An Evaluation of Intimate Partner Violence Services at a Pediatric Hospital

Mario Cruz, MD, FAAP
Assistant Professor of Pediatrics
St. Christopher’s Hospital for Children
Drexel University College of Medicine
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Disclosures

Dr. Cruz is on the speaker’s bureau for the Institute for Safe Families but has no commercial conflicts of interest to disclose.
Intimate Partner Violence *is* a Pediatric Issue

Eat your vegetables.

Don’t play with matches.

Finish your homework.

Respect women.

Thackery JD, et al. 2010
Barriers to IPV Screening

Personal Factors:
- Did not know that IPV was a pediatric issue
- Did not know how to screen for IPV
- Did not feel comfortable screening for IPV
- Forgot to screen for IPV

Systems-based factors:
- No protocol to manage positive screens
- Lack of time

CAMP- Children and Mom’s Project

• Collaboration with:
  – Lutheran Settlement House’s IPV Program
  – Institute for Safe Families

• Bilingual IPV counselor available 40 hrs/week
  – 4 days onsite
  – By pager on Fridays
  – Immediate and ongoing counseling services
The SCHC Approach to IPV: Frequent Education

- IPV education built into:
  - Pediatric residency curricula
  - Nursing “extended core” curricula

- Hospital-based Departments
  - Offered training annually and upon request

- New employee orientation
Utilization of IPV “Champions”

- From multiple disciplines:
  - Attending Physicians
  - Nurses
  - Social workers
  - Resident physicians
- Educate their colleagues on IPV
- Encourage screening for IPV
- Design protocols for IPV screening
IPV screening protocols

• All staff encouraged, but not expected to screen
• Verbal screening techniques
  – RADAR cards
• Do not screen if:
  – Another adult is present
  – Lack of privacy
• Caution if:
  – Child > 3 year old
• Document only with permission
Objective:

Describe the utilization of IPV services at St. Christopher’s Hospital for Children
Methods

• Retrospective review of all IPV client charts
• 53 months between Sept 2005 - Feb 2010
• Medical records were not reviewed
• Inclusion criteria:
  – IPV victim identified by SCHC staff
  – IPV victim interested in IPV services
  – IPV victim received services from our IPV counselor
Methods: Variables assessed

- IPV victim demographics
- Referral source
  - Hospital staff member
  - Hospital department
- Type of IPV screening
  - Routine vs. risk factor based
- Services provided by IPV counselor
- Rates of longitudinal service use
Results:
Number of IPV Victims Identified

• 453 unique IPV referrals over 53 months
  – 101 new referrals per year
  – Approx 8 new referrals per month
  – Range of 0 to 21 new referrals per month

• No identifiable temporal referral pattern
Demographics of New IPV Referrals

• IPV victim age
  – Range 14 – 71 yrs
  – Median of 24 yrs

• Number of dependents
  – 4%  Zero
  – 41%  One
  – 23%  Two
  – 32%  Three or more

• IPV victim gender
  – 100% Females

• IPV victim race
  – 44% Latina
  – 40% African American
  – 10% Caucasian

• IPV victim zip code
  – 33 zip codes
IPV Referral Source by Hospital Department

- Primary Care Offices: 35%
- Inpatient Units: 26%
- Emergency Department: 11%
- Subspeciality Clinics: 13%
- Child Protection Program: 7%
- Employees: 4%
- Other: 4%

N=453
IPV referral source by hospital staff

- Social Worker: 55%
- Attending Physicians: 17%
- Residents: 13%
- Nursing: 7%
- Self referral: 4%
- Other: 4%

N=453
Type of screening used to identify IPV victim

- Routine Screening: 73%
- Risk factor Screening: 27%

N=277
IPV services utilized by new referrals

- Supportive Counseling: 63%
- Safety Planning: 50%
- *Other: 22%
- Housing Support: 13%
- Legal Support: 10%
- Sexual Safety: 6%

N=453

*Other = mental health referrals, in-kind donations, financial planning, social service advocacy.
Time required for IPV new referrals

N=453

Range 5-300 minutes
Mean = 42 minutes
Median = 32 minutes
Longitudinal IPV service utilization

- Longitudinal use:
  > 3 encounters AND > 15 minutes of utilization
- 69% used services briefly
- 31% used services longitudinally

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More recently...

240 unique referrals in the last 12 months

3 former resident champions are now on the attending staff
Conclusions

• Hospital-wide IPV screening can be successful in pediatric settings

• Recommendations for other institutions:
  – *Routine* screening for both inpatient *and* outpatient settings
  – Supplement verbal screening with written screening
  – Designated IPV counselor

• Many QI opportunities exist
Thank you!

**IPV counselors**
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Ramona Peralta, BA

**Research assistants**
Ryan McGorty, MPH
Christine Weirich, MPH

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Martha Davis, MSS
Cynthia Delago, MD
Sandra H. Dempsey, MSS
Angelo Giardino, MD
Maria McColgan, MD
Karen Vogel, LSW

Mariocruz3@gmail.com
All caregivers
n ≈ 450,000

Caregivers screened per protocol

Staff determined feasibility of IPV screening

Screened for IPV

IPV status disclosed

IPV positive caregivers enrolled in CAMP (n = 453)

NOT enrolled in CAMP

* Children > 3 years old
  Caregiver was a man
  Another adult present in room

* Barriers: privacy, discomfort, time, language discordance

* Inadequate screening techniques

* IPV Services not needed
  Not willing to disclose IPV status

*Quality improvement opportunity
IPV referrals from resident clinic

IPV screening card introduced

EHR Introduced

“Senioritis”