Beyond Education: Changing Systems to Facilitate Healthcare-Based IPV Screening and Counseling

L. Kevin Hamberger, Ph.D.
Medical College of Wisconsin
Education on IPV is Necessary, but Not Sufficient

• Waalen et al., (2000)
• O’Campo et al., (2011)
• Sims et al. (2011)
The good news....

- Hamberger et al. (2004)
  - 3-hour training
  - N = 752
  - Pre-post-6-month follow-up

- RESULTS
  - Increased self-efficacy
  - Increased endorsement of HCP’s role in IPV
  - Increased comfort in making community referrals
    - Gains mostly maintained at 6 months
And now the bad news
Compliance with Screening After Training Only

% of patients screened

- Beh. Health: 95%
- Emer. A: 44%
- Emer. B: 0%
- Lab & Del: 40%
- OB/GYN: 0%
- Goal: 100%

High-Risk Departments
“Black Box” Model

In-service Training → Healthcare Professionals → Increased IPV Screening
System-Wide Barriers
Minsky-Kelly et al. (2005)

- Privacy concerns
- Time Constraints
- Patient flow
- Professional/Personal discomfort with subject
The Fix

• System-level interventions at the departmental level
  – Increase privacy
  – Modify patient flow
  – Provide department-level CQI feedback
  – Stress/vicarious trauma management
  – In-service skills training review
Emergency Departmentler A
DV Screening Compliance

% of Patients Screened

Month/Year of Chart Review

Sep. 99  | Dec. 99  | Feb. 00  | May-00  | Jul. 00  | Goal

44%     | 22%     | 62%     | 68%     | 83%     | 100%
OB/GYN
DV Screening Compliance

% of Patients Screened

<table>
<thead>
<tr>
<th>Month/Year of Chart Review</th>
<th>Oct-99</th>
<th>Jan-00</th>
<th>Apr-00</th>
<th>Jul-00</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>45%</td>
<td>71%</td>
<td>83%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Goal: 100%
Emergency Department B DV Screening Compliance

% of Patients Screened

Month/Year Charts Reviewed

Oct. 99  Jan. 00  Mar. 00  Apr. 00  Jun. 00  Goal

0%  0%  11%  32%  27%  100%

Goal
Another Example

• Hamberger et al. (2010)
  – Research suggests that written protocols, chart prompts and institutional support may be necessary to support application of the training.

  – We introduced a written protocol and chart prompt against a backdrop of ongoing training in screening and documentation for domestic violence by family physicians. (Phase 1 and 2)
– Research also suggests that training has a variable
effect on documentation with or without a
prompt so we studied screening and
documentation after subsequent removal of the
prompt. (Phase 3)
## Design, Intervention, Method

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 month</strong></td>
<td><strong>7 month</strong></td>
<td><strong>1 month</strong></td>
</tr>
<tr>
<td>Old H&amp;P forms</td>
<td>New H&amp;P forms</td>
<td>New H &amp;P forms</td>
</tr>
<tr>
<td></td>
<td>With a written protocol</td>
<td>without a written protocol</td>
</tr>
<tr>
<td>Training</td>
<td>Ongoing Training</td>
<td>Training</td>
</tr>
</tbody>
</table>
## Results (phase 1, 2 and 3)

<table>
<thead>
<tr>
<th></th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No-prior prompt</td>
<td>With prompt</td>
<td>Removal of prompt</td>
</tr>
<tr>
<td>Screening</td>
<td>2%</td>
<td>92%</td>
<td>72%</td>
</tr>
<tr>
<td>Documentation</td>
<td>2%</td>
<td>92%</td>
<td>36%</td>
</tr>
</tbody>
</table>
System-wide Changes go Beyond Screening

- MacMillan et al. (2009)
- Klevens et al. (2012)
- McCaw et al. (2001)
- Feder et al. (2011)
Healthcare Can Change From Within

• External attempts to induce change have not been effective
  – Professional association position statements
  – Accreditation efforts
  – Required cme for licensure

• Reliance on community resources to support change have been successful......
  – But there not enough resources
  – And when the funding goes.......
Change from Within Components

1) Health Care Advocates—Selected staff receive intensive training in IPV & health
2) Saturation training of all staff
3) Policies & procedures
4) Collaboration w/ advocacy agencies & experts
5) CQI
6) Primary prevention
4 findings re. Systems Change

1. Clinician knowledge, understanding & self-efficacy increased.
2. Clinicians rated their clinic as better prepared to identify, intervene and prevent IPV.
3. The clinic environment improved as measured by policies and procedures, and patient education materials.
4. Chart audit & self-report documented a sustained increase in IPV inquiry.
# Chart Audit of Clinical Inquiry About IPV

Ambuel et al. (2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes: Inquiry Documented</th>
<th>No: Inquiry not documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>30% (24)</td>
<td>70% (55)</td>
</tr>
<tr>
<td>2006</td>
<td>42% (32)</td>
<td>58% (45)</td>
</tr>
<tr>
<td>2008</td>
<td>60% (49)</td>
<td>40% (32)</td>
</tr>
</tbody>
</table>

Pearson chi² = 15.0466, Pr = 0.001

2005 vs. 2006: Pearson chi² = 2.1, Pr = 0.146

2006 vs. 2008: Pearson chi² = 5.67, Pr = 0.017
Quasi-experimental Findings
(Intervention vs. Usual Care) Hamberger et al. (in press)

• Intervention vs. Usual Care
  – Screening: Intervention > Usual Care
  – Talk to your doctor or nurse about IPV in past year: Intervention > Usual Care
  – Number of Doctor Visits: Intervention < Usual Care
  – Symptoms of injury: Intervention < Usual Care
No Group Differences

- Violence reduction
  - Significantly reduced for both groups
- Use of safety strategies
  - Significantly increased for both groups
- Quality of health/health status
- Patient satisfaction
Some Remaining Questions

• What is/are the most appropriate outcome variables?
• What are optimal research designs for measuring outcomes?
• Follow-up duration?
• Acute care model or chronic care model?
References


References


