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Federally Qualified Health Centers as Hubs for Victims of Violence

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Introduction

The City of Rochester, New York, is confronted with the issue of violent crime. According to the Rochester Police Department (RPD) homicide statistics in 2023, there were 27.5 homicides per 100,000 people; surpassing that of more densely populated cities like New York City, Chicago, and Compton (Rochester Police Department [RPD]). In the same year, Rochester experienced 248 shooting incidents with 288 victims. The evidence is indisputable that there are hundreds of individuals that are victims of violent crime. The consequences of persistent exposure to violent crime extends beyond individual victims and encompasses the well-being of entire communities. Providing necessary support and engagement for victims reduces the likelihood of isolation and can mitigate the manifestation of feeling powerlessness and anger (Office for Victims of Crime [OVC], 1998). Despite countless efforts to prevent crime over the previous decades, violent crime and victimization have persisted.

Adopting a public health perspective when addressing violent crime holds a significant potential in effectively assisting victims and other affected individuals. Central to this approach are the Federally Qualified Health Centers (FQHCs), a crucial safety net of healthcare providers that can play a pivotal role in supporting victims of violence. FQHCs are community-based and patient-directed organizations that prioritize accessibility and affordability, serving underserved populations that grapple with economic segregation, lack of insurance coverage, and higher disease burdens with limited resources (Health Resources & Services Administration [HRSA], n.d.; Hébert et al., 2018). Data from 2020 indicate that approximately 91% of patients are reported to be from low-income backgrounds, 81% are publicly insured or uninsured, and 63% are a part of racial or ethnic minority

groups (Wakefield, 2021). These same disadvantaged communities also face higher-than-average rates of violence compared to other populations (Bailey et al., 2022; Buggs, 2022; Rural Health Information Hub [RHIhub], n.d.). Leveraging the services and locations of FQHCs renders them as ideal hubs for victims of violent crimes in need of medical or emotional support.

FQHCs History

Community Health Centers (CHC) began in the 1960s amidst growing poverty and racial tensions in inner-city neighborhoods (Hébert et al., 2018). The first CHC projects began in Boston, Massachusetts, and Mound Bayou, Mississippi, in 1965, supported by federal funding as non-profit health centers and subsequently evolved into FQHCs. Currently, there are approximately 7,500 FQHCs in the U.S. varying in size from single clinics to multi-site systems (Healthcare.gov, n.d.). FQHCs focus on primary care services but also provide services by nurse practitioners, physician assistants, psychologists, clinical social workers, and home nursing visits. Furthermore, these centers can offer preventative health education, immunizations, pre/post-natal care, and other services for mothers. However, it should be noted that FQHCs do not cover health education classes or group education activities, eyeglasses, hearing aids, ambulance services, and prosthetic services. Despite these limitations, the services provided by FQHC have demonstrated significant benefits for the communities they serve.

FQHCs as Hubs for Victims of Violence

Research indicates that communities that face disproportionate rates of violence have underlying causes, including structural and systemic discrimination and economic segregation (Bailey et al.,

2022; Buggs, 2022). Economic disadvantage in these communities hinders access to quality education, safe housing, and adequate healthcare resulting in strain, frustration, and conditions conducive to violent crime. FQHCs strategically operate in medically underserved areas for medically underserved populations, aligning them with communities where violence is prevalent (Behr et al., 2022; Chang, et al., 2020). Additionally, FQHCs uphold a governance model where consumers and/or patients of FQHCs comprise 51% of the governing body to "represent the individuals being served by the center" (Wright, 2013 p.28). The community-oriented approach facilitates social cohesion and solidarity, making FQHCs a supportive environment for victims of violence and other patients.

FQHCs are instrumental in serving as hubs for victims of violence because they are crucial in being the initial point of contact for victims of sexual violence and human trafficking (Albert, 2022; Chang et al., 2020). Human trafficking is recognized as a public health issue and the consequences have been observed in disadvantaged populations in society. Communities exposed to high rates of violence also tend to have high rates of trafficking and a lack of resources to address the issue effectively (Albert, 2022). Chang et al. (2020) reported that:

> FQHCs serve a disproportionate share of the nation's poor and uninsured. Most patients are members of racial or ethnic minorities, and millions of health center patients are served in a language other than English. Trafficked persons may disproportionately share these characteristics. (p. 1081)

FQHCs can serve as the initial point of contact for victims of violence because they possess expertise and resources required by trafficked victims, including preventative services, health education

programs, and community outreach initiatives. FQHCs effectively mitigate common obstacles faced by victims in standard healthcare settings, providing enabling services for their needs.

The link between mental health, trauma, and violence has been extensively established (Jackson et al., 2019; Lathan et al., 2020). Victims and families of victims affected by violence experience increased risks in physical disability, mental distress, anxiety, depressive disorders, and reduced quality of life. Violence-related trauma affects 15% of all African Americans and rates escalate with the chronic exposure to violence particularly in low-income areas. Exposure to violent crime has been identified as a contributing factor to psychological distress and increased risk of developing depression, anxiety, and post-traumatic stress disorder (PTSD) (Curry et al., 2008). According to Collins & Derigne (2017), when utilizing the Hospital Anxiety and Depression Scale on adolescents it was found that over two-thirds of adolescents are considered moderately depressed and half reported severe anxiety. PTSD disproportionately affects low-income individuals with the overwhelming majority going untreated (Sripada et al., 2023). Symptoms of PTSD can lead to increased suicide ideation, suicide attempts, and mortality caused by traumatic events such as exposure to violence. FQHCs have demonstrated the capacity to address mental illness symptoms through mental health services for patients.

FQHCs have necessary resources and services to effectively address symptoms of anxiety and depression through the provision of mental health services for patients. FQHCs adopt the principles of trauma-informed care known as the “3 Es” (Lathan et al., 2020). According to this concept, a traumatic *event* happens to the victim and *experience*-related characteristics of the trauma predicts a

victim's physical and mental health *effects*. This framework enables an understanding of the impact of trauma to guide the recovery process. For patients of FQHCs suffering from depressive disorders and PTSD, Meredith et al. (2022) researched optimizing trauma-informed collaborative care (TICC) with motivational interviewing. TICC patients demonstrated significant improvements compared to patients without TICC. FQHCs providing mental health services have been shown to improve engagement and access to care for patients battling depressive disorders.

FQHCs as Referral Sources

FQHCs prove to be effective hubs for victims of violence through providing coordinated services and referrals for other services. Service coordination is an organization of activities between two or more organizations to facilitate the delivery of the appropriate services to victims (Duda-Banwar & Altheimer, 2022a). For a victim of violence in need of a specialized service which FQHC cannot provide, the victim can be referred by the FQHC to a more suitable organization providing those services. For example, violence victims are being provided primary care services within an FQHC and are struggling with maintaining employment; the FQHC can attend to the victims' medical needs while referring them out to a partnered organization that can assist in acquiring employment for such clients. As a hub, FQHCs can act as a “one-stop shop” that coordinates services across multiple systems and tracks the progress of the victims to keep them engaged and avoid revictimization. The goal of coordinated services and referring clients decreases service fragmentation and increases the quality of services for victims to further reduce revictimization (Duda-Banwar & Altheimer, 2022b). FQHCs can work to achieve this goal through collaborating and supporting the efforts of community outreach groups.

Community groups such as Community Engagement to Reduce Victimization (CERV), which was created in May 2019, can thrive with support from FQHCs (Bert & Altheimer, 2021). The program collaborates with hospitals and multiple community outreach groups with the goal of reducing violence, hospital re-admissions, the suffering of victims, and public health responses to retaliatory violence. FQHCs can support community groups like CERV through collaboration and providing services that fall within the boundaries of CERV's assessment of needs for victims. Victims of violence in need of substance counseling, primary care, and more can be referred to FQHCs for services. Subsequently, if additional services that FQHCs cannot provide are needed, the coordination and collaboration between CERV and FQHCs can be implemented to place the victim with the appropriate organization.

Even after disputes have been mediated for victims, FQHCs can support organizations like CERV because many services are still needed for the population of victims, such as emergency safe housing, transportation, supporting basic needs, counseling, etc. (Duda-Banwar & Altheimer, 2022b). FQHCs acting as the hub of coordinating services and referrals can take the lead in sharing information on the individuals seen, describing the services they need, and scouting for opportunities that victims would otherwise be unable to do for themselves. Additionally, FQHCs have access to more resources compared to organizations like CERV. FQHCs can utilize encrypted cloud databases to securely store victim case files. Hence, victim information can be kept confidential with protocols in place for who is allowed access and how the information can be used to benefit the victim.

Conclusion

Adopting a public health perspective and using FQHCs can show promise in the approach of combating violent crime and supporting those affected. The community-based and patient-centered approach of FQHCs prioritizes the accessibility and affordability of care which establishes them as ideal hubs for victims of violence. FQHCs offer services beyond primary care such as mental health care, dental care, and substance-use care. The strategic placement of locations in underserved areas where violent crime is higher than average enhances their need and effectiveness to the community. FQHCs have demonstrated the capacity to support victims of sexual violence, mental illness, and violent trauma through improving access and engagement to healthcare. FQHCs overall can make significant impacts in reducing the harm caused by violent crime and improving the well-being of individuals.

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