



There is tremendous potential for health IT to develop and implement tools for universal assessment and response for domestic and intimate partner violence (DV/IPV), particularly in the context of electronic health records (EHRs). A wide range of health care providers and community-based organizations could have the prompts needed to do universal screening, assessment and referrals right at their fingertips.

The Federal Health IT Strategic Plan makes important strides to encourage the adoption of robust and interoperable health IT systems—and Futures supports this goal. At the same time, we encourage federal policy makers, developers, vendors, and a wide range of health care providers to pay special attention to how to make these systems patient-centered with a focus on the unique needs of survivors of DV/IPV. There are many vital considerations for privacy and security—and detailed ideas about how best to integrate screening and referral tools. We understand that these will take time to fully integrate, and we look forward to working with policymakers to implement them.

Our specific comments about where special attention should be paid to the needs of survivors of DV/IPV follow.

**Goal 1: Expand Adoption of Health IT**

***Objective A: Increase the adoption and effective use of Health IT products systems and services***

Community-based providers, including domestic violence advocates, would benefit from use of an integrated EHR as they fill important medical, behavioral and other support services. As policy aims to increase the number of providers “across the care continuum who use interoperable health IT products, systems, and services” we encourage a strong focus on the integration of community-based providers as part of the health IT movement.

**Goal 2: Advance Secure and Interoperable Health Information**

***Objective A: Enable individuals, provider and public health entities to securely send, receive, find, and use electronic health information***

Futures Without Violence generally supports the use of interoperable health IT to increase care coordination across all providers through innovative care and payment models, shared care plans and integrated medical and behavioral health services. Working together, multiple members of the care team can provide a multi-faceted response to provide survivors the medical and behavioral services they need over the course of a lifetime.

However, survivors of DV/IPV have unique patient safety needs. More than anything, these individuals need to understand how their health records are being shared and who can access their health records and under what circumstances. Trusted providers must also be empowered to control the flow of data and limit access to EHRs in certain situations and in emergencies.

We underscore the necessity for EHRs to be protected *per patient preference*. All patients who disclose abuse should be offered preference on how or if their health records are used and or shared. They must understand the limits of the confidentiality—and understand what other providers may be able to access their information. Abusers may work as providers or as health system employees; in rural areas, the abuser or their extended family could be the only health provider in town. Medical providers are in a trusted position to provide support and services but victims will be reluctant to disclose abuse if they believe their medical record could be accessed by the abuser.

***Objective B: Identify, prioritize, and advance technical standards to support secure and interoperable health information***

It is critically important that standards are developed to support interoperable health information, and that attention is paid to allow for data segmentation and the redaction of sensitive health information.

***Objective C: Protect the privacy and security of health information***

There are new and emerging safety and privacy concerns with the move to electronic health information exchange, and with the ability of the whole care team to access a patient record. The policy governing these types of exchanges are being developed now and safety questions must be addressed. How will sensitive health information be redacted or blocked so that only those providers whom the victim gives permission to have access to the data?

Certain data or diagnosis codes should be always redacted from push/pull functionalities. Domestic violence should be considered sensitive health data and any references to it should be blocked or redacted in EHRs, HIEs, Explanation of Benefit letters and any other communications.

**Goal 4: Advance the Health and Well-Being of Individuals and Communities**

***Objective A: Empower individual, family and caregiver health management and engagement***

Individuals should be given choices of how they would like to communicate with—and receive communications from—their providers and plan, including by phone, email, etc., and under what circumstances. Communication preferences should be built in to electronic health records as mandatory fields.

Individuals have a right to access and request a copy of their health records. In the case of a victim of DV/IPV, the ability to review records—particularly in an electronic format—may increase trust in a provider and a deeper understanding of how his or her confidentiality is being protected. If the victim can see that information is presented in a thoughtful way, he or she may be more willing to trust that provider and not worry that inaccurate or incomplete information will result in retaliatory violence if

viewed by the abuser. It also would give the victim the ability to change his or her privacy settings, contact information, or consent from a safe, remote location if necessary.

***Objective B: Protect and promote public health and healthy, resilient communities***

FUTURES supports increased collection of population data (and access to this data) regarding an individual's exposure to violence to promote public health and health care collaboration.

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