Session title:

"Getting providers up to speed on IPV, strangulation, and screening: Educational programs for clinicians"

National Conference on Health and Domestic Violence

March 21, 2015

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Our Presentation Today:

An education program for healthcare providers designed to expand and enhance effective routine screening and the utilization of or referral to institutional and local resources.

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Program impetus/development

- Community along with local healthcare institutions recognition of DV/IPV as a healthcare issue

- Professional development programs designed to improve healthcare providers understanding and response to DV victims and survivors

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Project funders

- Verizon Foundation funding x 3 years, supporting and encouraging our expansion to other regions of the country
- 2014, secured a second focused grant from *The Healthcare Foundation of New Jersey*, to target only healthcare providers in 3 key counties of northern New Jersey

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Program research

Evaluation of program goals and overall efficacy.

Research design and compilation completed by

RUTGERS

The State University of New Jersey

School of Social Work

Center on Violence Against Women & Children

Project conducted by Laura Johnson, MSW

Under the leadership of

Sarah McMahon, MSW, Ph.D.

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Key components

- Word of mouth or key connection
- Free/low cost
- Continuing education credits (nurses, physicians, social workers – and some programs included additional disciplines)
- Pre-test, post-test, post posttest (one month later with participation incentive)
- Evaluation of the program – feedback encouraged

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Find and repeat what works

- Bring it to the participants, go where they are hospitals, healthcare centers and offices
- Bring food – breakfast, lunch or dinner
- Follow up with an e-newsletter, articles, etc.
- Presenter - a healthcare provider who has broad knowledge regarding DV/IPV
- Presenter is engaging and makes a difficult topic meaningful to the learners

Expanding the program… Beyond New Jersey

- Sought and established academic medical partners in Columbia, Missouri & Miami, Florida
- Phone collaboration followed by onsite collaboration to customize program for partners unique regional/population needs
- Assist in process of outreach to local hospitals
- Coordinate logistics, registrations and CEUs in other states

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Program core content

- Domestic Violence Background: National/Local State Facts
- Barriers to Effective Screening
- Screening Strategies
- Identification Indicators
- Resources and Referral Information

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Participant objectives

- Recognize the impact of domestic violence on the health of the public and chronic health conditions strongly correlated with a history of IPV
- Identify barriers that prevent or negatively impact IPV screening/referring, and develop ways to address and/or remove them
- Demonstrate effective routine screening and assessment of patients; refer those who respond affirmatively to appropriate services in the healthcare setting or community
- Identify and provide patients with appropriate community resources

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Program Reflection

Strong women and
Strong men
protect the children,
tend the ailing,
care for the aged,

and in fact,

reassure
the entire world.

Maya Angelou

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Program Dedication

Honoring the victims and the survivors…

May we listen to their voices,
hear their stories,
learn from what they share
and honor their lives ~ always.

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Setting the stage…

- Facts, prevalence and impact on health
- Dynamics of DV/IPV

Deeper Dive –
General Health Effects of IPV

- Headaches
- Dental issues
- Eating Disorders
- (Chronic) pain
- (Chronic) fatigue
- PTSD symptoms
- Depression
- Anxiety
- Suicidal ideation/attempts

- STDs
- Pregnancy complications
- Substance abuse
- (Chronic) abdominal pain/GI symptoms
- CNS and cardiac symptoms
- Acute trauma/injuries
- Death

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Health Care Barriers – or what gets in the way of effective and compassionate screening and referral:

- **Unaware prevalence**
- **Limited initial/continuing education**
- **Provider attitudes/misconceptions**
- **Time consuming**
- **Discomfort (two-way)**
- **Victim's reluctance to tell**

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Explore Patient Barriers

Discuss with healthcare providers how/what might a victim or survivor of domestic violence feel at the moment of being screened?

- **Fear**
- **Embarrassment**
- **Guilt**
- **Shame**

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Discuss healthcare's role to date

***Stop for a minute and reflect… as a* patient yourself**, *how often have you been screened for DV/IPV*?

- **Every visit;**
- **Frequently;**
- **Occasionally;**
- **Never**

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Why Routine Screening?

January 2013 (revised from 2004 statement)~

USPSTF Recommendation Statement Summary:

"…recommends that clinicians screen women of childbearing age (14-46) for IPV, (domestic violence) and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse."

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Participant comments

A physician - *"Routinely screening with practice will become easier for myself and will hopefully lead to better care of patients - especially those who are victims of DV"*

"Routine screening sends a strong message that DV is unacceptable and help is available."

"Screen regularly and be compassionate; don't blame the victim by asking why she stays."

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You may not think you need to say it…

The patient should be ALONE at the time of screening

No family or others present

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Different formats for questions

- **Direct**
- **Indirect**
- **Framing**

Screening Techniques/Tools

There are many - an acronym may help:

- **A**= ALONE
- **B**= BELIEF
- **C**= Confidential
- **D**= Document
- **E**= Educate
- (**S**= Safety)

Screening Techniques/Tools

- **R**=Remember to routinely screen
- **A**=Ask direct questions (you may begin with indirect or framing questions if more appropriate)
- **D**=Document your findings
- **A**=Assess patient safety
- **R**=Review options and referrals

Adapted from RADAR developed by the Massachusetts Medical Society 1992

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Screening Techniques/Tools

- It may be all about ***how you ask*** and the moment in time (is it safe to disclose)
- There is value in empathy –remember the feelings someone may have considering discloser
- Building shame resilience requires:
  - **Communication**
  - **Connection**
  - **Compassion**
  - **Courage**

Participant comment

OB nurse - *"I definitely feel the training on DV was an asset to my profession personally and could be for so many others in the healthcare profession. When the red flags go up when doing an intake in OB, I have learned to be more patient and wait for the right time to ask about DV. Being able to provide that alone time with the patient, giving the [patient] the opportunity to verbalize freely makes a huge difference in the response."*

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Provide a variety of question examples

"I don't know if this is a problem for you, but some of the women I (we) see are dealing with abuse in their relationships.

Some are too afraid or uncomfortable to bring it up themselves, so I (we) have started to ask about it routinely."

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Be ready for any response when routinely screening…

- **Prepare your verbal and non-verbal response (BREAKOUT session)**
- **Keep a list with referral information handy**
- **Provide an opportunity to contact referral agency from your office/agency**
- **ASK and ASSIST in Safety Planning and promotion of Safety Behaviors**
- **How to validate…**

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Participant comment

ED Nurse Educator - "The nurse pocket cards included in the materials are a great idea that I have decided to duplicate and implement. I feel that all bedside nurses should attend this training because it is often a challenge for staff to understand the dynamics of abusive relationships. They would be more supportive of the patients who are victims if they got this clearly beneficial training. The safety planning information was also particularly helpful."

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Posttest question: "…how likely are you to use the screening tools and resources discussed during this training?"

- **97 percent said they were "likely or very likely" to utilize the tools and resources provided during this training.**

- **On average 67 percent indicated that they had screened patients for domestic violence or sexual assault during the month following the training**

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Total educated Verizon Grant *Year 2014 = 427*

- **368 healthcare providers attended a 3-hour in-person seminar, in all 3 states**
  - **Missouri – 124 providers**
  - **Florida – 121 providers**
  - **NJ - 123 providers**
- **In NJ, an additional 59 providers attended a one-hour in-person presentation, or a webinar**

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Total educated overall

- Pilot presentation March 2012 = 27
- 2012-2013 Verizon Foundation funding = 447
- 2013-2014 Verizon Foundation funding = 427
- 2014-2015 Healthcare Foundation of NJ Funding= 138
- Other 2014-2015= 68
- Total to date = 1,107

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Program Evaluator Report

Domestic Violence and the Role of the Healthcare Provider Seminar

Following are table highlights from the final report compiled by our evaluators, Laura Johnson, MSW and Sarah McMahon, MSW, Ph.D. at the Center on Violence Against Women and Children - Rutgers University, School of Social Work

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Paired sample t-tests:

Table 18. Beliefs about Domestic Violence Dynamics & Survivors	Average Pretest	Average Posttest	Significance Level
It is never the victim's fault if her partner abuses her/him. (n=259)	4.27	4.59	$p < .001$
Women who experience IPV are common in the healthcare setting. (n=255)	3.77	4.43	$p < .001$
Most women will disclose about IPV if I ask them. (n=260)	2.45	2.71	$p \leq .001$
Domestic violence is more common in pregnant women than many other pregnancy conditions. (n=260)	3.51	4.46	$p < .001$
Abused women are often not identified when they utilize the healthcare system. (n=260)	3.93	4.39	$p < .001$

Paired sample t-tests:

Table 21. Beliefs about Domestic Violence Dynamics & Survivors	Average Pretest	Average Post Posttest	Significance Level
Women who experience IPV are common in the healthcare setting. (n=72)	3.79	4.22	$p \leq .001$
Domestic violence is more common in pregnant women than many other pregnancy conditions. (n=72)	3.58	4.26	$p < .001$

Paired sample t-tests:

Table 19. Professional Confidence with Working with Survivors of Domestic Violence	Average Pretest	Average Post Posttest	Significance Level
I feel confident in my knowledge of strategies to help victims of domestic violence. (n=71)	2.99	3.79	p < .001
I feel confident I can make the appropriate referrals for women who are victims of violence. (n=72)	3.39	3.97	p < .001
I feel prepared to provide services to patients experiencing domestic violence or sexual assault. (n=72)	2.97	3.69	p < .001

Remember the ripple effect…

- Based on the number of patients reported to have been seen/screened by participants per week it is estimated

  2,120 patients may have benefited on a weekly basis as a result of their provider attending Domestic Violence and the Role of the Healthcare Provider

- Or **110,240** annually
- With just 23 percent of the sample (100 participants) responding to this question, it is our hope that an even greater number of patients may have potentially benefited from the implementation of this training

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Domestic Violence *and* Health Care

Continuing to shift perspective…

"…redefining the goals of routine screening, so that the act of compassionate asking in and of itself , rather than the outcome of disclosure, constitutes success."

Annals of Internal Medicine; October 1999

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Participant comment

Clinical Nurse Educator - “In my previous role as a behavioral health nurse, we screened all patients for DV. I think that as a result of attending the training, the way that I would ask the required questions would be different. I also have a change in my thinking as to why would you stay in a situation where DV was taking place. I can now put the responsibility where it should be – with the abuser. I did recommend this seminar to others after attending, and I presented the webinar in a Nursing Grand Rounds forum at our facility.”

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Domestic Violence *and* Health Care

"Never doubt that a small group of committed citizens can change the world. Indeed, it is the only thing that ever has."

Margaret Mead

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