Building and Strengthening Healthcare Based Domestic Violence Programs

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New DHHS Guidelines on Domestic Violence Screening and Counseling

Successful Programs in Health Care Settings

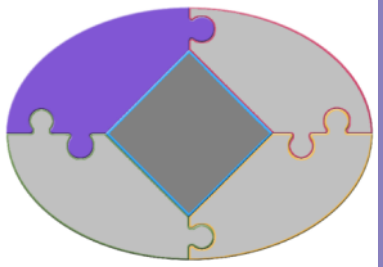
Key Elements

Key elements

Supportive Environment

What is it?

- Information: restrooms, exam rooms, on-line, podcasts, health ed classes
- Posters: “Let us know, we can help”
- Reaching patients everywhere they contact the health care system
- Engaged and informed workforce

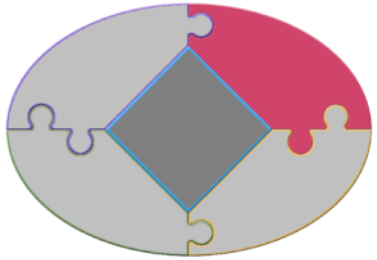


Inquiry and Referral

Role of the clinician (health care provider) is clear and limited

- **ASK**
- **AFFIRM**
- **ASSESS**
- **DOCUMENT**
- **REFER**

"Making the right thing easier to do."

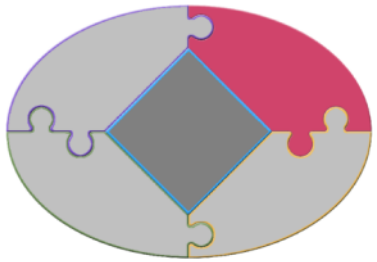


On-site IPV Response

Options for HOW to do this

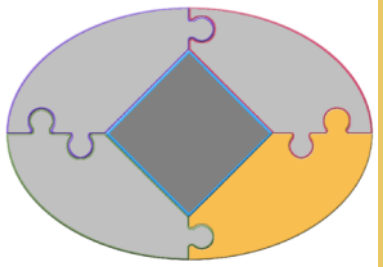
Customize using local resources

- Local DV agency provides on-site advocate
- Local DV advocate called to hospital or clinic
- In house DV-trained social work/mental health staff
- Brief intervention by staff with DV training
- Private place to access help via phone or on-line



On-site IPV Intervention: What it can include

- Danger assessment
- Safety plan
- Support groups
- Referral to community resources
- Triage for other mental health conditions



Community Linkages

What are they?

- DV advocacy
  - 24-hour crisis response line
  - Danger assessment, safety plan
  - Emergency shelter; transitional housing
  - Other services: MH counseling, legal services, Job counseling,
- Family Justice Centers, law enforcement

Features of effective and sustainable approaches

- Address the clinician's concern:

  What do I do when she says "yes"?

- Be patient centered
- Encourage multiple points of engagement
- Partner with community agencies
- Build on already existing resources

Leadership, Sponsorship, and Quality Improvement

DV Services Must Support National Health Care Priorities

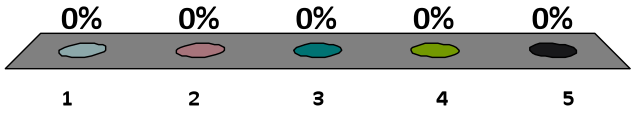
- Patient centered
- Safe, effective, efficient care
- Evidence informed
- Reduce healthcare disparities
- Prevent injury and chronic disease
- Improve population health and wellness

Health Care Based Domestic Violence Programs

Some Successful Models

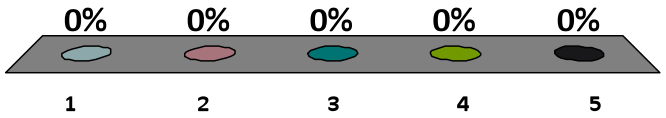
Which statement best describes your health care based DV advocacy program?

1. Uses dedicated, on-site DV advocates who are employees of the local DV agency
2. Uses dedicated, on-site DV advocates who are employees of my health care setting
3. Uses trained social workers or other trained health care staff to provide DV intervention
4. Does not yet have a DV program but I am interested in creating one
5. Other



Which statement best describes your setting?

1. Single hospital
2. Hospital with several affiliated clinics
3. Health care system with multiple facilities in a single area
4. Multiple organizations across the country
5. Other



WomanKind-

An Integrated Model of 24-Hour Health Response to Domestic Violence

"Health care providers may be the first and only professionals in a position to recognize violence in patients' lives".

Randall T., 1991; Short L, Hadley SM, Bates B, 2002.

WomanKind Model

"A Public Health Philosophy"

- Routine screening and assessment, identification and early intervention may result in the prevention of:
  - serious injuries & symptoms
  - mental health & psychiatric disorders
  - child abuse, violence & neglect
- WomanKind Vision:

To *integrate the issue* of domestic violence into the total health care of each patient, resulting in *comprehensive system change.*

DV Response in the Model

- 24/7 on-site case management / advocacy client services throughout health system by WK staff and volunteers
  1. Assessment and identification
  2. Service planning
  3. Coordination and monitoring
  4. Support and advocacy (volunteers)
- Education, training, technical assistance, consultation with health providers by program managers / director
- Advisory Board
- Funding: health system, hospitals' auxiliary; community

Training Features of the Model

- **DV training throughout hospital, medical offices, clinic staff:** nurses, physicians, aides, clerks, receptionists … all who interface with patients
- **Ongoing consultation** with health providers
- **Specialized training with professional staff** for issues and problem-solving
- **Technical assistance & training** in Twin Cities, including regionally / nationally
- **44-Hour volunteer training 2X year**
- **Medical Records:** WomanKind professional staff chart in medical chart to improve communication on patient care
- **Referrals to WK**: ED, OB, SW, Clergy, MedSurg, Chem Dep, mental Health, Oncology, Community

Strengths of the Model

CDC Evaluation of WomanKind

- **Integration into health system → system change**
  - 1,719 patients/victims identified / referred to WomanKind
  - 27 victims identified / referred to SW at comparison hospitals
  - 2,531 medical records ED providers at WK hospitals documented twice as frequently as ED providers at comparison hospitals.
- **Specialized health providers training** produced a significant, positive impact on KABB of health providers interacting with IPV victims

  → **A fundamental component of the WomanKind program**
- **Structured marketing campaign** to inform health providers and community members of program services
- **Evaluation: Overwhelmingly positive response** by heath care staff about WK program and their role within system.

Disadvantages of the Model

- Volunteer Program
  - Training, scheduling, supporting
  - Time consuming
  - BUT, provides 24/7 client services and continuing contact with patients after dc
- **Precarious funding** to finance program manager at each site

CDC Evaluation of WomanKind

Summary of Findings

The WomanKind program facilitated significant positive increases in -

- Health providers' awareness and belief that they **"can do something about it"**
- Health providers' confidence in their ability to **identify victims**, **communicate with** and **refer victims**
- Health providers' **screening** of patients
- Health providers' **documentation** in medical record
- Clients **receiving assistance**

Pennsylvania Coalition Against Domestic Violence Model

Nancy Durborow, MS

PA Advocacy-Focused Model

- Based on Womankind Model
- Collaboration between health care systems and local domestic violence programs
- Systems change through institutionalization of policy/ procedures and training
- Domestic violence services in the health care setting by advocate employed by local domestic violence program and based in the health care system
- Funded by general state dollars, block grant monies, TANF

DV Response in the Model

- Multidisciplinary Team with embedded decision making ability
- Response By:
  - Trained domestic violence advocates/immediate response
  - Trained hospital personnel or volunteers as backup
  - Trained on call domestic violence advocates
  - Follow-up response system when backup not available
  - On-site support groups
  - Follow-up services offered by advocates in health setting

Training Features of the Model

- DV101 with health impact for all staff
- Advance training for staff designated to conduct identification, assessment and referral/security
- Advance training for hospital staff providing services when advocates not available

Sessions vary:

- Health system employees; orientation for all new employees; grand rounds; department in-services; shift change; on-line training in larger systems; hospital wide events
- Students in teaching hospitals

Room for Improvement - Disadvantages

- Hospital/clinic based model that often does not include/reach primary care practices
- Precarious nature of public funding
- Need for continual advocacy
- Domestic violence program resources dwindling

Coalition's Role

- Funding – Obtain and distribute
- Specialized training for domestic violence advocates
- Technical Assistance
- Public Policy
- Medical Advocacy Task Force/ Coalition Structure
- Evaluation/standards/monitoring

Systems-Focused Model

Danica Delgado, MSW
Hartford Hospital

Elizabeth Stern, MPH
Duke University Health System

Systems-Focused Model

- Hospital or health system-wide program
  - Focus is systems change through policy/procedure development, and training of staff to identify and provide intervention
  - Formal response exists for patients and employees
- Hospital/health system-funded
- Staff/support
  - Program manager who focuses on systems-level work
  - Direct care provided by SW/nursing staff
  - Multi-disciplinary advisory board with champions

DV Response in the Model

- Referrals come from any MD/mid-levels, RNs, or other clinical team members in any unit or clinic
- Response by trained SW or health care staff
- Response is available immediately, 24/7
- Continuing medical care is scheduled, as needed
- Patient is referred to DV agency for ongoing services
- Tools/materials
  - Support for responders
  - Patient education

Training Features of the Model

- Two levels:
  - Basic training for medical/nursing staff around identification, assessment, and referral
  - Advanced training for DV responders (SWs, RNs)
- Trainings facilitated by program manager
- Sessions vary:
  - Hospital/health system employees
  - Learners
  - DV agency hospital response advocates

Challenges

- One program manager/trainer for entire system
- Program relies on local DV service provider for ongoing support to patients, yet has no control over the quality of those services
- Precarious/capricious nature of hospital funding
- Reliance on constant advocacy with administration/ decision makers

Strengths of the Model

- Low cost
- Program manager as hospital staff is well-integrated
- Internal staff is available 24/7 for referral
- Resources of hospital are accessible
- Creates connections with champions throughout system

Unexpected Responsibilities

Employee Domestic Violence:
How to Raise the Issue

Staff education:

- Awareness–raising about DV as an issue that also impacts employees
- Educating both employees and managers
- Utilizing the theme: “Are you concerned about a coworker?”

Employee Domestic Violence:
Raising the Issue

Venues for Education:

- Policies
- Orientations
- HR staff training and manager training
- Management forums
- Employee council
- Leadership core courses
- Staff development courses
- Health and safety events
- **Every DV training event**

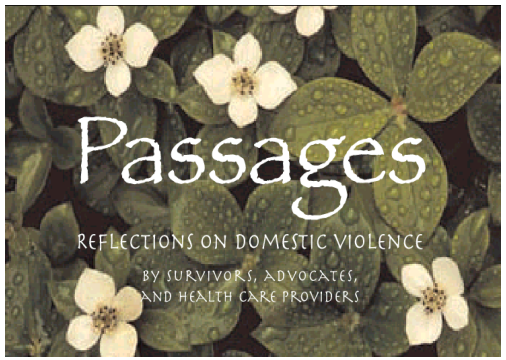
Employee Domestic Violence:
Who is Involved in Response

- Identify key departments:
  - DV program
  - EAP
  - Security
  - Occupational Health
  - Human Resources
  - Social Work
- Convene a Resource Team
- Train managers
- Train all staff in key departments

Passageway Model

Annie Lewis-O'Connor, PhD, NP, MPH

Brigham and Women's Hospital



Evolution of a Hospital Based Domestic Violence Program

PASSAGEWAY

1997

- 1997- Soft funding
- Steering committee formed
- Patient focused
- Staff: 2 advocates providing services to entire hospital

2012

- 100% supported by institution
- Advocates in 2 hospitals, 3 health centers and community (8.5 FTE)
- Forensic nurse examinations for IPV
- Based in the Center for Community Health and Health Equity
- Viewed in the context of a social determinant of health
- Focused on intersection of violence and health
- Patient, employees and community members
- Education and training

Future

- Intervention and PREVENTION of all intentional violence
- Expand forensic nursing services
- Evidence based
- Innovation
- Coordination across service lines AND with community

Kaiser Permanente Model

Brigid McCaw, MD, MPH, MS

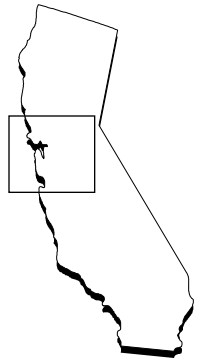
The Kaiser Permanente Approach

"Making it easier to do the right thing"

1998 KP NCal
DV Prevention Teams

KAISER PERMANENTE

NORTHERN CALIFORNIA

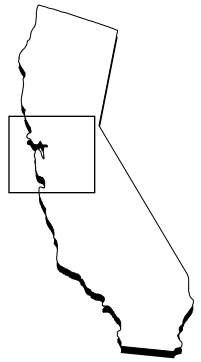


PACIFIC OCEAN

2008 KP NCal
DV Prevention Teams

KAISER PERMANENTE

NORTHERN CALIFORNIA



PACIFIC OCEAN

Implementation of IPV Services Underway in Every KP Region

"Scaling up"

- Simple map, step-wise implementation
- Champion, multi-disciplinary team every facility
- Implementation tools
- Regular meetings of facility champs and teams
- Quality improvement measures
- Use of new technology
- Big vision

AHRQ Innovations Solution: "Family Violence Prevention Program significantly improves ability to identify and facilitate treatment for patients affected by domestic violence,"
http://www.innovations.ahrq.gov/content.aspx?id=2343

Phases of Implementation

Intimate Partner Violence Prevention

Oversight:

Phase 1: ▪ Identify Physician/NP Champion; ▪ Create implementation team; ▪ Develop protocol for referral to mental health services for crisis and non-crisis IPV+ patients

Phase 2: ▪ Identify priorities and set timelines for the implementation team

Phase 3: ▪ Oversee implementation and training plan ▪ Use NCQA quality reports to guide implementation

Phase 4: ▪ Develop plan for long-term sustainability; ▪ Incorporate IPV prevention training into yearly staff trainings and new employee orientation

INQUIRY and REFERRAL

Phase 2:
- Develop process for making tools available to clinicians for evaluation, documentation and reporting

Phase 3:
- Provide trainings to MDs, NPs, nurses in ED/MIIC, Primary Care, Psychiatry, Specialty Depts, and the hospital on how to inquire, evaluate, document, report, and how to use the Tools Tile and OSCR;
- Provide training for support staff (MAs, receptionists) in ED/MIIC, Primary Care, Psychiatry, other Specialty Depts and the hospital;
- Provide training for PT, Chronic Care Managers and Health ED instructors;
- Develop plan for training managers on employee IPV issues

Phase 4:
- Establish Call Center protocols;
- Establish quality improvement measure for processes for inquiry and referral to on-site mental health clinicians;
- Coordinate/participate in workplace response to IPV
- Coordinate services between in-patient and out-patient setting

ON-SITE IPV SERVICES

Phase 2:
- Provide trainings and tools to mental health clinicians receiving referrals

Phase 3:
- Establish link between mental health providers and community advocacy organization
- Develop system for providing updated community resource materials to mental health clinicians

Phase 4:
- Develop systems for the following:
  a. Coordination between departments and clinicians providing mental health services (ex: Social Services and Psychiatry);
  b. Referral from mental health to community advocacy agency
  c. Provision of feedback to front-line clinicians regarding mental health services provided to individual patients
- Increase awareness of Employee Assistance Program (EAP) as a resource for KP employees affected by intimate partner violence

SUPPORTIVE ENVIRONMENT

Phase 2:
- Identify staff within Health Education department to participate on the implementation team, and to provide oversight for the environmental setup

Phase 3:
- Place appropriate materials in exam rooms, waiting areas, and restrooms
- Establish mechanism for restocking materials in exam rooms, waiting areas and restrooms

Phase 4:
- Develop outreach and publicity plan (such as articles in Member News, employee newsletter, etc.)
- Promote awareness of resources for Kaiser Permanente employees affected by intimate partner violence

COMMUNITY LINKAGES

Phase 2:
- Identify local community advocacy organization and invite a representative to implementation team meetings

Phase 3:
- Develop agreement with community advocacy organization for protocol for calling their emergency response team, availability of support groups, and materials to facilitate referral and follow-up;
- Identify other community resources such as law enforcement, judiciary/courts, Child Protective Services, and Adult Protective Services;
- Identify Kaiser liaison to communicate with community advocacy representatives and facilitate their inclusion in meetings and trainings

Phase 4:
- Actively engage in collaborative activities
- Develop and implement a tracking mechanism for evaluation of collaboration
- Explore opportunities for work with employer groups

Implementation: Getting Started

Step 1

- Form a local multi-disciplinary team with clinician champion
- Develop protocol for patients in urgent and non-urgent situations
- Identify community resources and develop partnerships

Step 2

- Visible patient education materials
- Ensure that on-site services are in place
- Choose quality measures and annual goals

Stakeholder communication and engagement

Implementation: Next steps

Step 3

- Clinician training- brief, frequent. Include tools and stories.
- Trend progress over time
- DV resources for employees

Step 4

- Leadership training for champion and teams
- Link to other initiatives- electronic medical record, chronic conditions
- Sustain partnerships with community advocacy
- Highlight ‘promising practices’

Stakeholder communication and engagement

Technology Can Improve Care and Facilitate "Scaling up"

Clinicians

- Tools in electronic medical record
- Intranet resource sites
- Training, quality improvement

DV Implementation Teams

- Tools, materials, resources

Patients

- Online information, resources
- Advice and Appointment Call Center

Looking toward the next decade…

Kaiser Permanente will continue to transform the health care response to Domestic Violence

Empowering. Offering Hope. Breaking the Cycle.

http://www.youtube.com/watch?v=uocoMbCg9N8

Talking Together

Small Group Discussions about Programmatic Challenges

Domestic Violence Training for the Health Care Setting

A Kaleidoscope of Methods

Advancing Practice Through Education

- Traditional didactic opportunities
- Yearly program with local and national scholars
- Credentialing (on-line training) for all providers
- Yearly competency - Healthstream
- Huddles at bedside, on units -- use to educate
- Notification of high risk cases via emails

Advancing Practice Through Education

- Keeping administration informed
- Use survey monkey to understand areas of improvement and opportunities for improvement
- Conduct quality assurance/reviews on ALL DV cases
- Develop a dash board- collect data on ALL DV cases

Some Training Methods

- Case studies
- PowerPoint strategies
- On-line skill-based training

Case Studies

As Teaching Tools

How to Advance the Practice using Case Studies

- **Case:**
  - 30 y/o mother arrives in ED by ambulance after teenage daughter finds her in kitchen unresponsive with blood on her face.
  - Workup in ED- broad- infectious, trauma, neuro, cardio-vascular….
  - 2 days later- disclosure of strangulation- never considered as differential diagnosis

Case Studies

- Interdisciplinary Grand Rounds
  - ICU
  - Emergency Department
  - Trauma Team
  - Neuro…etc
- Quality and Safety Rounds
- Notification of Risk Management
- Notification of Senior/Administration -- include in daily reports
- Use Marketing and Communication Departments

Presentations and PowerPoint

Strategies

Creating Wildly Successful Presentations

1. Learners want to know : “What’s in it for me?”

2. The audience will take away a theme and a few points at most

3. **You** are the presentation, PowerPoint is the *tool*

No More Death by PowerPoint!

- Clean, minimalist slides work
- Busy slides distract from you
- Audience involvement and engagement are key
  - Emotional engagement
  - Stories and cases
  - Learner-focused activities

READABILITY

- Make your text large enough

Make your text large enough

- CAPITALIZE AND COLOR ONLY TO EMPHASIZE

Capitalize and color only to EMPHASIZE

- Use a text color that contrasts with the background

Use a text color that contrasts with the background

- Use simple sans serif fonts

Use simple sans serif fonts

Some Sample Slides

THE GOOD, THE BAD AND THE UGLY

Child Exposure to Domestic Violence: Consequences

Behavioral/ emotional Sxs

- Depression
- Suicidality
- Substance abuse
- Withdrawal
- Aggressive behavior
- Truancy
- Criminal actions

Compromised cognitive development

Diminished social skills

Health problems

Risk of inadvertent injury

Risk of physical and sexual abuse

BETTER

Children hurt too

OK

Barriers to Leaving a Violent Relationship

- **Emotional effects of abuse**
  - Domestic violence can take a huge toll on health and mental health. Depression, post-traumatic stress symptoms, and damaged self-esteem can impact a victim's ability to plan and execute a change
- **Financial constraints**
  - Economic control, lack of work experience, and inability to support children can make leaving seem impossible
- **Fear**
  - Abusers often threaten harm, and their history of willingness to use violence backs it up
- **Cultural and religious pressures**
  - Messages from family, community, or faith system can keep victims trapped
- **Poor system response in the past**
  - Victims who have reached out and been blamed, disbelieved, or dismissed are unlikely to ask for help again from police, legal system, clergy, or healthcare providers
- **Hope and Love**
  - Abusers often promise change, and victims often have conflicted feelings about leaving

BETTER

Patient and Children

Remember,
Wildly Successful Presentations…

- Identify what's in it for me? and theme/ points
- Focus on YOU as the presentation, PP as the tool
- Use PowerPoint to engage
- Have slides that enhance, not distract

Online Training

Some Examples

Online Training for Clinicians (Inquiry and Referral)

How to provide a brief, caring, effective intervention
(14 minute training)

HHS Office on Women's Health

Education & Training of Health Care Providers & Students as a Coordinated Public Health response to Violence Against Women

Components

- Core curricula components
- Electronic and Web-based
- Video modules with case specific scenarios
- Homework assignments & recommended readings
- Evidence based references, state reporting requirements, database of resources and referrals
- Culturally competent
- Specified target populations
- Evaluation

Reproductive Coercion Vignettes

Marta: Oral-Contaceptive Visit

Maya: Repeat Pap, Emergency Contraception Visit

Measurement and Evaluation

Quality Improvement (QI) Measures in Health Care Based Domestic Violence Programs

Why are QI Measures so Important?

- How are we doing?
- Where and how should we target our efforts?
- Alignment with organizational priorities
- DV is similar to other health issues--we can measure how we are doing and improve.

Focus Areas for Measurement

- **Clinic, hospital, health care organization**
  - Delphi Instrument for Hospital Based Programs and Family Violence Quality Assessment Tool for Primary Care Offices
  - Process measures: champion, team, referral protocol
- **Clinicians or Health care providers**
  - Pre and post training surveys
  - Case studies
- **Patients**
  - Screening, identification, referral
  - Satisfaction, qualitative experience

Delphi Instrument
Domains of Program Activities

- Policies and procedures
- Physical environment
- Cultural environment
- Training of Providers
- Screening and safety assessment
- Documentation
- Intervention Services
- Evaluation Activities
- Collaboration

PCADV Health Care Provider Evaluation Toolkit

Measuring Knowledge, Attitudes and Practice

- 7 instruments

  5-question survey designed to gather information on the audience being trained - to a

  52-item survey designed to measure healthcare provider knowledge, attitudes, beliefs, and intended behaviors.

- All validated tools

Tools

The Respondent Profile is a five question survey designed to gather basic demographic and other information about the audience attending a training session or program.

The Respondent Profile II includes all questions on the Respondent Profile and adds additional questions on the type of clinical practice, previous training received in domestic violence, and the number of patients seen by the participant.

The Practice Issues Survey solicits specific information about the provider's experience in screening and diagnosing domestic violence and the use of patient education and referral resources.

Tools

The Presenter Evaluation Form consists of 10 questions designed to gain feedback from the audience and measure the effectiveness of the trainer.

The Presentation Evaluation Form contains 22 questions that focus more specifically on the content of the training and the usefulness of the material provided to the audience.

Tools

The Domestic Violence Healthcare Provider Survey is a measure of domestic violence-related knowledge, attitudes, beliefs and self-reported behaviors. This survey contains 42 items that are formatted on a response scale with ratings ranging from 1 to 5.

The Healthcare Provider Survey on Intimate Partner Violence is designed to measure health care provider knowledge, attitudes, beliefs, and intended behaviors associated with intimate partner violence. It is comprised of 52 items which are formatted on a response scale ranging from 1 to 7.

Show Me the Numbers

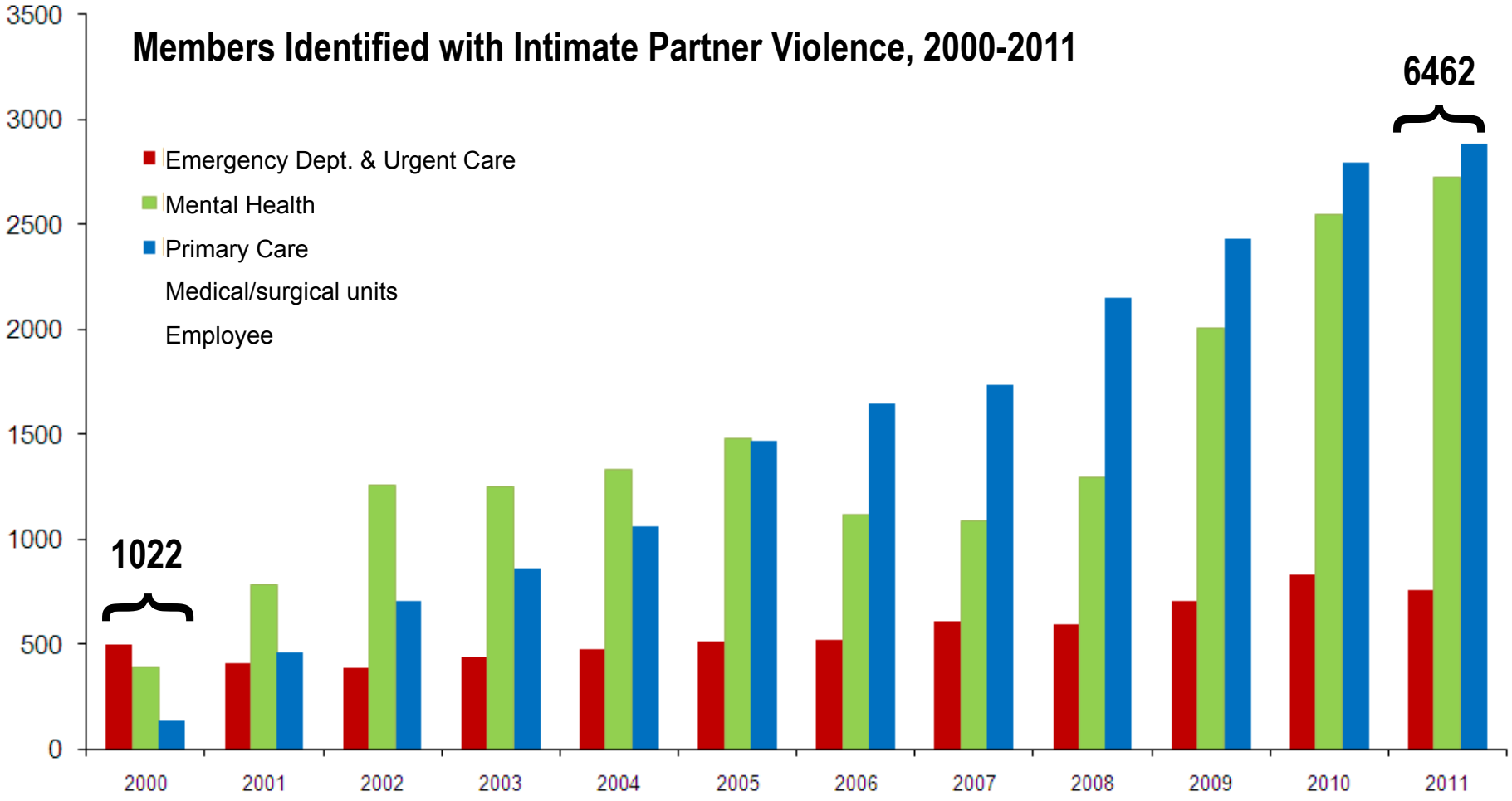
- Creating a "DASH Board" with IT to assess before, during and after an intervention (proactively collecting data)
- QI ALL cases of IPV, SA
- Link to organizational and industry standards
- Create a follow-up system (i.e., After Care Clinic)
- Include both quantitative and patient's narratives
- Who will you disseminate information to?

Kaiser Permanente
Quality Improvement Measures

- Use automated database
- Make sense clinically
- Actionable
- Linked with NCQA standard

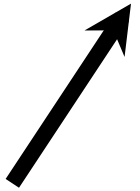
NCQA: "QI 11 – Demonstration of a health program showing continuity and coordination between medical and behavioral health care."

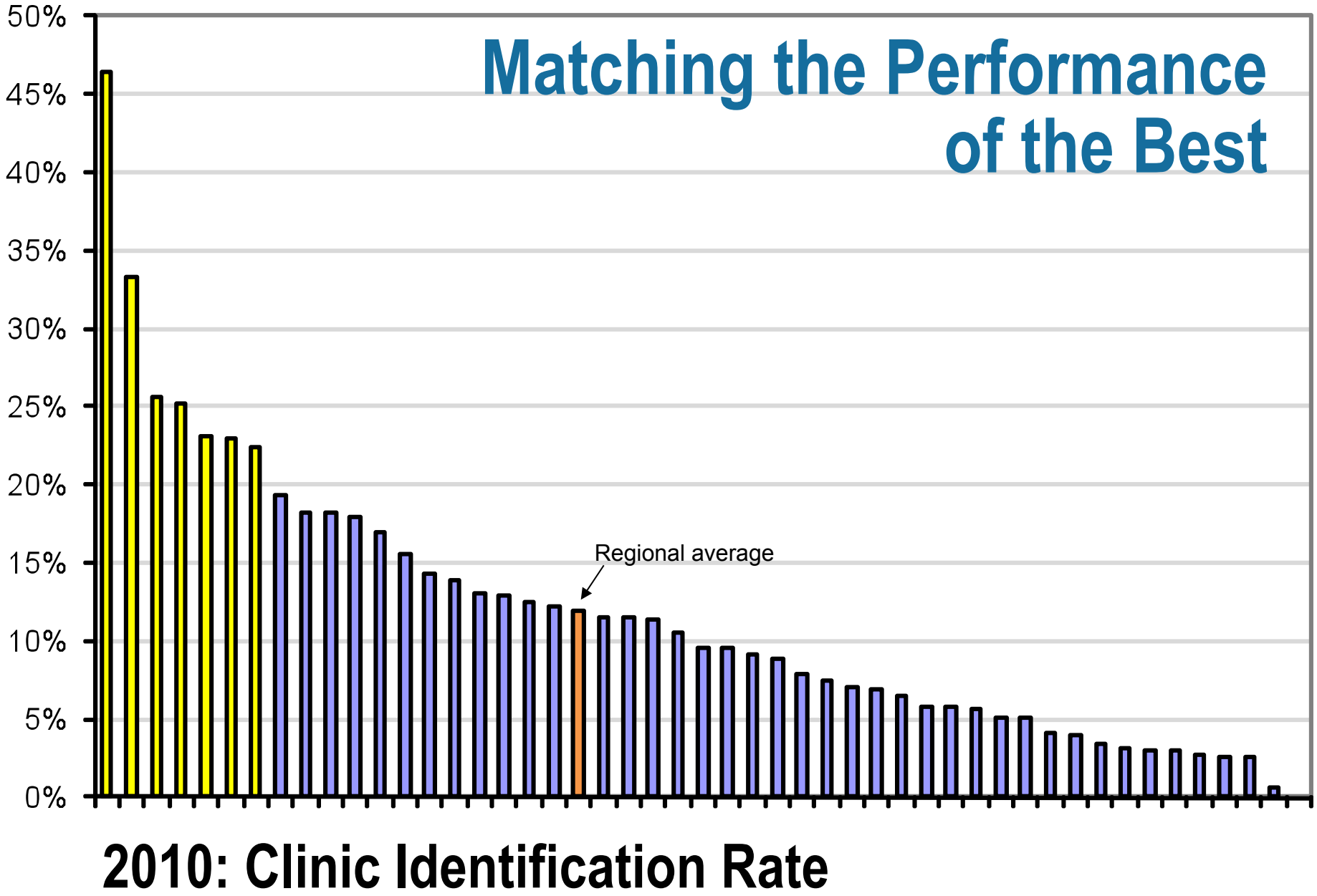
KP Northern California
Six-fold Increase in IPV Identification



Women's Health Dashboard
Outpatient Quality Metrics

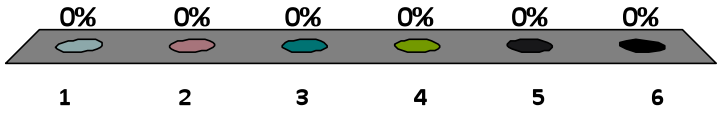
Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening	Post-Partum Visit Rate	PreNatal Entry	Intimate Partner Violence




Matching the Performance of the Best
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Regional average
2010: Clinic Identification Rate

What is your preferred method for connecting with others doing DV work in health care settings?

1. Informal email list
2. List serve
3. Facebook group page
4. Webpage
5. Other method not listed
6. I am not interested at this time



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