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INTIMATE PARTNER VIOLENCE: HOW CHWS CAN HELP PREGNANT WOMEN

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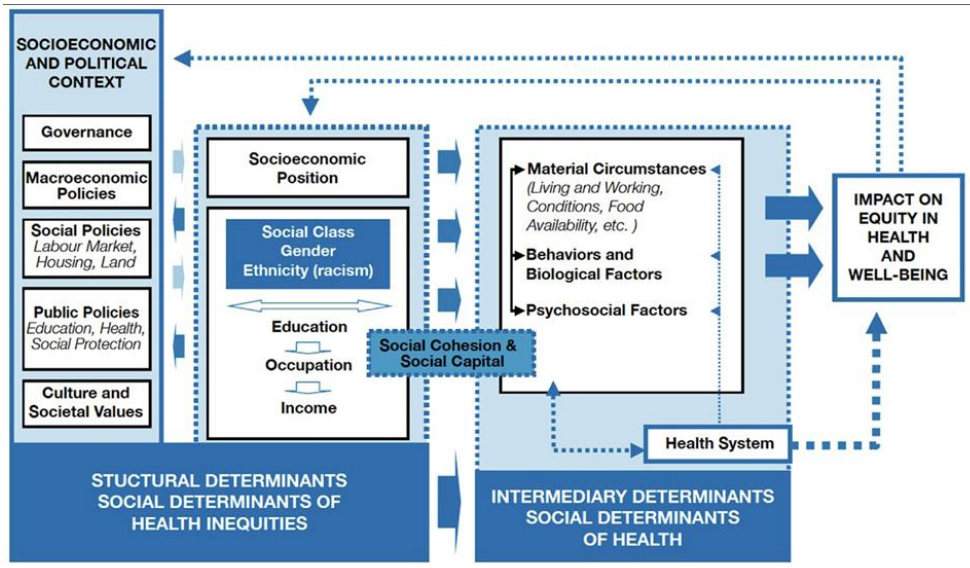
Table of Contents

Introduction

Pregnant women face many issues that must be overcome in the hopes that they will have a successful pregnancy and transition to motherhood. The social determinants of health model (See Figure 1), published by the World Health Organization[1] suggests that environment matters for all people's health. For pregnant women, the environmental variables that impact a successful pregnancy include: safe housing and relationships, adequate food, quality perinatal care, and good maternal health. When working with women in lower socioeconomic status, it is often difficult to strategize which variable to prioritize when there are competing priorities. This report focuses on one important issue facing pregnant women: safety within their intimate partner relationships.

Figure 1. Social Determinants of Health



Among women in the United States, approximately 5.9% are abused each year, and approximately 25% are abused in their lifetime.[2] Even lifetime exposure to violence can affect a woman's mental and physical health, thus impacting her pregnancy and the well-being of her child. Intimate partner violence (IPV) is known to affect a woman's health, and that is true for her baby as well. Studies report that women who have experienced IPV before, during or after their pregnancies, experience negative health outcomes that directly or indirectly affect their children's health. Women who experience IPV in the year prior to and/or during their pregnancies are at greater risk for sexual risk behaviors, alcohol and substance abuse, as well as smoking.[3, 4] "A large study in North America (n=118,579) found women reporting domestic violence prior to or during pregnancy were at higher risk of hypertension, edema, vaginal bleeding, vomiting and dehydration, urinary tract infections and pre-term delivery."[5] Children exposed to IPV, even intra-utero, experience changes to their biological health outcomes, and their mothers are less likely to breastfeed.[6] Children exposed to IPV are known to suffer higher

rates of asthma and developmental delays and other concerns that can affect them across the lifetime.[5,7,8]

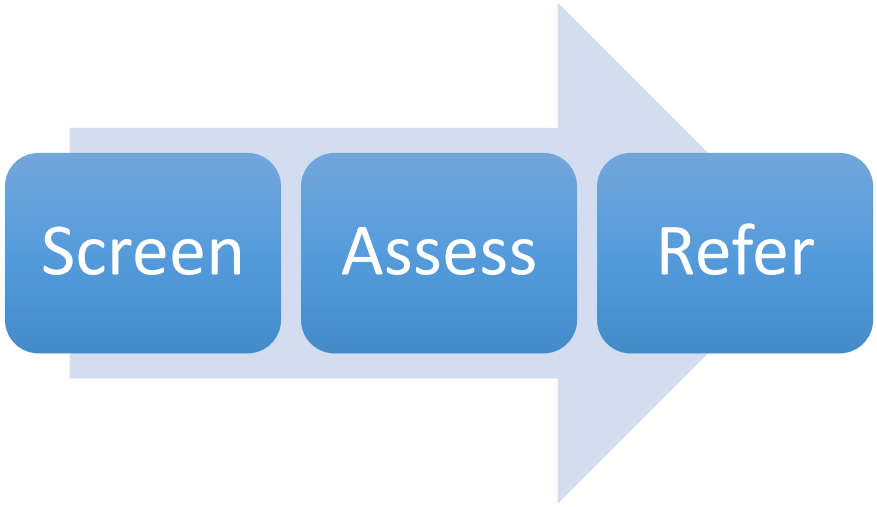
The Affordable Care Act recommends screening women of childbearing years for IPV. However, many professional organizations suggest screening of all women or all individuals regardless of race, gender, or sexual orientation. The United States Prevention Task Force also recommends screening with some limitations.[9] Lastly, the Joint Commission mandates screening for women in childbearing years for employees affiliated with hospital settings.[10] In support of screening during childbearing years, for more than half the women who reported IPV in a national study, the first abuse occurred between 18 and 24 years of age.[2] For some women, this vulnerable time period may also be while they are pregnant and becoming mothers for the first time. Because they may be help-seeking in an obstetrics-gynecology (Ob-Gyn) setting for these parenting and pregnancy needs, their physical and mental health might also be discussed at this time.[11]

For those Community Health Workers (CHW) who work with high-risk women, especially those employed within hospital settings, these combined recommendations and mandates are clear: screen for IPV. While these recommendations are suggested practice, there is little guidance for CHW on the state of the science and best practice guidelines. These recommendations often come without adequate training and resources given the time it takes to adequately screen, assess, and refer a client. This report fills a gap in the literature to help CHW working with low-income perinatal women understand the role they can play in helping a client seek safety.

Screen – Assess – Refer

While many of the recommendations for IPV discuss screening, few discuss the continuum of screening-assessment-referral.(See Figure 2) These acts are not isolated, but rather are a continuum. While some people are comfortable asking the routine screening questions recommended by their institutions and agencies, many are uncomfortable with the next step: Now what? The next step is assessment. After a positive endorsement of screening questions, a provider needs to assess what the patient is experiencing, the level of danger they are experiencing, and then provide appropriate referrals. While referral is a key step to helping clients with IPV get the services they need, it is often difficult for them to actually get to the resource a provider recommends. Thus, the primary provider who is actually learning about the disclosure must first conduct a safety assessment and create a safety plan, prior to providing a referral, in the event that the client does not link with services, which is all too common.

Figure 2. Screening, Assessment and Referral Continuum



Screening

There are many resources available to help a CHW and his/her organization know what screening tools to utilize. There are numerous resources for screening with best practices on the CDC website, which may be helpful to agencies struggling to decide what measure to use in the community for screening.

https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf . First, however, it is important to note for those providers working with pregnant women in a hospital setting, the national accreditation agency requires all personnel to screen for IPV. Secondly, many professional licensing agencies recommend and endorse screening for IPV. In choosing a screening tool, it is important for those professionals who are working with CHW's (i.e. nurses, NPs) to know what any association or affiliation they might belong to and whether their professional licensure has any requirements or recommendations for screening for IPV.

A screening measure which is frequently used was developed in 1997, published by Feldhaus, et al.[12], https://www.ncbi.nlm.nih.gov/pubmed/9134940 and asks three questions:

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Research has showed this is a good screening measure. For those who disclose IPV – a follow-up assessment is in order. While the Partner Violence Screen is brief, behaviorally-based, and succinct, the questions do not assess emotional abuse, sexual violence, power and control, and other tactics abusers might use. Of course, these issues are important to screen for as well. The questions also do not assess for perpetration – whether they abusing others. We know that many women who screen positive for perpetration are primary victims, meaning that they are using abuse to sometimes defend themselves and/or their children. As such, it is

important to let the client know it is ok to talk about abuse no matter who is doing the hitting and hurting. All of these complex abuse issues effect the mental and physical health status of all victims, [13, 14] and the events can have long-lasting consequences for survivors.

However, the three question measure remains an effective screening tool. While there are other screening measures, many of them are long but even so, don't show the same success at screening for IPV when compared to longer versions. In addition to the type of questions that are missed on these screening measures, another issue with any screening measure is "when" a CHW should screen. Once may not be enough. Many peoples' circumstances change over time. A follow-up study to the 1997 study found the three question measure predicted future violence as well (https://www.ncbi.nlm.nih.gov/pubmed/15296611), making it an effective "end-run" around the question of when and whether to screen multiple times.[15]

Some providers are afraid to screen for many reasons. They fear that screening may hurt their relationships with their clients, opening Pandora's Box and make matters worse. However, one study reported that asking about IPV in an emergency department did not make matters worse.[16,17] Furthermore, in studies conducted with survivors, women report being glad they were asked about their IPV experiences,[18,19] although survivors don't want a provider to tell them what to do.

Here are some accepted best practices for screening for IPV. Screening should happen in a private setting, without the client's partner in the area. It is important to know that even if the health provider and client are in a separate room, CHWs report that the abusive partner can be listening in from a room next door. CHWs should ask the selected questions in an open, non-judgmental fashion, and seek to secure the facts without placing any blame on the victim or perpetrator. Only in an open communication process will the client feel like she can truly share what is happening. The questions should be asked with enough time that if there is an endorsement, there is time to process the information, make an assessment, create a safety plan and refer the client for help.

Over the course of the past two decades, there have been a number of studies that have examined whether screening makes a difference in the lives of women effected by IPV, while less is known about male patients. However, these studies with women have resulted in mixed reviews. In a 2009 Journal of American Medical Association, an editorial authored by Drs. Moracco and Cole[20] stated that screening alone is simply not enough to reduce IPV. They discussed the state of the screening field, as well as an important article by MacMillan et al. (2009)[21] which documented that a randomized control trial (RCT) screening for IPV did not reduce their participants' IPV experiences. Moracco and Cole discussed the study's limitations, but their primary conclusion was that screening without assessment and referrals to interventions using evidence-based components, is simply not enough.

In summary, there continues to be a lack of evidence that universal *screening alone* improves health outcomes for IPV survivors. It is certainly understandable that clinicians and health care facilities have implemented universal screening programs, given the prevalence and potential severity of IPV. However, the results of the study by MacMillan et al. (2009) should dispel any illusions that universal screening with passive referrals to community services is an adequate response to violence in intimate relationships.

Assessment

Once the screening has happened, and a client endorses IPV, what is next? The next step is to assess the situation for safety. As with screening, there are many tools available to the CHW to assess danger. One recommended measure is the Danger Assessment, https://www.dangerassessment.org/, created by Dr. Jackie Campbell, at Johns Hopkins School of Nursing. The website offers a copy of the measure (See Appendix), along with an online training component for certification. The assessment asks a series of yes/no questions, and then provides an answer key which needs to be scored. Not each question is scored the same, as some questions are indicators that your client is at high risk, and are therefore weighted more heavily: have there been threats to kill, whether the perpetrator has a gun, and/or whether the partner has choked the client, etc.. A score is assigned according to four levels of danger. The tool is also helpful for safety planning and the referral process, even if the couple is staying together.

For purposes of this report, we also provide a copy of a sample safety plan (See Appendix), adapted from the National Census of Domestic Violence Services, as well as a safety planning diagram (See Appendix) for clients who may be unable to read. These safety documents can help a CHW work with their clients to learn what needs to happen via safety planning post-disclosure and assessment. Many ask about the role of Child Protective Services (CPS) when working with a victim population. It is important for every CHW to be aware of their agency's CPS directives and their role as a mandatory reporter under the New York State law if they are "…[h]ospital personnel engaged in the admission, examination, care or treatment of persons." http://ocfs.ny.gov/main/cps/faqs.asp#mandated. Even if you are not working in a hospital setting, you may be interested in learning more about child abuse reporting and the steps for keeping children safe. There is a free two-hour training provided by New York State: http://ocfs.ny.gov/main/cps/Mandated_Reporter_Training.asp.

Referral

Once a client has completed these initial steps, many CHWs ask what - if anything - can help their clients. There is no literature of which we are aware that specifically studies interventions that CHWs can administer to reduce IPV among high-risk women, other than our own recently completed study that delivered a personalized care plan to high-risk women (not all pregnant) recruited in an urban Ob-Gyn clinic. The study was created with patient advocates and CHW at the table and involves women taking an inventory that addresses their individual health, their living situation, and other needs they may have, via an iPad.[22,23] Half the women worked with a

CHW to help the client prioritize what issues were important to her; the other half were not assigned a CHW, but instead received four calls over the course of four months as a support to check on them. While the depression got better for both groups, those participants with an assigned CHW had a reduction in IPV over 4 months among those who reported IPV upon recruitment.

While there are few studies regarding interventions delivered by CHWs, there are a number of studies documenting interventions in other disciplines, delivered by nurses, therapists with masters degrees, para-professionals, and other health workers; this research, based on rigorous science, offers helpful information we can incorporate into our CHW activities. Almost 20 years ago, a study was conducted to examine the benefits of a nurse home-visiting program for children at risk due to poor environments. That study showed that high-risk women who received home visits after having babies were less depressed, had better child-parent outcomes, and were more engaged in care.[24, 25] In a more recent study using para-professionals visiting mothers, the women in the intervention group reported less IPV victimization and perpetration during the program. Long term follow-up also showed reductions in IPV for both the home-visit and paraprofessional intervention groups. Also, interventions which target the reduction of multiple risk factors, including IPV, can also have a positive effect at reducing victims' experiences of trauma.[26, 27] Some of these interventions targeted specific groups: women with low socioeconomic status, African-American women, and those with multiple risk factors. However, interventions which target reducing child abuse and neglect have found that IPV left unaddressed may limit the success of such programs to assist children.[28] Thus, it is imperative to screen, assess and refer clients to IPV-specific programs to address their needs if we hope to help the children as well.

In order for CHW to provide referrals to their clients, they must understand their client's community, transportation availability, and eligibility for some services that are specific to zip code requirements or financial need. However, all counties in New York State have free IPV services that are available to all victims regardless of financial circumstance. There are shelters available throughout the state that provide overnight care, and 24/7 hotlines. It is a good idea to connect clients to the IPV-specific providers to help with additional assessment and safety planning. Often, the police will provide transportation to a shelter if there is danger for the client and their children.

The New York State Coalition Against Domestic Violence is an excellent resource to help identify appropriate referrals, and they maintain a directory of services: https://www.nyscadv.org/statewide-dv-directory/. A CHW can help strategize with the client what is a helpful approach to gaining safety. For some clients it may be talking through the problem, making a phone call together to an IPV provider, or reviewing the safety plan and seeing what other agencies might be helpful. It is important to remember that not all clients experiencing IPV may be ready to accept a referral or act on it. In fact, some may connect with an IPV provider and chose to stay in their relationships despite the planning on the CHW's part.

Even if a CHW feels frustrated, it is important to know there are stages of change that people go through when deciding to change an aspect of their lives. In the case of IPV, screening, assessing and referring a client moves her through the stages of change, (https://www.prochange.com/transtheoretical-model-of-behavior-change) at least from pre-contemplation to contemplation. The client may not ever jump to the next level, of planning and action with you, but one can never go back to pre-contemplation. At least the CHW has provided safety planning and referrals should the client chose to take action at another time.

Conclusion and Recommendations

This report provides a brief overview of the literature for IPV-specific CHW home visitation programs as a form of intervention: screening-assessing-referring. There are limitations as with any report. However, given the few of studies regarding interventions delivered by CHW, this overview is helpful in providing the following recommendations:

1. CHWs should screen all their clients, in a safe and non-judgmental manner, for IPV throughout their care.
2. CHWs should utilize a tested IPV screen.
3. Once a client says she is an IPV victim, CHWs should follow-up with an assessment, safety plan, and referrals.
4. All CHWs should conduct safety planning given the client may not seek care elsewhere.

Before implementing IPV screening interventions, CHWs should be provided with adequate training regarding their own safety, what interventions are available in their locations, and CPS training. Often, IPV interventions have the unintended consequence of creating a backlash against clients with increased CPS referrals, as well meaning providers think they must report all their clients' IPV experiences to CPS. In New York State, IPV alone does not necessarily warrant a CPS report without other risk factors that result in immediate harm or threat of harm to the child. CHWs' employers should also provide training regarding vicarious trauma. Learning about their client's trauma can present information that might be upsetting or trigger memories of the CHWs' own experiences. While this work is difficult to do, it is important and can have significant impact on improving the lives and welfare of clients and their children, as well as breaking the cycle of violence.

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Appendix

Safety Planning Summary

Be careful when visiting websites and making calls if your partner is monitoring your social media.

Personalized Safety Plan: http://www.ncdsv.org/NCDSV_DVSafetyPlan-updated_8-2016.pdf

National DV Hotline: 800-799-SAFE **Willow Hotline**: 222-SAFE

Who is your go to person?

- If you have to leave, who could you stay with temporarily?
- Who could you tell about the violence?
- Who might call police for you if necessary?

Where can you go to avoid high-risk areas during an argument?

- Avoid kitchen, bathroom, and areas without access to an outside door.
- Try to move to an area that is not near weapons (i.e. living room, hallway, etc.)

Phone safety- what can you do to guarantee your privacy?

- Partners may sometimes track phone bills or phone via GPS.
- Could you use a friend's phone or a payphone/landline?

What can you do to make yourself feel safer at home?

- What steps can you take to feel more secure in your home?
- Changing locks, security systems, rope ladder, etc.

What your about your children?

- Who can pick up kids at schools, babysitters, etc.?
- Setting up ways to contact your emergency pickup if you need to leave by yourself

What Items should you take if/when leaving?

Most important

ID, Birth Certificate*	Passport
School and Vaccination Records*	Divorce papers
Checkbook, ATM card*	Medical records
Keys- car, house, office*	Lease/rental agreement, house deed,
Copy of protection order*	mortgage payment book
Medications*	Bank books, insurance papers
Welfare ID, work permit, green card*	Address book
Children's birth certificates*	Pictures
Social Security cards*	Jewelry
Money, credit cards*	Children's favorite toys/blankets
Driver's license/registration*	Items of special sentimental value

Summary adapted from NCDSV Domestic Violence Personalized Safety Plan


PASSPORT
United States of America
Medical Record
Name
Date
Your partner may be monitoring you. Be mindful of Internet, phone, computer use
Gather important items
Identify safe place/ person
Avoid high-risk areas
LABORATORY OF INTERPERSONAL VIOLENCE AND VICTIMIZATION | © 2016

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

www.dangerassessment.org

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following.
("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes	No		
____	____	1.	Has the physical violence increased in severity or frequency over the past year?
____	____	2.	Does he own a gun?
		3.	Have you left him after living together during the past year?
____	____		3a. (If have *never* lived with him, check here___)
____	____	4.	Is he unemployed?
		5.	Has he ever used a weapon against you or threatened you with a lethal weapon?
____	____		5a. (If yes, was the weapon a gun?____)
____	____	6.	Does he threaten to kill you?
____	____	7.	Has he avoided being arrested for domestic violence?
____	____	8.	Do you have a child that is not his?
____	____	9.	Has he ever forced you to have sex when you did not wish to do so?
____	____	10.	Does he ever try to choke you?
		11.	Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____	____	12.	Is he an alcoholic or problem drinker?
____	____	13.	Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car)?
			(If he tries, but you do not let him, check here: ____)
____	____	14.	Is he violently and constantly jealous of you?
			(For instance, does he say "If I can't have you, no one can.")
____	____	15.	Have you ever been beaten by him while you were pregnant?
			(If you have never been pregnant by him, check here: ____)
____	____	16.	Has he ever threatened or tried to commit suicide?
____	____	17.	Does he threaten to harm your children?
____	____	18.	Do you believe he is capable of killing you?
____	____	19.	Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
____	____	20.	Have you ever threatened or tried to commit suicide?

_____ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

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