Relationships as Health:

Towards a Universal Education Approach to Intimate Partner Violence in Primary Care

DATE: October 7th, 2017 PRESENTED BY: Tara O'Connor, PMHNP-BC, ARNP, & Joan Fleishman, PsyD

Introduction & Disclosures

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- Tara O'Connor, PMHNP-BC, ARNP

- No financial disclosures

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Learning Objectives

1. Identify at least 3 health indicators of IPV
2. Identify components of successful IPV interventions in primary care
3. Discuss benefits of universal education about IPV
4. Review essential components of early implementation of universal education model (or lessons learned so far)

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Before we begin, a word on self care

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Defining Intimate Partner Violence (IPV)

- The term “intimate partner violence” describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts, verbal and emotional abuse) by a current or former intimate partner.

- An intimate partner is a person with whom one has a close personal relationship (emotional connectedness, frequent contact, “couple”, on going physical or sexual contact, familiarity)

    - (Center for Disease Control [CDC], 2017)

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Prevalence

(CDC, 2017)

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Health Consequences of IPV

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Health Consequences of IPV

Bladder and kidney infections

HIV

Injury

Gastrointestinal disorders

asthma

homelessness

Unintended pregnancy

isolation

Fibromyalgia & chronic pain

Anxiety/PTSD

STIs

DEATH

Depression and suicide

Cardiovascular disease

Insomnia

Headaches

Circulatory conditions

Substance use disorder

Medication non-compliance

Increased Healthcare utilization

Traumatic brain injury

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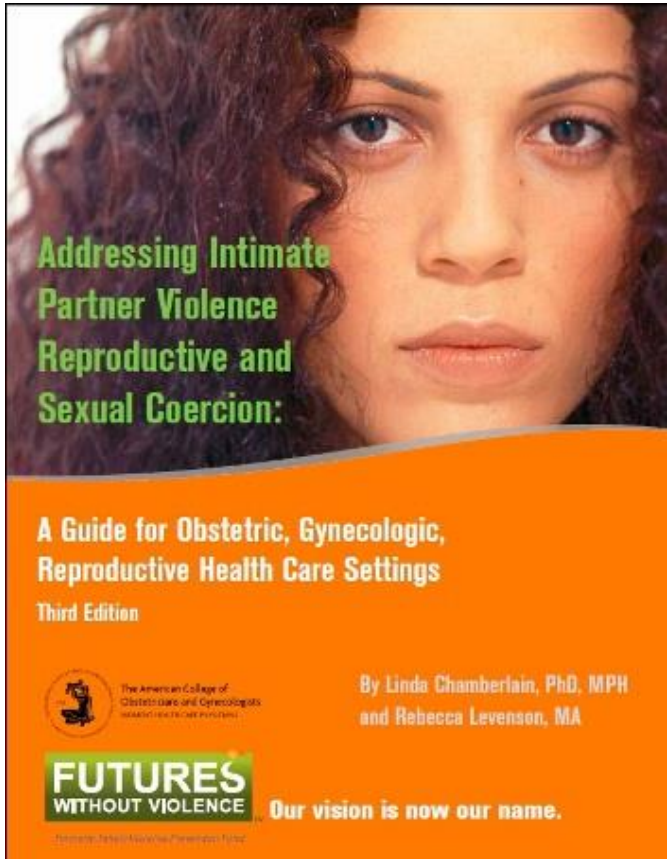
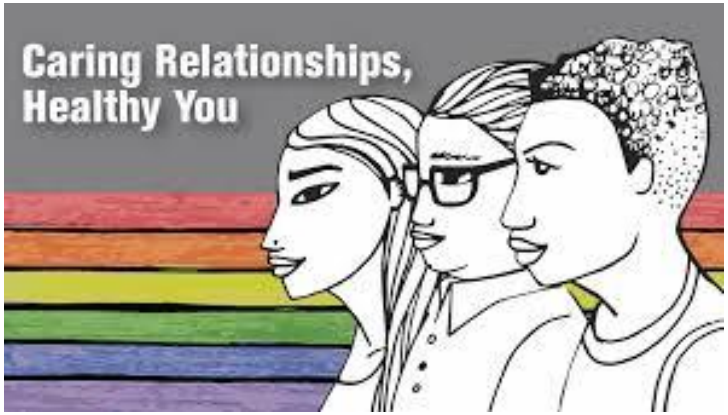

Addressing Intimate Partner Violence Reproductive and Sexual Coercion:
A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings
Third Edition
By Linda Chamberlain, PhD, MPH and Rebecca Levenson, MA
FUTURES WITHOUT VIOLENCE
Our vision is now our name.


Hanging out or Hooking up?


Caring Relationships, Healthy You

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Clinical Guidelines

- US Preventative Services Task Force (USPSTF),
- Institute of Medicine (IOM),
- American College of Gynecologists
- American Academy of Family Physicians (AAFP)
  - Limits recommendation, based on evidence available, to women of childbearing age
- Women's Prevention Services Initiative &
- Health Resources & Services Administration
  - expand their recommendation

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Benefits to Addressing IPV in Primary Care

- Evidence shows little to no harm (Nelson, Bougatsos, & Blazina, 2011).
- Patients want you to talk to them about it (Futures Without Violence, 2013).
- Patients are 4x more likely to use an intervention after talking to a provider about abuse (Futures Without Violence, 2017).

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Benefits to Addressing IPV in Primary Care

- Statistically significant:
  - Reductions of violence,
  - Improvement of physical and emotional health,
  - Safety promoting behaviors,
  - Use of IPV community based resources
    - (Bair-Merrit et al., 2014)
- Getting an accurate differential

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Barriers to Addressing IPV in Primary Care

- Screening rates in family practice are extremely low (as low as 2% in one study) (Hamberger, Rhodes, & Brown, 2015).

- Provider related barriers (Ambuel et al., 2013; Sprague et al., 2012):
  - time constraints,
  - a lack of protocols and policies,
  - lack of training,
  - lack of support,
  - perceptions or attitude barriers

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Barriers to Addressing IPV in Primary Care

- Patient related barriers:
  - Knowledge gaps about what is abuse,
  - Fear of not being believed,
  - Fear of social service involvement,
  - Partner present at visit, confidentiality concerns,
  - Self-blame,
  - Immigration status,
  - Gender or sexual orientation factors
  - Feeling pressured to leave
    - (Morse, LaFleur, Fogarty, Mital, & Cerulli, 2012; Rose et al., 2011).

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Facilitators to Addressing IPV in Primary Care

- How you ask: If you're not comfortable, your patients won't be either
  - Addressing providers' own history of trauma (personal and vicarious), biases, and attitudes
- Institutional support,
- Effective protocols,
- Initial and ongoing training,
- Rapid access to & knowledge of **referral services**

(Bair-Merrit et al., 2014; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011)

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Direct Screening

- Validated direct screening approaches (AHRQ, 2015):
  - HITS (Hurt, Insult, Threaten, Scream)
  - OVAT (Ingoing Violence Assessment Tool)
  - STaT (Slapped, Things and Threaten)
  - HARK (Humiliation, Afraid, Rape, Kick)
  - CTQ–SF (Modified Childhood Trauma Questionnaire–Short Form)
  - WAST (Woman Abuse Screen Tool)

- Limitation of Direct Screening
  - Ineffective on its own (Hegarty & Glasziou, 2011)
  - Fails to overcome most patient related barriers (Jewkes, 2013; Miller et al., 2017; Rees & Silove, 2014)

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Universal Education Model

- Trauma informed
- <60 second intervention
- Evidenced-based
- Increases awareness of DV services and hotlines
- Reduces the likelihood of staying in an unhealthy relationship
- Promotes altruism and safety access
- Disclosure is NOT the goal, but does happen– supports providers knowing what to do then
- Patient satisfaction
- Provider satisfaction

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Universal Education Model: CUES

C: *Confidentiality*: Disclose limits of confidentiality, understand state law; See patient alone

UE: *Universal Education* + *Empowerment*: Utilize card to normalize activity; Discuss the impact of healthy & unhealthy relationships on health; Hand 2 cards

S: *Support*: Included in card is a safety plan and 24/7 hotlines; Provide warm referral; Follow up at next appointment

(Marjavi & Levenson, 2017)

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Universal Education Model

Scripting with cards:

- “I give these cards to all of my patients because we know how important our relationships are to our health. Also, since this is such a common problem, I provide an extra card that you can share with someone you care about and may be concerned for.

- On confidentiality, “I want to let you know that you can talk to me about your relationship concerns and it will stay between us. However, there are some issues that I am mandated to report by law, like danger to a child. In those cases, we will talk through how to deal with that together”.

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Universal Education Model

Scripting with cards:

- Opening card, read through ”the card reviews some signs of healthy and unhealthy relationships, reviews ways our relationships impact our health, how to make a safety plan, and provides free & confidential resources on the back”.

Universal Education Model: Responding to Disclosure

- Safety Assessment:
  - Severity -Escalation -Threats
  - Risk to self

- Scripting with disclosure:
  - "I am glad you told me about this"
  - "I'm sorry this is happening; no one deserves this"
  - "I am concerned for you"
  - *Warm handoff*: "I have this colleague, Sonia, and she is an expert in helping people with safety planning and resources. Her services are free and confidential, would you like me to get you on the phone with her today?"

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Including IPV in your Differential Diagnosis

- 28-year-old female presenting with weight loss, IBS, and recurrent headache
- 31-year-old female presenting 4th unintended pregnancy
- 56-year-old female with history of chronic pain, and new concern of memory loss
- 17-year-old female with new dx chlamydia
- 60-year-old male with poor control of bipolar illness due to medication noncompliance. Presents with bruising and laceration on forehead

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Suggested Process for use of CUES model

1. Provide a safe, private space before discussing

2. Assure confidentiality & review limits

3. Normalize the intervention through framing

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Suggested Process for use of CUES model

4. Provided at annual exam or with health indicators.

Have MA scrub and place card on keyboard for prompting with:

- Annual screens (health maintenance),
- Prenatal visits (at least every trimester per ACOG guidelines),
- Reproductive health visits,
- Well adolescent visits.

5. Providers can utilize during a visit based on indicators

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Implementing the CUES Model

- **Documentation**
  - Privacy
  - Accurate, clear, & concise
  - Timely
  - Objective and avoids judgment
  - Creates evidence
  - Mandatory reporting & confidentiality discussion

- **Clinic protocol**

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Setting: A collaborative relationship between a health clinic & IPV advocate

OHSU Family Medicine at Richmond:

- Federally Qualified Health Center & Academic Medical Center
- Patient Centered Medical Home:
- Care Teams include Behavioral Health Consultant, Clinical Pharmacy, RN Care Manager, PCP, MA, Team Coordinator
- Full range primary care services includes family planning, pre-natal care, contraception, Primary Care, Behavioral Health, Pharmacy, X-ray, Walk In clinic

Setting: A collaborative relationship between a health clinic & IPV advocate

Volunteers of America: Home Free

- Emergency Hotline: 503-771-5503
- Emergency Housing through motel vouchers, food, safety planning, emotional support.
- Rent assistance and support for up to 2 years.
- Legal Advocacy re: Restraining and Stalking Orders, Court cases.
- Post-crisis assistance with one-on-one advocacy, support groups, service navigation, financial assistance, job club, financial literacy classes and parenting support.
- Child and Teen Advocacy
- Medical Advocacy

Implementation: Project Aim

- Increased referrals between partners result in better access to services (tertiary prevention)
- Early identification of unhealthy relationships (primary prevention)
- Improved relationship health= improved general health

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Implementation: Project Aim

- Increased provider confidence → increased utilization and identification of IPV as differential diagnosis →

- Intervention→ increased safety, self efficacy, altruism, and reduced stress→ improved health and reduced health costs

Implementing the CUES Model

Clinic readiness assessment

- Screening was rarely initiated with correlated health conditions (Hallock-Koppelman, 2014)

- Top three identified provider barriers
  - Lack of protocol
  - Difficulty getting the patient alone
  - Inadequate training

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Implementing the CUES Model

Clinic readiness assessment

- Use of QI/QA tool provider by Futures Without Violence
  - Prior to training, at 3 month intervals until practice well established

- Pre-training survey on provider practice

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Implementing the CUES Model

Training

- Funded clinic training
- Immediate post training survey and 6 months post training
- Clinic pilots
  - Champions remained so, but other clinic partners slower to adopt new practice
  - Need for improved EHR tools identified
- Full clinic training completed November, 2017.

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Implementation: Use of Information Systems & Technology

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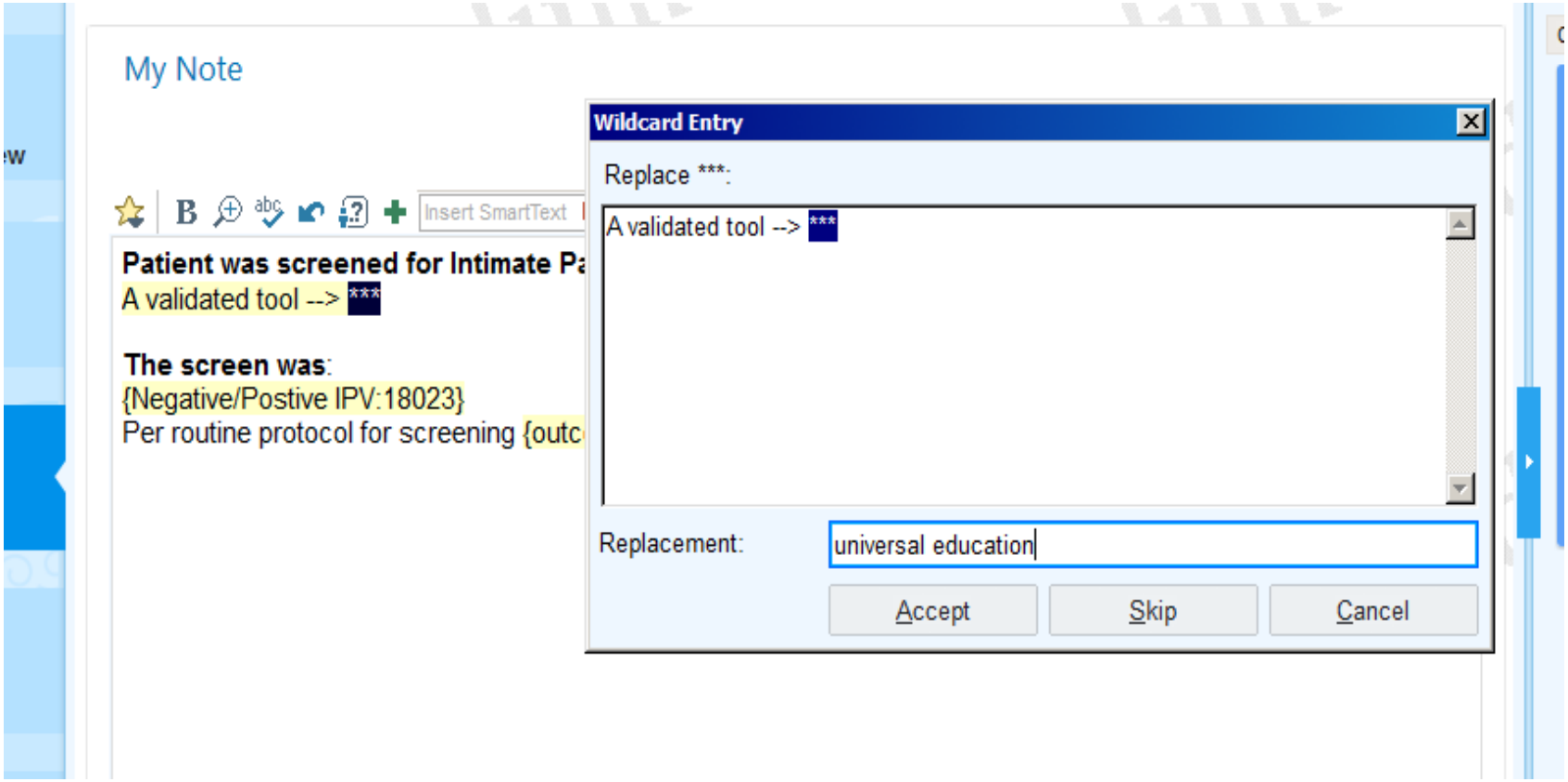

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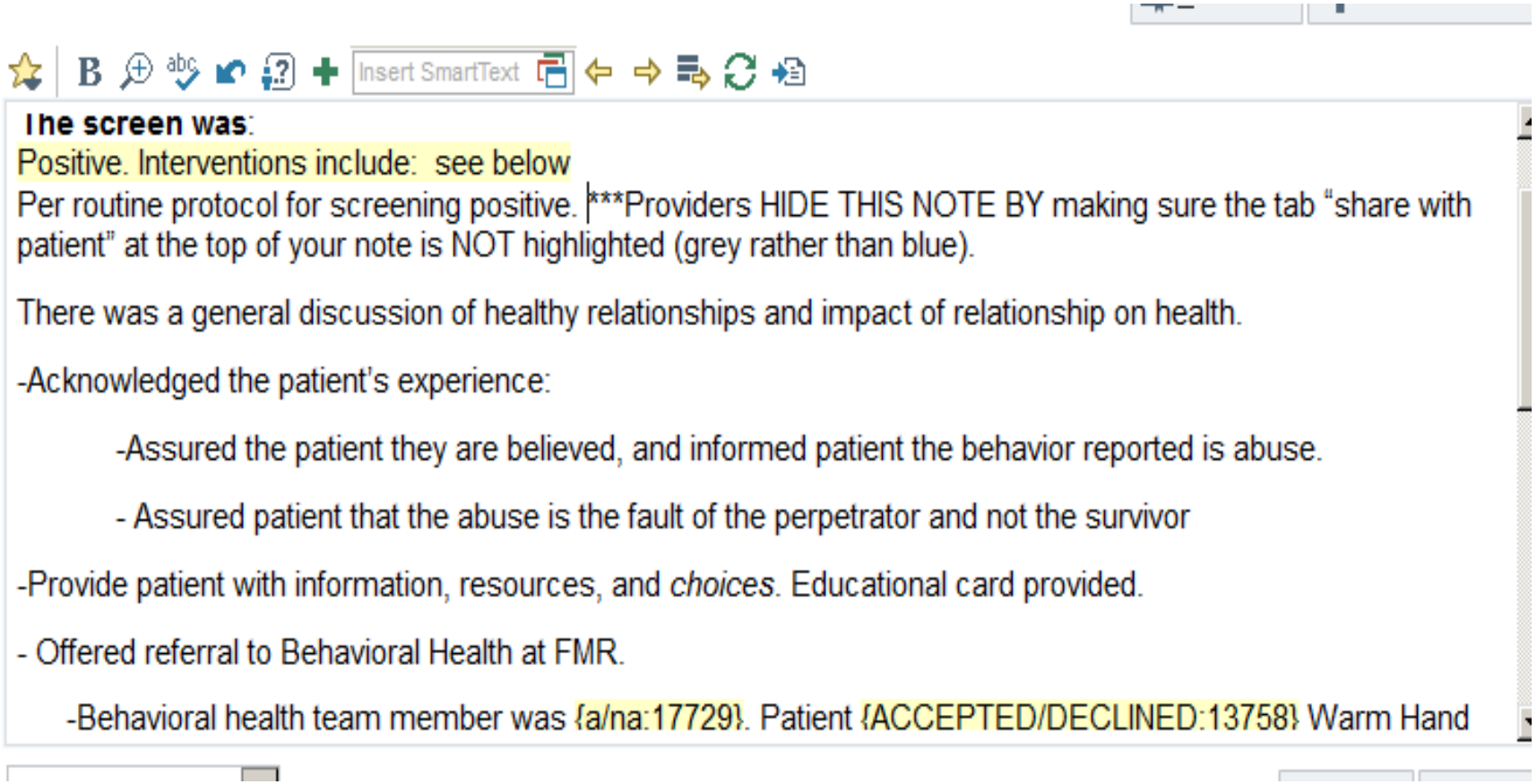
Proposed Implementation: Use of Information Systems & Technology



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Financial Considerations

- Training: Approximately $10,000 (Includes estimated fees for renting space, providing food, supplies)
- $10 flat shipping fee for free brochures, cards, booklets, and training materials
- All items also free to download from ipvhealth.org
- Train the trainer available at biannual conference, attendance is approximately $300

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Future Directions

- Expanding across Family Medicine clinics & our school based health center
- Merging with One Key Question?
- Surveying patient experience

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Conclusion

Implementing the universal education model can enable health care organizations to address IPV, empowering clinicians and patients alike to address relationships as health.

Resources

- **Ipvhealth.org**
  - Cards
  - Booklets on how to implement
  - QI/QA tool to assess your clinic preparedness (and how to improve)
  - Videos on using cards
  - Training webinars
- **Oregon Coalition Against Domestic & Sexual Violence**
  - www.ocadsv.org
- **National Resource Center on Domestic Violence**
  - http://www.nrcdv.org/
- **National Coalition Against Domestic Violence**
  - https://ncadv.org/
- **The National Domestic Violence Hotline**
  - http://www.thehotline.org/resources/

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Thank You