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>> Thank you all for standing by for today's conference. Please continue to hold. We will begin today's call momentarily. Again, please continue to hold. Thank you.

(captioner standing by).

>> MODERATOR: Welcome, and thank you all for standing by. At this time I would like to inform all participants that your lines have been placed in a listen only mode for the duration of today's presentation.

Today's call is also being recorded. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Ms. Jane Segebrecht, you may begin.

>> JANE: Great. Thank you so much. Welcome to the audience today. We know some folks are trickling on. We're excited to get started. We're glad everyone could join us today. Thank you on

behalf of the HRSA for joining this webinar, Sheltering in place, intimate Partner Violence and the response.

Today has three partners from the U.S. Health and Human Services and Health Services Resource oip administration, HRSA, Office of Regional Operations, Region 9, and Administration for Children and Families Family and Youth Services Bureau, Family Services Bureau or FSB.

We are hosting today's event as National Women's Health Week. And serve as reminder especially during the COVID 19 public health emergency to make their health a priority and take care of themselves. During today's webinar you'll learn about practical approaches to support your organization and your response to COVID 19, and our first presentation will be from Futures Without Violence and it's a leader on domestic health and violence. Then we'll hear from a frontline perspective from Dr. Kimberly Chang a HRSA supported health center in California.

A few housekeeping items at the start. Please feel free to type your name and organization you're joining with today into the chat box. We will not have a formal question and answer section, so if you have any questions as the webinar proceeds, please type them into the chat box and we'll try to respond to you individually.

If you would like to download today's slides and resources, please refer to the File Pod which is in the lower right hand corner of your screen. In the event that there are connection issues, we encourage everyone to download the slides at the start of today's presentation and that way you can follow along individually if you need.

I will now pass it over it our first speaker, Commander Nancy Mautone-Smith the acting direct of the HRSA Office of Women's Health. This is Nancy Mautone-Smith the Acting Director and above of HRSA and Office of Women's Health. I welcome you to this webinar. I'd like to personally thank HRSA staff, Jane and Jessica at the Office of Regional Operation Staff, Captain and Katrina Songco for work to make today's webinar to happen. I also would like to thank many other programs along with ACF grantee Futures Without Violence will be presenting much of the document today.

We provide a much needed health services to peep geographically isolated, economically or medically vulnerable and fund more than 3,000 awardees and serves tens of millions of people every year, including those living with HIV and AIDS, pregnant women, mothers and families, and those otherwise unable to access quality healthcare.

Next slide, please.

HRSA Office of Regional Operation has been critical to advancing HRSA's prevention work as their national network of 10 regional offices strive to increase access to quality care, information and resources throughout outreach and monitoring emerging regional and state trends. Their engagement with regional and local stakeholders were the key catalyst that led to this webinar today.

During these public health emergencies, individuals and community states are in precedent stress and numerous reports of increased intimate partner violence across the nation. Fortunately, there are resources that can help healthcare providers respond to domestic violence or the victims experiencing it.

And with that I'm pleased to introduce our next speaker, Elizabeth Darling Commissioner of Administration of Children Youth and Families.

>> Elizabeth: Hello, everyone. Thank you so much for joining us today. Thank you Commander, for the introduction. I'm Elizabeth Darling commissioner of the administration of children youth and families. We're house the under the umbrella of division to children and families. We address a variety of issues involving children, youth, and families and engage in robust research and evaluation to inform our work.

In our programs, with the address the intersecting issues of child welfare, domestic violence, homeless youth, and prevention of teen pregnancy. I'm happy to share remarks today about the family violence prevention and services act program.

Next slide, please. Congress first passed the Family violence Prevention and Services Act as part of the Child Abuse Amendment of 1984. FVPSA made history by being the first dedicated resource dedicated specifically to expand and support domestic violence shelter, services, and am practices.

After 35 years of significant efforts to meet the needs of survivors of domestic violence, in accomplishing significant system's change work, FVPSA remains unique. FVPSA supports community driven solutions to address domestic violence and promotes partnerships among FVPSA funded programs with community based agencies, services, and supports.

FVPSA serves millions of victims or survivors each year through our grants to shelters, community based programs, tribes, and hotlines. The majority of those served receive nonresidential services such as advocacy, support groups, legal or housing assistance.

Next slide, please. Should be Slide 7. Thank you.

FVPSA provides funding for state domestic training coalitions and a network of training and resource center in culturally specific institutes. The national domestic hotline and the Strong Heart Native Helpline. Community connectedness is a social determine determinant of health and specifically a protected factor against domestic violence. FVPSA going out to 1600 places, this network of technical assistance providers helps us to build resilient communities and support the healing of survivors and their children. With greater community and social networks, then the less likely women are to experience domestic violence or to return to an abusive partner.

My vision is that every community has a multi-disciplinary community based trauma informed, integrated system of care. Working together at the Federal and State levels to leverage resources and expertise helps us to bring that vision to life. Next slide, please.

Our Federal partnership with HRSA's Office of Women's Health and HRSA Bureau of healthcare through Project Catalyst is an excellent example of leveraging federal and state resources to affect practice and policy change.

Project Catalyst, statewide transformation on health and intimate partner violence is focused on fostering collaboration around domestic violence, sexual violence, human trafficking, and health leadership at the state and community level to improve health and safety outcomes for survivors.

You can see the states and territories that have been engaged in stages one, two, and three of Project Catalyst and we're currently modifying implementation of Phase 3 due to the current COVID 19 Public Health Emergency.

These states and territorial leadership teams' work together to promote state level policy and systems changes, to engage community health centers and victim advocacy programs to partner with one another on trauma informed practice transformation. Great universal education about intimate partner violence and human trafficking response into healthcare delivery statewide, and to train HRSA funded public health clinics in their respective state or territory.

Now I'd like to hand it over to our presenters from Futures without Violence. We're very proud of the work that the Health Resource Center on Domestic Violence has done with Project Catalyst among other key health system changes and we also value the great work being done by the promising futures children services capacity building team. The next person you'll hear from is Anna Marjavi.

>> ANN: Thank you Commissioner Darling and Commander for your work. I would like to extend thanks to Jane and all others for organizing the webinar and giving us a chance to present. Good afternoon to everyone and hello from San Francisco. I'm Anna a program director at futures Without Violence and in San Francisco. I'm joined by several colleagues that you can see at the top of this slide and Anisa and I work with our national health resource center on domestic violence that Commissioner Darling was talking about and Mie and Leianna work with promising futures capacity building center that focuses on families with children experiencing domestic violence. L you'll hear from the four of us today and also on the bottom of the slide you'll also hear from Dr. Kimberly Chang a physician and human trafficking and healthcare policy fellow atation Health Services and Vice Speaker for the House for the National Association of Community Health Centers and so today the five of us are going to share strategies to promote safety, support, and health access for survivors of intimate partner violence and trafficking and also some points for parents as well in the time of COVID 19.

I'm going to pass it now to my colleague, Leiana who will tell us about the impact of COVID 19 on survivors, trauma, and abuse.

>> Thanks, Anna. Good afternoon, everyone, my name is a program director at futures woip without Violence I'm based in the Boston office. I want to start the presentation by saying thank you, thank you to all of you on the line for your work that you're doing every day to support families and help folks be healthy and safer. We know that community health clinics and programs are on the frontlines of this crisis and you're all implementing creative and innovative strategies to provide clinical services for families.

Programs are open and ready to help, and for that I'm so thankful. I've heard stories of advocates wearing purple scarfs at grocery stores and putting cards in grocery bags. Advocates are writing messages on pizza box, clinicians using chat during tele-house to avoid being overheard by abusive family members and innovation and shape shift are happening all over in the response to the process.

COVID 19 has changed our entire world. It is upended life as we know it from how we work, play, and live. No corner of our world has been untouched by the public health crisis. Many have lost loved one and many are struggling financially and emotional as we all try to embrace the reality. For me, I have two small children, a 3.5 year old and 8 month old with an underlying health condition, trying to keep

them safe, do my work, manage anxiety and keep the house together is overwhelming. I know many of you on this webinar can relate.

When we turn our attention to survivors of family violence, we all know that COVID 19 has made everyday survival that much more difficult. It is intensified isolation and so many of the dynamics that perpetuate violence. It's also put a spotlight on systemic and social inequalities that have always been there. COVID 19 has had tremendous impact on people surviving violence, including children and youth. Survivors may no longer be able to leave due to work. Children may be home with the person sexually assaulting them. Parents are now trying to take care of kids, home school, and maintain income. Children are often thought of school or activities as safe havens no longer have access and may even be difficult to reach out to friends or other support networks.

Increased stress and proximity to the person using harm may also intensify the abuse. Systemic inequities are contributing to increased burdens for marginalized and oa prosed communities. Increases likelihood of chronic health conditions due to the social determinants of health and higher likelihood of being laid off or working a lower paid job with little time off and lack of access to childcare.

We know from the data that indigenous and black and brown families are faring the worst right now with the disproportionately high numbers of COVID 19 cases. All of these factors increase burden, stress, and trauma on adult and child survivors.

We are also hearing mixed information from the field about it. In some states and communities, reports are down. In some, numbers are up, and this can be attributed to several factors. Many people are isolated, more so than ever. Our systems are often set up for surveillance and monitoring and those entry points and many safety nets aren't as readily available such as schools, workplaces, activities, healthcare, those can drive reports down.

Some states are sharing lower rates of child abuse reports but an increase in hospital visits from major injuries for children, and we're also hearing about increased call to the hotlines and networks calls are up from March and April. Report 50% of calls are from minors asking for help and information, and sometimes making disclosures, and many were actually asking for information for peers they were worried about. This suggests that violence is escalating and increasing for many. There is a need for us to get creative in our responses across all forms of violence.

Next slide.

Another slice of this issue of human trafficking and increased risk during this crisis. Trafficking is an issue that affects the most vulnerable people, those with disparities related to health, housing, food, disability, immigration status, income, racial, sexual, gender discrimination, and others. People who experience homelessness are higher risk of sexual trafficking and exploitation. Traffickers pray on children with minimal social support. Children experiencing violence at home, homelessness or those in foster care have limited networks to turn to in times of stress are particularly at risk. When you add in the current six of COVID 19, things get much harder. We are hearing from advocates that youth who are aging out of foster care and relying on housing through college have had those supports ripped away. The sheltering in place rules have limited options such as staying with friends or staying with family, and this can lead to a rise in survival sex work. Housing insecurity and job loss leads to increased vulnerability and trafficking. With everyone staying at home, there is increased online activity for all of

us, and this increases pedestrian tree recruitment by traffickers. This increased stress and violence at home, more youth are thinking about or actually running away and also making it more vulnerable.

So, next slide.

What can we do in the face of this? I want to offer some principles that we have developed as an organizing framework as a humble offering to programs and advocates to inform their policy practice and program design. These nine principles were extracted from research and literature on trauma, adversity, and resilience. The principles are designed to support strategies that reduce stress and burden on children and families, especially those experiencing violence. We have been talking to a lot of groups about these, so we offer these for your consideration as you innovate and develop strategies. You know your systems and communities the best and can use these as a guide to develop solutions. Consider what you're already doing, how they apply to these principle, and how you can use these to expand your strategies.

Reduce burden and stress, enable positive family interactions between the child/parent and sibling/sibling. Prioritize safer and more stable living conditions, promote equity. We have seen just how inequity our current systems and responses are. This is one that should really drive our efforts in distribution of resources. Encourage predictability and harm reduction along with healthy social, and spiritual community connections.

Next slide. Can folks still hear me?

>> Yes.

>> Okay. Great. Thank you. So build and practice core life skills with children and families, including problem solving and planning, growth mindset, physical and emotional regulation and incremental goal setting. We hope to encourage you all beyond creating awareness or teaching you, but to create the actual conditions that help people use it and practice them. It's important to set small goals and not overwhelm folks and just build agency. Limit restrictions. It's time we check ourselves. Which rules and policies can we ease up on or change to support family agency and increase safety? Foster joy. All people. Not just children need to have positive experiences. It's not just about reducing stress and burden, but creating joy and fun for families. Collaborate with others. Everything is hyperlocal right now so look for partnerships in your community, library, schools, food banks, online neighborhood parent communities, grocery stores, and others.

These principles are about supporting families to take the actions that they believe will help them and not what we believe will help or make them jump through hoops to reach us. I want to thank you all again for the work that you do and hope the principle can provide a frame for your practice innovation, and now I hand it over to my colleague, Anise who will share more. Thank you.

>> ANISE: Thank you. As many of you know, most community health centers and DV programs remain open and continue to support survivors and children during this public health emergency, whether that's in person or virtually. Health centers are one of the few places that people are still allowed to go even with shelter in place restrictions and many are also being seen via telehealth, so health centers in a sense are really uniquely positioned to support survivors.

Many DV advocacy programs also continue to operate and have adapted their services to meet the needs of survivors and their children during this time. So, we'll be highlighting some key services offered by each setting and we'll also walk through the benefits of community health center and DV program partnerships.

Next slide, please. So, DV programs often serve as primary referrals for both domestic violence and trafficking survivors, and in fact for many survivors of trafficking, they may contextualize their experiences within the context of relationships. For example, referring to them as a boyfriend, daddy, or house. Domestic violence advocates really have the know-how to work with and support all survivors through immediate and long term safety planning and making survivors aware of the unique legal, criminal, and housing supports that are available to them.

Some communities might also have human trafficking specific programs which are often embedded within criminal justice systems so folks can assess what's available in individual communities and can expand their partnerships.

Also, folks should become familiar with the current operations and hours for DV programs in their area and so while DV services are up and running, some operational protocols may have shifted due to the current public health emergency.

So, for example, in some states, DV programs are now housing survivors in hotel rooms if they've been exposed to COVID 19 rather than in their shelter, and then in other states, support groups are being held virtually rather than in person.

Next slide, please. So, federally funded community health centers are both community based and patient directed organizations, and they provide services regardless of a patient's ability to pay, and they also charge for services on a sliding fee scale. They deliver comprehensive primary care and also often include a pharmacy, mental health services, substance abuse programs, oral health services and pregnancy perinatal and post-partum care. Community health centers also have supportive services such as health education, language translation, and transportation that promote access to healthcare.

And then some health centers also focus on special populations, including those experiencing homelessness, migratory and seasonal agricultural workers, and then residents of public housing, and they are also located in areas where economic, geographic, or cultural barriers limit access to affordable healthcare services.

So you can actually use the Find a Health center Tool up on the screen and that can help you to locate the health center that's closest to you. Next slide, please.

So we've talked about what those health centers and DV programs each offer survivors, and we also want to emphasize how formalizing partnerships between the two can really be instrumental to support survivor health and promote safety in a coordinated way. Health centers and DV advocacy programs have shared health and safety goals and they both serve clients at increased risks for COVID 19.

For example, those that are living in close quarters with others, people who are experiencing homelessness, elders, people with chronic health issues, and those who are immune compromised, for example, people living with HIV.

And our goal with DV advocacy programs and health center partnerships is to develop and enhance these relationships and build bidirectional referrals to increase health access and promote safety. This is true not only for their clients or patients, but also for their staff who sometimes need the same types of support.

DV programs can attempt to help these for survivors and children entering DV programs or by calling hotlines, and increase their health access by providing referrals to a partnering health center, and health centers can improve health and safety for survivors accessing health centers and can promote universal education messages around intimate partner violence and human trafficking, which we'll talk about shortly and can provide a referral if needed to the partnering DV program.

The staff from both agencies can also benefit from this partnership personally as they themselves may need this type of support for themselves, friends, or family members. And children can also benefit from these partnerships by removing barriers to health and mental health services which can include trauma informed interventions and child well visits, and with that I'm going to pass it to my colleague, Anna.

>> ANNA: Thanks. Next slide, please. Right now as many of you know on the line and also might be a part of, health centers have been getting up and running with telehealth offering patient visits remotely by either screen or phone, and because of the isolation that was described earlier, healthcare providers really might be the first and perhaps only person reaching out to a patient or the first person the patient has been allowed to speak to outside of their home, and in fact, you might also be the only person who has shared a kind word with the patient in the past few weeks or months, and so we really see this as an opportunity to reach out and support survivors of violence and exploitation using telehealth, but we also recognize the reasons that some people may not feel safe disclosing abuse or trafficking, and so we want to spend the next few minutes offering you a universal education approach which can reach all patients with information about healthy and abusive relationships and exploitation and where they can go for more information or for help.

We call this approach CUES. Next slide, please. So in order to talk about violence or exploitation with patients but decrease risk, we do recommend offering a universal education approach on IPV and trafficking, and in place of a screening tool that poses, yes/no questions to a patient. This practice shift is really critical for patients who may have a long history of distrust in systems or who may fear further violence or harm in terms of answering the questions and really are just unable to say, yes, or talk openly about what's going on.

So looking at the slide, CUES stands for each step of the intervention, confidentiality and making patients aware of any limitations, universal education on both IPV and exploitation, empowerment, which is sharing information not only with the patient but also as something that they can share with family or friends, and then support, which includes making those connections to local advocacy programs as Anise talked about and also sharing validating messages for those who choose to disclose. While CUES is typically done in-person using a brochure or safety card that some of you might be familiar with, we adapted now for telehealth with enhanced scripting that we'll share with you. Next slide, please.

So while today I'm not going to get into all of the actions that are associated with CUES, you can learn more online on our online toolkit at IPVhealthpartners.org that will walk you through more and provide

additional types of guidance like you can see on the slide, which includes things like pointers to enhance patient privacy during virtual health visits, sample scripts, providing guidance on universal education and how to respond to disclosure, and we also, you know, consider principles like how to enhance patient privacy and ways to share resources safely, as well as pointers for patients to enhance their own privacy, thinking about their digital footprint.

Another big piece of guidance that we offer on the online toolkit is what Anise was talking about, which is how health centers can really partner closely with local domestic violence programs, and this will really support the way that your staff are offering those warm, bidirectional referrals to one another's programs, and at the same time, letting your patients know a little bit about what the local domestic violence program offers and the role of an advocate and how to reach them.

Next slide, please.

So, many of you who are either healthcare practitioners or healthcare staff are already opening your patient visits with COVID 19 related questions as well as acknowledging with your patients as was talked about, that it's really just a hard time for all of us right now and that the stress can feel overwhelming.

A conversation like this can also serve as a bridge to then discuss intimate partner violence, and so on the slide is one sample script which I'll read at this time because of the stress we're sharing about information about resources not available. For example, with he may experience stress in our relationships including increased fighting or harm and that can affect your health and parenting. There is a free, confidential help available to you or someone you know, if someone you know is being hurt or is being hurt in the relationship.

So, of course, you know, you can adapt that script to fit your own language, your own style, and just know that trusting the patient to help be a public health advocate and share the information with their friends and family really helps them heal, it helps others, and ensures that they have the information if they need it, you know, any time down the line, but perhaps can't disclose to you in your you know, over the phone or in a telehealth visit.

Providers can still ask direct questions and state any concerns they may have for the patient, but you've also opened up a space there for the patient to disclose or not, and again, the provider should always ask if it's okay before following up with resources, whether they're in the mail or a text or an email. You want to make sure that that works for them and that's a safe way to reach them.

Next slide, please.

On this slide, similarly, can you see a sample script on providing universal education related to human trafficking and I'll read it. Many people are also feeling pressure around money and paying rent or bills. Sometimes others take advantage of people for work and also for sex. So we're sharing information about resources that are available if you find yourself in a situation like this. Can I give you unemployment resources, housing and food support, and other things to share if you know someone who needs it?

And again, that script can be adapted, you can put it in your own language, fit your own style, but it's something to build from and you'll notice that in both of these scripts, while we don't talk about domestic violence or human trafficking, we're getting at some of the key dynamics that are more

relatable to many people. And we know that human trafficking is an issue that affects the most vulnerable people, those who are looking to earn a basic living and just survive so that the economic conditions of today put many more people at risk for this type of exploitation.

Both of the scripts I offered are intended to highlight some of the additional stressors during COVID 19, and in this case a provider could follow up with resources and hotlines, you know, associated with food and housing, job or economic support, as well as domestic violence and national trafficking hotlines or resources, and you can bundle this as a group so that it's not pointed that you're just sending them trafficking or domestic violence resources in isolation.

Next slide, please.

So the E in CUES stands for empowerment, and this is really the opportunity to share information with patients that they can also share with their friends and family, and more and more the science is telling us that altruism heals and tapping into the patient for a resource in the community is important, and can you see on the slide the recent New York Times article highlights a number of studies that demonstrate how helping others, whether it's volunteering, donating money, or giving advice is beneficial for people's wellbeing and can actually increase their resilience. This is especially important during COVID 19 when people and especially survivors are experiencing increased levels of stress and feelings of helplessness. Not only do they receive the info for themselves but it can also be healing to share with others. Next slide, please.

How do we measure success? Success is not measured by fixing people's problems or telling people what to do, but rather in the ways that we reduce isolation and improve health and safety outcomes for survivors, and one of the foundational actions to operationalize this goal is to establish or expand partnerships between health centers and DV advocacy programs which we've detailed today.

As a first step, community health centers can begin by identifying your own local domestic violence program or programs and including them as part of your care team. One way to do this is to visit the national coalition against domestic violence's website where they have a complete list of all of the state and territory coalitions, and those coalitions include member program, member local domestic violence programs all across their state and so you can look there at that listing as one way to identify your own local program.

When you do so, reach out, get to know their staff, find out what services they provide, especially now during COVID 19, and you can also find sample MOUs and other tools to help establish those relationships of IPV health partners. Also know that the national domestic violence hotline can also connect you or a patient directly to a local program and they can actually patch you in over the phone to that local program.

Also, there is a Strange Hearts Helpline that offers cultural appropriate violence for Native Americans. The national run away is a helpline for youth and parents in crisis and runaway and homeless youth, and lastly the national human trafficking helpline is available for trafficking survivors via phone or text, and just to note that in the webinar platform, can you see the little box for File, and there are a number of handouts there. One of them includes the sample scripts that I just shared with you as well as other systems change pointers and some other ideas in terms of establishing partnerships between your health center and your domestic violence program, and so take a look at that.

We're now going to shift gears and hear from Dr. Kimberly Chang who is going to share with us some of the ways that her health center in Oakland, California is adapting care for survivors and domestic trafficking. I want to extend our gratitude to everyone on this webinar, and others working on this topic, like Dr. Chang has continued to provide care to your patients or clients during coronavirus despite the risk that this poses to your own health and perhaps friends and family who are close to you as well, so just our humble gratitude to Dr. Chang and all of you on the line who are first responders, and it's my pleasure now to turn it over to Dr. Chang.

>> Kimberly Chang: Hello. And thank you for inviting me to share Asian Health Services experience today and most importantly like was expressed, I want to thank all the listeners because each of you can be a lifeline to vulnerable people in your community and so thank you for listening and learning a little bit today.

A little background about Asian Health Services, we're a community health center, a federally qualified health center in Oakland, California, and we serve 50,000 patients in the East Bay area where they're providers of choice and also where the safety net for high quality primary care in 14 different Asian languages and cultures.

Just like the approximately 1400 other SQHC health centers across the country we provide a wide range of crucial health service, primary care, dental care, mental health, youth programs, community outreach and advocacy. Asian Health Services like other centers see each of our patients as a whole person and not just a case or illness. What this means is most often there are multiple issues present from poverty to language barriers, isolation to domestic violence, and even discrimination. Our safety net extends to our sister nonprofits in the community as we intentionally refer and bring in supports and create partnerships like this Project Catalyst from other services like legal aid, social services, food banks, elder care and more.

I want to share now some general trends of what we're hearing and seeing on the frontlines of care. We had a staff meeting a couple of weeks ago of almost 500 people on a Zoom. Can you believe that? Can you imagine that? It was really, really engaging with chats and breakout room discussions. We asked our staff to share some of the most compelling patient stories from the frontlines, as we reach out and connect with our patients, with he witnessed the firsthand impact of self-isolation among our elderly, heightened stress among our families and adults, and we've seen a high demand in significant increase in mental health counseling, telehealth visits as we swiftly and rapidly transformed the majority of our in person visits to virtual phone and video care, critical lifelines for the most vulnerable patients.

One woman, one patient attempted suicide triggered by being kicked off of her insurance, and the financial pressures and family discord.

Those diagnosed with HIV, some of our HIV patients are petrified to go out for supplies and medication given their compromised immune systems. Others shared they're unable to self-isolate because they're essential workers at grocery stores, care to elderly, delivery drivers, warehouses, delivery drivers and they can't lose their job because their boss disallows sick leave.

Our teen program is getting desperate pleas of youth afraid of going hungry. They're out of school and many without any stable source of hot meals or income. Patients with cancer are no longer able to

afford medications, many have lost job, face language barriers in filling out employment forms and fear potential healthcare costs of contracting COVID.

At the same time, you may have heard about the fuel of anti-Asian racism that's risen in our society. We had a patient wearing a mask told to sit at the back of the bus. A youth bullied because he was associated with the "Chinese virus" to rocks thrown at another child while she rode her bike while the perpetrators screamed and yelled at her corona, corona.

So in terms of violence, all of these issues and general trends impact and have shown an increase in the general trends of domestic violence and risks of exploitation among our patients. The violence doesn't occur in isolation of these issues, and our staff have definitely noted the increase in escalating domestic violence situations. One staff recounts making a police report to request a welfare check on a situation, a domestic violence situation, and the patient later expressed really sincere appreciation for the welfare check because it made the abuser or perpetrator realize that he is being monitored by support systems like us, and that we're watching out for her safety.

Another patient reached out to our HIV counselors to say her husband has been abusing her since COVID 19 and the counselors have worked with our partners to help her leave the abusive situation and get alternative housing, and so another patient expressed that her husband was angry, angry all the time and more angry, and she's afraid because he has more than 30 guns in the house. And over and over again, the themes that emerge from the patients during this time of COVID and shelter in place is that patient's home and violence situations are worsened because patients are worried about three things, children, money, and housing.

As you heard from the previous speakers, COVID has worsened all of these things and showing up much more starkly in the clinical setting. In terms of exploitation, financial situations are making everything harder for patients already living precariously on the edge on the edge of not having enough money to get basic needs met.

We had a youth patient living in foster care who days after shelter in place went into effect was transferred to a different county to another foster shelter. Our counselor and partners noted the youth patient somehow was getting a lot of money without having a job they knew of, and they're concerned the youth is at much higher risk for sexual exploitation and continuing to find out more information and working with folks in her new county.

Some of these challenges we're facing are similar to pre COVID challenges, workforce challenges where patients want a female counselor or staff, but only male staff are available that they are maybe not available right away, there are issues of language and culturally specific resources with partner organizations. For example, we work very closely with Asian Women's Shelter based in San Francisco, a separate county for us, and often we know often times shelters have limited availability and worsened by COVID and compounded by language barriers where sometimes our patients have even more limited resources available to them, and we don't have any language component services in my county, so geographic limitations are there as welling.

Issues of isolation, already well known in our population, due to anti-immigrant stigma, language and cultural barriers, poverty, these are all magnified during this time.

So lots of challenges amplified and lots of new challenges too in terms of delivering care, outreaching, providing accurate and timely information to these already marginalized communities. It's crucially important that health centers mobilize because COVID affects everyone and even more so in the vulnerable populations that we serve.

So in response during the time of COVID we have to rapidly develop new services and transform our operations to safer ways of connecting, monitoring, outreaching, and delivering care, like other health centers across the country, literally overnight, probably like many of you, shifted to mostly telehealth audio and video services across all departments and we're rapidly employing our network to reach out to patients and non-patient community members to provide the necessary lifeline to our most vulnerable, and education and outreach through our new We Chat, and We Chat is a social media that is popular in Asian communities and we have a new account, social, Asian Pacific Icelander, YouTube, telehealth and tele-touch service, remote health monitoring equipment like portable Pulse Oximeter and others that don't require Wi-Fi.

In items of violence prevention protocols, we're continuing internal operation's teams and getting training out on the CUES intervention and doing this all through Zoom and such. We streamlined and modified our warm handoffs to our integrated behavior health team with the manager and supervisor getting all the referrals that they can touch and aware of every single patient needing services at this time and they're triaging and assisting the level of intervention needed. We've developed for us an internal crisis hotline of support for the providers and staff to reach the more expert behavioral health and case management teams since we're all no longer in the same physical space.

Our case management department is organizing meal delivery for seniors, helping patients apply for unemployment insurance, helping patients with rent negotiations, patients without computers are, or who aren't IT savvy are getting help over the phone to set up online applications, and our case managers are doing it for them online, and they're having to navigate lots of boundaries and ethical issues, so we're developing internal policies around these types of services. We're proactively and systematically outreaching to our vulnerable patients and population. Our community programs, like our community liaison unit, our youth programs, our program for youth at risk of sexual exploitation, we're working with outside partners like the domestic violence programs, legal aid, cultural organizations, and other youth programs to strengthen the safety net holding up our patients and communities.

On a higher level, our county community health center network which is a consortium of all the health centers in our county, we're embarking on developing county wide health center protocols with sharing an intentional equitable collaboration with other social service partners, including the domestic violence programs to specifically address violence across the health centers for our patients.

So there is a lot going on and we're actively responding and thinking through the future operations for our patients. One last thing I want to mention, and this is some cultural competency here, and while this is a huge crisis for everyone across the globe, it's also a key time for rising to the challenge and creating new and hopefully better ways of providing care. In Chinese, the word for crisis is actually composed of two characters which individually mean danger and opportunity. So let's meet our challenges and seize the opportunity to be better going forward.

Thanks, everyone, for your time and most importantly your care for people. Now I'll turn it over. Thanks, everyone.

>> Thank you, Dr. Chang. Your program sounds amazing. Thank you so much for sharing. Hi, everyone. My name is Mia and I'm a program manager at Futures woip without Violence on the children and youth team and thank you so much for having me here today and I'm grateful to be here. Now we're going to take a little shift from talking about children experiencing domestic violence and ways that we can support them and their healing.

I'll start by saying it isn't uncommon to see children and young people left out of the conversation of domestic violence because it is, unfortunately, still a common belief that children are not impacted by domestic violence and that they're too young to understand what is going on and that the younger the child, the more likely they will not remember the violence.

However, as many or all of you already know, children are definitely affected by domestic violence, although not all children are impacted in the same way.

And even though individual variability and children have something to do with this, it is definitely not the full picture. The science in our own experience has help that had context matters and specifically the experiences, conditions, and systems that children are exposed to. They all have the potential to either buffer the impact of adversary and trauma or to accent wait the impact.

And even though we know that the harmful impact domestic violence can have on children, the story doesn't have to have there. Children can heal, and we have a huge role in creating the context in which healing can happen. Our next slide, please.

So, let's talk about protective factors. When folks start talking about why certain children respond differently to adversity, particularly why some children overcome the hard things they've experienced in life and why other children can't, folks reference the role of nature versus nurture.

So how much the question is how much of a role does the person's specific traits and attributes have on their ability to heal versus the conditions and environments they grew up and live within. We now know from the science that it's actually both. Nature and nurture, and that it's the same when we talk about protective factors.

So, protective factors we like to think on two levels. On one level it's about individual people healing from the trauma of domestic violence and effects it has on us on three domain, biological, psychologically, and socially op on a different level, what we as providers working in organizations and systems can do to reverse the negative effects of trauma and encourage, amplify, advance, sustain the healing process of individuals.

So a key takeaway here is that there are concrete steps and organizing principles like the ones that were spoken to at the beginning of the presentation that we can use to design policies, programs, and practices that can help bolster individual attributes and also create the environments around conditions that promote healthy development, foster the recovery, support healing, and ensure wellbeing and thriving which is what we ultimately want for everybody.

Next slide, please.

So what you're seeing on the screen a graphic to represent five interrelated protective factors specific to children and adults survivors of domestic violence that we know from research and science buffer the

negative impact of domestic violence and promote healing for adult and children survivors of domestic violence.

This is a product that we created through our quality improvement center on domestic child and child welfare which is a national research project of Futures funded by the Children's Bureau and more information is actually in the downloadable file. There is a brief that you can read that has more information on the protective factors, but adds you can see, I think these are hexagon, but they're connected in the graphic which is meant to convey that these protective factors create a sort of ecosystem of wellness and growth.

The five factors represent the types of experiences and conditions that benefit and protect survivors of domestic violence from medium and short and long term harm, and it's worth pointing out that the protective factors are interdependent, which means that when you are promoting one protective factor, you're actually also laying the foundation for strengthening the other protective factors as well.

So the five protective factors are safer and more stable conditions for survivors, social, cultural, and spiritual connection, resilience and growth mindset, nurtures parent and child interactions, and social and emotional abilities.

So, yeah, and if you are interested in learning more, please check out our brief. Next slide, please. So, now, I'm going to go from the ecosystem kind of conversation down to more of the specifics, so introducing you to our five healing gestures and these gestures come out of our Changing Minds Initiative and stems from the same body of research and science that we've been talking about that helps to promote healing for children experiencing domestic violence.

These are more kind of like concrete things you or any adult who are working or interacting with children can do to create a positive interpersonal interactions that help create positive experiences for children and support their healthy development. So the five gestures are to comfort children, listen to them, inspire them, collaborate with them, and celebrate them.

One of the things that we like to do with groups when we talk about gestures is to ask folks to share ideas and experiences about how they've actioned out some of these gestures because there are just so many ways that you can, for example, comfort someone, listen to them, right. So it's a great learning opportunity to kind of hear from people what they do to kind of demonstrate these gestures, so since we can't do that now, I encourage people to take some time after the webinar and think about how you personally have and would action out these gestures and maybe ask colleagues and other folks for ideas because it's just I think it's a great learning opportunity.

Next slide, please. So I'm going to start referencing my favorite Sesame Street they have great resources for families and providers, there are two videos I highly encourage folks to check out if you haven't already. The first is called traumatic experiences, and the second is big bird's Comfy Cozy Nest and these both speak to the power of relationships and powerful role that we can play in supporting children and children's healing, and they do that through these two characters which is Big Bird and Allen.

Next slide, please. On their website, they have a ton of other resources that I think are really helpful, a the least for me, and so I encourage the whole group to please check out the Sesame Street Communities website, they have topic specific resource, one specifically on trauma and now also a COVID 19 topic issue website as well.

Next slide, please.

So before I pass it to close us out, I just want to highlight two national resource centers. The first is our national Health Resource Center on DV where we provide tools and technical assistance to improve health care's response to domestic so sexual violence and increase health care access to survivors within community based programs.

And the second is Promising Futures Capacity Building Center we do similar things and provide things for agencies experiencing and parents experiencing domestic violence and we lean heavily on the principles we spoke to and uplifting the power of parent/child relationships, and so with that I pass it over to Kenya. Thank you.

>> Thanks, everyone, for your presentations today. They were fantastic and I really enjoyed hearing the content and seeing the chat and the conversations and dialogue that's happening there. Thank you all so much for that. Thank you again to Commissioner Darling and Commander Mautone-Smith for sharing amazing remarks, it was so heartfelt to hear about passion and dedication for the work and what's happening.

So I just want to point out a couple of resources that we have that we really encourage you all to take some time to review and to also share with your colleague, and then I'll pass it over to Jane to make closing comments to close us out.

So you can see here on the slide that we have one toolkit that we have been really proud of that has come out of Project Catalyst as well as our work with the Health Resource Center on Domestic Violence and that is IPVhealthpartners.org and it was a toolkit developed with community health center input and experience, and it includes resources for health centers and domestic violence organizations to form partnerships, and it also provides a step by step information and guidance on how to implement the interventions that we've discussed and that have been talked about today on this webinar session.

There is also some practical and actionable steps, script, training curricula, templates, and other quality assurance and quality improvement tools that are available, so please take a moment to check it out.

And the URL is very easy to remember, IPVhealthpartners.org and also I want to share approximate these, we rgly partner with the HHS office of coif trafficking in Persons and some of colleagues may have been on the webinar today and we wanted to uplift their COVID 19 resource page. The HHS Office works to prevent human trafficking and ensure that children and adults that have experienced trafficking in their families get the support and care they need to live safe and healthy lives. So on their resource's page, they do provide information regarding disruptions to housing, economic stability and social disconnection which can further increase the risk of victimization and exploitation for human trafficking victims and also for survivors.

So with that, I will pass it over to Jane to make the closing remarks for the webinar.

>> JANE: Great. Thank you so much. So in closing we're sharing contact information for leadership the HRSA office of women's hes and office of Region 9 and you will be able to visit this and find resources for sharing slides and we'll email out the slides and recording of the webinar. Please reach out any time to cover the topics discussed in today's webinar. On the next slide, we encourage you to learn more at HRSA at HRSA.gov and also describe to our e newsletter to stay informed about events such as today's

webinar and just a sincere thank you to today's speakers and everyone that joined today. Thank you for the work that you are leading as first responders, providers, and advocates for your patient, clients, communities, family, and children.

Our gratitude to you all and continue to be well. Thank you.

>> MODERATOR: Thank you. That does conclude today's conference. Thank you all for participating. You may now disconnect.

(session completed at 3:03 p.m. CST)

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