The Domestic Violence Response Initiative Program Evaluation Results

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Executive Summary

The Domestic Violence Response Initiative (DVRI) is a program of the Maine Chapter of Physicians for Social Responsibility (PSR Maine). It trains and encourages health care providers to routinely screen patients for domestic violence exposure and refer patients who are experiencing domestic violence to their local domestic violence prevention agency. Since 2004, more than 1,400 Maine health care providers have attended DVRI trainings.

During 2009 and 2010, PSR Maine conducted an evaluation of how well DVRI increases the frequency with which health care providers screen patients for domestic violence. The evaluation was made possible by the Bingham Program, the Frances Hollis Brain Foundation, the Simmons Foundation and the Verizon Foundation. PSR Maine contracted Daniel Meyer, PhD, to design the evaluation and interpret the results. Dr. Meyer developed a longitudinal study of DVRI training participants that consisted of a self-reporting survey instrument that was administered three times over a six month period. Participants completed the survey just before attending the training, again three months after attending the training, and again six months after attending the training.

Data sets from 16 primary care clinicians who participated in the DVRI training in 2009 and 2010 were analyzed, showing dramatically increased screening rates for the five different office visit categories studied.

Reported screening rates increased an average of 54% during pregnant patient visits, 47% during new female patient visits, 40% during visits of females with significant life changes, 39% during annual female patient visits and 33% during visits of males with domestic violence risk signs. Across all five visit categories, screening increased an average of 42.6%.

These evaluation results strongly suggest that the Domestic Violence Response Initiative is effective over the long term in increasing the frequency with which primary care providers screen patients for domestic violence.

Introduction

The Domestic Violence Response Initiative (DVRI) is a program of the Maine Chapter of Physicians for Social Responsibility (PSR Maine). DVRI trains and encourages health care providers to routinely screen and refer patients for domestic violence exposure. Since it began in 2004, DVRI has trained more than 1,400 providers. Current and past funders of the project include the Bingham Program, the Frances Hollis Brain Foundation, the Davis Family Foundation, the Maine Community Foundation, the Simmons Foundation and the Verizon Foundation.

Between 1998 to 2007 the rate of reported domestic violence assaults in Maine increased 49.7%. Physician members of PSR Maine started DVRI in response to this mounting levels of domestic violence.

“In the late 1990s, awareness was increasing of domestic violence as a significant public health problem in Maine. We asked prevention experts how we as health care providers could help address the problem,” says DVRI co-founder Daniel Oppenheim, MD. “Screening kept coming up as a big need. So we created DVRI as a way to increase screening rates and transform doctor’s offices into safe places for victims to find help.”

In December, 2008, the Maine CDC issued a Public Health Alert on the subject. It warned that "domestic violence and sexual assault are serious and underlying causes of poor health for many people in Maine" and recommended that "health care providers play a vitally important role in identifying and responding to victims through routine screening and appropriate referral." The alert specifically referred providers to the DVRI program as a learning resource.

DVRI equips health care providers to meet the Maine CDC's recommendations by deploying a two-person training team to medical practices and conferences. The team, made up of a volunteer physician and a domestic violence prevention advocate, holds a one hour training on domestic violence screening and referral. Volunteer trainers attend regularly scheduled train-the-trainer sessions that address both content and presentation skills.

Using physicians as trainers is a particularly important component of the program. Like members of most professions and peer groups, doctors typically listen to other doctors. They share common training, values and experiences. Having a physician volunteer time to travel to another physician's practice to present the DVRI training sends the message that domestic violence screening and referral is a priority in the medical community and that incorporating it into clinical practice is an accepted and appropriate protocol.

DVRI is administered by PSR Maine's Domestic Violence Program Director and oversight is provided by a six-member steering committee.

Evaluation Methods

To conduct an evaluation of DVRI's effectiveness, PSR Maine engaged evaluation consultant Daniel Meyer, PhD, to create a pre- and post-test survey instrument that would reveal any changes among trainees' screening frequency. PSR Maine staff and Dr. Meyer collaborated to create a brief survey that trainees would complete immediately before taking the training (as a pre-test) and then again 3 months after the training and 6 months after the training (as post-tests).

The survey collected information about screening frequency during five different office visit categories: new female patient visit, annual female patient visit, pregnant patient visit, and visits of males with domestic violence risk factors. Surveys were distributed and collected in person, electronically and via U.S. mail.

Both primary care providers and specialty providers participated in the evaluation but the specialty providers did not contribute enough data to be statistically significant. The evaluation results reported here are drawn from the data provided by primary care providers only.

Evaluation Results

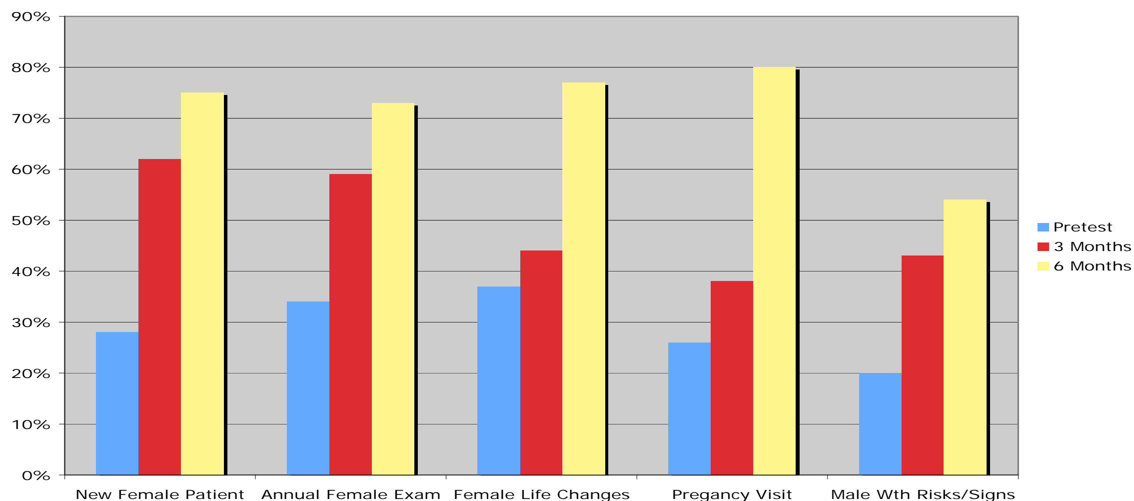
Between May, 2009 and August, 2010, a total of 16 trainees completed all three surveys, providing a complete data set. Another five completed only the pre-test and three month post-test. Another three completed only the pre-test.

Of the 16 trainees who provided complete data, all were primary care providers with either an MD or DO degree. Four (25%) were female. Two (12%) saw 30 or fewer patients per week, five (31%) saw 31-60 patients, five (31%) saw 61-90 and three (19%) see 91 or more.

The changes over time in the percentage of patients these 16 trainees screened are reported in Table 1, broken down by office visit category. The average change over six months for each category is reported in the last column. These data are also reported visually in Graph 1.

Table 1
Results for 16 trainees in primary care practice.

	Percentage of Patients Screened			
Visit Category	Before training (%)	3 months after (%)	6 months after (%)	Average change (%)
New female patient	28	62	75	47
Annual female exam	34	59	73	39
Female life change	37	44	77	40
Pregnancy	26	38	80	54
Male with risk/signs	20	43	54	33



We found significant increases in screening rates in all five visit categories. The largest was seen in visits of pregnant patients: an increase of 54%. This is encouraging since studies suggest that pregnancy is a time of increased risk for violence. Across all five visit categories, screening rates increased an average of 42.6%

These results are particularly dramatic given that in most categories three or four trainees reported very high screening rates of 80 to 100% before participating in the DVRI training. The average of the remaining trainees was thus initially quite low and improved substantially by six month follow-up.

The survey also asked trainees to report whether or not they had ever made contact with their local domestic violence prevention agency: the agency to which they would refer a patient exposed to domestic violence. Before participating in the DVRI training, only one of 16 (6%) trainees had ever spoken with their local domestic violence prevention agency. An additional 5

(31%) reported such contact at the three months post-test and an additional trainee at the six months post-test. Thus the proportion of trainees who had ever spoken with their local agency increased from 6% to 44%.

Discussion

A modest number of DVRI trainees responded to all three rounds of the evaluation survey. We found that they required constant personalized communication in order to submit follow up surveys. The use of a mass-generated online survey yielded few results. Trainees often bypassed the opportunity to follow a link to the actual survey or the survey was filtered into their spam folder. After investigating alternatives to the mass-generated evaluation, DVRI staff determined the most effective way to elicit a response was to send personalized surveys to trainees embedded in the body of an email. This email was followed by a phone call to trainees to remind them to email the completed response back.. This method generated many more responses overall. Even with these efforts, the response rate was modest. Complete data was obtained from 31% (16 of 51) of the primary care providers who participated in the DVRI training during the evaluation period.

Those who did complete all three surveys indicated impressive increases in screening rates. Final average rates of reported inquiry at the six month post-test ranged from greater than 50% for males with domestic violence risk signs to greater than 70% for all four categories of female patients.

With regard to the training's encouragement of physicians to speak directly with their local domestic violence prevention agencies, rates of contact increased 38%.

In conclusion, this evaluation suggests that DVRI training is effective in increasing the percentage of patients that primary care trainees screen for domestic violence.

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This evaluation project and report was funded by the Bingham Program, the Frances Hollis Brain Foundation, the Simmons Foundation and the Verizon Foundation. Daniel Meyer, PhD, the evaluation consultant,, is a medical sociologist and from 1987 to 2009 was a member of the Dartmouth Medical School faculty and Director of Research at Maine-Dartmouth Family Medicine Residency. He is now an independent public health evaluation consultant who can be reached at dmeyer49@yahoo.com. To learn more about the DVRI program, please contact Paul Santomenna, Executive Director of PSR Maine, at (207) 869-1014 or psantomenna@psr.org.

Appendix 1
Survey Instrument

Physicians for Social Responsibility **CLINICIAN SURVEY** DV Response Initiative

Thank you for participating in PSR Maine's Domestic Violence Response Initiative (DVRI). You can help improve DVRI's efficacy and document its outcomes by providing data for our program evaluation. Please fill out the survey below. We will ask you to take the survey again in three and six months to provide a longitudinal view of DVRI's impact on domestic violence screening practices. Results of the evaluation will be reported in aggregate and will NOT include names or contact information of those who provide data. We ask for the information only so we can contact you to take the survey three and six months post-training.

About me- Sex: Female_____ Male _____ Credential: NP/PA_____ MD/DO _____
My practice setting is- Primary Care: ___________ Specialty Care: _________________
Average # of patients I see per week:
Less than 10 11-30 31-60 61-90 91-200 More than 200

What percentage of NEW FEMALE PATIENTS do you currently screen for domestic abuse?

¨ 0% ______ 60% _____
¨ 10% _____ 70% _____
¨ 20% _____ 80% _____
¨ 30% _____ 90% _____
¨ 40% _____ 100% ____
¨ 50% _____ n/a _____

What percentage of FEMALE PATIENTS HAVING AN ANNUAL EXAM do you currently screen for domestic violence exposure?

¨ 0% ______ 60%_____
¨ 10% _____ 70% _____
¨ 20% _____ 80% _____
¨ 30% _____ 90% _____
¨ 40% _____ 100% ____
¨ 50% _____ n/a _____

What percentage of FEMALE PATIENTS EXPERIENCING CHANGES IN DOMESTIC CIRCUMSTANCES do you currently screen for domestic violence exposure?

¨ 0% ______ 60% _____
¨ 10% _____ 70% _____
¨ 20% _____ 80% _____
¨ 30% _____ 90% _____
¨ 40% _____ 100% ____
¨ 50% _____ n/a _____

What percentage of PREGNANT PATIENTS do you currently screen for domestic violence exposure?

¨ 0% ______ 60% _____
¨ 10% _____ 70% _____
¨ 20% _____ 80% _____
¨ 30% _____ 90% _____
¨ 40% _____ 100% ____
¨ 50% _____ n/a _____

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What percentage of MALE PATIENTS WITH INCREASED RISK FACTORS OR SHOWING SIGNS OF ABUSE do you currently screen for domestic violence exposure?

- 0% ______
- 10% _____
- 20% _____
- 30% _____
- 40% _____
- 50% _____
- 60% _____
- 70% _____
- 80% _____
- 90% _____
- 100% ____
- n/a _____

Of the patients you have screened for domestic violence, what percentage have you referred to your region's domestic violence prevention project?

- 0% ______
- 10% _____
- 20% _____
- 30% _____
- 40% _____
- 50% _____
- 60% _____
- 70% _____
- 80% _____
- 90% _____
- 100% ____
- n/a ______

Have you spoken with someone from your region's domestic violence project? If so, how recently?

- Yes _____
- No _____
- Unfamiliar with program in my area. _____

Additional Comments:

Your contact information:
Your information will be used only to contact you to retake the survey in 3 and 6 months.

Your Name:____

Email: ____

Telephone: ____________________________ Best time of day to call__________

Mailing address: ____

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