among local programs and institutions.

Since 1995 a centralized intake system, Cornorstone, has collected information on all clients receiving services from the public health system in Illinois—since its inception this intake system has included a question on domestic violence. Public health staff have received training on violence prevention in various public health venues and conferences as funding and programming have permitted.

INDIANA

Statutes Addressing

Fatality Review: Burns Ind. Code Ann. §§ 12-18-8-1 through 12-18-8-16 allows each county to establish a domestic violence fatality review team for the purpose of reviewing a death resulting from domestic violence, but shall review only those deaths in which the person who commits the act of domestic violence resulting in death is charged with a criminal offense that results in final judgment or is deceased. The teams must contain an expert in the field of forensic pathology, a coroner, or a deputy coroner, and a medical practitioner with expertise in domestic violence.

Insurance Discrimination: Burns Ind. Code Ann. § 27-8-24.3-1 to 10 applies to health, life and disability insurance. It requires that those insurers in Indiana deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue or otherwise terminate or restrict coverage on an individual under an insurance policy because the individual has been, is or has the potential to be a victim of abuse, or seeks or has sought shelter from abuse or medical or psychological treatment for abuse

Mandatory Reporting: Burns Ind. Code Ann. § 35-47-7-1 requires every case of injury arising from or caused by the discharge of a firearm, every case of a wound which is likely to or may result in death and is actually or apparently inflicted by a knife, ice pick, or other sharp or pointed instrument to be reported by either the physician attending or treating the case, or by the manager, superintendent, or other person in charge if the case is treated in a hospital, clinic, sanitarium, or other facility or institution, to law enforcement authorities.

Burns Ind. Code Ann. § 35-47-7-3 requires any second or third degree burns covering more than 10% of the body, burns to the upper respiratory tract from inhalation and any others that may cause serious bodily injury to be reported by the physician treating the person, or the hospital administrator or the hospital administrator's designee of the hospital or ambulatory outpatient surgical center (if the person is treated in a hospital or outpatient surgical center), to the state fire marshal.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

INDIANA (Cont.)

Public Health Responses

Indiana State Department of Health (ISDH) employs a Violence Prevention Program Director. The Director sits on the Indiana Coalition Against Domestic Violence's Prevention Committee and facilitates the Sexual Violence Primary Prevention Council.

ISDH is funded by the Rape Prevention and Education Cooperative Agreement through the Center for Disease Control and Prevention and, in turn, funds community-based sexual violence primary prevention efforts. The Indiana State Department of Health also facilitates the Indiana Sexual Violence Primary Prevention Council, which released its second 5-year sexual violence primary prevention plan in 2016. The plan lists 7 goals and identifies key stakeholders (including domestic violence agencies) for building sexual violence primary prevention throughout Indiana.

The Indiana Coalition Against Domestic Violence was one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Focus grant from the Center for Disease Control and Prevention (CDC). From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

IOWA

Statutes Addressing

Fatality Review: Iowa Code §§ 135.108 - 135.111 establishes a domestic abuse death review team which should include a representative of the state medical examiner, a licensed physician or nurse who is knowledgeable concerning domestic abuse injuries and deaths, including suicides, a licensed mental health professional who is knowledgeable concerning domestic abuse, and the director of public health.

Insurance Discrimination: Iowa Code Ann. § 507B.4(3)(g)(3) applies to health, life, disability and property insurance. It prohibits insurers in Iowa from making or permitting any discrimination in the sale of insurance solely on the basis of domestic abuse.

Mandatory Reporting: Iowa Code 147.111 mandates that any health-related professional licensed under Title IV, Subtitle 3, who administers treatment to persons suffering from a gunshot, stab wound, or other serious bodily injury (defined in §702.18), which appears to have been received in connection with a criminal offense, must report to a law enforcement agency where the crime was committed or treatment was attainted.

Iowa Code §147.113A also requires such licensed professionals to report to local law enforcement treatment of burns that are of suspicious nature, those to the upper respiratory tract, are likely to result in death, or appear to have been received in connection with a criminal offense.

Protocols: Iowa Code 135B.7(4) requires each hospital to establish and implement protocols for responding to the needs of patients who are victims of domestic abuse.

Under Iowa Code 481-51.7(135B), such protocols, at a minimum, must provide for an interview with the victim in a place that ensures privacy, confidentiality of the person's treatment and information, sharing of information regarding domestic abuse hotlines and programs, and education of appropriate emergency department staff to assist in the identification of victims of domestic abuse.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: STOP VAWA $55,000 for domestic violence specialist in the Public Health Department.

Others: None.

IOWA (Cont.)

Public Health Responses

Since 1997, the Iowa Department of Public Health (IDPH) has received dedicated money to address Violence Against Women in the Health Care System. Iowa currently receives U.S. Department of Justice STOP Violence Against Women Act (VAWA) funds, which support IDPH's work on public health approaches to violence against women, in addition to other federal and state funds to do primary prevention of sexual violence.

The Iowa Domestic Abuse Death Review Team was established in 2000 to identify the causes and manner of deaths resulting from domestic abuse in Iowa. It is established by statute in the *Code of Iowa*, Chapter 135.108-135.112. The Domestic Abuse Death Review Team is staffed by the IDPH and reports to the Iowa Legislature regarding the annual death review findings and recommendations.

Since 2012, Iowa has included questions related to Domestic Violence on the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire, administered through IDPH, with questions covering physical abuse before and during pregnancy, control of birth control, and physical safety before, during and after pregnancy. Beginning in 2016, a portion of Iowa's STOP VAWA funds have been used to support the coordination and implementation of "Healthy Moms, Healthy Babies," a curriculum offered to home visitation programs and family service workers in Iowa to address domestic violence.

Iowa was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project 6,000 health care providers were trained to assess for, and respond to, domestic and sexual violence in clinical settings. The initiative helped strengthen partnerships between the Iowa Department of Public health, the Iowa Coalition Against Domestic Violence, and the Iowa Coalition Against Sexual Assault to effectively identify and refer victims of abuse. As part of that project, Iowa was successful in linking to other federally funded programmatic initiatives to Project Connect objectives, including state requirements for assessment of reproductive coercion and IPV that includes warm referrals to local DSV agencies for all teen pregnancy prevention (PREP) and home visitation (MIECHV) grantees, and working towards making training for Title X and Title V contractors mandatory.

In 2015-2016 Iowa participated in Phase II of the Improving Health through Violence Prevention: Fostering Sustainable State/Territory and Systems-Level Transformation for Community Health Centers and Domestic Violence Programs in which a community health center and domestic violence program were partnered to work together to promote the safety and health of people seeking services in either program. Training and technical assistance were provided by Futures Without Violence, with evaluation provided by the University of Pittsburgh and funding through a collaboration of U.S. Department of Health and Human Services, including the HRSA Bureau of Primary Health Care, the HRSA Office of Women's Health, and the Administration for Children and Families' Family and Youth Services Bureau, Family Violence Prevention and Services Program.

Iowa was one of five states participating in *Project Catalyst: Statewide Transformation on Health and Intimate Partner Violence (2017-2018).* A leadership team consisting of the Iowa Department of Health, the Iowa Primary Care Association, and the Iowa Coalition Against Domestic Violence, promoted policies and practices that support ongoing integration of intimate partner violence (IPV) and human trafficking (HT) responses into community health centers and domestic violence programs statewide. The state leadership team offered training and technical assistance to five community health centers and five domestic violence advocacy programs that partnered with one another on

IOWA (Cont.)

trauma-informed practice transformation and made significant inroads into the implementation of an action plan to train and engage at least 50% of the HRSA-funded health centers across Iowa. In their efforts to spread this work throughout Iowa, the leadership team provided trainings and presentations for agencies in the State Department of Health, and with programs within the state Primary Care Association. The leadership established a stakeholder group of diverse members throughout Iowa to help strengthen and spread their work, including adapting the Project Catalyst curriculum for work with culturally-specific victim service agencies. Learn more about Project Catalyst and to download the training curricula and tools, visit **www.ipvhealthpartners.org.**

KANSAS

Statutes Addressing

Fatality Review: The Domestic Violence Fatality Review Board was created by Gov. Kathleen Sebelius in executive order No. 04-11.

Insurance Discrimination: KK.S.A. § 40-2404(7)(d) applies to health, life, and accident insurance. It prohibits those insurers in Kansas from: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an applicant who is the proposed insured; or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse.

Mandatory Reporting: None.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

KENTUCKY

Statutes Addressing

Fatality Review:

KRS § 403.705 allows local domestic violence coordinating councils, if authorized by the local coroner or a medical examiner, to create a domestic violence fatality review team. The purpose of such a team shall be to prevent future deaths and injuries related to domestic violence.

Insurance Discrimination:

K.R.S. §§ 304.12-211 and 304.17A-155 applies to health and property insurance. It requires that those insurers in Kentucky cannot use the fact that an applicant or insured incurred bodily injury as a result of domestic violence and abuse committed against him or her as the sole reason for rating or underwriting decisions, refusing to insure, refusing to continue to insure, or limiting the amount, extent, or kind of coverage available to an applicant or insured or exclude property coverage for intentional acts, the insurer shall not deny payment to an innocent co-insured if the loss arose out of a pattern of domestic violence and abuse and the perpetrator of the loss is criminally prosecuted for the act causing the loss. Payment to the innocent co-insured may be limited to his or her ownership interests in the property as reduced by any payments to a mortgage or other secured interest.

Mandatory Reporting:

Under KRS 209A.100, upon the request of a victim, a professional shall report an act of domestic violence and abuse or dating violence and abuse to a law enforcement officer. A professional who makes a report under this chapter shall discuss the report with the victim prior to contacting a law enforcement officer. A professional shall also report to law enforcement his or her belief that the death of a victim with whom he or she had a professional interaction is related to domestic or dating violence and abuse.

KRS 209A.130 requires professionals who have reasonable cause to believe that a victim with whom they have had a professional interaction has experienced domestic or dating violence and abuse to provide the victim with educational materials related to domestic or dating violence and abuse including information about how he or she may access regional domestic violence programs or rape crisis centers and information about how to access protective orders. Professional includes: physician, osteopathic physician, coroner, medical examiner, medical resident, medical intern, chiropractor, nurse, dentist, optometrist, emergency medical technician, paramedic, licensed mental health professional, therapist, cabinet employee, child-care personnel, teacher, school personnel, ordained minister or the denominational equivalent, victim advocate or any organization or agency employing any of these professionals."

Protocols:

See below.

Screening:

None.

Training:

KRS § 194A.540 requires the secretary for health and family services, in consultation with the applicable licensure boards, to develop domestic violence related train-

KENTUCKY (Cont.)

ing courses for mental health professionals (licensed or certified under KRS Chs. 309, 319, and 335), alcohol and drug counselors (certified under Ch. 309), physicians who practice primary care (defined in § 164.925) or who meet the definition of a psychiatrist under § 202A.011, and who are licensed under Ch. 311, nurses licensed under Ch. 314, Paramedics certified under Ch. 311, emergency medical technicians certified under Ch. 2, coroners (defined in § 72.405), and medical examiners (defined in 72.240). Such courses shall include the dynamics of domestic violence and its effects on adult and child victims, legal remedies for protection, lethality and risk issues, model protocols for addressing domestic violence, available community resources and victim services, and reporting requirements. All health professionals listed above must complete a three hour training course meeting these requirements.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

LOUISIANA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: La. R.S. 22:1078 applies to health insurance. It requires that no health insurance issuer or nonfederal governmental plan shall engage in any of the following acts or practices on the basis of the abuse status of an applicant or insured: restricting, excluding, or limiting benefit plan coverage solely as a result of abuse status; adding a rate differential solely because of abuse status, denying or limiting payment of a claim incurred by an insured, enrollee, member, subscriber, or dependent solely because the claim was incurred as a result of abuse status. La. R.S. 22:1063 addresses group health plans and group health plan insurers. It prevents group health plans and insurers from considering any conditions that arise from domestic violence incidents when determining eligibility, both initial eligibility and continued enrollment.

Mandatory Reporting: La. R.S. 14:403.5 requires medical professionals, practitioners, or associated persons, to notify local law enforcement of every case of gunshot wound or injury.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

MAINE

Statutes Addressing

Fatality Review:

19-A M.R.S. § 4013-4 establishes a Domestic Abuse Homicide Review Panel comprised of multiple law enforcement, health profession and victim services representatives. This panel shall collect and compile data regarding domestic homicides with the goal of developing recommendations for improving the system for protecting victims of domestic abuse. The panel's proceedings are closed and confidential.

Insurance Discrimination:

24-A M.R.S. § 2159-B applies to health, life, and disability insurance. It requires that those insurers not deny, cancel, refuse to renew or restrict coverage of any person or require the payment of additional charges based on the fact or perception that the person is, or may become, the victim of domestic abuse, under Title 19-A, section 4002.

Mandatory Reporting:

17-A M.R.S. § 512 makes it a crime for healthcare practitioners and emergency medical service persons to willfully fail to report to a law enforcement agency injuries apparently caused by the discharge of a firearm.

Protocols:

None.

Screening:

None.

Training:

32 MRSA §3831 establishes a training requirement that psychologists applying for initial or renewal licensure must complete three hours of course work in family or intimate partner violence screening and referral and intervention strategies, including knowledge of community resources, cultural factors, evidence-based risk assessment and same-gender abuse dynamics. This is a one-time training requirement, which goes into effect Jan. 1, 2020.

32 MRSA §3835 establishes a training requirement that licensed clinical social workers applying for initial or renewal licensure must complete 12 hours of course work in family or intimate partner violence screening and referral and intervention strategies, including knowledge of community resources, cultural factors, evidence-based risk assessment and same-gender abuse dynamics. This is a one-time training requirement, which goes into effect Jan. 1, 2020.

32 MRSA §7053 establishes a training requirement that licensed clinical professional counselors applying for initial or renewal licensure must complete 12 hours of course work in family or intimate partner violence screening and referral and intervention strategies, including knowledge of community resources, cultural factors, evidence-based risk assessment and same-gender abuse dynamics. This is a one-time training requirement, which goes into effect Jan. 1, 2020.

MAINE (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None

Others: None.

Public Health Responses

The Maine Center for Disease Control and Prevention (Maine CDC) actively works on violence prevention. As a partner in Maine's Safe Families Partnership, the Maine CDC assisted in developing and implementing trainings for public health nurses, Women, Infants, and Children (WIC) staff, home visitors, and school nurses on the identification of domestic violence. The Attorney General's Office coordinates training for sexual assault nurse examiners.

Beginning in 2005, Maine CDC was a participant in the Safe Families Action Learning Lab. Maine was one of five states selected to participate in this program, and Maine CDC provided leadership and support in the development of Maine's Safe Families Partnership. The primary output of the work has been the development of trainings to educate public health related workers on the signs of domestic and intimate partner violence as well as local resources to support families experiencing such violence.

Maine was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project health care providers working in family planning and adolescent health settings were trained to assess for, and respond to, domestic and sexual violence. The initiative also helped establish and strengthen partnerships between the Maine CDC, Department of Education, the Family Planning Association of Maine, Maine Coalition to End Domestic Violence, Maine Coalition Against Sexual Assault and school-based health centers. The Family Planning Statewide Clinical Advisory Group also adapted the Project Connect integrated assessment for reproductive coercion and intimate partner violence into their clinical standards, including mandatory training and use of Project Connect tools. In addition, their clinical grant application performance measures require a formal partnership with their local domestic violence/sexual assault programs for all delegates (their contractors for providing family planning services).

MARYLAND

Statutes Addressing

Fatality Review: Md. FAMILY LAW Code Ann. §§ 4-701 through 4-707 establishes local domestic violence review teams whose members shall be drawn from local agencies including hospitals and the local health department.

Insurance Discrimination: MD Code Ann. Ins.§ 27-504 applies to health and life insurance. It requires that those insurers in Maryland not cancel, refuse to underwrite or renew, or refuse to issue a policy; refuse to pay a claim, cancel, or otherwise terminate a policy; increase rates for life insurance, health insurance, or a health benefits plan; or add a surcharge, apply a rating factor, or use any other underwriting practice that adversely takes the information into account.

Mandatory Reporting: Md. HEALTH-GENERAL Code Ann. § 20-703 requires physicians, pharmacists, nurses and dentists to report treatment of an individual for injury that was caused, or shows evidence of having been caused by gunshot.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: Hospital-based domestic violence programs are a state priority for VAWA STOP grants awarded in Maryland.

Others: None.

Public Health Responses

The Maryland Health Care Coalition Against Domestic Violence (the Health Care Coalition) was formed in 1998 to provide leadership within the health care community to promote a proactive and effective response to domestic violence through screening, identification, education, intervention, and treatment of domestic violence victims. The Health Care Coalition has developed educator and patient tools including public education campaigns; and also provides trainings, works with undergraduate and health professional students and faculty, and has championed statewide policy in this area.

In 2013, Maryland was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Connect 2.0 was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against

MARYLAND (Cont.)

Women Reauthorization Act of 2006. The Project Connect 2.0 work in Maryland was led by the Maryland Department of Health partnership with the Maryland Network Against Domestic Violence and the Maryland Coalition Against Sexual Assault, to develop state policies to require assessment for reproductive coercion and intimate partner violence, and partnership with local advocacy organizations for all state-funded family planning settings. In addition, providers from five clinic sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

In 2016, the Maryland Department of Health's (MDH) Core State Violence and Injury Prevention Program (VIPP) program developed the Violence and Injury Prevention in Maryland: A Resource Guide for Decision-Makers, which includes a section on intimate partner violence. The Rape and Sexual Assault Prevention Program (RSAPP) coordinates a statewide alliance, Reducing Intimate Partner Violence and Sexual Assault Every Day in Maryland (RISEMD), which brings together multidisciplinary stakeholders throughout the state to address the prevention of sexual assault and related forms of interpersonal violence, which includes intimate partner violence. VIPP, the Maryland Network Against Domestic Violence (MNADV), the Maryland Coalition Against Sexual Assault (MCASA), and local domestic violence/rape crisis centers and others participate in RISEMD.

MASSACHUSETTS

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: ALM GL ch. 175, §§95B, 108G, 120D; ch. 176A §3A; ch. 176B §5A; ch, 176G §19 applies to health, life, disability, and property insurance. It requires that all insurers in Massachusetts cannot cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a insurance policy on information that such person has been a victim of abuse.

Mandatory Reporting: ALM GL ch.112, §12A. requires physicians, or whenever the following is treated in a hospital, sanatorium or other institution, the manager in charge to report injuries resulting from firearms to the colonel of the state police and local police agencies, and in the case of burns affecting five per cent or more of the surface area of the patient, to the state fire marshal and local police agencies. Wounds caused by knife or other sharp or pointed instrument shall also be reported to the police authorities of the town in which treatment took place should the attending physician believe that a criminal act was involved.

In cases of examination or treatment of a person with injuries resulting from opiate, illegal or illicit drug overdose, a hospital, community health center or clinic shall report information related to the incident to the commissioner of public health in a manner determined by the commissioner that complies with 42 U. S. C. section 290dd-2, 42 C. F. R. Part 2 and 45 C. F. R. section 164.512. The department of public health may promulgate regulations to enforce this section and to ensure that serious adverse drug events are reported to the Food and Drug Administration's MedWatch Program.

ALM GL ch.112, § 12A½ : Every physician attending, treating, or examining a victim of rape or sexual assault, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the department of criminal justice information services and to the police of the town where the rape or sexual assault occurred but shall not include the victim's name, address, or any other identifying information. The report shall describe the general area where the attack occurred

Protocols: None.

Screening: None.

Training: ALM GL ch. 112, § 264 The board of registration in medicine, the board of registration in nursing, the board of registration of physician assistants, the board of nursing home administrators, the board of registration of social workers, the board of registration of psychologists and the board of registration of allied mental health and human services professions shall develop and administer standards for licensure, registration

MASSACHUSETTS (Cont.)

or certification pursuant to this chapter, as applicable, and any renewal thereof, that require training and education on the issue of domestic violence and sexual violence, including, but not limited to, the common physiological and psychological symptoms of domestic violence and sexual violence, the physiological and psychological effects of domestic violence and sexual violence on victims, including children who witness such abuse, the challenges of domestic violence and sexual violence victims who are gay, lesbian, bisexual, transgender, low-income, minority, immigrant or non-English speaking, availability of rape and sexual assault shelter and support services within the commonwealth. Training shall also address the pathology of offenders including, but not limited to, identifying the system of abusive behaviors used to maintain control, the intentionality of the violence, the tendency to minimize abuse and blame the victim and the risk to the victim created by joint counseling. Each board may work with community-based domestic violence, rape and sexual assault service providers and certified batterer's intervention programs in order to develop the standards required by this section. Each board shall: (i) promulgate rules and regulations establishing the standards required by this section; and (ii) identify programs or courses of study which meet these standards and the promulgated rules or regulations. Each board shall provide a list of the identified programs or courses of study to an applicant for licensure, registration or certification, or renewal thereof.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

In 2017, The Massachusetts Department of Public Health (MDPH) established the Division of Sexual and Domestic Violence Prevention and Services, as it engaged in a procurement process and issued contracts to approximately $34 million dollars in funding to 68 non-profits.

In November 2014, the Massachusetts Department of Public Health (MDPH) issued a Circular Letter, DHCQ 14-11-622 to Massachusetts hospitals with guidance on "DPH Resources to Support Hospital Care and Population Health Management for Survivors of Domestic and Sexual Violence." The document offered two recommendations that promote collaboration with community-based advocacy organizations, best practices, and trauma-informed approaches.

In 2015, MDPH funded The Strengthening Health Care Collaborations Project at Jane Doe, Inc (The Massachusetts Coalition Against Sexual Assault and Domestic Violence) to build capacity with sexual and domestic violence organizations to enhance collaborations with health care and address the health consequences of violence. Jane Doe Inc. has held an Annual Health Care Learning Forum to bring together providers and advocates to learn about each other's systems and how to address SDV as a health and public health issue. Beginning in 2016, Jane Doe Inc. has convened a quarterly Health Care Advisory Group to provide guidance on health-related issues and health care col-

MASSACHUSETTS (Cont.)

laborations for sexual and domestic violence organizations.

Massachusetts Department of Public Health and Jane Doe Inc. are ongoing members and participants in the Conference of Boston Teaching Hospitals Domestic Violence Council, a monthly leadership council of sexual and domestic violence programs within hospitals, community health centers and community-based programs in the Greater Boston area.

Annually, Jane Doe Inc. holds a Prevention Summit that highlights public health and other perspectives on addressing the sexual and domestic violence. A 2017 #Reimagine Manhood Summit: Explore Gender Equity, Racial Justice and Healthy Masculinities explored the impact these issues may have on survivors of gender-based and community violence. This Summit drew over 300 participants. In addition, the Jane Doe Inc. Initiative for Safety and Justice addresses issues of trauma and secondary trauma.

Massachusetts is one of four states participating in the Providers, Advocates, and Technology for Health and Safety (PATHS) Project, partnering with the Johns Hopkins School of Nursing, the University of Pittsburgh, the Office on Women's Health, and Futures Without Violence. A leadership team is working with 3 sites to utilize the CUES universal education intervention, using the MyPlan safety decision aid, for supporting survivors of domestic violence and sexual assault, and to promote healthy relationships.

MICHIGAN

Statutes Addressing

Fatality Review: MCL § 400.1511 allows a state or county to establish an interagency domestic violence fatality review team which must include a health care professional with training and experience in responding to domestic violence and a medical examiner.

Insurance Discrimination: MCLS §§ 500.2246, 500.3406j, 550.1401(3)(d) applies to health and life insurance. It requires that those insurers in Michigan that deliver, issue for delivery, or renew a life insurance policy shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a policy solely because an insured or applicant for insurance is or has been a victim of domestic violence. For additional information on the provisions of the statute go to **legislature.mi.gov/doc.aspx?mcl-500-2246.**

Mandatory Reporting: MCLS § 750.411 mandates that a person, firm, or corporation conducting a hospital or pharmacy in this state, the person managing or in charge of a hospital or pharmacy, or the person in charge of a ward or part of a hospital to which one or more persons come or are brought suffering from a wound or other injury inflicted by means of a knife, gun, pistol, or other deadly weapon, or by other means of violence, have a duty to report that fact immediately, both by telephone and in writing, to local law enforcement authorities in which the facility is located or to the county sheriff if outside the limits of a village or city. A physician or surgeon who has under his or her charge or care a person suffering from a wound or injury inflicted in the manner described above has a duty to report that fact in the same manner.

Protocols: MCLS § 400.1504 authorizes the domestic violence review board to establish a reporting system and protocols to help treat victims of domestic violence and create reliable data collection.

Screening: MCLS § 333.17015a applies to screening for DV in visits for the purpose of having an abortion. If a patient discloses that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11). If a patient discloses coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).

Training: MCLS § 400.1504(f) gives the domestic review board the task of coordinating training and education on domestic violence with professional organizations.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

MICHIGAN (Cont.)

Public Health Responses

Michigan developed a prevention plan (2010-2015) entitled "Preventing Intimate Partner and Sexual Violence in Michigan." This plan uses a public health approach to build the capacity of individuals, organizations, and systems to more effectively identify, implement, and evaluate prevention strategies, especially those that prevent first-time violence perpetration. The plan was developed through a two-year process funded by the Centers for Disease Control and Prevention (CDC), the Michigan Coalition to End Domestic and Sexual Violence (MCEDSV), the Michigan Department of Health and Human Services (MDHHS), the Michigan Domestic and Sexual Violence Prevention and Treatment Board (MDVPTB), and a multidisciplinary group of experienced prevention practitioners stakeholders, and advocates formed a Prevention Steering Committee that conducted a statewide needs and resources assessment. From this assessment, three goals (and priority populations) were developed to prevent the first-time occurrence of intimate partner and sexual violence.

Michigan was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project, over 500 health care providers in reproductive health and adolescent health were trained to assess for, and respond to, domestic and sexual violence in clinical settings. Each of their six clinical pilot sites made changes to policy and protocol in response to Project Connect, including the mandate of additional training for staff on assessing and intervening for IPV, and addressing IPV within the workplace.

MCEDSV is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. MCEDSV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

MINNESOTA

Statutes Addressing

Fatality Review: Minn. Stat. § 611A.203 allows each judicial district to establish a domestic fatality review team to review domestic violence deaths that have occurred in the district. Members must include the medical examiner, a mental health provider and a physician familiar with domestic violence issues.

Insurance Discrimination: Minn. Stat. § 72A.20 Subd. 8(d) applies to health and life insurance. It prohibits those insurers in Minnesota from refusing to offer, sell, or renew coverage; limiting coverage; or charging a rate different from that normally charged for the same coverage under a policy or plan because the applicant who is also the proposed insured has been or is a victim of domestic abuse. For additional information about the provisions of the statute go to **www.revisor.mn.gov/statutes/?id=72A.20.**

Mandatory Reporting: Minn. Stat. § 626.52 requires health professionals to immediately report all bullet wounds, gunshot wounds, powder burns, or any other injury arising from, or caused by the discharge of a firearm, or any wound that the reporter has reason to believe has been inflicted on a perpetrator of a crime by a dangerous weapon other than a firearm (defined in § 609.02) to local law enforcement authorities. Health professionals must also report second or third degree burns of more than 5% of the body, burns to the upper respiratory tract or those that are life threatening to the state fire marshal. As used in this section, "health professional" means a physician, surgeon, person authorized to engage in the practice of healing, superintendent or manager of a hospital, nurse, or pharmacist.

Protocols: None.

Screening: None.

Training: 1993 Minn. Laws Chap. 326, Art. 12, Sec 15 creates The Higher Education Center on Violence and Abuse (now called the Minnesota Center Against Violence and Abuse) to serve as an informational resource to assist higher education in developing curricula in violence and abuse, funding projects to stimulate such curricula, and coordinate policies to ensure professions interacting with victims have the appropriate knowledge and skills to prevent and respond appropriately to the problems of violence and abuse. It requires that task forces be formed for professions that work with victims including physicians, nurses and psychologists, who must review current programs, licensing regulations and examinations, and accreditation standards to identify specific needs and plans for ensuring that professionals are adequately prepared and updated on violence and abuse issues.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

MINNESOTA (Cont.)

Others: None.

Public Health Responses

The Minnesota Department of Health (MDH) Sexual Violence Prevention Program (SVPP) is federally funded through Center for Disease Control's Rape Prevention and Education grant. Key partners include the Minnesota Coalition Against Sexual Assault (MNCASA), Men as Peacemakers (MAP), the University of Minnesota's Urban Research and Outreach-Engagement Center (UROC), and the Minnesota Coalition for Battered Women (MCBW). The MDH SVPP works collaboratively with these organizations to strengthen primary prevention efforts in Minnesota using a public health lens. In addition to a focus on sexual violence prevention, MDH SVPP also works with partners on intersecting issues such as domestic violence, suicide, alcohol and drug abuse, etc. They use the Prevention Institute's Spectrum of Prevention as a tool to educate and encourage our stakeholders to focus on the upper levels of the Spectrum, specifically organizational policy and practice change, in order to address causes and conditions, and change environmental/social norms. The MDH SVPP connects with stakeholders largely through their Sexual Violence Prevention Network (SVPN) by hosting quarterly meetings/presentations focused on sexual violence topics and by using the Spectrum of Prevention to guide our meeting discussions around prevention strategies.

The MDH SVPP collaborates in training efforts with the MDH Family Home Visiting Program, and the Minnesota Coalition Against Battered Women (MCBW), to educate home visiting practitioners around the state on how to better identify, understand, and respond to Intimate Partner Violence and Sexual Violence observations/incidents in homes, how to use a trauma informed approach in their response, and how to make referrals for services.

In 2013, Minnesota was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Connect 2.0 was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The Project Connect 2.0 work in Minnesota was led by the Minnesota Coalition for Battered Women, in partnership with the Minnesota Department of Health to develop state policies to require universal education on healthy relationships, targeted assessment for reproductive coercion and adolescent relationship abuse for sexually active young women, and partnership with local advocacy organizations for school and community-based adolescent health settings. In addition, providers from five clinic sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

Minnesota was one of five states participating in *Project Catalyst: Statewide Transformation on Health and Intimate Partner Violence (2017-2018)* as a self-funded participating state. A leadership team consisting of the Minnesota Department of Health, the Minnesota Coalition for Domestic Violence, and Community Health Services Inc., promoted policies and practices that support ongoing integration of intimate partner violence (IPV) and human trafficking (HT) responses into community health centers and domestic violence programs statewide. In their effort to spread this work throughout Minnesota, the leadership team incorporated the 3.5 hour Project Catalyst curriculum into a number of trainings, including: regular trainings to state health department providers, a training for the home visitation program, for an adolescent health program, and for a reproductive health clinic. Learn more about Project Catalyst and to download the training curricula and tools, visit **www.ipvhealthpartners.org.**

MISSISSIPPI

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: MISS. CODE ANN. §§ 83-71-1 to -15, 51 to 65, 101 to 115 applies to health, life, and disability insurance, and establishes that it is discriminatory to deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health benefit plan or restrict or exclude health benefit plan coverage or add a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status; or to exclude or limit coverage for losses or deny a claim incurred by an insured on the basis of the insured's abuse status.

Mandatory Reporting: Miss. Code Ann. § 45-9-31 requires physicians, surgeons, dentists, paramedical employees, nurses, or any employee of a hospital, clinic, or any other medical institution or office where patients regularly receive care, who treat any patient suffering from a wound or injury with reason to believe or ought to know that the injury was caused by gunshot or knifing, shall immediately report to local law enforcement.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

MISSOURI

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: Mo. Ann. Stat. §§ 375.1300, 375.1312 applies to health, life, disability and property insurance. It requires that no insurers in Missouri can on the sole basis of the status of an insured or prospective insured as a victim of domestic violence: deny, cancel or refuse to issue or renew an insurance policy; require a greater premium, deductible or any other payment; exclude or limit coverage for losses or deny a claim; or designate domestic violence as a preexisting condition for which coverage will be denied or reduced. It does require that a police report and sworn affidavit be completed by an "innocent coinsured" when there is a property insurance claim.

Mandatory Reporting: § 578.350 R.S. Mo. mandates that any physician, nurse, therapist or other medical professional licensed under Chapter 334 or 335, who treats a person for a wound inflicted by gunshot must report to local law enforcement and include the nature of the wound and its circumstances.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Office on Women's Health, Missouri Department of Health and Senior Services (DHSS) administers the Rape Prevention and Education Grant. This grant is used to fund evidence based sexual violence prevention, which addresses many of the same risk factors as domestic violence prevention. Additionally, the Office on Women's Health works with other DHSS divisions, such as those that work with home visiting and child safety, to include domestic, sexual, and teen dating violence information in curriculum.

The Missouri Coalition Against Domestic and Sexual Violence (MCADSV) works with their member programs to help them prevent and respond to survivors of domestic and sexual violence. MCADSV also facilitates multi-disciplinary statewide teams, including the Missouri Sexual Assault Team (MO-SART), a statewide team, representing victim advocates, medical-based staff, law enforcement, prosecutors, hospitals, crime labs, state offices, and elected officials, to identify the gaps in the full range of services and systemic responses to sexual assault.

MONTANA

Statutes Addressing

Fatality Review: Mont. Code Anno. § 2-15-2017 establishes a domestic violence fatality review commission in the Department of Justice whose members must include medical and mental health care providers who are involved in issues of domestic abuse.

Insurance Discrimination: Mont. Code Ann. §§ 33-18-216 applies to health, life, disability and property insurance. It prohibits all insurers in Montana from denying, refusing to issue, renew, or reissue, canceling, or otherwise terminating an insurance policy or certificate of coverage; restricting or excluding or adding a premium differential on the sole basis that the applicant or insured has been the victim of abuse.

Mandatory Reporting: Mont. Code Ann. § 37-2-302 requires a physician, nurse or other person licensed to practice a health care profession, who treats a victim of a gunshot wound or stabbing to report, as soon as possible, to local law enforcement. A written report must be submitted by mail within 24 hours.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

NEBRASKA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: R.R.S. Neb. § 44-7401 to 44-7410 applies to health, life, disability and property insurance. it prohibits all insurers in Nebraska from: denying, refusing to issue, renew, or reissue, canceling, or otherwise terminating, restricting, or excluding coverage on or adding a premium differential to any policy on the basis of the applicant's or insured's abuse status; excluding or limiting coverage for losses, denying benefits, or denying a claim incurred by an insured as a result of abuse; and terminating group health coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily. For additional information on the provision of the statute go to **nebraskalegislature.gov/laws/browse-chapters.php?chapter=44.**

Mandatory Reporting: R.R.S. Neb. § 28-902 requires every person in the practice of medicine and surgery, or in charge of any emergency room or first-aid station, to report any injuries of violence which appear to have been received in connection with a criminal offense to local law enforcement where the treatment occurs.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

Nebraska Department of Health and Human Services subsidizes a network of domestic violence and sexual assault centers throughout the state to ensure the every county has accessible services. Nebraska adopted the Lindsey Burke Act in 2009, which requires all schools to provide education about teen dating violence. The Nebraska Department of Health and Human Services supports the Nebraska Coalition to provide technical assistance, identify program needs, training, and devise improvement plans. Local domestic violence and sexual assault programs are available to provide training to healthcare providers upon request. Each program across the state offers and provides training to health care providers in different ways depending on the needs of the community.

NEVADA

Statutes Addressing

Fatality Review: Nev. Rev. Stat. Ann. § 217.475 Allows a court or an agency of a local government to organize or sponsor one or more multidisciplinary teams to review the death of the victim of a crime that constitutes domestic violence. If created, such teams must include representatives of organizations concerned with issues related to physical or mental health. The court or agency shall review the death of a victim upon receiving a request of a relative of the victim within the third degree of consanguinity. The reports may be provided to any similarly related persons.

Insurance Discrimination: Nev. Rev. Stat. Ann. §§ 689A.413, 689B.068, 689C.196, 695A.195, 695B.316, 695C.203, 695D.217, 695F.090 applies to health insurance. It requires that those insurers in Nevada cannot deny a claim, refuse to issue or cancel a policy because the claim involves an act that constitutes domestic violence or because the person applying for or covered by the policy was the victim of such an act of domestic violence, regardless of whether the insured or applicant contributed to any loss or injury.

Mandatory Reporting: Nev. Rev. Stat. Ann. § 629.041 requires every health care provider who treats an injury which appears to have been inflicted non-accidentally by means of a firearm or knife to promptly report the injury to an appropriate law enforcement agency.

Nev. Rev. Stat. Ann § 629.045 requires health care providers to submit a written report to the appropriate local fire department the treatment of persons with second or third degree burns consisting of five percent or more of the body area, burns of the upper respiratory tract and any other burns that may result in death within three days of treatment.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: Funding provided for healthcare training and curriculum development.

Others: Maternal and Child Health Block Grant funding used for training of healthcare providers. Screening for sexual violence and intimate partner violence (IPV) is offered to health professionals through Rape Prevention and Education (RPE) funding.

Public Health Responses

The Division of Public and Behavioral Health's Home Visiting Program requires all funded recipients to screen for Intimate Partner Violence (IPV).

NEW HAMPSHIRE

Statutes Addressing

Fatality Review: The Governor's Commission on Domestic and Sexual Violence has a Domestic Violence Fatality Review Committee that was created by Executive Order of the Governor.

Insurance Discrimination: RSA 417:4 VIII (f) applies to health, life, disability, and property insurance. It prohibits all insurers in New Hampshire from refusing to insure or to continue to insure, or limiting the amount, extent or kind of coverage available solely because the applicant who is also the proposed insured has been or may become the victim of domestic abuse or violence.

Mandatory Reporting: RSA 631:6 makes it a misdemeanor for a person, having knowingly treated or assisted another for a gunshot wound or any other injury believed to be caused by criminal act, to fail to notify a law enforcement official of all the information they possess. A person is excused from reporting if the victim is over 18, has been the victim of a sexual assault offense or abuse (defined in RSA 173-B:1), and objects to the release of any information to law enforcement. However, this exception does not apply if the victim of sexual assault or abuse is also being treated for a gunshot wound or other serious bodily injury.

Protocols: RSA 21-M:8-d requires the NH Department of Justice to adopt and implement rules establishing a standardized rape and domestic violence protocol to be used by all physicians or hospitals in the state when providing physical examinations of victims of alleged sexual offenses and alleged domestic abuse.

Screening: None.

Training: RSA 173-B:20 proves that a statewide organization shall serve as the coordinator for the Domestic Violence Grant Program and shall conduct educational programs on domestic violence for the general public and specialized groups like medical personnel.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: The Division of Public Health Services provided partial funding for replication of the National Violence Against Women Survey in New Hampshire. The report of the NH Violence Against Women Survey, which documented the negative health consequences of violence against women, can be found at **www.nhcadsv.org.**

Public Health Responses

The New Hampshire Coalition Against Domestic and Sexual Violence has worked with the Division of Public Health to provide training for contract agencies including maternal and child health programs and family planning programs. Additionally, the Division of Public Health is represented on the Governor's Commission on Domestic and Sexual Violence.

NEW JERSEY

Statutes Addressing

Fatality Review: N.J. Stat. §§ 52:27D-43.17b through 43.17e establishes the Domestic Violence Fatality and Near Fatality Review Board whose members must include the state medical examiner, a psychologist with expertise in the area of domestic violence or other related fields, and a licensed health care professional knowledgeable in the screening and identification of domestic violence cases.

Insurance Discrimination: N.J. Stat. §§ 17:23A-13.3, 17:29B-17, 17:48-6t, 17:48a-7s, 17B:27-46, 17:48E-35.18, 17B:26-2.1q, 17B:27-46.1t; NJ ADMIN.CODE § 11:4-42.5(a) applies to health, life, disability, and property insurance. It prohibits those insurers in New Jersey from: denying, refusing to issue or renew, cancelling or otherwise terminating an insurance policy; restricting, excluding or limiting benefits, or denying a covered claim on the basis that the insured or prospective insured is or may be a victim of domestic violence; employs a person who is or may be a victim of domestic violence; or is a domestic violence shelter that is operating pursuant to the standards set forth or is employed by a domestic violence shelter.

Mandatory Reporting: N.J. Stat. § 2C:58-8 requires every case of a wound or any other injury arising from or caused by a firearm, destructive device, explosive or weapon to be reported by the physician consulted, attending or treating the case or the manager, superintendent or other person in charge, whenever such case is presented for treatment or treated in a hospital, sanitarium or other institution, immediately to local police authorities in the municipality where the person reporting is located or to the State Police. Burns which are associated with the use of an accelerant, treatment is not sought within a reasonable amount of time, cause a reasonable suspicion of arson, the patient or an accompanying person volunteers information about arson, or which fulfill any other guidelines provided by the Department for Community Affairs must also be reported.

Protocols: None.

Screening: None.

Training: N.J. Stat. § 52:27D-43.36 provides that the Director of the Division on Women in the Department of Community Affairs, in consultation with Health and Senior Services, shall establish a domestic violence public awareness campaign in order to promote public awareness of domestic violence among the general public and health care and provide information to assist victims of domestic violence and their children. The campaign should include outreach efforts to promote education and prevention of domestic violence and should include a number of subjects including causes, risk factors and availability of resources in the community.

NEW JERSEY (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

Through federal funding from the New Jersey Department of Health, Division of Community Health Services, Preventive Health and Health Services Block Grant, there is a mandatory set aside for RPE prevention and education to administer activities related to rape and sexual assault.

NEW MEXICO

Statutes Addressing

Fatality Review: N.M. Stat. Ann. § 31-22-4.1 creates the Domestic Violence Homicide Review Team whose members should include medical personnel with expertise in domestic violence and representatives from the Department of Health who deal with domestic violence victims' issues.

Insurance Discrimination: N.M. Stat. Ann. §§ 59A-16B-1 through 59A-16B-10 applies to health, life, disability, and property insurance. It prohibits all insurers in new Mexico from: denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy on the basis of a person's abuse status; a person that provides shelter, counseling or protection to victims of domestic abuse; a person who employs or is employed by a victim of domestic abuse; or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. N. M. Stat. Ann. § 59A-23E-11 prevents group health plans from restricting initial or continued eligibility based upon conditions arising out of domestic violence.

Mandatory Reporting: None.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: NM Stat § 11-6A-3 New Mexico counties may use Local DWI (LDWI) Grant Program funds to support programs and services that prevent or reduce incidences of domestic abuse related to DWI, alcohol abuse, or drug abuse.

Public Health Responses

The New Mexico Children, Youth, and Families Department (CYFD) provides funding to domestic violence service providers throughout the state for both residential and non-residential services. Under these grants, agencies are asked to develop collaborative relationships with their local public health offices and private medical practitioners.

New Mexico's Family Violence Protection Act requires medical personnel to document abuse and the name of the alleged perpetrator in the victim's medical file and provide information and service referrals to victims. New Mexico public health offices also implement the Violence, Alcohol Abuse, Substance Abuse and Tobacco Use tool to assist in screening for domestic violence and making referrals. These questions and brief interventions are used by health practitioners and social workers to further assist clients.

NEW YORK

Statutes Addressing

Fatality Review: NY CLS Exec § 575(10) establishes a fatality review team to review deaths associated with domestic violence in order to examine trends and patterns of domestic violence and develop public responses and education plans to mitigate those trends. The review team shall include members of law enforcement and the judicial system, and optionally can include health care professionals and victim advocates.

Insurance Discrimination: N.Y. Ins. Law § 2612 applies to health, life, disability, and property insurance. It requires that all insurers in New York cannot refuse to issue or renew, deny or cancel any insurance policy or contract or charge a higher premium based on an individual being a victim of domestic violence. Domestic violence also cannot be treated as a preexisting condition or an underwriting criterion.

Mandatory Reporting: NY CLS Penal § 265.25 requires every case of gunshot wound or other injury caused by the discharge of a firearm, and every case of wound that is likely to or may result in death and is or appears to be inflicted by a knife, ice pick or other sharp instrument to be reported by the physician attending or treating the case or the manager, superintendent or other person in charge, whenever such case is treated in a hospital, sanitarium or other institution, immediately to local police authorities where the person reporting is located.

NY CLS Penal § 265.26 requires all second or third degree burns to more than 5% of the body, burns to the upper respiratory tract, and every case of a burn which is likely to or may result in death to be reported by the physician attending or treating the case or the manager, superintendent or other person in charge, whenever such case is treated in a hospital, sanitarium, institution or other medical facility, to the office of fire prevention and control who shall take the report and notify the proper investigatory agency.

Protocols: NY CLS Pub Health § 2803-p requires every hospital with maternity and newborn services to provide information concerning family violence to parents of newborn infants at any time prior to the discharge of the mother which must include available services. Also, see "Screening" and "Training" sections below.

Screening: NY CLS Pub Health § 2137 requires development of protocol for the identification and screening of victims of domestic violence who may either be an individual diagnosed with HIV/AIDS or a partner who requires notification.

Training: NY CLS Exec § 575 creates the New York State Office for the Prevention of Domestic Violence which develops and delivers training on domestic violence to professionals in the health and mental health fields. It also requires the establishment of a model policy, behaviors, and education for health agencies and professionals regarding identification, assessment, intervention, and referral policies and responses to victims of domestic violence.

NEW YORK (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence:

VAWA: None.

Others: None.

Public Health Responses

The Sexual Assault Reform Act, enacted in FY 2000, significantly expanded the Department of Health's role in addressing sexual assault. Upon the request of a qualifying hospital, the Department of Health may designate that hospital as having an approved Sexual Assault Forensic Examiner (SAFE) program. Such hospital program shall meet the standards for treatment of sexual assault victims and maintenance of sexual offense evidence and shall make available to survivors, on a 24-hour per day basis, specially trained forensic examiners. Such programs (may also be referred to as Sexual Assault Nurse Examiner (SANE) and Sexual Assault Examiner (SAE) programs) are comprehensive by providing medical care and forensic examinations in a private setting; provide specialized standards of medical care and evidence collection; and coordinate an interdisciplinary collaborative effort involving a hospital-based SAFE program, a rape crisis center, law enforcement, the prosecutor's office and other appropriate service agencies to provide a coordinated response that can effectively meet the needs of the survivor as well as improve the overall community response to sexual assault.

NORTH CAROLINA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: N.C. General Statute § 58-68-35 prohibits group health insurers from using conditions arising from domestic violence to determine eligibility, including continued eligibility, of any individual or their dependent.

Mandatory Reporting: N.C. Gen. Stat. § 90-21.20 requires every case of gunshot wound or other injury caused or appearing to be caused by the discharge of a firearm, every case of illness apparently caused by poisoning, every injury caused or appearing to be caused by a knife or sharp instrument if it appears that a criminal act was involved, and any other grave bodily injury or grave illness that appears to have resulted from a criminal act of violence to be reported by the physician or surgeon treating the case, or, if such case is treated in a hospital, sanitarium or other medical institution or facility, by the Director, Administrator, or other person designated by the Director or Administrator, to local law enforcement where the place of treatment is located.

Protocols: None.

Screening: None.

Training: The North Carolina Coalition Against Domestic Violence (NCCADV) offers statewide training for professionals on domestic violence, mental health, and substance use disorders. In addition, all statewide trainings are open and accessible to healthcare providers.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The North Carolina Coalition Against Domestic Violence (NCCADV) participates on a state Technical Advisory Group for Social Determinants of Health, whose work includes considering future Medicaid funding for intimate partner violence services. NCCADV receives funding from the U.S. Office on Women's Health Intimate Partner Violence Provider Network Project to improve the health care response to patients experiencing abuse. NCCADV also trains health care providers in intimate partner violence screening and response and works to strengthen networks between clinics and domestic violence agencies.

The North Carolina Coalition Against Domestic Violence (NCADV) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence

NORTH CAROLINA (Cont.)

coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. NCADV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

North Carolina is one of three states/territories participating in *Project Catalyst Phase II: State and Territory-Wide Transformation on Health, Intimate Partner Violence, and Human Trafficking (2018-2019),* focused on fostering intimate partner violence, human trafficking, and health leadership and collaboration at the U.S. state/territory level to improve the health and safety outcomes for survivors of IPV and human trafficking and to promote prevention. The leadership team consists of leaders from NCCADV and the North Carolina Community Health Center Association.

NORTH DAKOTA

Statutes Addressing

Fatality Review: N.D. Cent. Code § 14-07.1-20 allows the attorney general's office to establish a fatality review commission composed of law enforcement, victim advocates and health care professionals.

Insurance Discrimination: N.D. Cent. Code § 26.1-04-03.7(b) prohibits all insurers from considering an individual's history or status as a victim of domestic abuse in evaluating insurance coverage and considerations. N.D. Cent. Code § 26.1-39-24 applies to property insurance. It requires that those insurers in North Dakota issuing or renewing a policy of property and casualty insurance in this state may not base any rating, underwriting, or claim-handling decision solely on whether an applicant or insured suffers from domestic violence.

Mandatory Reporting: N.D. Cent. Code § 43-17-41 requires a physician, physician assistant, or any other person licensed under § 43-12.1to report to local law enforcement when they diagnose or treat an individual suffering from any wound, injury or physical trauma inflicted by the individual's own act or by the act of another by means by means of knife or gun, or, when the physician has reasonable cause to suspect the injury was inflicted in violation of criminal law. When a report of domestic violence or physical injury resulting from a sexual offense is reported in accordance with this section, the physician must provide the individual with information regarding a domestic violence sexual assault organization or other victim's assistance program.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The North Dakota Department of Health collaborates with a state committee to develop and implement a state intimate partner and sexual violence primary prevention plan. The family planning programs, funded through the North Dakota Department of Health, receive periodic domestic violence trainings and resources. Violence Against Women Act funding is provided for Sexual Assault Nurse Examiners programs and statewide multidisciplinary trainings on domestic violence, sexual violence, and stalking. Healthcare providers are invited to the trainings. The North Dakota Health Department continues a strong working relationship with the North Dakota Council on Abused Women's Services related to funding and policies and protocols for responding to domestic violence.

OHIO

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: ORC Ann. 3901.21 applies to health and life insurance. It prohibits those insurers in Ohio from: limiting coverage under, refusing to issue, canceling, or refusing to renew, limiting coverage, refusing to issue, adding a surcharge, denying or limiting coverage for the reason that the insured or applicant for insurance is or has been a victim of domestic violence. It also prohibits the use of domestic violence as an underwriting factor.

Mandatory Reporting: ORC Ann. 2921.22 makes it a misdemeanor in the second degree for a physician, limited practitioner, nurse, or other person giving aid to a sick or injured person, to negligently fail to report to law enforcement authorities any treated or observed gunshot wound, stab wound, or other serious physical harm that the reporter knows or has reasonable cause to believe resulted from an offense of violence. Second and third degree burns, burns to upper respiratory tract or any burn or that may result in death must be reported to the local arson, fire and explosion investigation bureau. Known or suspected domestic violence must be noted by the physician in the patient's records.

Protocols: ORC Ann. 3727.08 requires all hospitals to adopt protocols for conducting interviews with patients, one or more interviews separate and apart from the patient with any family or household member present, and for creating whenever possible a photographic record of the patient's injuries when a health care professional knows or has reasonable cause to believe that the patient has been the victim of domestic violence. By Executive Order, the Ohio Domestic Violence Network (ODVN) and the Ohio Department of Health (ODH) developed a workplace violence protocol for the Department of Health which was then expanded into a Governor's Executive Order to develop training for all state employees.

Screening: None.

Training ORC Ann. 4723.25 The board of nursing shall approve one or more continuing education courses of study that comply with divisions (E) and (F) of section 4723.07 of the Revised Code and that assist nurses in recognizing the signs of domestic violence and its relationship to child abuse. Nurses are not required to take the courses.

ORC Ann. 4731.282 requires that the state medical board shall approve one or more continuing medical education courses of study included within the programs certified by the Ohio state medical association and the Ohio osteopathic association that assist doctors of medicine and doctors of osteopathic medicine in recognizing the signs of domestic violence and its relationship to child abuse;

ORC Ann. 4732.141 requires the State Board of Psychology to approve one or more continuing education courses that assist psychologists and school psychologists in recognizing the signs of domestic violence and its relationship to child abuse. Psychologists are not required to take the courses.

OHIO (Cont.)

ORC Ann. 4757.34 requires the counselor, social worker, and marriage and family therapist board to approve one or more continuing education courses of study that assist social workers, independent social workers, social work assistants, independent marriage and family therapists, marriage and family therapists, professional clinical counselors, and professional counselors in recognizing the signs of domestic violence and its relationship to child abuse. Such professionals are not required to take the course.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: In 2010, ODVN received funding from the Ohio Department of Mental Health and Addiction Services (OHMAS) to develop a manual for local domestic violence programs related to trauma informed approaches. Building on that, in 2016, ODVN received funding from the Department of Justice, Office of Victims of Crime (OVC) to develop and demonstrate best practice models for working with survivors of trauma (brain injury and mental health) in collaboration with local programs.

Public Health Responses

From 2004 to 2010, ODVN was a recipient of family violence prevention funding from the HealthPath Foundation (formerly Anthem Foundation of Ohio). Funding was aimed at providing technical assistance and training to four community based coalitions as well as capacity building at the state level for prevention approaches.

The Ohio Domestic Violence Network (ODVN), the Ohio Alliance to End Sexual Violence (OAESV) and the Ohio Department of Health (ODH) jointly convene a state level Prevention Consortium that is now implementing a statewide prevention plan for sexual and intimate partner violence.

Ohio was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project nearly 1,200 health care providers in adolescent health, home visitation, and family planning settings were trained to assess for, and respond to, domestic and sexual violence. In addition, training requirements and funding incentives for addressing reproductive coercion were added to Title V and Title X contracts.

ODVN is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. ODVN was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level.

OKLAHOMA

Statutes Addressing

Fatality Review:

22 Okl. St. §§ 1601 and 1602 establish the Domestic Violence Fatality Review Board whose membership shall include the State Commissioner of Health, Chief of Injury Prevention Services of the State Department of Health, two physicians and a nurse.

Insurance Discrimination:

36 Okl. St. § 6060.10A prohibits health benefit plans (defined within the statute) from denying coverage, refusing to issue or renew, cancel or otherwise terminate, restrict or exclude any person from any health benefit plan issued or renewed on or after November 1, 2010 on the basis of the insured's or applicant's status as a victim of domestic abuse as defined in § 60.1 of Title 22. No health benefit plan can deny a claim based on the insured's status as a victim of domestic violence nor can domestic abuse be considered a preexisting condition.

Mandatory Reporting:

22 Okl. St. § 58 mandates that criminally injurious conduct, as defined by the Oklahoma Crime Victims Compensation Act, which appears to be or is reported by the victim to be domestic abuse, as defined in Section 60.1 of this title, or domestic abuse by strangulation, domestic abuse resulting in great bodily harm, or domestic abuse in the presence of a child, as defined in Section 644 of Title 21 of the Oklahoma Statutes, shall be reported to the nearest law enforcement agency. However, any physician, surgeon, resident, intern, physician assistant, registered nurse, or any other health care professional examining, attending, or treating a victim is not required to report such domestic abuse if the victim is over age 18 and is not incapacitated, unless the victim requests them to do so orally or in writing. In all cases what is reported to be domestic abuse shall clearly and legibly be documented by the health care provider and any treatment provided. In all cases, the health care provider shall refer the victim to domestic violence and victim services, including the number of the statewide hotline.

Protocols:

22 Okl. St. § 58 requires that in all cases of what appears to be or is reported to be domestic abuse, the physician, surgeon, resident, intern, physician assistant, registered nurse, or any other health care professional examining, attending or treating the victim of what appears to be domestic abuse shall refer the victim to domestic violence and victim services programs, including providing the victim with the twenty-four-hour statewide telephone communication service established by Section 18p-5 of Title 74 of the Oklahoma Statutes. In addition, they shall clearly and legibly document the incident and injuries observed and reported, as well as any treatment provided or prescribed.

Screening:

None.

Training

59 Okl. St. § 3206 requires that all applicants for licensure as an anesthesiologist assistant submit a notarized statement showing completion of one hour of continuing medical education on domestic violence including the number of patients in that practice likely to be victims or perpetrators, screening procedures for determining whether a patient has a history as a victim or perpetrator and instructions on how to refer to services.

OKLAHOMA (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Oklahoma State Department of Health (OSDH) works to prevent domestic violence and sexual assault through its public health services. OSDH service areas provide training and tools to address intimate partner and domestic violence in the healthcare setting and healthcare practitioners. OSDH partners with other organizations to provide programs, services, and education to prevent domestic violence, child abuse and sexual assault. The Injury Prevention Service works with seven community preventionists across the state to educate youth on healthy relationships and sexual assault prevention. Additionally, the magnitude of intimate partner and domestic violence homicide is monitored through OSDH public health surveillance systems.

OREGON

Statutes Addressing

Fatality Review: ORS § 418.714 allows local domestic violence coordinating council recognized by the local public safety coordinating council or by the governing body of the county to establish a multidisciplinary domestic violence fatality review team to assist local organizations and agencies in identifying and reviewing domestic violence fatalities. Any such team shall include medical personnel with expertise in the field of domestic violence, local health department staff, medical examiners or other experts in the field of forensic pathology and other domestic violence advocates.

Insurance Discrimination: ORS § 746.015(4) applies to health, life, disability, and property insurance. It requires that no insurers in Oregon on the basis of the status of an insured or prospective insured as a victim of domestic or sexual violence, shall do any of the following: deny, cancel or refuse to issue or renew an insurance policy; demand or require a greater premium or payment; designate domestic violence as a preexisting condition for which coverage will be denied or reduced; exclude or limit coverage for losses or deny a claim; or fix any lower rate for or discriminate in the fees or commissions of an insurance producer for writing or renewing a policy. Domestic violence status cannot be used as a rating criterion.

Mandatory Reporting: ORS §§ 146.750 and 146.710 require any physician, including interns and residents, having reasonable cause to suspect that a person coming before them for examination or treatment has had injury caused by knife, firearm or other deadly or dangerous weapon, or any other serious physical injuries inflicted (regardless of weapon involvement) upon them by non-accidental means to report immediately to the medical examiner. § 146.730 allows the medical examiner or the district attorney to investigate any injury that occurred under suspicious or unknown circumstances. Whenever the medical examiner concludes that a crime may have been committed in causing the injury, they must report that conclusion to the district attorney under § 146.740.

Protocols: ORS § 146.740 contains the proper reporting protocols for physicians reporting to the medical examiner, and the medical examiner reporting to the district attorney potential domestic violence offences.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

OREGON (Cont.)

Public Health Responses

The Oregon Attorney General's Sexual Assault Task Force (SATF) and the Oregon Health Authority receive federal Rape Prevention Education (RPE) funds from the Centers for Disease Control and Prevention (CDC). The SATF funds four community sites to do rape prevention education. Oregon administers a portion of CDC Preventive Health and Health Services Block Grant funding to the Oregon Coalition Against Domestic and Sexual Violence. The Oregon Public Health Department (OPHD) receives funds from the federal intimate partner violence and pregnancy assistance grant to work with pregnant and parenting community college students to promote healthy relationships, as well as put in place services, linkages, and referrals on campus. In addition, the state's Children, Adults, and Families office provides funding to place 22 domestic violence advocates in local field offices.

From 2010 to 2017, the Oregon Department of Justice provided funding for *Safer Futures*, which supported onsite domestic violence advocacy services in health care settings across Oregon, to improve the health and safety of expectant, pregnant, and parenting women.

In 2013, Oregon was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Connect 2.0 was supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The Project Connect 2.0 work in Oregon was led by the Oregon Health Authority, working in partnership with the Oregon Coalition Against Domestic and Sexual Violence to develop state policies to require assessment for reproductive coercion and IPV, and partnership with local advocacy organizations for all state-funded family planning settings. In addition, providers from five clinic sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

PENNSYLVANIA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: 40 P.S. §§ 1171.3, 1171.5(14) applies to health, life, disability, and property insurance. It prohibits all insurers in Pennsylvania from taking any of the following actions because the insured or applicant for an insurance policy or insurance contract is a victim of abuse: denying; refusing to issue; refusing to renew; refusing to reissue; canceling or terminating an insurance policy or insurance contract; restricting coverage under an insurance policy or insurance contract; adding a surcharge, applying a rating factor, or using any other underwriting standard or practice which adversely takes into account a history or status of abuse; excluding or limiting benefits or coverage under an insurance policy or insurance contract for losses incurred; or, With respect to a policy of a private passenger automobile, a policy covering owner occupied private residential property or a policy covering personal property of individuals, refusing to pay an insured for losses arising out of abuse to that insured under a property and casualty insurance policy or contract to the extent of the insured's legal interest in the covered property if the loss is caused by the intentional act of another insured or using other exclusions or limitations which the commissioner has determined unreasonably restrict the ability of victims of abuse to be indemnified for such losses.

Mandatory Reporting: 18 Pa.C.S. § 5106 mandates that any physician, intern, or resident, or any person conducting, managing, or in charge of any hospital or pharmacy, or in charge of any ward or part of a hospital, to whom shall come or be brought any person suffering from any wound or other injury inflicted by his own act or by the act of another which caused death or serious bodily injury, or inflicted by means of a deadly weapon as defined in § 2301, or upon whom injuries have been inflicted in violation of any penal law, must report such cases to law enforcement authorities. The report shall state the name of the injured person, if known, the injured person's whereabouts, and the character and extent of the person's injuries. Failure to report such injuries when the act caused bodily injury (defined in § 2301) is not an offense if the victim (1) is an adult; (2) the injury was inflicted by an individual who is the current or former spouse or sexual or intimate partner, has been living as a spouse or who shares biological parenthood; (3) the victim has been informed of the physician's duty to report and that report cannot be made without the victim's consent; (4) the victim does not consent to the report; and (5) the victim has been provided with a referral to the appropriate victim service agency.

Protocols: 35 P.S. § 7661.3, which establishes the Domestic Violence Health Care Response Program, requires that in the selected medical advocacy project sites, medical professionals will provide available educational materials to inform victims of domestic violence about the services and assistance available through the domestic violence program.

Screening: 35 P.S. § 7661.3, which establishes the Domestic Violence Health Care Response Program, requires that the selected medical advocacy projects develop and implement

PENNSYLVANIA (Cont.)

uniform multidisciplinary domestic violence policies and procedures which incorporate all staff who provide services or interact with victims of domestic violence, including the identification of victims through universal screening.

Training: 35 P.S. § 7661.3 establishes the Domestic Violence Health Care Response Program. The program requires that medical advocacy projects develop and implement a multidisciplinary, comprehensive and ongoing domestic violence education and training program for hospital, health center, or clinic personnel adapted to their particular demographics, policies, staffing patterns and resources. The training shall include identifying characteristics of domestic violence, screening patients for domestic violence, appropriately documenting in the medical record and offering referral services, including domestic violence resources available in the community.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Pennsylvania Coalition Against Domestic Violence partnered with Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs to raise public awareness for domestic violence and health issues, such as develop tools to educate primary care medical assistance providers to help them identify and refer patients experiencing domestic violence to the national hotline and local domestic violence program. This partnership also trains and equips medical advocates to provide health care providers with model practices that will best serve domestic violence survivors, and features articles about domestic violence in quarterly newsletters received by all medical assistance recipients.

In 2013 Pennsylvania was one of six states and five native health facilities selected to participate in Project Connect: 2.0, a national initiative to change how adolescent health, reproductive health and Native health services respond to sexual and domestic violence. Futures Without Violence, in collaboration with the Office on Women's Health, provided technical assistance and monitored the grantees for the three year initiative (2013-2015). Project Connect 2.0 is supported by the Office on Women's Health, U.S. DHHS and funded through the Violence Against Women Reauthorization Act of 2006. The Project Connect 2.0 work in Pennsylvania was led by the Pennsylvania Coalition Against Domestic Violence, in partnership with the Pennsylvania Department of Health, Alliance of Pennsylvania Councils, Pennsylvania Coalition Against Rape, and the Pennsylvania Association of School Nurses and Practitioners. The team worked to develop state policies to require universal education on healthy relationships, targeted assessment for reproductive coercion and adolescent relationship abuse for sexually active young women, and partnership with local advocacy organizations for school-based adolescent health settings. In addition, school nurses from five sites were trained to use an evidence-based intervention using a patient safety card, that includes universal messages on healthy relationships, as well as harm reduction strategies and referrals to local advocates when abuse is disclosed.

PENNSYLVANIA (Cont.)

The Pennsylvania Coalition Against Domestic Violence is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families.

Pennsylvania is one of four states participating in the Providers, Advocates, and Technology for Health and Safety (PATHS) Project, partnering with the Johns Hopkins School of Nursing, the University of Pittsburgh, the Office on Women's Health, and Futures Without Violence. A leadership team is working with 3 sites to utilize the CUES universal education intervention, using the MyPlan safety decision aid, for supporting survivors of domestic violence and sexual assault, and to promote healthy relationships.

RHODE ISLAND

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: R.I. Gen Laws §§ 27-60-1 to -7, 27-60.1-1 to 8, 27-61-1 to-7 applies to health, life, and property insurance. It prohibits those insurers in Rhode Island from: denying, refusing to issue, renew or reissue, canceling or terminating a health benefit plan, or restricting or excluding health benefit plan coverage or adding a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status; excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse on the basis of the insured's abuse status; or terminating group coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily.

Mandatory Reporting: R.I. Gen. Laws § 23-28.2-24 requires the report of second or third degree burn injuries sustained to 5% or more of the body, burns to the upper respiratory tract, or those which are likely to cause or may result in death by the physician attending or treating the case, or the manager, superintendent or other person in charge, whenever the case is treated in a hospital, sanitarium, institution, or other medical facility to the state fire marshal. The fire marshal shall accept the report and notify the proper investigatory agency.

R.I. Gen. Laws § 11-47-48 requires that every physician or institution attending to or treating a case of a gunshot wound or any other injury resulting from the discharge of a firearm to report to local police authorities where the physician is located.

R.I. Gen. Laws § 12-29-9 creates Medical Data Collection Reports as part of the Domestic Violence Prevention Act. It is a mandatory report for health care providers for any indicated or suspected cases of domestic violence. However, the report should not contain any identifying information including names.

Protocols: None.

Screening: None.

Training: None.

RHODE ISLAND (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: A portion of the VAWA Victim Services funding is utilized for the operations of the statewide Victims of Crime Helpline, which provides domestic violence/sexual assault advocates to accompany victims of domestic violence or sexual assault to hospital emergency rooms throughout the state.

Others: A VOCA grant supports the hospital advocacy services described above, provided through the statewide Helpline for Victims of Crime.

Public Health Responses

The Rhode Island Coalition Against Domestic Violence (RICADV) is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families. RICADV was also one of ten state domestic violence coalitions to receive the DELTA Focus grant from the CDC. From 2013-2018, grantees worked to prevent IPV at the national, state, and local levels by implementing strategies to change the environments and conditions in which people live, work and play. Each grantee supported one or two coordinated community response teams (CCRs) to implement IPV prevention strategies at the local level. The Rhode Island Department of Health (RIDOH) has been a key partner on the Rhode Island DELTA State Steering Committee that developed a statewide plan to prevent domestic violence, led by RICADV.

The Rhode Island Department of Health also co-facilitates the Rhode Island Sexual Violence Prevention Planning Committee with Day One, the state sexual assault coalition, and recently released a plan to address sexual violence prevention.

SOUTH CAROLINA

Statutes Addressing

Fatality Review: SECTION 16 25 720, 730, 740, 750. Each Circuit Solicitor shall establish an interagency circuit wide Domestic Violence Fatality Review Committee to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases pursuant to the provisions of this chapter or any other relevant provision of law. Domestic violence fatality review committees may be comprised of, but not limited to: experts in the field of forensic pathology; medical personnel with expertise in domestic violence and domestic violence abuse organization staff. Meetings of the committee are closed to the public and are not subject to the provisions of the Freedom of Information Act when the committee is discussing an individual case. All information and records acquired by the committee in the exercise of their purposes and duties pursuant to this article are confidential. Each each domestic fatality review committee shall make recommendations regarding training that would decrease the likelihood of domestic violence.

Insurance Discrimination: S.C. Code Ann. § 38-71-860 states that health insurers may not use conditions arising from domestic violence abuse as a health status-related factor to determine eligibility for coverage or premium charges.

Mandatory Reporting: S.C. Code Ann. § 16-3-1072 requires a physician, nurse, or any other medical or emergency medical services personnel of a hospital, clinic, or other health care facility or provider to report treatment or requests for treatment for a gunshot wound to the sheriff's department of the county in which the treatment is administered, unless an officer is present at the time of treatment.

Protocols: None.

Screening: None.

Training: S.C. Code Ann. § 16-3-1410 states that The Victim Compensation Fund is authorized to provide information, training and technical assistance to groups involved in victim and domestic violence assistance, including hospital staff, when appropriate funding is available.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

SOUTH DAKOTA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: S.D. Codified Laws § 58-33-13.3 prohibits life and health insurers from asking about an individual's status as a victim of domestic abuse for the purposes of offering, selling, or renewing coverage; limiting coverage; or charging a rate different from that normally charged for the same coverage under any life or health insurance policy.

Mandatory Reporting: S.D. Codified Laws § 23-13-10 requires any person treating a gunshot wound, or any other wound caused by the discharge of a firearm, to report such treatment to the sheriff of the county in which the wound is treated.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

TENNESSEE

Statutes Addressing

Fatality Review:

Tenn. Code Ann. § 36-3-624 allows counties to establish an interagency domestic abuse death review team whose membership may include medical personnel with expertise in domestic violence, county health department staff who deal with domestic abuse victims' health issues, coroners and medical examiners, and domestic abuse shelter staff.

Insurance Discrimination:

Tenn. Code Ann. §§ 56-8-301 to 56-8-306 applies to health insurance. It prohibits those insurers from: denying, refusing to issue, renew or reissue, canceling or otherwise terminating, or restricting or excluding coverage, or adding a premium differential to any health benefit plan; excluding or limiting coverage or denying a claim incurred by an insured on the basis of the applicant's or insured's abuse status or as the result of abuse; and, terminating group coverage for a subject of abuse on the basis of the insured's abuse status where coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily, on the basis of the applicant's or insured's abuse status. For additional information on the provisions of the statute go to **www.lexisnexis.com/hottopics/tncode/.**

Mandatory Reporting:

Tenn. Code Ann. § 38-1-101 requires all hospitals, clinics, sanitariums, doctors, physicians, surgeons, nurses, pharmacists, undertakers, embalmers, or other persons called upon to tender aid to persons suffering from any injuries caused by knife, firearm or other deadly weapon, or by other means of violence, suffocation or poisoning to report such treatment to law enforcement officials. However, if the patient is over the age of 18, believed to be a victim of domestic violence, there was not a deadly weapon or strangulation involved, and the patient objects to the information being released to law enforcement, than the patient should not be included in the report.

The exception does not apply and the injuries shall be reported if the injuries incurred by the sexual assault or domestic abuse victim are considered by the treating healthcare professional to be life threatening, or the victim is being treated for injuries inflicted by strangulation, a knife, pistol, gun, or other deadly weapon.

Protocols

None.

Screening:

None.

Training:

Tenn. Code Ann. § 68-140-323 provides that under the Emergency Medical Services Act, the Department of Health shall approve and coordinate the use of materials concerning domestic violence as part of its training curriculum for emergency medical services personnel.

TENNESSEE (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Tennessee Department of Health (TDH) Rape Prevention and Education (RPE) program works collaboratively with diverse stakeholders to provide prevention services, program development, and technical support to five Metro Health Departments and health educators in County Health Departments across the state to implement and maintain evidence based sexual violence prevention efforts such as Safe Dates and Coaching Boys into Men. The health educators collaborate with local sexual assault centers, community partners, county health coalitions, and key stakeholders to coordinate initiatives and to maximize RPE and primary prevention in the community. Tennessee was one of the 11 states selected to participate in the 2017 Center for Disease Control and American Public Health Association's Campus Sexual Assault Action Planning Meeting.

The Tennessee Coalition to End Domestic and Sexual Violence (TCEDSV) receives funding from Tennessee Department of Health (TDH) for the primary prevention of sexual assault. TCEDSV provides grants to eight community-based domestic violence and sexual assault centers across the state. TCEDSV, in partnership with TDH, developed a statewide Rape Prevention and Education (RPE) Institute. Each year, the annual RPE Institute provides opportunities for local grantees, staff, and partners to learn concepts and skills necessary to the development, implementation, and evaluation of comprehensive primary prevention focus programs.

Finally, TCEDSV is one of ten state domestic violence coalitions to receive the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Impact grant from the Center for Disease Control and Prevention (CDC). Since 2018, each participating domestic violence coalition has been working to implement and evaluate up to four programs or policy efforts under the following three categories: engaging influential adults or peers, creating protective environments, and strengthening economic supports for families.

TEXAS

Statutes Addressing

Fatality Review: Tex. Health & Safety Code §§ 672.001 - 672.013 allows counties to establish a multidisciplinary and multiagency unexpected fatality review team ("unexpected fatality" defined as one that appears to be from suicide, family violence or abuse) whose membership may include a public health professional, a mental health services provider, and other domestic violence advocates.

Insurance Discrimination: Tex. Ins. Code § 544.151-158 applies to health and life insurance. It requires that those insurers in Texas cannot: because of an individual's status as a victim of family violence: deny coverage to the individual; refuse to renew the individual's coverage; cancel the individual's coverage; limit the amount, extent, or kind of coverage available to the individual; or charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage.

Mandatory Reporting: Tex. Health and Safety Code § 161.041 requires a physician who attends or treats, or who is requested to attend or treat, a bullet or gunshot wound, or the administrator, superintendent, or other person in charge of a hospital, sanitarium, or other institution in which a bullet or gunshot wound is attended or treated or in which the attention or treatment is requested, to report the case at once to the law enforcement authority of the municipality or county in which the physician practices or in which the institution is located.

Protocols: Tex. Fam. Code § 91.003 requires medical professionals who treat a person for injuries that they have reason to believe were caused by family violence to immediately provide them with information regarding the nearest family violence shelter, document in their file that they have been given such information and the reasons for the medical professional's belief that the injuries were caused by family violence, and give them with a written notice, provided in the statute, regarding their rights.

Screening: Tex Health & Safety Code 34.0055 Requires physicians and other persons licensed or certified to conduct a domestic violence screening of pregnant women, and provide domestic violence prevention and intervention resources in each region of the state. Educational materials on domestic violence shall also be made available on the commission's website.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

TEXAS (Cont.)

Public Health Responses

The Texas Department of State Health Services (DSHS) is actively involved in a variety of projects that will bring about a better understanding of the incidence of domestic violence in Texas and the role domestic violence plays in overall health status. Efforts are also in place to ensure effective referral when domestic violence is identified in health settings.

Texas Health and Human Services Commission's Women, Infants and Children (WIC) program routinely screens for domestic violence on all of the client health history forms and provides If a "yes" response is provided, an appropriate referral is made to programs in the area along with a toll free number for a domestic violence hotline.

Texas was one of eight states that participated in the first phase of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (2010-2012) funded by the Office on Women's Health, U.S. Department of Health and Human Services (DHHS) with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project 1,000 health care providers were trained to assess for, and respond to, domestic and sexual violence in home visitation settings. The initiative also helped strengthen partnerships between public health programs and domestic and sexual violence advocates to effectively identify and refer victims of abuse. As part of Project Connect, The Texas Project Connect team worked with the four regional Healthy Start collaboratives in the state to develop two tools for home visitation programs, "Domestic Violence Protocol for Home Visitation Programs" and "Home Visitation Guidelines on Screening, Assessment and Response to Domestic Violence," which are being disseminated and widely utilized throughout the state. Texas Project Connect also engaged in extensive work with three family violence programs offering on-site health services through a pilot project.

The Texas Department of State Health Services' Quality Management section included in 2015 a requirement for programs that: "The agency has a written policy related to preventing intimate partner violence (IPV), which includes annual staff training." In 2015 this applied to numerous DSHS programs including WIC, Family Planning, and others.

UTAH

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: Utah Code Ann. §§ 31A-21-501 to 31A-21-506 applies to health, life and disability insurance. It prevents those type of insurers in Utah from considering whether an insured or applicant is the subject of domestic abuse as a factor to: refuse to insure the applicant; refuse to continue to insure the insured; refuse to renew or reissue a policy to insure the insured or applicant; limit the amount, extent, or kind of coverage available to the insured or applicant; charge a different rate for coverage to the insured or applicant; exclude or limit benefits or coverage under an insurance policy or contract for losses incurred; deny a claim; or terminate coverage; or fail to provide conversion privileges under a group accident and health policy for the insured because the coverage was issued in the name of the perpetrator of the domestic violence or abuse. However, underwriters may consider mental or physical conditions that are a result of abuse if there is a correlation between the condition(s) and a material increase in insurance risk. The act or existence of abuse does not constitute a mental or physical condition.

Mandatory Reporting: Utah Code Ann. § 26-23a-2 mandates that any health care provider who treats or cares for any person suffering from any wound or injury inflicted by a person's own act or the act of another by knife, gun, pistol, explosive, infernal device, or deadly weapon, or in violation of any criminal statute must report to the law enforcement agency the facts of the injury.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Department of Health and the Utah Domestic Violence Council (UDVC), Utah's state domestic violence coalition, has published and printed "Clinical Guidelines for Assessment and Referral for Victims of Domestic Violence: A Reference for Utah Health Care Providers." Copies have been distributed to health care providers and advocates throughout the state.

VERMONT

Statutes Addressing

Fatality Review: 15 V.S.A. § 1140 establishes the Domestic Violence Fatality Review Commission whose members shall include the commissioner of the department of health, or his or her designee, the chief medical examiner, or his or her designee, a physician, appointed by the governor, a victim or survivor of domestic violence and other domestic violence advocates.

Insurance Discrimination: None.

Mandatory Reporting: 13 V.S.A. § 4012 requires every physician treating a bullet or gunshot wound, or any other wound caused by the discharge of a firearm, to report to local law enforcement officials or the state police.

Protocols: 15 V.S.A. § 1171 creates a Vermont Council on Domestic Violence, which is tasked with establishing collection and reporting procedures on domestic violence, education, model policies and procedures for both the criminal justice and human services sectors.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

Vermont's Agency of Human Services (AHS) Domestic Violence online training is required for some AHS staff, and strongly recommended for others. There is also a Supervisor's Guide that supports the online training.

VIRGINIA

Statutes Addressing

Fatality Review: Va. Code Ann. § 32.1-283.3 requires the Chief Medical Examiner to develop a model protocol for the development and implementation of local family violence fatality review teams whose membership may include health care professionals, the medical examiner, other experts in forensic medicine and pathology, health department professionals and family violence victim advocates.

Insurance Discrimination: Va. Code Ann. § 38.2-508(7), 16.1-228 applies to health, life, disability and property insurance. It prohibits any insurer in Virginia to consider the status of a victim of domestic violence as a criterion in any decision with regard to insurance underwriting, pricing, renewal, scope of coverage, or payment of claims on any and all insurance.

Mandatory Reporting: Va. Code Ann. § 54.1-2967 requires physicians, or any other person rendering medical aid or treatment, to report to the sheriff or chief of police where the treatment is rendered, treatment of any wounds which the physician knows, or has reason to believe, which were caused by a weapon specified in § 18.2-308 and which they believe or have reason to believe was not self-inflicted.

Protocols: None.

Screening: Va. Code Ann. § 32.1-11.6 establishes the Virginia Pregnant Women Support Fund to be administered by the Board of Health to support women and families facing unplanned pregnancy. The fund shall create a program for screening pregnant women and new mothers for domestic violence, dating violence, sexual assault and stalking.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: Through the Centers for Disease Control and Prevention (CDC) Rape Prevention and Education Program, Violence Against Woman Act (VAWA) funds are used to support the implementation of sexual violence prevention and education programming by local domestic and sexual violence agencies.

Others: CDC Preventive Health and Health Services (PHHS) Block Grant – Sexual Assault Set Aside funds are used to support the development of assessment strategies and tools, training curricula, educational materials and policy/procedure guidance to better enable family planning clinic staff and home visitors to identify and provide support and referral to individuals and families impacted by sexual and domestic violence.

VIRGINIA (Cont.)

Public Health Responses

Virginia was one of eight states funded as part of Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women, funded by the Office on Women's Health, U.S. DHHS with support from the Administration for Children and Families, U.S. DHHS, and coordinated by Futures Without Violence. As part of that project 2,000 health care providers were trained to assess for, and respond to, domestic and sexual violence in clinical settings. The initiative also helped establish partnerships between public health programs and domestic and sexual violence advocates to effectively identify and refer victims of abuse. Women and infants' health, injury and violence prevention, the statewide Home Visiting Consortium, and the statewide sexual and domestic violence coalition partnered to collaborate on best responses in home visiting and family planning settings. The Project Connect team also informed the development of domestic violence shelter-based health services for women and children.

WASHINGTON

Statutes Addressing

Fatality Review: RCW §§ 43.235.010 to 43.235.901 creates regional domestic violence review panels which, subject to availability of funds, the Department of Social and Health Services can contract with an entity with expertise in domestic violence policy and education and with a statewide perspective to coordinate review of domestic violence fatalities. Membership shall include medical personnel with expertise in domestic violence abuse, coroners or medical examiners or others experienced in the field of forensic pathology, if available, local health department staff and other domestic violence advocates. A biennial statewide report will be issued in December of even numbered years.

Insurance Discrimination: RCW § 48.18.550 applies to health, life, disability, and property insurance. It requires that all insurers in Washington cannot deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

Mandatory Reporting: RCW § 70.41.440 requires hospitals to report to local law enforcement agencies, as soon as is reasonably possible, whenever they provide treatment for a bullet, gunshot or stab wound to a patient. If the patient states his or her injury is the result of domestic violence, the hospital shall follow its established processes to inform the patient of resources to assure the safety of the patient and his or her family.

Protocols: None.

Screening: None.

Training: ARCW § 43.70.610 mandates that the Department of Health shall establish within available department general funds, an ongoing domestic violence education program as an integral part of its health professions regulation to raise awareness and educate health care professionals regarding the identification, appropriate treatment, and appropriate referral of victims of domestic violence.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Washington State Department of Health (WSDH) provides information about domestic and sexual violence to health care providers electronically and posted to the Department of Health (DOH) website. Information is shared with many offices within the WSDH to share with both constituents and stakeholders.

WASHINGTON (Cont.)

Funded by the Office of Adolescent Health at the Department of Health and Human Services, the WSDH has developed a strong partnership with the Attorney General's Office through the Pregnant Teen and Women Grant to improve services for pregnant teens and women who are victims of domestic violence, sexual assault, and stalking.

The Washington State Coalition Against Domestic Violence (WSCADV) has been working with the Department of Early Learning (DEL) and the Department of Health to provide training to home visiting professionals throughout Washington on "Domestic Violence: Assessment and Response and Safety Planning with Families."

The DOH partners with the Washington Department of Commerce to fund community-based organizations to implement comprehensive initiatives that address the primary prevention of sexual violence. These initiatives use a public health approach and are funded through Center for Disease Control's Rape Prevention and Education (RPE) Program.

The DOH periodically collects data on domestic and sexual violence through the Healthy Youth Survey (HYS) and the Behavioral Risk Factor Surveillance System (BRFSS).

Clients accessing family planning clinics in Washington are routinely screened for domestic violence during visits, and referrals are made to supportive services when there is a disclosure.

WASHINGTON, DC

Statutes Addressing

Fatality Review: D.C. Code §§ 16-1051 to 16-1058 establishes a Domestic Violence Fatality Review Board which shall consist of one representative from agencies including the Office of the Chief Medical Examiner, the Department of Health and the Fire and Emergency Medical Services Departmen.

Insurance Discrimination: D. C. CODE § 31-2231.11 (a-c) covers health, life, and accident insurance and establishes that no person shall refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of marital status, race, color, personal appearance, sexual orientation, gender identity or expression, matriculation, political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking.

Mandatory Reporting: D.C. Code § 7-2601 requires reporting by any physician, including persons licensed under Chapter 12, Title 3, with reasonable cause to believe that a person coming to them for examination, care or treatment has suffered injury caused by a firearm, whether self-inflicted, accidental or during the commission of a crime, or injury caused by any dangerous weapon in the commission of a crime to the Metropolitan Police Department.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

WEST VIRGINIA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: W. Va. Code Ann. § 33-4-20 applies to health, life, and disability insurance. It requires that those insurers in West Virginia cannot deny, refuse to issue, refuse to renew, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage on any individual because that individual is, has been or may be the victim of abuse; add any surcharge or rating factor to a premium of an insurance policy because an individual has been or may be the victim of abuse; exclude or limit coverage for losses or deny a claim incurred because an individual has been or may be the victim of abuse; or require as part of the application process any information regarding whether that individual has been or may be the victim of abuse.

Mandatory Reporting: W. Va. Code § 61-2-27 mandates that any medical provider who provides treatment to a person suffering from a wound caused by a gunshot, knife, or other sharp pointed instrument which would lead a reasonable person to believe resulted from a violation of state criminal laws shall report to law enforcement agencies located in the county in which the wound was treated.

W. Va. Code § 61-2-27a requires any health care provider who examines or renders medical treatment to a person suffering from an injury caused by a burn resulting from fire or a chemical, where the circumstances under which the examination is made or treatment is rendered, or where the condition of the injury gives the health care provider reasonable cause to suspect that the injury occurred during the commission, or attempted commission, of an arson as defined in article three of this chapter, shall report the same to the office of the state fire marshal.

Protocols: W. Va. Code § 48-26-502 requires the Bureau for Public Health of the Department of Health and Human Resources to make available to health care facilities and practitioners a written form notice of the rights of victims and the remedies and services available to victims of domestic violence. A health care practitioner whose patient has injuries or conditions consistent with domestic violence shall provide to the patient, and every health care facility shall make available to all patients, a written form of the notice.

Screening: None.

Training: W. Va. Code § 48-26-503 requires the Bureau for Public Health of the Department of Health and Human Resources to publish model standards, including specialized procedures and curricula, concerning domestic violence for health care facilities, practitioners and personnel, to be developed in consultation with public and private agencies that provide programs for victims of domestic violence, advocates for victims, organizations representing the interests of shelters and personnel who have demonstrated expertise and experience in providing health care to victims of domestic violence and their children.

WEST VIRGINIA (Cont.)

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The West Virginia Coalition Against Domestic Violence (WVCADV) partnered with the West Virginia Bureau of Public Health to develop a state plan to reduce domestic violence, with implementation plans being developed by a domestic violence workgroup through the Bureau for Public Health. WVCADV also partnered with the West Virginia Bureau for Behavioral Health and Health Facilities to provide statewide training on domestic violence for behavioral health and substance abuse providers. Additionally, WVCADV sits on the Advisory Board for the WVD-HHR Bureau of Behavioral Health and Facilities. Finally, The West Virginia Department of Health and Human Resources (WVDHHR) Bureau for Public Health Office of Maternal, Child and Family Health is partnering with WVCADV to address domestic violence through education and training of all staff working in Home Visitation programs.

West Virginia is one of four states participating in the Providers, Advocates, and Technology for Health and Safety (PATHS) Project, partnering with the Johns Hopkins School of Nursing, the University of Pittsburgh, the Office on Women's Health, and Futures Without Violence. A leadership team is working with 3 sites to utilize the CUES universal education intervention, using the MyPlan safety decision aid, for supporting survivors of domestic violence and sexual assault, and to promote healthy relationships.

WISCONSIN

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: Wis. Stat. § 631.95 applies to health, life, disability, and property insurance. It requires that those insurers in Wisconsin cannot: refuse to provide or renew coverage, or cancel coverage; or use as a factor in the determination of rates exclude; or limit coverage of, or deny a claim. or limit benefits on the basis that the person has been, or the insurer has reason to believe that the person is, a victim of abuse or domestic abuse or that a member of the person's family has been, or the insurer has reason to believe that a member of the person's family is, a victim of abuse or domestic abuse.

Mandatory Reporting: Wis. Stat. § 255.40 requires health professionals (defined in ch. 441, 448 or 455) to report to law enforcement, in the area where treatment is rendered, treating a patient suffering from a gunshot wound, any wound which gives them reasonable cause to believe it occurred as a result of a crime, or, any burns of the second or third degree to more than 5% of the body, burns to the upper respiratory tract, and any other burns which they have reasonable cause to believe were incurred as the result of a crime.

Wis. Stat. § 255.40 requires health professionals (as defined in §441, 448, or 455) to report patients suffering from recent gunshot wounds and injuries (including some types of burns) believed caused as a result of a result of a crime.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Wisconsin Adolescent Health Program of the Department of Health Services (DHS) is funded by Rape Prevention Education (RPE) from the Centers for Disease Control and Prevention, Personal Responsibility Education Program (PREP) from the Family and Youth Services Bureau, and the Maternal and Child Health Title V Block Grant. The Adolescent Health Program funds local health departments and sexual assault service providers to implement preventive education and programming with youth. The Wisconsin DHS is also supporting the Wisconsin Coalition Against Sexual Assault to provide education and training to women's health clinics on screening, intervention, and referral for sexual violence.

WYOMING

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: W.S.1977 § 26-19-107(g)(vii) stipulates that an insurance policy cannot establish rules for eligibility, including continued eligibility, for any enrollee based on evidence of insurability, including conditions arising out of acts of domestic violence.

Mandatory Reporting: None.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

The Wyoming Department of Health has formed a statewide injury prevention advisory committee to put together a state plan for injury prevention. In the Community and Public Health Division, federal grant funds are used to support sexual assault prevention. The Wyoming Department of Health contracts with the Wyoming Coalition Against Domestic Violence and Sexual Assault to carry out the state plan to prevent sexual assault.

AMERICAN SAMOA

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: None.

Mandatory Reporting: None.

Protocols: A.S.C.A. 47.0803(a) requires the Department of Public Health to make available to practitioners and health care facilities a written notice of the rights of victims and remedies and services available to victims of domestic or family violence.

Screening: A.S.C.A. 47.0803(b) A practitioner who becomes aware that a patient is a victim of domestic or family violence shall provide to the patient and every health care facility shall make available to all patients the notice provided pursuant to subsection (a).

Training: None.

Public Funds Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

GUAM

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: None.

Mandatory Reporting: None.

Protocols: 19 Guam Code Ann. § 15102 charges the Family Violence Task Force with establishing standards, procedures, and curricula for healthcare facilities and practitioners regarding victims of family violence.

Screening: See above.

Training: See above.

Public Funds Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

Guam is one of three states/territories participating in *Project Catalyst Phase II: State and Territory-Wide Transformation on Health, Intimate Partner Violence, and Human Trafficking (2018-2019),* focused on fostering intimate partner violence, human trafficking, and health leadership and collaboration at the U.S. state/territory level to improve the health and safety outcomes for survivors of IPV and human trafficking and to promote prevention. The leadership team consists of leaders from the Guam Coalition Against Sexual Assault & Family Violence, the Pacific Islands Primary Care Association, and the Guam Department of Public Health & Social Services.

NORTHERN MARIANA ISLANDS

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: None.

Mandatory Reporting: None.

Protocols: PL 12-19, § 2 (403): The Department of Public Health is required to put forth standards for healthcare facilities, practitioners, and personnel in the facilities including specialized procedures and curricula concerning domestic or family violence.

Screening: None.

Training: None.

Public Funds Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

PUERTO RICO

Statutes Addressing

Fatality Review: None

Insurance Discrimination: None.

Mandatory Reporting: None.

Protocols:

Note: Laws are described in English followed by Spanish.

Law 54 (August 15, 1989), Prevention and Intervention with Victims of Domestic Violence, provides guidelines for professionals who assist victims of domestic violence to promote the health and wellbeing of survivors. The law (Article 4.1) further requires the development of prevention strategies to: (section d) Sensitize professionals about the needs of victims of abuse and their families; and (section e) Develop strategies to foment changes in policies and procedures within governmental agencies with the goal of improving responses for victims of abuse.

Ley 54 del 15 de agosto de 1989 para la Prevención e Intervención con Víctimas de Violencia Doméstica-se compromete a dar énfasis y atención a situaciones de violencia domestica para evitar la muerte de personas y proteger la salud física, emocional y sexual de sus sobrevivientes. Art. 4.1 Medidas para prevenir (8 L.P.R.A.sec. 651): (d) Concientizar a los profesionales de ayuda sobre las necesidades de las personas víctimas de maltrato y las de sus familias; y (e) Desarrollar estrategias para fomentar cambios en las políticas y procedimientos en las agencias gubernamentales con el fin de mejorar sus respuestas a las necesidades de las personas víctimas de maltrato.

Rulings that require all ER facilities in Puerto Rico to comply with the protocols established by the Department of Health and the Center for the Support of Victims of Rape

1. Secretary of Health Ruling No. 117 (December 1, 2004) regulates the Licensing, Operation, and Maintenance of Hospitals in the Commonwealth of Puerto Rick. i. Administrative fines and penalties for non compliance (Article 6). ii. Chapter XXI: Emergency Rooms in a Hospital Institution, (Article 7) authorized with the Center of Victims of Rape, the establishment of a mandatory Protocol for the intervention of victims of sexual assault and domestic violence.

Reglamentos que requieren a todas las facilidades de salud de Puerto Rico cumplir con lo establecido en los protocolos del Departamento de Salud y del Centro de Ayuda a Víctimas de Violación

1. Reglamento del Secretario de Salud Núm 117 para reglamentar el Licenciamiento, Operación y Mantenimiento de los Hospitales en el Estado Libre Asociado de Puerto Rico del 1 de diciembre de 2004 i. Artículo 6- Multas administrativas y penalidades—por incumplir alguna orden emitida por el Secretario de Salud. ii. Capítulo XXI: Salas de Emergencia en una Institución Hospitalaria; Artículo 7 establece como Protocolo

PUERTO RICO (Cont.)

mandatorio el de Intervención con Víctimas de violación u otros protocolos semejantes y autorizados con el Centro de Ayuda a Víctimas de Violación (ej.Protocolo de Intervención con Víctimas/Sobrevivientes de Violencia Doméstica).

2. General Ruling No. 99 for the Operation and Function of Health Facilities in Puerto Rico (Oct. 19, 1999).

Note: As a result of two rulings (#117 and #99), the following policy was developed: ***Administrative order No 214*** (November 15, 2006) from the Secretary of the Department of Health fulfills the requirement of the public policy protocols on intervention with victims/survivors of sexual violence and domestic violence to maintain monthly records of sexual assault and domestic violence cases assisted in the emergency rooms and facilitate in the audit process of sexual assault and domestic violence files.

Nota: De estos dos reglamentos surge la ***Orden Administrativa Núm 214 de la Oficina de la Secretaria del Departamento de Salud*** del 15 de noviembre de 2006- Lograr el cumplimiento con la política pública establecida en los protocolos de intervención con víctimas /sobrevivientes de agresión sexual y de violencia doméstica, del Departamento de Salud, que se mantengan los registros mensuales de casos de agresión sexual y violencia doméstica atendidos en las salas de emergencia y se facilite el proceso de auditoría de expedientes de agresión sexual y violencia doméstica.

Intervention Protocol with Victims/Survivors of Domestic Violence from the Support Center to Victims of Rape from the Department of Health 2004, establishes public policy for the prevention and intervention with victims of DV in the emergency rooms of public and private hospitals. These are mandated guidelines by rulings 99 and 117 for health facilities. This is an educational guide to train health care professionals, administrators and medical directors on the standards and the steps to take in the intervention with victims in health facilities.

Protocolo de Intervención con Víctimas /Sobrevivientes de Violencia Doméstica del Centro de Ayuda a Víctimas de Violación del Departamento de Salud del 2004 - establece la política pública para la prevención e intervención con las víctimas/sobrevivientes de violencia doméstica en las salas de emergencia de los hospitales públicos y privados. Es una guía educativa para orientar a profesionales de la salud, administradores/as y directoras/as médicos sobre los estándares en los pasos a seguir en la intervención con las víctimas en las facilidades de salud.

Screening: None.

Training: Law No. 139 (August 1, 2008): Law from the Licensing Council and Medical Discipline requires sixty (60) credit hours in Continued Medical Education in order to

PUERTO RICO (Cont.)

renew the medical license every three years. The sixty (60) hours are broken in the following: thirty four (34) credit hours on free topics, ten (10) on illness prevention and/or health conditions and the advancement of health, and **ten (10) credits, courses on the topic of assault: physical, emotional, sexual, domestic violence, etc.**

Ley Núm 139 del 1 de agosto de 2008: Ley de la Junta de Licenciamiento y Disciplina Médica Reglamento General de la Junta de Licenciamiento y Disciplina Médica: Artículo 9.3- Todo médico licenciado deberá completar un mínimo de sesenta (60) horas crédito en cursos de Educación Médica Continua acreditados por la Junta o el Comité que a los efectos se designe, durante el periodo correspondiente a cada trienio de recertificación…Dichas sesenta (60) horas se desglosarán de la siguiente manera: Treinta y cuatro (34) horas crédito en temas libres de los cuales diez (10) serán en el área de prevención de enfermedades y/o condiciones de salud y en promoción de la salud. **También se requerirá dentro de los diez (10) créditos cursos en tema de agresión: física, emocional, sexual, violencia doméstica, etc.**

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: The Women Advocates Office (Oficina de la Procuradora de las Mujeres) assigns special legislative funds to train staff in emergency room care to victims of domestic violence and sexual assault and to verify protocols compliance.

Public Health Responses

The Department of Health has an Agency Protocol to address Domestic Violence in the Workplace. It also offers training and consulting professionals through the Rape Crisis Center (Centro de Ayuda a Victimas de Violacion). Every emergency room has to conduct a domestic violence screening and provide referral resources in the community as established by Protocol.

VIRGIN ISLANDS

Statutes Addressing

Fatality Review: None.

Insurance Discrimination: None.

Mandatory Reporting: None.

Protocols: None.

Screening: None.

Training: None.

Public Funding Earmarked for Health Care and Domestic Violence

VAWA: None.

Others: None.

Public Health Responses

None.

Notes

Everyone has the right to live free of violence. Futures Without Violence works to prevent and end violence against women and children around the world.

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