Internal Assessment of DHS Healthcare Facilities

Survey Development

Assessing the environment of healthcare facilities of the Los Angeles County, Department of Health Services was a crucial part of the IPV strategic planning process. It enabled us to identify key strategic areas and to guide future strategic decisions. With assistance from a UCLA survey development expert, two surveys were developed: one for staff and the other for administrators and managers. The objectives of the surveys were to:

- Assess staff's knowledge base on intimate partner violence policies, IPV laws and reporting, and current practices of their facilities;
- Identify issues, current problems, and strengths with IPV policies and current practices;
- Assess training needs and current training practices;
- Identify current practices of data collection, measurement, monitoring and evaluation of data;
- Identify utilization of resources within and outside of DHS facilities/programs. Surveys for administrators and mangers added important aspects of institutional environment and the level of support from management team.

Sampling Selection and Methodology

The Data Collection sub-committee initially identified a list of healthcare facilities and programs within LAC-DHS for surveying, defined the inclusion and exclusion criteria for participation in the survey, and selected probability sampling as a sampling methodology. However, due to the magnitude of DHS healthcare facilities and the number of eligible DHS staff, sampling methodology was reconsidered for feasibility given a tight project schedule and limited resources. It was thus decided to reframe the list of eligible job classifications and target hospital units with high probability of encountering victims of IPV.

Eligible job classifications were full time and County employed physicians, dentists, hospital, clinic and public health nurses, social workers, public health investigators, community workers, and patient resource workers. For LAC/USC hospital, Emergency Department and walk-in clinics for Women's hospitals, OB/GYN and walk-in clinics for Olive View hospital, and Outpatient clinics and prenatal for Martin Luther King/Drew Medical Center were selected.

Data Collection and Analysis

Surveys were distributed to six county hospitals, five comprehensive health centers, clinics in all eight Service Planning Areas (SPA), and two public health programs that provide direct services to the public. To facilitate data collection process, a liaison staff for each health care facility was requested and the Internal Working Group members were utilized. The Data Collection sub-committee members hand-delivered and collected surveys for staff and administrators during all-staff and manager meetings at different locations. Further, several Internal Working Group members representing Harbor UCLA, High Desert, and Rancho were already involved with IPV strategic planning. These individuals played a crucial role in distributing and collecting surveys, hand-delivering and collecting questionnaires to and from eligible staff and managers within their own facilities. The majority of hospital staff surveys (75%) came from Harbor UCLA, High Desert, and Rancho.

Approximately one half of all returned staff surveys came from the six hospitals (n=392); about one-fourth (n=214) came from staff within SPA clinics, and the rest were returned from Comprehensive Health Centers (n=189) and public health programs (n=28). Most administrators/managers' surveys came from the SPAs (n=40) and hospitals (n=39); the remainder came from the five Comprehensive Health Centers (n=21) and the two public health programs (n=2). The Olive View, Martin Luther King/Drew, Claude Hudson and Long Beach Comprehensive Health Centers distributed the surveys with employee paychecks, and a total of 7, 13, 46, and 14 surveys were returned from these facilities, respectively.

In addition, we asked each facility to provide the total number and names of eligible employees to estimate return rates. With inconsistent responses for this request, the best estimated return rates were 52% for staff and 36% for administrators and managers. The estimated return rate for the staff survey did not include the five Comprehensive Health Centers.

A database was created in Microsoft Access by the project coordinator and all variables in the survey were appropriately coded. In-depth instruction on survey structures and coding was given to two student professional workers, who then entered data into the database from April 14th through June 11th, 2004 as surveys were returned to us. To examine the quality of the data, the first 20 records and every 15th record thereafter were checked for errors. A few minor errors were found and corrected. The quality of the data was thus deemed excellent.

Data were entered and analyzed from 392 staff surveys from six county hospitals, 189 staff surveys from five Comprehensive Health Centers, 214 staff surveys from SPA clinics, and 28 staff surveys from two public health programs. Data were entered and analyzed from 39, 23, 40, and 2 administrators/managers' surveys from the six county hospitals, five comprehensive health centers, all SPA clinics, and two public health programs, respectively.

All variables in the database were converted into SAS for descriptive analysis. The following findings are from a total of 823 staff surveys and 104 administrators and managers surveys.

Results

Key findings from the staff surveys:

- A majority of staff respondents were nurses (n=609) and physicians (n=123). Thirty-three social workers responded to the survey and other job categories included public health investigators, patient resource workers, and community workers (n=58).

- Fifty-four percent (n=447) of respondents stated that their facility did have a policy for providing services to victims of intimate partner violence (IPV). Of these, 40% (n=181) were familiar with this policy. Twenty-nine percent (n=241) stated that their facility did have a designated staff or unit to whom they refer victims of IPV.

- Seventeen percent (n=136) of respondents stated that they were knowledgeable about IPV such as definition, facts, types, and dynamics.

- About forty percent (n=338) of the respondents were aware of the standard countywide injury reporting form for reporting intimate partner violence. Of these, only 14% of the respondents (n=48) have used the form to report IPV to local law enforcement during the past 12 months. Majority of those who have not used the form stated no IPV patients were identified (n=219).

- About two-thirds (n=532) were aware of the laws about IPV mandated reporting requirements for health care providers and of these 22% (n=180) stated that they were familiar with IPV laws.

- When asked if they were a mandated reporter for IPV, 65% of physicians (n=82) and 71% of the licensed nurses (n=381) responded yes.

- During employment with LAC, 37% (n=305) have attended a training session either offsite or onsite on IPV.

- When asked about perceived barriers to providing adequate services to victims of IPV, twenty-three percent (n=190) identified inadequate training on IPV as a barrier followed by language barrier with patients (n=163), inadequate resources to help identified IPV victims (n=157), and lack of time (n=136). Some staff felt they were not comfortable in discussing IPV with patients (n=72) while 4% (n=32) believed that IPV was a private matter and not a health concern.

Key findings from the administrators and managers:

- A majority of these were managers or supervisors for nurses (n=53), physicians (n=29), and social workers (n=4). Other job classifications included hospital

administrators, Area Health Officers, Area Medical Directors, Department Chairs, and Staff Analysts (n=16).

- When asked if their facility had a policy for screening victims of IPV, forty-five percent (n=47) stated yes. The rest did not have such policy (n=35) while some were not sure (n=22). IPV screening was usually conducted by a physician and/or nursing staff (n=40).

- Forty-four percent (n=46) stated that their facility did have written policies for treating, intervening, and referring for IPV. Of these, eighty-five percent (n=40) stated that it describes mandatory reporting procedures, referring procedure (n=38), intervention procedure (n=37), definition of IPV (n=35), and how to document an intervention (n=30).

- When asked about IPV training requirement at their facility, more respondents stated that IPV training was required for nurses (n=23) than for physicians (n=15).

- Seventeen percent (n=18) stated that they had an IPV coordinator/unit at their facility. These facilities were Harbor UCLA, LAC/USC, Hudson and Roybal Comprehensive Health Centers, North Hollywood Clinic (SPA 3&4) and Whittier Clinic (SPA 7&8).

- When asked if their facility has a standardized form that it uses to record information about known or suspected cases of IPV, twenty-nine percent (n=30) responded yes.

- About one-third (n=33) of the respondents stated their facility offered IPV training for staff and of those over half (n=19) stated that the training was mandatory. Forty-four percent (n=46) stated their facility did not offer IPV training.

- When asked if there were posters or brochures about IPV in their facility, twenty-eight percent (n=29) stated yes, over fifty percent (n=56) responded no, and the rest were not sure or did not answer (n=19).

- About one-fifth (n=22) of the respondents stated that their facility collected IPV data. Among these, seventy-three percent (n=16) collected data on number of IPV cases identified, sixty-four percent (n=14) on number of patients screened, and over fifty percent (n=12) stated that their facility collected data on number of IPV cases reported to law enforcement.

- Respondents were asked to comment on institutional weaknesses. Comments included: no established polices, no system to re-enforce the policy, need for an IPV coordinator, insufficient support and participation from administration, physicians, and the quality improvement unit, lack of training and need for on-going training, time constraints, high volume and acuity, lack of privacy, and poor collaboration with law enforcement and other agencies.

Limitations

The results of the survey should be interpreted with caution. Due to the magnitude of eligible sample population employed within LAC-DHS healthcare facilities, probability sampling was beyond the scope of the project timeline and resources. Survey results may not be representative of all LAC-DHS staff because not all eligible employees were included in the sampling frame.

Variation in response rates by healthcare facility is likely due to survey distribution methods. Although we attempted to work with and through a liaison staff at each facility, we did not have comparable control of survey distribution at each health care site. This resulted in a wide range of the number of returned surveys. Those health care facilities where internal working group members took the surveys, and hand-delivered them to a group of eligible employees, showed higher response rates than those facilities without existing internal resources. In addition, survey distribution with paychecks showed very low return rates.

Further, the level of administrative support from each facility for the project was uneven. This presumably resulted in an inconsistent level of survey participation from their staff and managers. Mid-Valley Comprehensive Health Center chose not to participate in the survey.

The surveys were to be distributed to full time County employees. However, we were not able to determine how many part time or per diem employees completed surveys because we did not include a question about employment status.

It is highly possible that respondents from the same facility may have given different and /or conflicting answers to the same question. This may be due to individual job function, personal interest, and/or familiarity with the facility policy on the topic.

In addition, for some questions, respondents did not follow the survey instructions. For example, there was a subsequent question to be answered only if a previous question was answered positively. Respondents frequently did not follow these instructions.

A few of the survey questions may have been ambiguous. For example, question #15 in the staff survey "Does your facility/program provide direct services to clients/patients?" was confusing. It was not clearly defined what 'direct services' were; therefore, interpretations and responses to the question varied.

Funding of this project was too limited to examine the true magnitude and scope of issues related to intimate partner violence within LAC DHS healthcare facilities. Despite limitations, this survey was probably the first attempt of its kind to assess IPV related policies and practices distributed to DHS health care facilities in Los Angeles County.