



DVHCP BACKGROUND

Domestic and sexual violence (DSV) is a public health epidemic and one of the most significant social determinants of health, impacting 1 in 4 women and 1 in 7 men in the US, as well as their family members, friends and communities. DSV contributes to injuries, chronic health issues and high-risk health behaviors, and creates significant strains on the healthcare system:

- Health care utilization costs for DV survivors are 20% higher than for those not impacted.
- The medical cost-burden in the US from domestic violence in the year after victimization is as much as \$7 billion.

In 2014, [Blue Shield of California Foundation](#) funded 19 [Domestic Violence and Health Care Partnerships \(DVHCP\)](#)—6 of which were in LA County—to better address the intersections of health and DSV, **improve systems of care within the safety net across California**, and improve the health of Californians. The primary focus of this initiative was to **promote collaboration between domestic violence (DV) and health organizations** in order to increase access to high-quality, integrated health and DV services for vulnerable populations.

Through training, trauma-informed response, universal education, warm referrals and organizational policy change, intentional partnerships were established to promote systems change, provide comprehensive coordinated care, support survivor health, and prevent violence in a way that was unprecedented.

DVHCP KEY FINDINGS + LESSONS LEARNED

Key Findings

1. Health care providers are twice as likely to screen for domestic violence.

Health care providers doubled their rate of assessment of domestic violence and sexual assault during patient encounters and 2 out of 3 patients reported having their provider talk to them about healthy and unhealthy relationships (with some sites achieving 100%).

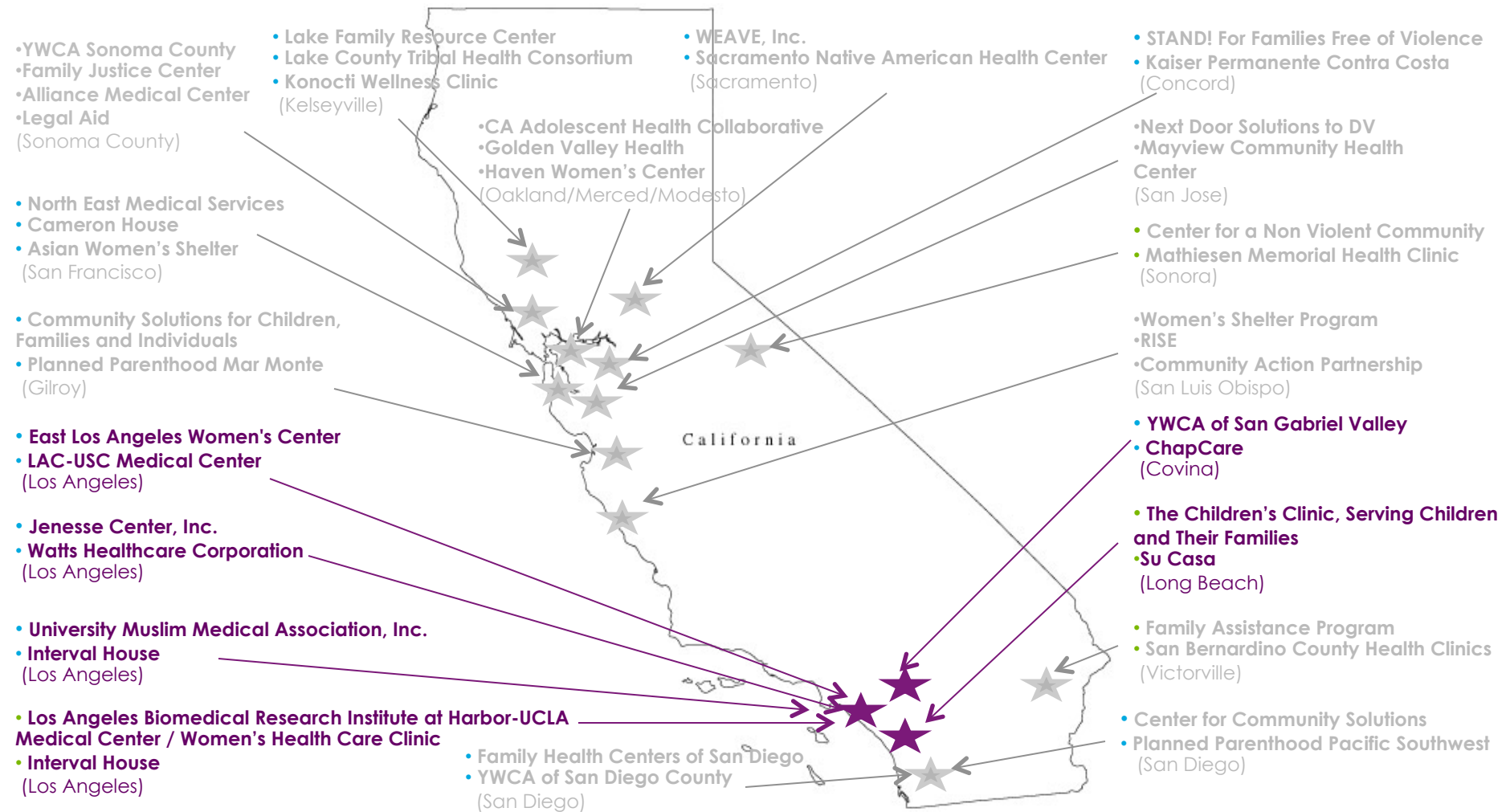
2. Patients are more likely to report domestic violence.

Among patients with prior exposure to unhealthy relationships, more than 1 in 3 reported that they shared this with their health care provider (compared with normal rates of fewer than 1 in 10).

3. DV clients are more likely to focus on health needs.

82% of clients reported an increased understanding of the effects of domestic violence on personal health after being seen at a partner health care organization.

DVHCP Sites





Clients receiving DV services were **uniformly supportive of being asked about and receiving health related services** in the context of receiving advocacy program services.

Increased **number of programs offering health services on site** in domestic violence programs/agencies.

4. DV advocates and health care providers are more likely to make referrals.

Both advocates and health care providers reported significant increases in their confidence referring to each other's organizations.

- Health care providers are more likely to be confident in referring clients to their DV partner organization. (Increased from 22% of providers to 50%.)
- DV advocates are more likely to be "completely confident" in referring a client to their partner organization. (Increased from 38% of advocates to 66%.)

5. Health care providers are more likely to discuss domestic violence with their patients.

One in five providers reported that they discussed DV with their patients "all of the time" a 50% increase from before the initiative. Providers also reported greater comfort with helping patients connect to DV services.

6. There is strong leadership support for collaboration.

- 99% of leadership team members from participating agencies agreed or strongly agreed that, "My organization benefits from being involved in this collaboration."
- Feelings of trust, sense of shared goals, and both formal and informal communication improved over time.

Other Key Data Findings

- Thousands of health care providers were trained, over 1,000 participated in evaluation
- Hundreds of DSV advocates were trained, nearly 300 participated in evaluation
- Training resulted in a **twofold increase in provider and DSV advocate confidence** in responding to DSV and survivor health issues, and making warm referrals to their partner organization
- 100% of health care providers lean on partners in DSV, Child Protective Services and law enforcement for training support
- 94% of health care providers now integrate education on healthy relationships in clinical visits



- 72% of health partners have implemented trauma-informed policies around screening patients alone and **workplace policies for staff exposed to DSV**
- 95% of DSV advocates **educate survivors on the health impacts of DSV**
- Over 75% of DSV advocates participate in **booster trainings** on health assessment and intervention for survivors
- Almost half of DSV advocate partners now have scripts to respond when medical concerns are disclosed
- Well over 90% of partners agree they have what it takes to make a partnership work including:
 - The expertise and innovation necessary to work with underserved communities
 - A clear process for ongoing communication and joint decision making
 - The ability to adapt to changing conditions and overcome staff turnover

Other Lessons Learned

1. **Confidence and trusting relationships are foundational in changing practice and policy** to better address and respond to DSV and promote survivor health.
2. The majority of DVHCP sites reported that **at least some staff from their health care partner self-reported and accessed DV services.**
3. Establishing **formal agreements and written protocols to facilitate a bidirectional referral process was a critical step.** Health centers developed written protocols for assessment and response to DV while DV agencies developed procedures for routine health assessment and expeditious referrals to medical services.
4. Educational materials for patients/survivors need to be adapted to be culturally and linguistically relevant and became more readily available on site at both health centers and DV agencies.
5. **One time trainings are not sufficient, they should be ongoing and accessible for all staff,** and be integrated into orientation procedures in order to reach new staff.
6. DV agencies and health centers worked together to sponsor community education to talk about healthy relationships and abuse, bringing communities together around the issue of DV and health.
7. Some partners identified **sustainable funding streams** to support model programs and approaches, while expanding their partner network across sectors.
8. Sites have disseminated successful integration models across regions and nationally since the close of DVHCP.



DVHCP DATA PILOT FINDINGS + LESSONS LEARNED

Three years after the DVHCP project, a smaller cohort of 6 Southern CA sites participated in a data pilot to measure the impact of partnerships—and their associated policy and practice change—on access and health outcomes for survivors of DSV. The following was measured:

- DSV assessment and response in the health setting
- Health assessment and response in the DSV advocacy setting
- Bi-directional referrals
- Impact of coordinated care on:
 - Accessed care and ongoing healthcare utilization among survivors
 - Ongoing partnership communication on referral outcomes
 - Depression screening (data was inclusive)
 - Sexually transmitted infections screening, treatment and follow-up

DVS programs are powerful conduits for addressing survivor health and improving health access

Access to care was greatly improved as a result of the practice changes made during this pilot. The impact on survivor health outcomes were remarkable; for example, because of the sites coordinating services and tracking referral outcomes, 100% of survivors who tested positive for sexually transmitted infections were treated and completed their follow-up visit three months post screening. Stories like these continue to inspire and justify making health advocacy and cross-sector collaboration an organizational priority:

- A survivor living with type 2-diabetes was trying to self-manage her symptoms without medical care. Upon accessing DSV advocacy services, she was immediately connected to a medical home, assisted in enrolling in health coverage, and assigned to a skilled physician. She was able to receive necessary medical attention, better manage living with the condition, and learned to advocate for her own health.
- Deprived of medical care by her abuser for years, a survivor feared she had been exposed to HIV and was afraid to be tested. The health advocate at the DSV program she attended created seamless accessibility in linking her to needed health services, and she was finally provided the HIV education and screening she needed.

Lessons Learned:

- Data collection is vital and has its challenges. Practice change and data collection in clinical settings is even harder.
- Survivors face real barriers to accessing services.
- Confidential data sharing across partners is possible.
- Electronic health records (EHR) present a different set of challenges.
- Ongoing training on assessment, response and *particularly* universal education is needed and critical to streamlining data practices.
- Partnerships, collaboration and clearly identified staff roles are vital to data collection.

REFERRAL DATA	ACCESSED SERVICES + HEALTHCARE UTILIZATION
<p>152 Health assessments completed in DSV programs</p> <p>84% (128) Referrals for health services from assessment</p> <ul style="list-style-type: none"> • 62% (79) were non-urgent referrals • 1.5% (2) were urgent referrals (within 72 hours) • 5.5% (7) were referrals for children • 29% (37) had no indication for referral • 10% (14) of referrals declined by survivor • 15.5% (20) ineligible referrals at partner site 85% of which received an outside referral 	<p>63% (81) of referrals led to a scheduled appointment</p> <p>80% (65) of scheduled appointments led to a completed health visit</p> <ul style="list-style-type: none"> • 68% (44) for general medical care (including emergency & dental) • 21% (14) for reproductive health • 11% (7) for mental health and/or substance abuse • Referrals for children: outcomes not tracked <p>12% of survivors received follow-up/ongoing care</p>
HEALTH OUTCOMES	<p>53% no-show rate (failed appointments)</p> <p>Self sufficiency in appointment scheduling:</p> <ul style="list-style-type: none"> • 30% survivor scheduled • 70% advocate scheduled <p>DV and health partners communicated on referral outcomes 62% of the time</p>
<p>Sexually Transmitted Infections (STI)</p> <ul style="list-style-type: none"> • 22% screened, 56% not indicated for screening • 11% of those screened tested positive for an STI, 100% of which were treated • 100% of those treated for an STI scheduled their 3-month follow up visit • 100% of those scheduled for a 3-month follow up visits completed this visit 	
QUALITATIVE DATA	
<p>Reported reasons for failed referrals/utilization:</p> <ul style="list-style-type: none"> • Exiting DSV program prior to health visit • Survivor ineligibility for health services (type of insurance or out-of-network) • Survivor lost to follow-up • Location and transportation issues • Legal issues (police custody, arrests) 	<p>Reported reasons survivors declined referrals:</p> <ul style="list-style-type: none"> • Seeking care elsewhere • Desire to self-refer • No identified health issues by advocate • Survivors feel they are in good health • Convenience and timing concerns • Location or near “danger zone” (close proximity to abuse)
<p>Reported health concerns on health assessments:</p> <ul style="list-style-type: none"> • Depression/Anxiety • Insomnia • Chronic PTSD • Dermatological issues, dry skin • Asthma 	<ul style="list-style-type: none"> • Overweight/obesity • Irritable bowl syndrome • Migraines • High STI risk • Pregnancy and post-partum • Access to medications