Universal Education: A Local Approach to Improving Health Outcomes for Survivors through Integration

ANNUAL DOMESTIC VIOLENCE CONFERENCE
10/16/2020
SAN JOSE, CA
Agenda

1. Why this matters: Health impacts of IPV
2. Why address IPV in the healthcare setting?
3. Overview of CUES model
4. Local IPV & healthcare project
5. Why is CUES important for survivors?
6. Questions & Answers
7. Resource sharing
1. Why This Matters: Health Impacts of Intimate Partner Violence
Vision & Mission

- Our community is **safe, healthy, and strong**.

- Individuals and families experiencing abuse will receive **high quality integrated care** addressing the social factors and systemic inequities that prevent them from living a safe and healthy life.
Why IPV?

- **1 in 4** women experiences Intimate Partner Violence (IPV), and rates can be even higher for LGBTQ and other marginalized communities.

- IPV is **more prevalent** for women in the U.S. than breast cancer and diabetes combined.

- Studies have shown that survivors are **4 times more likely to seek help** for IPV after speaking with a healthcare professional about abuse and how it affects their health.

Source: Futures Without Violence
**HEALTH IMPACT:** Women exposed to intimate partner violence are

**Mental Health**
- Twice as likely to experience depression

**Sexual and Reproductive Health**
- Almost twice as likely to have alcohol use disorders
- 16% more likely to have a low birth-weight baby
- 1.5 times more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhoea

**Death and Injury**
- 42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result
- 38% of all murders of women globally were reported as being committed by their intimate partners

Source: https://vawnet.org/sc/impact-domestic-violence-health
## Common health consequences of violence against women (2–5)

<table>
<thead>
<tr>
<th>Physical</th>
<th>Sexual and reproductive</th>
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| • acute or immediate physical injuries, such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth  
• more serious injuries, which can lead to disabilities, including injuries to the head, eyes, ears, chest and abdomen  
• gastrointestinal conditions, long-term health problems and poor health status, including chronic pain syndromes  
• death, including femicide and AIDS-related death | • unintended/unwanted pregnancy  
• abortion/unsafe abortion  
• sexually transmitted infections, including HIV  
• pregnancy complications/miscarriage  
• vaginal bleeding or infections  
• chronic pelvic infection  
• urinary tract infections  
• fistula (a tear between the vagina and bladder, rectum, or both)  
• painful sexual intercourse  
• sexual dysfunction |

<table>
<thead>
<tr>
<th>Mental</th>
<th>Behavioural</th>
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| • depression  
• sleeping and eating disorders  
• stress and anxiety disorders (e.g. post-traumatic stress disorder)  
• self-harm and suicide attempts  
• poor self-esteem | • harmful alcohol and substance use  
• multiple sexual partners  
• choosing abusive partners later in life  
• lower rates of contraceptive and condom use |
A Tale of Two Zip Codes
What are Social Determinants of Health?

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Health status</td>
<td>Community engagement</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Functional Limitations</td>
<td>Discrimination</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Health care expenditures</td>
<td>Quality of care</td>
<td></td>
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<td>Support</td>
<td>Walkability</td>
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Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Why do SDOCs matter?
Why do SDOCs matter?

2. Why is it important to address intimate partner violence in the healthcare setting?
History of El Comite de Mujeres Fuertes

- Established in 2017
El Comite’s Leadership Development

- First Two Years
  - Training
  - Develop mission
  - Establish guiding principles
  - Build relationship (both with NDS and themselves)
  - Practice public speaking

- Expanded from survivor story to survivor input and community involvement
- Advocating for themselves
- Advising/evaluating NDS services and systems change
“It is important to build a trusting relationship with our doctor. So we can have the confidence to talk about our relationship. If the doctor recognizes that we are not in a healthy relationship, they may refer to services such as Next Door Solutions. They will inform us of our rights and can help us plan how to get out of that relationship.

This information can help the doctor understand where some of our illnesses or injuries came from. Some illnesses are more common in people who have been or are experiencing domestic violence for example: diabetes, asthma, anxiety, depression, drug addiction, sexually transmitted diseases, and many more.”
“I'm going to share with you a personal example:

During my first pregnancy, I went to the emergency room for an injury to my knee. I told them that I had fallen. After 2 months, I went to the emergency room again because I fell from the stairs. The ER doctor never questioned me why I was falling so often. I imagine he hadn't looked through my medical history. A week later I went to my regular appointment with my gynecologist and she didn’t ask anything about my emergency room visits. She was always running in a hurry. Perhaps I would have shared my situation with them if they had given me that time or had built a trusting relationship. Unfortunately that was not the case and I was in an unhealthy relationship for 25 years.

That is why it is very important that doctors work together with agencies like Next Door Solutions to train and achieve a better relationship with their patients and provide the necessary resources.”
Key points

- Take time to build/establish relationship with the patient
- Make the connection between domestic violence and health conditions
- Review medical history
- Establish partnerships with domestic violence agencies
“It’s a human right to be able to visit the doctor and lead a healthy and dignified life. It is important that when the doctor is with the patient that they keep their hands unoccupied without the cell phone or the computer and that they look directly at their patients. Above all, be relaxed. Tell the patient that everything they talk about is completely confidential and ask:

- Do you feel comfortable and safe at home?
- Are you being physically, verbally, or sexually abused? Even if it is not your partner.
- Do you know that if someone forces you to have sex, that is rape? Even if it’s your husband.
“At the time that I was experiencing domestic violence I went to the hospital for losing my 4-month pregnancy. When I was with the doctor I wanted to tell him what I was going through and I wanted him to ask me those things. He did not look me in the eye, he was always on the computer and was in a hurry. I felt like I was wasting his time and that he didn't care. If he had asked me these questions, my life would be so much better and healthier. Domestic violence greatly affected my health. Since then I have suffered from migraine headaches and pain in my waist.

When a doctor has good communication with their patient, they educate and empowers us. That leads to living with dignity. The intervention gives us a huge opportunity and provides information on resources that are out there. This is very valuable for our health.”
Key points

- Survivors do want screening
- Opportunity for an intervention
- Going over limits of confidentiality
- Body language (bedside manners)
- Communication leads to education and empowerment
“I want to share that I am a survivor of domestic violence in my marriage of 30 years. Domestic violence affected my health as I became ill with gastritis, nervous colitis, depression, and anxiety. At one point I was very ill for 3 weeks and my husband never took me to the doctor. As an immigrant I did not know the city and when I was able to go out, I got lost and was afraid. Then at church I met someone who took me to a clinic. The first time I went, it was due to a very strong back and head pain. I told the doctor but, she only asked me several times how much it hurt and she checked my back over my clothes. I would have liked her to lift my shirt and check my back and ask me what had happened to me. In the end she just prescribed Tylenol for the pain. When I got home I told my niece to check my back and she told me I had a big bruise. The pain did not go away since my husband had pushed me very hard against the door.”
“The second time I went to another clinic, the doctor didn't check my back either and she made me cry with her bad attitude and yelling since she couldn’t understand what I was trying to tell her. I told her that I had been through domestic violence but she didn't tell me anything or refer me to any resources to discuss my domestic violence situation. She was just annoyed when I spoke, since she did not understand my English, but I spoke as best I could and I just wanted her to understand me. Later she brought in a medical assistant to interpret for me, but I was crying and the doctor was angry by then, so I was not comfortable at all by this point. When my appointment was over, she referred me to another hospital to do some tests, but when I got to the hospital they made me sign some documents which I didn’t know what they were and then they charged me. That stressed me out so much since I had no money to pay. If I had known that they would charge me so much, I would not have gone.”
El Comite De Mujeres Fuertes

“A few months before the pandemic I went to the hospital for a headache and dizziness and the doctor told me that I had vertigo and tension. Although the doctor had not asked me I told him that I had been through domestic violence, but once again he did not tell me anything. My immigration status causes me sadness and concern, so it also affects my health. Until now I don't have a primary care doctor since I am afraid to go and be treated like I don’t matter and get charged, since I don’t have any money to pay.”

“I would have liked them to ask me questions and give me information on resources because maybe my situation would have ended and I would not have suffered so much and right now I would be better off. Even though the “would’ve” does not exist, I don’t want other people to go through what I did.”
Key points

- Immigration status has an impact
- Health access can be challenging
- Language access and barriers
- Importance of being trauma informed
3. Overview of CUES
The CUES Model

C: Confidentiality

• See patient alone & disclose limits of confidentiality.

UE: Universal Education + Empowerment

• Normalize the activity: "I've started giving info on healthy relationships to all of my patients."
• Make the connection: Open the card and do a quick review: "It talks about healthy and safe relationships...and how relationships affect your health."

S: Support

• "Thank you for sharing this with me. I’m so sorry this is happening. What you’re telling me makes me worried about your safety and health."
• Warm referral if needed: "Would you like some resources that can help?"
• Follow up at next appointment.
“We Always See Patients Alone First”

CUES
AN EVIDENCE-BASED INTERVENTION TO ADDRESS DOMESTIC AND SEXUAL VIOLENCE IN HEALTH SETTINGS
shown to improve health and safety outcomes for survivors

Survivors say they want health providers to:
- Be nonjudgmental
- Listen
- Offer information and support
- Not push for disclosure

"We Always See Patients Alone First"

- How could doing the assessment with others in the room be harmful?
- What worked well?
- What would you change?
- How could the process have been improved to be more culturally responsive?
C: Confidentiality

Before any discussion of IPV in the health setting, providers must:

- Understand their reporting requirements
- See the patient alone
- Disclose the limits of confidentiality
  - Update Notice of Privacy Practices (NOPP)
You might be the first person to talk to your patient about what is going on in their relationship.

IS YOUR RELATIONSHIP AFFECTING YOUR HEALTH?
You might be the first person to talk to your patient about what is going on in their relationship.

How's It Going?

Everyone deserves to have partners listen to what they want and need. Ask yourself:

- Is my partner or the person I am seeing kind to me and respectful of my choices?
- Is my partner willing to talk openly when there are problems?
- Does my partner give me space to spend time with other people?

If you answered YES to these questions, it sounds like you have a supportive and caring partner. Studies show that being cared for by the person you are with leads to better health, a longer life, and helps your kids.
Patient-Centered Care

- Patients want providers to talk to them about IPV.
- Empower patients with information, regardless of disclosure.
- Patients may not disclose due to concerns of how information will be used.
- Disclosure is NOT the goal.
Sample Script: Medical Assistant

“This is a card we are giving to all of our patients because your relationship impacts your health. It describes what a healthy relationship is and has resources on the back. You may not need this information, but please share it with friends or family if it would be helpful to them. If you have any questions, please let us know.”
Why universal education?

- Screening w/o response is ineffective.
  - Survivors often choose not to disclose: Not ready, distrust of formal systems, limited resources, fear of retaliation, CPS.
  - For example, in family planning study 50% of women disclosed in study – but only 10% to trained providers.
- Universal education provides an opportunity to promote healthy relationships and increase safety for survivors.
S: Support

- Thank patient for sharing.
- Convey empathy for the patient who has experienced fear, anxiety, and shame.
- Validate that IPV is a health issue that you can help with.
- Let them know you will support them unconditionally without judgment.
Sample Script: Provider

“I’m very sorry to hear that this is happening to you. Our priority is to provide you support and any resources you may need, and to make sure that you’re safe. We have a domestic violence advocate that can help. Would it be OK to call her? Her name is Rose.”

If a DV report is required: “I need to let you know that if you tell me you have current injuries that are due to the abuse, I will need to report it to the police. Let’s talk to our DV advocate Rose about your safety and how to protect you. The police will have your contact information and may call you for more information, so let’s call Rose in before we talk more.”
What not to say

- “You should call the police.”
- “You are definitely in an abusive relationship.”
- “That does not sound like rape to me…”
- “Your partner is crazy, you need to break up with them.”
- “What did you do to set them off?”
- “So what happened after that, and what happened after that, and...?”
How are confidential advocates different from behavioral health counselors?

- Specialized training
- Confidentiality
- Free for clients
- Shorter wait time for appointments
- Access to other services
- Culturally responsive services
- Are not mandated reporters and cannot disclose any information about their work with patients.

Advocates compliment existing BH service providers.
A Survivor’s Journey

mapping the system, a survivor’s journey

A survivor can receive IPV services in Santa Clara County from a number of different organizations, some of which provide multiple services, while others provide a single type of service.

A Trauma-Informed Approach
4. Local IPV & Healthcare Project
Foundation of AACI’s IPV Integration Project

- Based on work done by Mayview Community Health Center & Next Door Solutions that started in 2014
- **Erica Villa** was the Project Coordinator
- Created a Tool Kit with 9 steps
Integration Project
between
AACI’s Health Center (HC) &
AACI’s domestic violence program called
Asian Women’s Home (AWH)
December 2014 - July 2015

- AWH’s awesome MPH intern Vanndy Loth creates a 54-page Intimate Partner Violence Toolkit for Health Center!
- Included workflows, updated P&P, and an IPV 101 training series for the HC to identify and support survivors of IPV.
- Was not implemented due to staff turnover.
Staff from AWH and HC start meeting weekly to discuss how to remove barriers for referrals.

We identify barriers that prevent access to services and update Vanndy’s IPV toolkit and work flow to fit HC needs.
Barriers Preventing Access to Services

- Services need to be low- or no cost for survivors.
- Survivors don’t want to use their insurance for health services because it is tied to abuser.
- Getting an appointment in Health Center needs to be easy.
- Survivors need medical AND behavioral health services.
- Staff lack awareness of prevalence of IPV.
- Confidentiality is paramount.
KEY DRIVERS

- **For DV survivors:** Safety, privacy, accessibility
- **For DV program:** Confidentiality
- **For Health Center:** Impact on workflow
February 2019

- We talk to Futures Without Violence and our approach **COMPLETELY** changes from screening to **universal education** (CUES).
CUES: AN EVIDENCE-BASED INTERVENTION TO ADDRESS DOMESTIC AND SEXUAL VIOLENCE IN HEALTH SETTINGS
shown to improve health and safety outcomes for survivors

Survivors say they want health providers to:
Be nonjudgmental • Listen • Offer information and support • Not push for disclosure

C: Confidentiality
- Know your state’s reporting requirements and share any limits of confidentiality with your patients.
- Always see patients alone for part of every visit so that you can bring up relationship violence safety.
  - Make sure you have access to professional interpreters and do not rely on family or friends to interpret.

“Before we get started I want to let you know that I won’t share anything we talk about today outside of the care team here unless you wanted to tell me about (find out your state’s mandatory reporting requirements).”

UE: Universal Education + Empowerment
- Give each patient two safety cards to start the conversation about relationships and how they affect health.
- Open the card and encourage them to take a look. Make sure patients know that you’re a safe person for them to talk to.
  - Offering safety cards to all patients ensures that everyone gets access to information about relationships, not just those who choose to disclose experiences of violence.

“I’m giving two of these cards to all of my patients. They talk about relationships and how they affect our health. Take a look, and I’ve also included one for a friend or family member. On the back of the card there are resources you can call or text, and you can always talk to me about how you think your relationships are affecting your health. Is any of this a part of your story?”

S: Support
- Though disclosure of violence is not the goal, it will happen — know how to support someone who discloses.
- Make a warm referral to your local domestic/sxual violence partner agency or national hotlines (on the back of all safety cards).
- Offer health promotion strategies and a care plan that takes surviving abuse into consideration.
  - What resources are available in your area for survivors of domestic and sexual violence? How about for LGBTQ, immigrant, or youth survivors? Partnering with local resources makes all the difference.

“Thank you for sharing this with me, I’m so sorry this is happening. What you’re telling me makes me worried about your safety and health...
A lot of my patients experience things like this. There are resources that can help. (Share name, phone and a little about your local DV program) I would be happy to connect you today if that interests you.”

For more information or to order materials contact the National Health Resource Center on Domestic Violence:
M-F 9am-5pm PST | 415-678-5500 | TTY: 866-678-8901
nhrcenter.org

- place this poster in your health staff break room -
March 2019

- We find out about a grant that can support our integration pilot. We are awarded the contract from county Social Services Agency/Office of Gender-Based Violence Prevention!

Gerard Manual,
AACI Director of Wellness Services
June 2019

• We invite **Next Door Solutions** to provide technical assistance.

• We start planning training & our pilot roll out for fall 2019.
September 2019

- We train all HC staff on IPV. We tailor the training specifically for clinic needs, i.e. make it introductory based on what staff knew & had expressed.
Integration Timeline

**October 2019**
- Providers meet with legal & healthcare experts about Mandated Reporting

**Ruth Silver-Taube**, Adjunct Professor, SCU School of Law

**Laura Brunetto**, Former Deputy Director, SCC Public Health Nursing Services
November 2019

2nd training in prep for pilot

- We receive feedback from HC staff about patients’ cultural needs and have to COMPLETELY change our approach again.
Why was change needed?

Impact of Cultural Factors

- AACI’s patient population is very mixed & changing – elderly (65+) monolingual Mandarin & Cantonese speakers PLUS many other ethnicities (Vietnamese, Hispanic, Persian, Arabic, Caucasian).

- Looked at dynamics of waiting room and what’s going on, i.e. perceptions of different treatment.

- Trauma triggers for current patient population –
  - Separating would re-traumatize them.
  - Singling out would re-traumatize them.

- AACI is community centered – patients have a lot of input. So goal is to NOT to make sudden changes for patients OR staff, introduce ideas over time.

- Goal is to NOT trigger or traumatize population.
Why was change needed?

Impact of Cultural Factors

- Looked at what other clinics with similar populations did.
- Realized even with CUES 1 size does not fit all – can’t implement in only 1 way.
- Goal is to normalize the topic - which takes time.
- Decided to do modified CUES model – not room alone at the start of the project but with goal to get there.
- And CUES is flexible so that can make changes to fit needs of your population – fundamental part is to do universal education.
Steps Taken

- Talked to funder – need for flexibility – they said ok!

- **Original idea**: do 2 small pilots, 1st with English speakers & then Mandarin speakers. Use 1 provider & MA team.

- **Planning group met & changed to**:
  - Expand to all patients and all providers, no pilot groups
  - Had to translate all materials into 3 languages – Mandarin, Vietnamese & Spanish
  - Had to train all staff instead of a few
  - Impact on ENTIRE Health Center workflow
March 2020

- We start doing **universal education** with all patients on 3/9.
  - Gave out **78 cards** in 6 days.
  - Had **1 referral** for DV services.
  - Empathy of MA helped patient ask for help

- **COVID** hits and everything **COMPLETELY** changes again. Patients stop coming in 3/17, which halts CUES implementation.
April 2020

- We re-envision CUES in a post-COVID world.
- We get funded for Year 2.
- We have a Spanish-speaking DV advocate in the HC 2 days/week to better serve our diverse clientele.
Present Day - October 2020

- DV advocate in the HC left in summer but is still the goal
- **Important to keep system changes in place.** Importance of 2 champions in HC & DV program
- Melissa’s involvement in East San Jose PEACE Partnership
- Sarita (CEO) saw purpose of implementing model & supported efforts
Results

- **FY2018-2019:** 2 referrals between the programs (2 from AWH to HC)

- **FY2019-2020:** 14 referrals between the programs (10 from AWH to HC, 4 from HC to AWH)
Which means better care for our patients.
Which has led to…

- **Reduced barriers to access**: Strong collaboration to get survivors’ COVID health care needs met, esp. on weekends.

- **Greater support** for whole DV network: HC offering no-cost COVID testing to any DV agency staff and clients who wants it.

- Specific outreach & information to DV agencies about our HC services.

AACI Medical Director
Lessons Learned

1. **Strong Executive Leadership** – CEO was steadfast & committed.

2. **Shared Vision and Values** – Agreement that supporting IPV-impacted families was worth our collective time and energy.

3. **Consistent & Committed Project Leadership** – In both Health Center & DV program. Were aligned and steadfast.

4. **Build Trust** - Meeting frequently built trust and understanding between the two programs.

5. **Flexibility** - We had to pivot 3 times because things changed COMPLETELY.
   - The model changed from screening to CUES
   - We received staff feedback and changed the implementation to be more culturally responsive
   - COVID-19 happened
6. **Address Mandated Reporting Concerns Early** – This was critical.

7. **Include Cultural Factors** – Need to understand & address patients’ cultures. Some IPV words do not exist in other languages and hard to translate on spot. MAs wanted actual script in other languages.

8. **Apply the Strategy Consistently** - Make sure patient doesn’t feel singled out because their culture might have stigma. Make sure patient knows you are giving info to everyone.

9. **Involve more HC staff** – Do this earlier in process to build support so when have changes in leadership & staff the project continues because more are invested.

10. **Leverage Available Resources & Information** – Use what is already out there!
5. Why is this intervention (CUES) important for survivors?
El Comité De Mujeres Fuertes

“Cuando un doctor tiene buena comunicación con su paciente, ellos educan y nos empoderan. Eso nos lleva a vivir con dignidad. La intervención nos da una gran oportunidad y nos proporciona información sobre los recursos que están allí. Este es muy valioso para nuestra salud”
“I want to tell you, doctors, to take more time with your patients, ask questions, educate the patient on how their relationship can affect their health, and give them information on resources in the community. Doctors have to be more empathetic towards their patients. Many times, due to the situation we are in, you are the only resource that patients have. We do not need the doctor to mistreat us or make us feel less when we are already going through that in our relationship at home. We need you to support us.”
“I am really excited to hear that CUES is being implemented. I believe that with this method of early intervention we will be able to help doctors and all medical staff understand the importance of being able to educate those individuals and families that are at risk or are experiencing domestic violence on what a healthy relationship looks like.”

“I truly believe that among the doctors providing services and those that are a resource, we can have a strong support system and provide guidance to the person so that they get out of the abusive relationship. At same time the doctor will be able to have information about the situation of their patient. This will help the doctor understand the root cause of their health issues. By following up and providing this medical care it will help prevent severe physical and mental damage in the future of the patient.”
El Comite De Mujeres Fuertes

“This is why it is very important to build a relationship and gain trust from the beginning. How are we going to achieve this? Only by having proper training such as CUES, "The goal is early intervention" With this I am sure that we will save many lives and have a united and healthy community.”
6. Questions & Answers
7. Resource Sharing