The Red Women Rising Best Practices Guide was developed by the California Consortium for Urban Indian Health, and funded by the Blue Shield of California Foundation. We thank staff at Sacramento Native American Health Center and WEAVE, Inc., particularly:

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The Red Women Rising Best Practices Guide aims to improve services for survivors of domestic violence at Urban Indian Health organizations. This Guide was developed by the California Consortium for Urban Indian Health (CCUIH), and funded by the Blue Shield of California Foundation. It was informed by the partnership between Sacramento Native American Health Center (SNAHC) and WEAVE, Inc., part of the Blue Shield of California Foundation’s statewide project to integrate health care and domestic violence response throughout California. During this partnership, SNAHC and WEAVE developed a cross functional team of champions and a framework of policies and procedures that CCUIH has documented to share with our membership and other Indian health programs. This Best Practices Guide leverages the SNAHC/WEAVE partnership and materials developed by Futures Without Violence.

CCUIH supports health promotion and access for American Indians living in cities throughout California. CCUIH’s Red Women Rising Project supports culturally responsive domestic violence (DV) services for Urban Indians by increasing public awareness and enhancing collaborations between Urban Indian health organizations, domestic violence service providers and traditional healers.

The public awareness component of the Red Women Rising project is a community driven media project that tells the story of violence against Urban Indian women. Red Women Rising’s mix of digital and print media amplify the innovation and resilience reflected in the talking circles and digital storytelling workshops that CCUIH held in 2015. This campaign has started many important conversations about recognizing abuse, stopping violence, and healing as a community through social media outlets and at our members’ sites. You can visit the Red Women Rising Page on the CCUIH website to view all of the Red Women Rising media, including videos, a #RedWomenRising Social Media Kit, a Domestic Violence Resource Directory, and additional resources from allied organizations that can enhance UIHOs’ capacity to serve Urban Indian victims and survivors. Visit ccuih.org/red-women-rising to view our public awareness campaign.

The "Framework of Policies and Procedures" section of this guide provides information about assessing your health organization’s quality of services for DV survivors, enhancing screening practices, employee DV policy, and getting health services to DV clients.

The “Cross Functional Team of Champions” section of this guide describes how partnering with a DV program can benefit your organizational capacity to meet community DV needs through the buddy system, cross-trainings, and community programming.
Violence Against Native Women

Domestic violence is a highly prevalent public health issue that impacts individuals, families, and communities. Values and practices at Urban Indian health organizations and other community health settings should reflect this reality. This section will discuss the prevalence of DV, the landscape of violence for American Indian and Alaskan Native (AIAN) women, and why the health care setting is well-positioned to address these issues.

DV has a direct impact on the mortality of women; it has been estimated that 30% of female murder victims in the US are killed by their current or former partner. While the Department of Justice estimates that 95% of reported spousal or ex-spousal assaults are committed by men against women, DV occurs in a diversity of relationships that should not be ignored.

The immediate impact of physical violence is not the only outcome of DV. Physical and psychological violence can take additional mental and emotional tolls, causing depression, dysphoria, and high risk or help-seeking behaviors. Abuse is also linked to chronic conditions such as arthritis, chronic neck or back pain, migraine, STIs, frequent indigestion, diarrhea, or constipation.

Children who are raised in DV situations not only deal with immediate and long-lasting physical and psychological issues, but are at high risk of continuing the cycle of violence, and are more likely to depend on alcohol and drugs as coping mechanisms.

It is important not to discount the DV experiences of adolescent girls and young women. Girls and young women between the ages of 16 and 24 experience the highest rate of DV compared to other age groups, almost tripling the national average.

Violent relationships in adolescence increase the likelihood of behaviors such as substance abuse and risky sexual behavior. Teen girls who are sexually and physically abused are six times more likely to become pregnant and twice as likely to have an STI. Additionally, suicide attempt rates are higher for teens that experience intimate partner violence or sexual violence.

American Indian women experience violence at a higher rate than most other demographics. In 2008, the CDC estimated that 39% of American Indian women experience intimate partner violence in their lifetimes, a rate higher than
any other ethnic or racial group.

A new report from the National Institute of Justice has found that most AIAN adults have experienced violence, and while rates of violence are similar for men and women, women are more likely to experience sexual violence and stalking. These victimization rates are higher for the AIAN population compared to other races. It is also important to note that among AIAN victims, interracial violence is statistically more prevalent than intraracial violence.

![Box with stats]

According to estimates in a new report from the National Institute of Justice:

- 56% of AIAN women and 43% of AIAN men have experienced physical violence in their lifetimes.
- 9% of AIAN women and 6% of AIAN men have experienced physical violence in the past year.
- 49% of AIAN women and 19% of AIAN men have experienced stalking in their lifetimes.
- 56% of AIAN women and 28% of AIAN men have experienced sexual violence in their lifetimes.
- 14% of AIAN women have experienced sexual violence in the past year.


**Historical Trauma**

Interpersonal violence is not rooted in traditional practices. Prior to colonization, indigenous ways of life focused on community interdependence and the balance of physical, mental, emotional, and spiritual health. In this way, respect for women was fundamental, and when abuse situations arose, communities dealt with them by restoring safety to the victim and holding the perpetrators accountable.

Colonization disempowered Native women from their position of power and respect as life givers and nurturers. Violence was taught to our communities through many aspects of colonialism and assimilation, including boarding schools and missions.

The collective trauma that AIAN people now hold exacerbates abuse in our communities and makes it more difficult for victims to heal from the trauma of DV. Now that the majority of AIAN people live in urban settings, Urban Indian health organizations (UIHO) must now step up to help DV survivors in their healing journey.

**Role of UIHOs in Intervening DV**

Health care providers are in a unique position to help identify victims of DV, provide referrals for support, and contribute to an organizational culture that prevents DV in our communities. Most AIAN community members are seen by a health care provider for routine medical care, and victims of DV may also seek treatment for their injuries and conditions associated with chronic mental stress caused by DV. Assessing for intimate
partner violence can be effective in identifying victims, and studies have shown that patients are generally not offended when asked about current or past DV.\(^7\)

Regular screening, early recognition, and intervention can significantly reduce morbidity and mortality resulting from DV. Additionally, screening for lifetime experience of abuse can greatly improve understanding of chronic conditions and behavioral health needs and help put an end to cycles of violence.

The Government Performance Results Act (GPRA) requires UIHOs to annually screen female patients ages 14 to 46 for DV. Additionally, California Health & Safety Code § 1233.5 requires that clinic boards adopt policies and procedures that include documenting patient injuries or illnesses attributable to DV and providing patients who exhibit signs of DV a current referral list of agencies that provide services for DV survivors.

The key to better serving DV victims and survivors at your health organization is to ensure that staff is educated about the issues and able to respond empathetically and appropriately.

Creating an organizational culture that values healthy relationships and recognition of abuse is important for prevention, intervention, and healing. According to the Substance Abuse and Mental Health Service Administration (SAMHSA), a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (SAMHSA, 2014). All health organizations are on a spectrum of trauma informed care and all people, patients and staff included, are at different levels of healing. You can find links to more information about trauma-informed care in Appendix A.

The following sections discuss ways to enhance your organization’s policies and procedures, and build a cross-functional team of champions that can work to address DV in the communities that you serve.

**Guiding Principles Adapted from Warm Springs Health and Wellness Center Guidelines for Clinical Assessment and Intervention on Domestic Violence:**

1. Treat patients with dignity, respect, and compassion, and with sensitivity to age, culture, ethnicity and sexual orientation, while recognizing that domestic violence is unacceptable in any relationship.

2. Recognize that the process of leaving a violent relationship is often a long and gradual one.

3. Attempt to engage patients in long-term continuity of care within the health care system, in order to support them through the process of attaining greater safety and control in their lives.

4. Regard the safety of victims and their children as priority.

Assessing Your Program

To assess the quality of your organization’s DV services, see Appendix B: The Family Violence Self-Assessment Tool for Health Organizations, from Futures Without Violence. This tool assesses how well an organization’s prevention and intervention efforts address family violence, including intimate partner violence, sexual assault, child abuse/neglect, and elder abuse. In completing the assessment, you will consider how office policies and procedures, physical environment, cultural environment, training, documentation, management, evaluation activities, and collaboration impact DV prevention and intervention at your organization. The information gathered can serve as a benchmark for your program to develop goals and engage in ongoing quality improvement. Futures Without Violence recommends that you complete the tool twice: once at the beginning and before you make changes, and again in six months.

Enhancing Screening

Women who talk to their primary care provider about DV are 4 times more likely to seek out DV services. When clinics do not screen for DV, it is a missed opportunity, allowing patients to fall through the cracks.

*It takes an average of 7 asks for someone to admit to being a victim of DV.* This means, by following the GPRA requirement of an annual screening, it could take 7 years to get a survivor to disclose abuse. For this reason, CCUIH advocates for universal screening, which is the most effective method to identify and help DV survivors. Universal screening means that the same questions are asked of every woman despite demographics.

The Affordable Care Act guarantees that health insurance cover screening and brief counseling for DV. As of April 29, 2015, survivors of domestic violence qualify for a Special Enrollment Period (SEP). Survivors may apply for health insurance through their health insurance exchange, such as Covered California, at anytime, rather than waiting for for Open Enrollment. To learn more about this SEP visit the Covered California website or [www.healthcaresaboutipv.org/](http://www.healthcaresaboutipv.org/).

At SNAHC, they aim to take an integrated approach to universal DV screening, by screening in the primary care, behavioral health, and dental departments. This creates opportunities for re-screening and more diverse opportunities for disclosure. When providers receive a positive screening, they can call a specific provider hotline through WEAVE, and because of their close relationship and location, a DV advocate will be onsite at SNAHC within 15-20 minutes to help the survivor. There are protocols set in place so that all departments are notified when there is a positive screen. Referrals can also be generated when disclosure occurs in group settings. For example, a public health nurse running a chronic condition support group can call the hotline and trigger the protocol to alert other providers. For quality improvement, SNAHC implements chart audits and reviews to assess where their system can improve.
While considering screening policies, it is important to keep in mind that women of childbearing age are most likely to be victims of DV, but all women and adolescent girls should be screened, in addition to men and adolescent boys who present with signs of DV. It is also important to screen caregivers/parents who accompany their children.

Patients who present with the following conditions may indicate violence in the home: substance abuse, injury inconsistent with patient’s explanation, repeated use of the emergency room, eating disorders, chronic pain syndromes, injury during pregnancy, prior history of trauma, vague psychosomatic complaints, multiple injuries in various stages of healing, a partner who will not leave the exam room, injury to the head, neck, torso, genitals, breast or abdomen, delay between onset of injury and seeking care, and psychological distress (suicidal, depression, anxiety or sleep disorders).

During a DV assessment, victims should be given information about their safety options and available resources, which should include but not be limited to hotlines and information about local DV programs. Futures Without Violence, in partnership with The National Indigenous Women’s Resource Center, created a free AIAN “Women are Sacred” education card that talks about how relationships can impact health. Tools like these can supplement verbal screening. You can find a link to order the cards and view other in Appendix A.

As you enhance your screening protocol, it is important that providers do not ask leading questions or make light of a situation, in addition to ensuring that the screening takes place in a private setting. Review the sample universal screening tool and provider script on the next page and compare it to your current screening tools. You can find links to more DV screening tools in Appendix A.

While developing your DV screening protocols, make sure to include a disclosure of limits of confidentiality due to mandatory reporting laws, which in California include Cal. Penal Code 11160, 11161, and 13823.11.

When a provider receives a disclosure, they should be prepared to help make the patient feel validated and supported. These skills can be cultivated through training from a local DV program. In order to ensure that patients with a positive DV screen get the services that they need, providers must have the resources to respond empathetically and appropriately with the knowledge to get the patient to the right services. All staff must understand the warm hand off process in order for it to work.

At SNAHC, the primary care provider uses a standard patient health questionnaire to assess behavioral health issues. When the primary care provider gets a positive DV disclosure, the medical assistant notifies the behavioral health therapist, who then offers a consult at the end of the primary care visit. At this point, the patient is given the opportunity to consider their alternatives and schedules a follow up call or next visit.

If a patient’s screening is negative, resources should still be made available by keeping take away materials in the exam rooms, and acknowledging that the UIHO can be a resource if any-
Sample Universal Screening Tool
Developed by Kenetta E. Harsh, MSN, CRNP

1. Do you feel safe at home?      Yes No
   If no, why do you feel this way?

2. Have you ever been the victim of physical abuse?   Yes No
   (hitting, punching, kicking, biting, burning, etc.)
   Comments:

3. Have you ever been the victim of emotional abuse?   Yes No
   (Neglect, name calling, etc.)
   Comments:

4. Have you ever been the victim of sexual abuse?    Yes No
   (unwanted sexual acts)
   Comments:

5. Would you want to talk to someone about receiving help?  Yes No
   Optional: Your Name ______________ Phone ____________
   Is it safe to call?  Yes No

Sample Universal Screening Provider Script
Adapted from Kenetta E. Harsh, MSN, CRNP

“We are concerned by the prevalence of violence in our community and the effect that violence has in the lives of our patients. For these reasons, we are committed to screening our patients for domestic violence and providing assistance to victims of abuse. Strict confidentiality will be maintained for all screening information. The information obtained will allow us to provide you with available community services. Please fill out the questions and return this form to your nurse. Thank you.”
thing happens in the future, or to someone that the patient knows. This step will give patients the opportunity to consider their options outside of the office and increase awareness and recognition of abuse in the community.

Some Indian health providers have opted for paper screening tools for GPRA’s behavioral health measures, including DV. This may help some victims feel safer answering questions more honestly. A sample paper screening tool can be found in Appendix D, from K’ima:w Medical Center. Because this brochure is distributed to all adult patients, universal DV screening is made even easier.

**Seen Alone Policy**

SNAHC created a “Patient Only” Policy that requires that patients be seen alone during their visit. See Appendix C to read SNAHC’s Patient Only Policy. Using this policy, which begins at age 12, SNAHC was better able to facilitate conversations about domestic violence. Implementing this policy was not without difficulties, as some patients were accustomed to coming in with their partners, but once implemented, it was clear that the policy gave patients more freedom to discuss their behavioral health challenges.

**Employee DV Policy**

A trauma informed approach to leadership and management can improve job satisfaction for employees who are survivors and limit trauma response in the workplace. Trauma informed management should include a set of policies and procedures for employees in DV situations. Employee DV policy and procedures should include guidelines for supervisors when they suspect that an employee may be dealing with DV or DV disclosures. The policy should emphasize confidentiality and include a template for creating a workplace safety plan. You can find a link for additional resources on workplace violence in Appendix A and contact DV programs to provide trainings. SNAHC was able to receive a training from WEAVE called “Violence Doesn’t Work Here,” which helped staff become more empathetic with both staff and patient survivors.

**Health Services to DV Clients**

Not only may a DV program want more options for health care referrals, but they may not have an Indian health provider in their network to provide culturally competent care to AIAN survivors. WEAVE staff suggested that UIHOs send DV programs flyers with general information about the UIHO, including specific services that clients would be interested in, such as Well Woman Visits. These flyers should be directed at both providers and clients.

Additionally, UIHOs should check to make sure that they are on the DV program’s internal referral guide, so when clients seek health services, the UIHO can be an option, particularly for AIAN clients. This internal referral guide is used for both on-site clients and those that call the support line.
Best Practice: Cross Functional Team of Champions

Developing an effective working relationship with a local DV shelter or advocacy program can drastically enhance DV intervention at your organization by improving provider confidence in screening and referrals. By connecting with a DV or sexual assault program, health care providers can access the resources to provide necessary referrals to address safety planning, housing, and legal alternatives beyond the scope of the clinic setting. Check out the Red Women Rising page on the CCUIH website to view the Domestic Violence Resource Directory to identify a program in your area.

A collaborative, goal-oriented effort is necessary for sustainable change. Through their partnership, SNAHC and WEAVE developed a cross-functional team of champions across both organizations. Agreeing on shared values and keeping each organization’s unique strengths in mind, allowed this collaboration to maintain a strength-based approach. As discussed below, this team was developed, fostered, and sustained through cross-trainings, the Buddy System, and an integrated approach to community programming.

Cross-Trainings

To enhance your organization’s capacity to help AIAN survivors, engage in opportunities for education. Cross trainings provide a way to exchange information, establish trust and common ground, and build a shared vocabulary between DV and health programs. Cross Trainings provide an opportunity to exchange materials; making family violence and sexual assault materials available in the health care setting and culturally specific health materials available in the DV program setting.

Through DV training, providers will become more confident in their referrals to DV programs as they understand the eligibility requirements and the services provided, in addition to building skills and a knowledge base that can enhance their interactions with survivors. Without this information and DV trainings, providers are less likely to engage in DV conversations because they may be worried about not knowing the answers to questions and concerns survivors bring up after DV a DV disclosure. After receiving training from WEAVE, SNAHC staff reported a significantly increased understanding of what to say and not to say to DV survivors and how to help them. Your organization can also access AIAN specific DV training through organizations such as the Strong Hearted Women’s Coalition.

One of the important lessons that SNAHC learned from trainings from WEAVE was about reproductive coercion. Reproductive coercion is when a partner is trying to get a woman pregnant against her will or control the outcome of a pregnancy through threats, intimidation, or by tampering with contraception. Now that SNAHC is aware of this relatively new concept, health and wellness educators now include this information in their prevention and harm reduction efforts. You can find a link to more information about reproductive coercion in Appendix A.

It was also important for WEAVE to receive trainings from SNAHC regarding
the specific needs and risk factors for AIAN clients, and to learn about the clinic services, so that they could confidently refer AIAN clients to receive medical care. DV programs should know about specific AIAN needs so that they are prepared to respond to clients that need to smudge, go ceremony, or other unique cultural needs. Keep in mind that it is appropriate to make the DV programs accountable to serve the AIAN population. For WEAVE, these trainings were key to increasing awareness and helping staff realize how AIAN clients may be inadequately served under general cultural competency training.

There are also health needs at DV programs that can be better served through trainings from health organizations. For example, SNAHC included WEAVE staff in mental health first aid training for personnel who are not in mental health roles but come into contact with patients who are dealing with mental health issues. SNAHC also reframed the importance of STI and HIV testing at WEAVE, and in general prioritizing the health and wellness of clients.

It may be the case that your organization is not be the best equipped to provide trainings regarding the specific needs to AIAN clients, or that further AIAN-specific training is needed. In this case, you can recommend that the DV organization reach out to the American Indian Training Institute, Inter Tribal Council of California, or check out webinars from the National Indigenous Women’s Resource Center to learn more about the specific nuances and sensitivities around providing care for AIAN survivors.

**Buddy System**

SNAHC and WEAVE developed the Buddy System to give individuals at each respective organization the opportunity to build relationships with a point person and work together to meet goals. See the Buddy System graphic below, to review which positions at the DV program were paired with positions at the health program. The Buddy System encourages open and effective inter-

![Buddy System Diagram]

The buddy system gives individuals at each organization the opportunity to build relationships with a point person. Over time, the information transfer that occurs in these relationships turns into organizational knowledge.

**SNAHC**
- CEO
- Director of Operations
- Behavioral Health Director
- Behavioral Health Program Manager
- Medical Assistant
- Home Visitor
- Health Educator
- Director of HR

**WEAVE**
- CEO
- Chief Program Officer
- Program Director
- Program Director
- DV Advocate
- DV Advocate
- DV Advocate
- Director of HR
organizational dialogue outside of larger inter-organizational meetings. Over time, the information transfer that occurs in these relationships turns into organizational knowledge. The Buddy System was key to maintaining the partnership while dealing with turnover at both organizations, by allowing new people in positions that were part of the Buddy System to get up to speed quickly and effectively.

A variety of roles represented in the Buddy System or working group are required to create sustainable collaboration. For the SNAHC/WEAVE partnership, buy-in from CEOs and key staff was integral to making organizational changes that supported collaboration. Equally important are the relationships between providers who interact directly with patients/clients; conversations between DV advocates and Medical Assistants can make a huge impact on survivor intervention. Time spent on buddy relationships depended on their level of involvement in the project, for example those that focused on programmatic activities met weekly or bi-weekly and those focused on human resources met monthly or even less.

The primary objective is to create a collaborative learning environment in which “buddies” feel less hesitant to raise questions and express their needs. The Buddy System enables participants to develop less formal relationships and support each other in dynamically. In this way, buddies were able to work together toward organizational goals, even if these goals were outside of scope of the original partnership. For example, because of their comfortable relationship, when WEAVE asked SNAHC to provide on-site medical services, staff at SNAHC were able to have a frank conversation about why they could not, but gave WEAVE resources to identify someone who could.

If the Buddy System does not sound like a good fit for your organization, your organization can set up a working group with representation from both organizations to set goals and facilitate information exchange.

Community Programming

Including community programming in your plan to address DV at your organization is key to a holistic approach. SNAHC has integrated family violence information in their Family Support Programs, such as parenting classes, family counseling, and anger management classes. These programs offer resources such as safe temporary housing, WIC, CalFresh/SNAP, and family counseling. Healthy relationship curriculum is also included in SNAHC’s Gathering of Native Americans (GONA) activities for youth, which promote culture and understanding of self, family, and community as a protective factor against substance abuse and suicide.

As part of their partnership, SNAHC also held DV talking circles for WEAVE clients. These talking circles empowered participants to shift the narrative by telling their own stories, and helped them get in tune with what they emotionally and spiritually needed. They allowed clients to share space with people that they lived with and were powerful for everyone involved, including non-Native participants.

SNAHC has integrated DV priorities into
their Home Visiting program, which provides wellness case management for low-income families with young Native children. In addition to the Home Visitors receiving DV peer counseling training, WEAVE’s Violence Prevention Navigator (VPN) regularly joins home visits for healthy family or healthy relationship education. The VPN and Home Visitor take care to conduct their screenings and education in a way that builds comfort levels with the information and does not make the participant feel targeted.

WEAVE and SNAHC offer a free Legal Clinic to the community once a month with a family law attorney at SNAHC. They realized this need after noticing that the DV advocate spent a significant amount of time at WEAVE dealing with restraining orders and custody issues that could be better handled onsite where patients are more comfortable. This clinic provides legal information for restraining orders and related matters, all family law matters including parentage, divorce, child custody, child visitation, child support, spousal support, separation, annulment, and property division.

Conclusion

By building a strong working relationship, WEAVE and SNAHC continue to work together beyond their initial funded partnership. WEAVE now has embedded AIAN staff at SNAHC, so that it is even easier for survivors to connect with DV advocates.

Agreeing on shared values allowed their collaboration to maintain a strength-based approach and the investment from leadership at both organizations was integral to their success. The education and collaboration resulting from this partnership fosters the opportunity for warm hand offs that are necessary for intervention and continuity of care.

We can all learn from this strong partnership and commitment to addressing DV. By prioritizing DV survivors, we can end cycles of violence and heal our communities.

“You are a part of something important. You are part of a community. That community values everything that you are and everything that you’re going to be.

You are not alone, so even when someone comes into your life and makes feel like you are less than, like you are nothing, you know from your core that that is never true. You are very much valued for who you are as a person in this world.”

- Dr. Cutcha Raising Baldy

#REDWOMENRISING  CCUIH
References


Appendix A: Links to Additional Resources

Healthcare and Domestic Violence
Futures Without Violence: https://www.futureswithoutviolence.org/health/
IPV Screening and Counseling Toolkit: http://www.healthcaresaboutipv.org/

Public Awareness
Red Women Rising Campaign: http://ccuih.org/red-women-rising/
Futures Without Violence: https://www.futureswithoutviolence.org/aian/
Teen Dating Violence Materials: https://thatsnotcool.com/
Native Love Campaign: http://nativelove.niwrc.org/nativelove-youth/

Culturally Relevant Trauma Informed Care
Traditions of Health: http://ccuih.org/traditions-of-health/
Nuka System of Care: https://www.southcentralfoundation.com/nuka/

Models for Holding Batterers Accountable
The Duluth Model: http://www.theduluthmodel.org/
Mending the Sacred Hoop: http://mshoop.org/resources/

Child-Related Resources
Promising Futures: Best Practices for serving Children, Youth and Parents
Experiencing Domestic Violence: http://promising.futureswithoutviolence.org/

Reproductive and Sexual Coercion
Futures Without Violence: https://www.futureswithoutviolence.org/addressing-intimate-partner-violence/

Workplace Violence
Workplaces Respond to Domestic and Sexual Violence: http://www.workplacesrespond.org/
Appendix B: Family Violence Office Self-Assessment Tool

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<thead>
<tr>
<th>FAMILY VIOLENCE OFFICE SELF-ASSESSMENT TOOL</th>
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<tbody>
<tr>
<td>Today's date:</td>
<td></td>
</tr>
<tr>
<td>Directions: Circle the most appropriate answer</td>
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</table>

Office is part of a Health and/ or Hospital System | YES | NO |
Office is part of a Public Health or Community Health Network | YES | NO |

*If your office is part of a hospital system consider using the hospital based tool, available at http://endabuse.org/programs/display.php3?DocID=265*

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<th>TYPES OF PATIENTS:</th>
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<table>
<thead>
<tr>
<th>LOCATION OF OFFICE</th>
<th>urban</th>
<th>suburb</th>
<th>rural/small town</th>
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Number of clinicians (physicians, midwives, nurse practitioners, physician assistants): | | |
Number of years Family Violence (FV) effort to improve identification and management in place at the office?: 1-24 months 24-48 months >48 months

**Definition:** *Family Violence (FV) includes child abuse/neglect, intimate partner abuse/violence, elder abuse/neglect or vulnerable adult and sexual assault. Both prevention and identification/intervention activities are included.*

**CATEGORY 1: OFFICE POLICIES AND PROCEDURES** *Deals w/ existence of program efforts, WRITTEN policies and procedure in place to support ongoing identification and management of Family Violence (FV).*

1.1 Are there official, written office policies based on current guidelines regarding the assessment and treatment of victims of FV? *If policies are understood, but NOT written, then the answer is NO. If NO, skip to Category 2. If YES, review the guideline to see if the following components are present.*

<table>
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<th>YES (0)</th>
<th>NO (16)</th>
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<tbody>
<tr>
<td>a) Definition of family violence</td>
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<td></td>
</tr>
<tr>
<td>i. child abuse/neglect</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>ii. intimate partner violence (IPV)</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>iii. elder abuse/neglect</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>iv. sexual assault</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>b) Policy on FV training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. FV training is mandated is for all office staff.</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>ii. FV training is at least encouraged for all office staff.</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>c) Is there a written universal and/or routine assessment policy in place that advocates screening all patients:</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>i. a written policy that advocates screening at least a subset of patients, such as all pregnant patients, all children for child abuse/neglect.</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
<tr>
<td>d) Defines who is responsible for assessing, i.e. MD or nurse.</td>
<td>YES (0)</td>
<td>NO (1)</td>
</tr>
</tbody>
</table>
e) Addresses confidential documentation for IPV, a way to document IPV with increased confidentiality (same method as STD's, HIV, etc).

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. If pediatric patients, includes a “code” or “term” to indicate intimate partner abuse in the chart. [Note: This is particularly important in Pediatrics because the perpetrator, if a guardian, has access to the child’s chart.]</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>f) If children are also seen in the office, does the policy address screening for child abuse/neglect as related to IPV:</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>i. Screening for child abuse/neglect if IPV is present.</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>ii. Screening for IPV if child abuse/neglect is present.</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>g) Addresses legal reporting requirements appropriate to the situation--mandated reporting (i.e. county, state, and/or affiliated institution):</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>i. child abuse/neglect</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>ii. intimate partner violence</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>iii. elder abuse/neglect</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1.2 Addresses confidentiality and privacy by having the following policies:

<table>
<thead>
<tr>
<th>Policy</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Confidentiality and privacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Private time with provider for all adolescent and adult patients.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ii. Not to confirm a patient is at the office.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>iii. No messages left on the phone machine unless the patient gives permission.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>b) Safety and security for office staff, such as when to call the police or security.</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

1.3 Is there a staff member/position “family violence coordinator,” an individual designated to update FV information/resources and secure/stock brochures?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

1.4 Evidence of an office-based violence/abuse task force group/committee.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

1.5 Does the office provide adequate staff or financial support for family violence program? (i.e. Staff time allocated to securing resources, discussion time at staff meetings, $ for training)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**TOTAL NO COLUMNS**

**CATEGORY 1** Total NO column and subtract from 26 =
**CATEGORY 2: OFFICE PHYSICAL ENVIRONMENT**  
Deals w/ the presence of violence/abuse prevention or intervention (posters) and info/resources available.  
NOTE: Multiple places in one room equal one location.

2.1 Are there posters related to violence/abuse on public display in the office?  
Total number of locations up to 10.

2.2 Are there brochures related to violence/abuse services (educational/referral information—local, state, or national phone numbers) that patients can take with them on public display in the office? i.e. in exam rooms, bathrooms, waiting room, hallways  
Total number of locations up to 10.

TOTAL 2.1 and 2.2

**CATEGORY 3: OFFICE CULTURAL ENVIRONMENT**  
Deals w/ office culture—workplace issues and cultural competence

3.1 In the last 3 years, has there been a formal (written) assessment of the office staff's knowledge and attitudes about family violence?  
YES (0)  NO (1)

3.2 Is there an office policy covering the topic of intimate partner violence in the workplace, personnel policies outline specific policies and procedures for assisting employees who are experiencing intimate partner violence? (May include contacting the Employee Assistance Program)  
YES (0)  NO (1)

a) Is the topic of intimate partner violence in the workplace (experienced by employees) covered in office training sessions and/or orientation for new employees?  
YES (0)  NO (1)

b) Are supervisors/managers trained to how to manage an employee with an intimate partner violence issue?  
YES (0)  NO (1)

3.3 Cultural Competency:

a) In the office's policies, is universal and/or routine assessment specifically recommended regardless of the patient's racial/ethnic background?  
YES (0)  NO (1)

b) Are translators/interpreters available, or is the way to access outside translators outlined, or is the National DV hotline referenced for working with victims if English is not the victim's first language?  
YES (0)  NO (1)

c) Does the policy address not using family members to translate for FV discussion and other sensitive issues?  
YES (0)  NO (1)

d) Are there referral information and brochures related to family violence available in languages of the major non-English speaking communities served?  
YES (0)  NO (1)

TOTAL NO COLUMN

**CATEGORY 3** Total NO column and subtract from 8=
**CATEGORY 4: TRAINING OF PROVIDERS**  
*Deals w/ provisions for assessing and enhancing office staff's knowledge about FV.*

4.1 Training plan for the office about FV:

| a) Are there provisions outlined for regular, **ongoing** education of provider staff (such as doctors, NPs, midwives, PAs)? | YES (0) | NO (1) |
| b) Are there provisions outlined for regular, ongoing education of nursing staff (such as RN, LPN, MA)? | YES (0) | NO (1) |
| c) Are there provisions for regular, ongoing education for non-clinical staff (reception, lab, x-ray)? | YES (0) | NO (1) |
| d) Is training part of the orientation for new staff? | YES (0) | NO (1) |

4.2 In the last 12 months, has the office administration provided training on FV or communicated FV training opportunities to staff and subsidized their attendance? | YES (0) | NO (1) |

4.3 In the last 12 months have professionals or community experts with expertise in violence/abuse provided training at the office? [Such as referral and management of batterers, child exposure to IPV, elder abuse/neglect, child abuse/neglect, sexual assault, and same sex IPV?] | YES (0) | NO (1) |

4.4 If there is a periodic newsletter, does it include updates on violence prevention/intervention issues? | YES (0) | NO (1) | N/A (0) |

4.5 If there are regular staff meetings, do periodic discussions occur about violence/abuse issues? | YES (0) | NO (1) | N/A (0) |

**TOTAL NO COLMUN**

**CATEGORY 4 Total NO column subtract from 8 =**

---

**CATEGORY 5: ASSESSMENT**  
*Deals with tools and resources for proper assessment of FV*

5.1 Have standardized assessment instruments (written, computer prompts, and/or verbal) been included on the medical record forms to assess patients for issues of violence and healthy relationships?

<table>
<thead>
<tr>
<th>a) Type of abuse assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. child abuse/neglect</td>
</tr>
<tr>
<td>ii. intimate partner violence</td>
</tr>
<tr>
<td>iii. elder abuse/neglect</td>
</tr>
<tr>
<td>iv. sexual assault</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Forms on which any of the below are present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. on the health information form</td>
</tr>
<tr>
<td>ii. physical exam form such as well child/teen/ adult or prenatal care.</td>
</tr>
<tr>
<td>iii. office visit form</td>
</tr>
</tbody>
</table>

5.2 What percentage of eligible patients have documentation of FV screening (based on a random sample of 20 charts) in the past 12 months?

| not done | 5 |
| 0-10% screened | 4 |
| 11-25% screened | 3 |
### CATEGORY 5
Total NO column and subtract from 12=

### CATEGORY 6: DOCUMENTATION
Deals with tools for proper documentation of FV

6.1 Is there a standard intervention checklist, electronic resource or card prompt for staff to use/refer to when victims are identified?

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
<th>N/A (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) for child abuse/neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) for intimate partner violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) for elder abuse/neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) for sexual assault</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.2 Are the following tools available:

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
<th>N/A (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) a body map to document injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) safety assessment (IPV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) safety plan (IPV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) risk assessment tool for lethality (IPV)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.3 Is a digital camera or a camera with film available for photographs?

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) If so are staff trained to use the camera?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Are photo consents available?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Are photographs offered to all patients with physical injuries?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CATEGORY 6 Total NO column and subtract from 12=

### CATEGORY 7: MANAGEMENT
Deals with tools and resources for proper management of FV

7.1 Are lists of local family violence resources available in the office? If no local, then are state or national resource numbers/materials available?

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
<th>N/A (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) child abuse/neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) intimate partner violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) batterer’s programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) elder abuse/neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) sexual assault</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.2 Is there a list of mental health counselors knowledgeable about FV?

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
</tr>
</thead>
</table>

7.3 Are there on-site victim advocacy services regularly or periodically available? [This does not include a social worker, see 7.4]

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
</tr>
</thead>
</table>

7.4 Is there a social worker available on site?

<table>
<thead>
<tr>
<th>Section</th>
<th>YES (0)</th>
<th>NO (1)</th>
</tr>
</thead>
</table>
7.5 Is there a clinician or nurse who is a champion in the office for violence/abuse prevention or intervention? | YES (0) | NO (1) |
---|---|---|
7.6 Are there procedures to assist with safe transport from the office to shelter? (For example, bus tokens or taxi vouchers or mechanism appropriate to the area.) | YES (0) | NO (1) |

**TOTAL NO COLUMN** |  |

**CATEGORY 7** Total NO column and subtract from 12= |  |

**CATEGORY 8: EVALUATION ACTIVITIES** Deals with the evaluation and monitoring of the office’s FV efforts

8.1 Does the office have a plan for monitoring FV patient issues as part of the quality assurance process? [NOTE: Monitoring a segment of patients such as only pregnant patients is YES.] | YES (0) | NO (1) |
---|---|---|
a) Is there a confidential list of FV patients that are tracked and monitored? | YES (0) | NO (1) |
b) Does the process include peer-to-peer case reviews around FV and feedback? | YES (0) | NO (1) |
c) Is there a mechanism to periodically assess and document percentages of eligible patients screened? | YES (0) | NO (1) |
d) Are there incentives/positive reinforcers to promote screening and prevention efforts? | YES (0) | NO (1) |

8.2 Is there any measurement of client satisfaction and/or community satisfaction with the office’s FV program? | YES (0) | NO (1) |

**TOTAL NO COLUMN** |  |

**CATEGORY 8 Total NO column and subtract from 6=** |  |

**CATEGORY 9: COLLABORATION** Deals with efforts to collaborate w/ others: community agency(ies) or other divisions/offices within the health system or network.

9.1 Collaboration with the office’s FV program and other offices in the same health system/community or public health network: (If the office is not part of a system, then N/A):
---|---|---|---|
a) collaboration with training | YES (0) | NO (1) | N/A (0) |
b) collaboration with policies and procedures | YES (0) | NO (1) | N/A (0) |
c) collaboration on the Family violence task force | YES (0) | NO (1) | N/A (0) |
d) collaboration with on site services | YES (0) | NO (1) | N/A (0) |

9.2 Does the local office send a representative to the community or county's coordinated community response meeting? | YES (0) | NO (1) | No such effort locally N/A (0) |

9.3 Does a staff member or clinician from the office work with the community child protection or adult protection agency? | YES (0) | NO (1) | If serve only women N/A (0) |

9.4 Does a staff member or clinician from the office work with the local sexual assault or victim’s services agency? | YES (0) | NO (1) | If serve only children N/A (0) |

**TOTAL NO COLUMN** |  |

**CATEGORY 9 Total NO column and subtract from 7=** |  |
<table>
<thead>
<tr>
<th>Office Score</th>
<th>Multiply Score x</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATEGORY 1</td>
<td>x 0.45 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 2</td>
<td>x 0.80 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 3</td>
<td>x 1.58 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 4</td>
<td>x 1.29 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 5</td>
<td>x 1.05 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 6</td>
<td>x 0.99 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 7</td>
<td>x 0.88 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 8</td>
<td>x 0.88 =</td>
<td></td>
</tr>
<tr>
<td>CATEGORY 9</td>
<td>x 1.30 =</td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>
Appendix C: SNAHC’s Patient Only Policy

Patient Only/ (Patient Privacy) Policy

Purpose:
The Purpose of the “Patient Only Policy” is to provide patients with an opportunity to respond to questions regarding their personal safety, reproductive choice, address mental health concerns and any other highly personal issue directly with their provider void of influence from a caretaker or family support person.

Policy:
Federal and state law requires that all patients including qualified minors are entitled to confidentiality protections as required by federal HIPAA law (Pub. L. 104–191). If the patient is determined to be incompetent or unable to understand their medical treatment due to a physical or medical disability it will be recorded in the medical chart.

A patient is competent if the patient (1) understands the nature and consequence of his/her medical condition and the proposed treatment and (2) can communicate his/her decision. Providers can make their own assessment of a patient’s competency and do not need a judicial ruling or psychiatric diagnosis in order to find a patient incompetent.

Procedure:
During the initial visit to Member Services, it will be identified that a patient may need assistance performing regular daily activities. This will be identified and confirmed by Member Services staff using the “Daily Activities Section” of the patients health history form.

When assessing whether the patient understands the nature and consequences of his/her medical condition (and can communicate his/her decision) take into account the following:

1. Always start with the presumption that a patient is competent.
2. Minority age alone is not a sufficient basis for determining if someone is incompetent. The law specifically deems minors capable of providing consent in certain medical situations (CFC 6925).
3. Physical or mental disorders alone are not a sufficient basis for finding incompetency.
4. The nature and consequence of the medical condition must be explained in easy to understand terms.
5. Believing that the patient is making an unwise or “wrong” medical decision is not a sufficient basis for finding the patient incompetent.
6. Competency is situation specific. A patient deemed incompetent in one situation may not be considered incompetent in all situations.

When Member services identifies a lack of competency, the Release of Information (ROI) process identifying the caretaker, family member or appropriate support person is identified and documented per SNAHC requirements.
Charts will be flagged notifying Patient services staff, Medical Assistants and Providers of caretaker inclusion in patient visit. Signage will be posted throughout clinical departments “Patients only beyond this point”

Training Staff and Providers

- Lay out the course of the visit, for example ( “We will spend some time talking together about Joseph’s health history and any concerns that you or he might have, and then I will also spend some time alone with Joseph. At the end of the visit, we will all meet together again to clarify any tests, treatments or follow-up plans.”)
- Explain your office/clinic policy regarding adolescent or impaired visits.
- Validate the caregiver’s role in the patients’ health and well-being.
- Elicit any specific questions or concerns from the caregiver
- Direct questions and discussion to the patient while attending to and validating caregiver input.

Remove
1. Invite the parent/caregiver to have a seat in the waiting area, assuring them that you will call them prior to closing the visit

Revisit
2. Once the caregiver is out of the room, revisit issues of consent and confidentiality with the patient, including situations when confidentiality has to be breached (suicidality, neglect, abuse, etc.).
3. Revisit areas of parental/caregiver concern with the patient and obtain the patients’ perspective.
4. Conduct the psycho-social interview and physical exam (ascertain whether the patient desires caregiver’s presence during PE and accommodate patient preference).
5. Clarify what information from the psycho-social interview and PE the patient is comfortable sharing with caregiver.

Reunite
6. Invite the caregiver back to close the visit
Appendix D: Wellness Screening Questionnaire

This tri-fold brochure is from K’ima:w Medical Center and was presented at the 2016 California GPRA Best Practices Conference. This brochure is easy, quick, and confidential, and covers all GPRA prevention questions (as of 2016). When staff hands this out they also hand out packets of literature created to cover the educational requirement. The inside of the brochure is below and the outside of the brochure is on the next page.

**Tobacco Use Screening**

Do you currently smoke tobacco or use chewing tobacco?

A. No
   1. Never used Tobacco
   2. Quit Smoking or chewing less than 6 months ago.

B. Yes
   1. Smoke
   2. Chew Tobacco
   3. Both

How often do you smoke or chew tobacco?

A. Everyday
B. Some days, but not everyday

Are you ready to quit?

YES NO

When you are ready to quit, we can inform the Provider to assist you today.

**Alcohol Use Screening**

Have you consumed, beer, wine or other alcohol beverages in the past?

YES NO

A. On average how many days a week do you drink? _____.
B. When you drink, how many drinks do you usually have? _____.
C. When was your last drink? ____.

**Activity Screening**

How active are you?

A. Very active (Engage in 5 hours of physical activity per week.)
B. Active (Engage in 2 1/2 to 5 hours per week.)
C. Some Activity (Engage in less than 2 1/2 hours of physical activity.)
D. Inactive (Little or No activity.)

**Intimate Partner Violence Screening**

Have you ever been in a relationship with a person who has physically or emotionally hurt you?

YES NO

Are you currently in a relationship with a person who physically/emotionally hurts or threatens you?

YES NO

Do you feel safe in your current relationship?

YES NO

**Depression**

In the last 2 weeks, how often have you been bothered by:

A. Little interest or pleasure in doing things?
   0. Not at all
   1. Several days
   2. More than half the days
   3. Nearly everyday

B. Feeling down, depressed or hopeless?
   0. Not at all
   1. Several days
   2. More than half the days
   3. Nearly everyday
WHY WE ASK THESE QUESTIONS?

K'ima:w Medical Center is committed to providing complete and comprehensive care for our patients.

Part of providing this care is to screen for conditions like Depression, Intimate partner violence, Alcohol abuse, and Tobacco use. The questions in this brochure will help us to know when to pursue additional help for our patients.

The information you provide is part of your medical record and is confidential.

In some cases concerning active domestic violence, KMC is required by law to report to the authorities.
**Artist Biography**

CCUIH was pleased to work with Sarah Biscarra Dilley on the Red Women Rising Project, whose art is featured in multiple infographics above. Sarah is a multidisciplinary artist and weaver currently residing in the unceded homeland of the Ohlone people. She is a member of Black Salt Collective, whose liminal and ever-expanding body of work expresses a contemporary non-linear identity in which experience results in atmosphere.

Her interdisciplinary process explores the spaces between the worlds; between blood sickness and bloodlines, between grief and joy, between body and land. Being raised in Chumash, Chicano, and queer family traditions between urban and rural environments has directly informed her understandings of embodiment and place as spatial, temporal and grounded in relationship. Anchored in the intention and practices of indigenous resurgence through contradiction, complexity and communion, she uses found footage, cut paper, archival material, handwork, language and thread to trace landscapes of indigenous resilience and shifting relationships of belonging, displacement, and home.

Her academic and visual work has been exhibited nationally and internationally, individually and with Black Salt Collective. Sites of engagement include: Yerba Buena Center for the Arts, California Historical Society, University of California at Santa Barbara, SOMArts Cultural Center, First Peoples House at University of Victoria, Intertribal Friendship House, Toronto Free Gallery, Open Engagement, and Native American and Indigenous Studies Association (conferences at UC Davis/Sacramento and Washington D.C).

While much of her foundations are shaped by body, land, and the worlds in and around us, she has a BA in Urban Studies from the San Francisco Art Institute and is currently pursuing a PhD in Native American Studies at University of California, Davis. She is full of birds.