"The Potential Unintended Effects of the UCLA Domestic Violence Intervention on Clinical Workflow and Staff Perception of the Intervention at St. John's Well Child & Family Center"

Background

In the United States, domestic violence is one of the most serious threats to women's health, and the St. John's Well Child and Family Center has a unique opportunity to influence systemic change that can greatly assist battered women – and even prevent the continuation of domestic violence. St. John's Well Child and Family Center (SJWCFC), an independent community health center and Federally Qualified Health Center, serves patients of all ages through a network of ten clinic sites spanning across of Central and South Los Angeles and Compton (St. John's Well Child & Family Center, 2012). This organization has matured from a small, volunteer clinic founded in 1964 to one of the most significant and comprehensive safety net providers in Los Angeles County. SJWCFC provides primary medical, mental health and social support services to uninsured, underserved and economically disadvantaged individuals. SJWCFC's stated mission is to eliminate health disparities and foster community well being by providing and promoting the highest quality care in South Los Angeles.

The demographics of the patients served include immigrant, limited-English proficient individuals. These individuals live in low-income households earning up to or less than 100% of the Federal Poverty Level. Many are also uninsured refugees and victims of abuse. Latino/a (including Mexican, Central and South American) patients compose the majority of the patients at the center with 74%, followed by

Black with 17%, White with 5%, Asian with 1%, and 3% other (St. John's Well Child & Family Center, 2012).

Domestic violence crosses all demographic and socioeconomic lines, but poor women may be most at risk. Based on the 1998 California Women's Health Survey, the state Department of Health Services found that women reporting annual household incomes less than $15,000 were at increased risk for intimate partner abuse compared to higher income women (Weinbaum, Stratton, Chavez, Motylewski-Link, Barrera, Courtney, 2001). Since 1999, the California Institute for Mental Health has been studying welfare reform efforts in six counties in California. Interviews of welfare recipients in Kern and Stanislaus counties assessed barriers to employment, including domestic violence. The survey found a high incidence of abuse among the welfare population (Meisel, Chandler & Rienzi, 2003).

According to the California Penal Code Sections used in domestic violence, domestic violence is defined as "abuse committed against an adult or fully emancipated minor who is the spouse, former spouse, cohabitant, former cohabitant, who has a dating relationship, former dating relationship, engagement relationship, former engagement relationship, or parties having a child in common" (US Department of Justice, 2012) Nearly 2 million injuries and 1,300 deaths resulting from domestic violence occur nationwide every year (Centers for Disease Control and Prevention, 2003). In the city of Los Angeles alone, 31,081 incidents of domestic violence were reported to the Los Angeles Police Department (LAPD) Bureau in 2012. Morbidity associated with domestic violence, also known as partner violence against women (PVAW) and intimate partner violence (IPV), explains why

these victims repeatedly visit health service sites (Arrendondo-Provecho et al. 2012). Furthermore, the same intimate partner often repeatedly assaults a woman. The National Violence Against Women Survey found that women who were assaulted averaged seven physical assaults by the same partner (US Department of Justice, 2000). A separate study also found that 44% of women murdered by their intimate partner had visited an emergency department within 2 years of the homicide. Of these women, 93% had at least one injury visit to an emergency department (Crandall, Nathens, Kernic, Holt and Rivera, 2004).

These repeated cases of patient morbidity makes primary care settings an ideal place for detection and first aid, due to its easy accessibility and continuity. Although the primary care setting is an important site for identification and intervention, there have been challenges in determining how health care professionals can best address this issue in practice (Gutmanis, Beynon, Tutty, Wathen and MacMillian, 2007). One study, based on medical records in the primary care setting, indicates that fewer than 10% of women experiencing domestic violence had been identified by doctors (Mullender and Hague, 2000). Women who are victims of domestic violence frequently seek healthcare services, but often report difficulties in disclosing their experiences to healthcare providers (Chang, Decker, Moracco, Martin, Petersen and Fraiser, 2003). Survivors report that validation of abuse and encouragement by a provider can be life-changing if it is done without judgment, but many providers experience difficulty discussing domestic violence effectively and supportively (Yam 2000). Approximately 35% of emergency department patients indicate that abuse is a current issue in their lives,

but most providers do not directly question patients about when abuse occurred and providers probe with follow-up questions only one-third of the time following a patient's disclosure of abuse (Rhodes, Frankel, Levinthal, Prenoveau, Bailey and Levinson, 2007). Furthermore, fewer than one-third of emergency department patients who disclose abuse to a healthcare provider have the abuse documented on their medical charts (Rhodes et al., 2007). Specific domestic violence referrals were offered in only 25% of patient disclosures of abuse and only 4% of patients disclosing domestic violence were seen by a social worker (Rhodes et al., 2007).

Due to the identification of domestic violence as a major health issue and the apparent need to improve patient-physician communication regarding domestic violence, California now enforces laws to increase the identification of domestic violence victims. Significant laws require those who provide health care to be trained in the detection of domestic abuse; hospitals and clinics to adopt written policies on the treatment of victims of battering; and health practitioners to report cases of domestic violence to law enforcement (California Senate Office of Research, 2003). Health practitioners employed in a local or state public health department, health facility, licensed clinic or physician's office are mandated reporters. Only physical injuries caused by domestic violence, which are observed during the provision of medical services for a physical condition, must be reported. The law requires reporting even if the patient is seeking medical attention for another reason (California Senate Office of Research, 2003).

St. John's Well Child and Family Center has readily complied with California's law and mandated a domestic violence policy. The purpose of this policy is to create

an awareness of domestic violence and provide guidelines for addressing domestic violence by assisting victims in finding appropriate resources, and by assisting abuse victims in finding treatment programs (St. John Well Child & Family Center, 2013). In order to strengthen the identification and referral systems for victims of domestic violence in Los Angeles County, SJWCFC partnered with the University of California, Los Angeles (UCLA) to use technology to improve outreach to victims at four of the clinics: Williams, Compton, Magnolia and East Compton. Using a grant provided by Blue Shield of California Foundation, SJWCFC and UCLA intend to develop and strengthen collaborative networks between health care providers and local community-based agencies, addressing the problems of domestic violence and human trafficking through the development of in-language, 3-4 minute screening video and improved referral networks that will help providers identify and treat female victims, focusing on immigrant women with low English language abilities.

According to the needs statements found in the project proposal to Blue Shield of California Foundation, many female victims of domestic violence in California are often unaware of their rights and what services are available to them. Because some may be undocumented or very dependent on their spouses, they may be afraid or ashamed to speak out about domestic violence. Many immigrant women lack literacy skills, which further restricts their access to information and services. Breaking down the barriers that isolate them and improving their access to services and support is vitally needed. Multi-lingual, culturally appropriate tools could aid victims in self-identification and give them critical basic information. This could

reduce the amount of time providers would need to identify and inform victims, and could help providers focus on suitable referrals.

Although the implementation of the in-language screening video has potential benefits for patients, it is important to understand the possible unintended effects this intervention could impose on an already burdened system, where the patient load is great and expendable time is rare. In order to determine these unintended effects, it is important to understand the current workflow at a St. John's clinic. The purpose of this study was to investigate current clinical workflow at St. John's and provider perception of the intervention, to order to discover some of the unforeseen impacts of this intervention at the Williams Health Center. A major concern expressed by the Chief Medical Officer (CMO) regarding the implementation of the intervention was its potential effect on temporal workflow. The opinions of the staff in relation to this intervention were also investigated to determine their perceptions. The amount of time the patient spends in the exam room alone and with medical staff, including medical assistants and health care providers, was determined. Spatial workflow was also investigated as a part of the clinical workflow study.

Method

This study took place at the William's Health Center, one of the ten sites of St. John's Well Child and Family Center in Los Angeles, California. This small, urban center contains twelve exam rooms: six for the pediatric patients and six for the adult patients. Since the intended participants of the UCLA domestic violence

intervention are female patients over the age of 15, the main data collection took place in the adult section of the center. The components of the study include staff perception, temporal workflow and spatial workflow.

Five in-depth interviews were conducted with SJWCFC staff members involved with the project to ascertain the St. John's staff's perception of the proposed UCLA domestic violence intervention. The five staff members consisted of SJWCFC's CMO, the clinical informaticist, the associate director of development and grant evaluation, and two health care providers. Interviews were transcribed, coded and analyzed to identify inductive themes. In hopes that the intervention would begin before the end my project study, two provider surveys were also composed to gather more information on provider perception of domestic violence identification in the primary care setting and their perception of the intervention itself. Unfortunately, the intervention did not begin in time. These surveys, however, can be seen in Figure 1 and Figure 2, in the appendix.

The cross-sectional study utilized a convenience sample to garner data concerning the amount of time patients spent in the exam room with a medical assistant, alone, and with the health care provider. The only patients excluded from the study were patients under the age of 15.

The observation hours to collect temporal workflow data took placed between 8:00 am and 4:00 pm, Tuesday through Friday for a total of 30-hours. The information being sought after included the patient's sex, age, and reason for visiting. This data was inputted into an electronic chart. A copy of this chart can be seen in Figure 1. It was also important to discover how many patients were alone

during the time of their visit into the exam room since the UCLA domestic violence intervention called for the patients to be alone when they watched the video in the examination room. The patient's arrival time and appointment time were also noted. Furthermore, the amount of time patient spent in the examination room with the medical assistant and then the health care provider were also noted. Lastly, the amount of time the patient spent in the exam room alone was recorded. The particular piece of data was crucial in determining if the intervention would extend the amount of time a patient spent in the exam room during any given visit.

The observation hours to collect spatial workflow data took place of 9:00 am and 5:00 pm, Monday through Friday for a total of 40-hours. The information was gathered using an ethnographic observation method, following the patients during their visit at the center, starting from the moment they checked-in to the clinic. These patients were informed that they would be followed during their visit but the observation would not have any influence on their medical treatment. Permission was obtained from the patient to be imperceptibly followed around the center. The observer would not enter the examination room while the provider was in the exam room. Information was recorded using pen and pad.

	Patient 34	Patient 35	Patient 36	Patient 37*	Patient 38	Patient 39	Patient 40	Patient 41
Sex								
Age								
Reason For Visit								
Is patient alone?								
Time of Arrival								
Time of Appointment								
Time Called by M.A. into Exam Room								
Time M.A. Leaves Exam Room								
Time Seen by Provider								
Time Provider Leaves Exam Room								

Figure 1. Chart used to during the recording of temporal workflow data. The highlighted section represents information that was crucial for data analysis.

Results

Interview Themes

Based on 5 in-depth interviews conducted, four themes were developed. The four themes, organized from most frequently to least frequently expressed by the staff members, were:

- Time constraints within the center prevent providers from feeling comfortable with the intervention taking place in the exam room;
- Domestic violence does not appear to be a high priority for providers who must deal with more pressing medical issues;
- Providers are already asking their patients about domestic violence when the key indicators of domestic violence are present; and
- Some providers do not believe that the issue of domestic violence should be brought up during every single visit.

Temporal Workflow Patient Participants

Of the 50 patients seen entering examination rooms, 39 (78%) were female (Figure 2). The average age of the patients seen was 47.6 ± 13.6. The youngest patient seen was 15 years old, while the oldest patient see was 71 years old (Figure 3). Ninety percent of the patients encountered were not accompanied into the examination room.

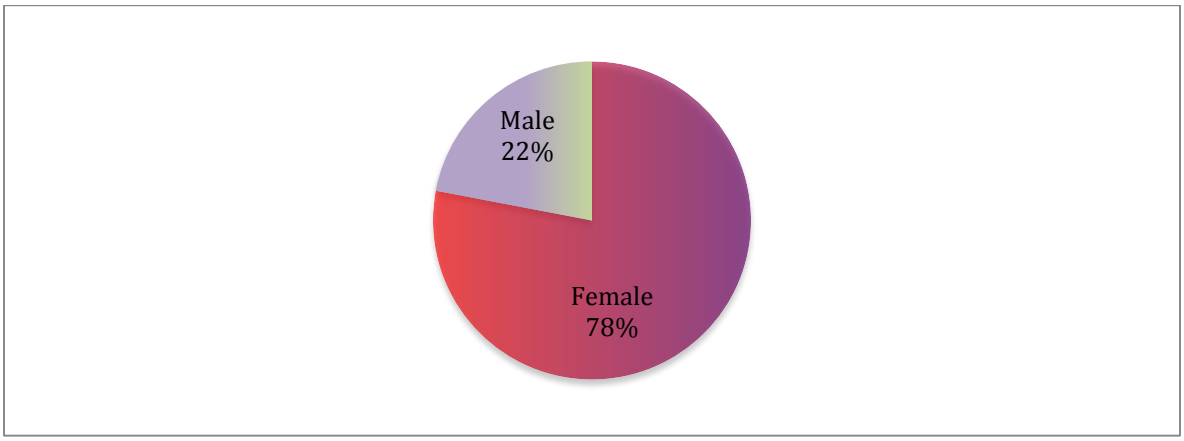


Figure 2. Gender of Patient Participants During Temporal Workflow Observation Period

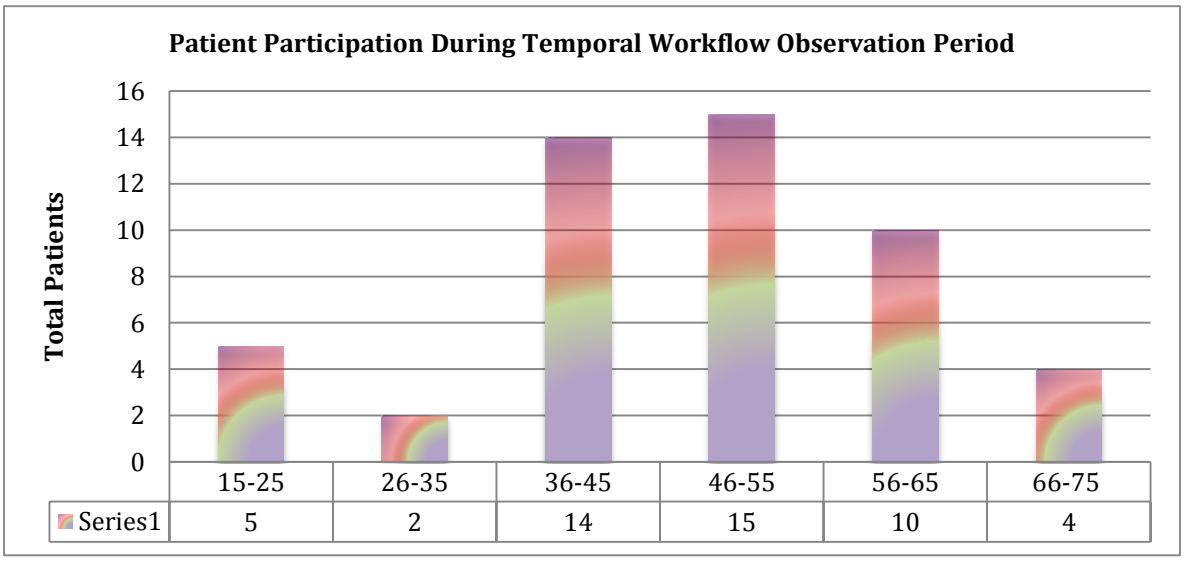


Figure 3. Age of Patient Participants During Temporal Workflow Observation Period

Temporal Workflow Data

According to the data collected, patients spent an average of 47 minutes waiting to be placed into an examination room from the time of their appointment in the back waiting room. The shortest waiting time was 0 minutes, while the longest waiting time was 2 hours and 26 minutes. The median waiting time was 44 minutes. The patients spent an average of 4.1 minutes with a medical assistant in the exam room once called in. After the medical assistants left the room, the patients spent approximately 13.0 minutes in the examination room alone. Once the health care provider entered the room, the patient spent about 9.5 minutes with the provider.

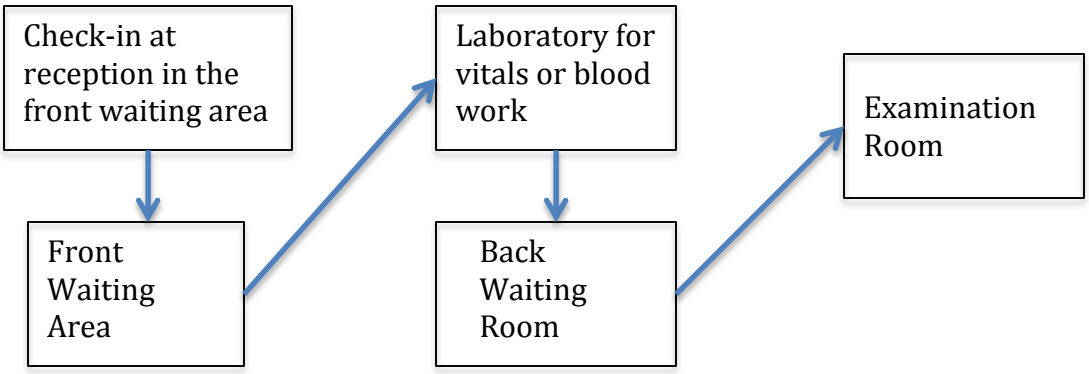
Table 1. The Amount of Time, in Minutes, Spent on Each Indicated Activity

	Time Spent Waiting for Exam Room from the Time of the Appointment	Time Spent with Medical Assistant in the Exam Room	Time Spent Alone in the Exam Room	Time Spend with the Health Care Provider in the Exam Room
Mean	46.9	4.1	13.0	9.5
S.D.*	40.6	3.8	9.2	6.2
Median	44	4	11	8.5
Min	0	0	0	1
Max	146	15	39	25

*S.D. = one standard deviation from the mean

Spatial Workflow Data

The follow diagram illustrates an overview of workflow at the St. John's Well Child and Family Center, Williams Health Center.



Discussion

Implications of Results

Since the average waiting time is 13 minutes, a 2-6 minute screening video should not greatly effect the amount of time the average patient would have to spend in the examination room if the videos were shown during the period in which the patient is alone in the examine room. If, however, the providers are still required to discuss the video with the patients, then the amount of time the providers spend with the patients might increase. One provider recommended showing the patients the screening video while they waited in the waiting room. That, unfortunately, would not be able to work since the female patients watching the video must be alone during the viewing process. If however, the patients were sent into another nearby room to watch the video in private, then maybe that would be feasible should the examination rooms become unavailable. Furthermore, because another individual accompanied only 10% of the patients into the examination room, a majority of the patients would be eligible to watch the screening videos in the privacy of the exam room.

Providers showed concern about being required to ask their patients about domestic violence during each visit. A cross-sectional study identifying domestic violence in primary care sought to measure the attitudes of women towards being questioned about domestic violence by general practitioners or practice nurses. In this study, at least 202/1010 (20%) women objected to screening for domestic violence (Richardson, Coid, Petruckevitch, Chung, Moorey, & Feder, 2002). Overall, only 4% of women reported that their general practitioner had ever asked them if they had been hit, injured, or abused by a partner or former partner. Of those who had experienced physical violence, 32% of them reported they had told their doctor. The acceptability of being asked was not significantly different between women who were and were not currently experiencing domestic violence.

Recommendations

Because the primary care setting is an ideal place to screen potential domestic violence victims and the prevalence of domestic violence is high and carries a high morbidity, those involved in health care should have a role in identifying victims. That is why providers should ask their patients about domestic violence. To prompt providers to do this, a domestic violence tab should be included in the social history component in the Electronic Medical Record (EMR). If patients are experiencing domestic violence, an encoded referral should be added to the printed patient instructions given to the patient at the end of the visit, in addition to the "warm hand-off" for counseling that would occur at the center prior to clinic discharge.

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Appendix

Figure 1. Provider and Medical Assistant Survey – UCLA Domestic Violence Intervention

St. John's Well Child & Family Center

GE-NMF PRIMARY CARE LEADERSHIP PROGRAM PCLP

St. John's Well Child and Family Center requests your help. Please complete the following survey for a domestic violence (DV) intervention set to begin at this site. Thank you for your time. Your input is greatly appreciated.

Please circle your position at SJWCFC: Health Care Provider Medical Assistant (M.A.)

Please rate the following according to the scale provided by placing a check in the appropriate box.

Preparedness

	Strongly Agree	Agree	Disagree	Strongly Disagree
I would be hesitant to ask about DV because I have little or no experience in dealing with this situation*				
I feel prepared asking about abuse of women who appear to me to be at risk of having been or being abused				
I feel ready to respond to a woman who says "yes" to my question about abuse				
I am hesitant to ask women about DV because I have not been appropriately trained*				

Self-confidence

	Strongly Agree	Agree	Disagree	Strongly Disagree
I am confident with my ability to address the issue of domestic violence				
I feel that I am able to support a patient while she gets the right help				
I would feel confident if I were required to ask women about DV.				
I feel comfortable supporting the patient during the interview even though she may not be ready to deal with this problem in the same way I would want her to				

Comfort following disclosure

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel I am able to listen to women's stories as they disclose the abuse they have experienced				
I am able to continue the discussion after a disclosure to assess the needs of the patient				

Need

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel there is a need to question every female patient, over the age of 15, about her possible experience with DV				
I believe the prevalence of domestic violence is high in the area that I service.				

Practitioner lack of control

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel that I am not able to help women who are abused*				
I am reluctant to intervene in case I make matters worse*				
I would give her written information about domestic violence and/or available resources, but would not talk about her situation*				

Professional supports

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel comfortable discussing these practices situations with colleagues to help them deal effectively with DV				
I have enough supports from colleagues, mentors, supervisors, etc. to help me feel comfortable in asking about DV and in dealing with the responses				

Practice pressures

	Strongly Agree	Agree	Disagree	Strongly Disagree
I may forget to ask her about domestic violence*				
I just don't have the time to address this possible abuse issue in the exam room*				
I am reluctant to ask about DV because there are not sufficient community resources to provide assistance*				
I feel frustrated because I don't have the time to talk about abuse*				

Abuse inquiry

	Strongly Agree	Agree	Disagree	Strongly Disagree
Most of the patients I see are often accompanied into the exam room by a family member or friend				
I won't put her on the spot by initiating the topic of abuse				
I feel cultural difference make it difficult to talk to patients about DV				
I feel language barriers make it difficult to talk to patients about DV				

☐ Please check this box if you attended the *Assessing Domestic Violence in the Health Care Setting* presentation held May 2013

Figure 2. Provider Perception of Implemented UCLA Intervention

St. John's Well Child & Family Center

GE-NMF PRIMARY CARE LEADERSHIP PROGRAM PCLP

St. John's Well Child and Family Center requests your help. Please complete the following survey for a domestic violence (DV) intervention set to begin at this site. Thank you for your time. Your input is greatly appreciated.

ircle your position at SJWCFC: Health Care Provider Medical Assistant (M.A.)

Please rate the following according to the scale provided by placing a check in the appropriate box.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel the video is advantageous when dealing with patients that may have experienced domestic violence.				
I feel the video reduces the amount of time I have to spend with the patient talking about domestic violence.				
I feel the video makes it easier to talk to patients about domestic violence, despite possible cultural differences and/or language barriers				
I believe that the patient was receptive to the video shown				
I believe that the patient felt uncomfortable after watching the video.				

☐ Please check this box if you attended the *Assessing Domestic Violence in the Health Care Setting* presentation held May 2013

☐ Please check this box if you are willing to act as a reference for this study. If so, please provide your contact information (name and email address) here: