LAC-DHS Intimate Partner Violence Prevention Strategic Plan 2006-2010

Intimate Partner Violence Prevention Strategic Planning Coalition &

Injury and Violence Prevention Program

Los Angeles County Department of Health Services

Los Angeles County Department of Health Services

IPV Prevention Five-Year Strategic Plan

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This publication was supported by the Preventive Health and Health Services Block Grant from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

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Special thanks is extended to Dr. Jonathan Fielding for his support and commitment for this project

Appreciation is extended to Billie Weiss, former IVPP Director, for her vision, support and involvement throughout the planning process

Thanks to the following IVPP staff who assisted with data entry and other logistics

Victoria Cervantes
Fabiola Chavez
Tegra Jackson
Katie Martin
Voncille McKinney (Former IVPP Acting Director)

We would like to acknowledge Gale Feldman, consultant to this project. Her expertise, skills, vitality and creativity were invaluable to the success of this project.

We would also like to acknowledge the following members who played a crucial role in developing the IPV Strategic Plan for LAC-DHS. Without their continued support, commitment, and dedication, this project would not have been possible.

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Abbreviations Key

- **AHO:** Area Health Officer
- **CDC:** Center for Disease Control and Prevention
- **CEO:** Chief Executive Officer
- **EAG:** External Advisory Group
- **EPIC:** Epidemiology and Prevention for Injury Control
- **IPV:** Intimate Partner Violence
- **IVPP:** Injury and Violence Prevention Program
- **IWG:** Internal Working Group
- **JCAHO:** Joint Commission on Accreditation of Healthcare Organizations
- **LAC-DHS:** Los Angeles County Department of Health Services
- **LCSW:** Licensed Clinical Social Worker
- **MSW:** Masters in Social Work
- **MyPHD:** My Portal Healthcare Data
- **NCVS:** The National Crime Victimization Survey
- **NVAWS:** The National Violence Against Women Survey
- **OB/GYN:** Obstetric and Gynecology
- **PHI:** Public Health Investigator
- **PHN:** Public Health Nurse
- **SPA:** Service Planning Area
- **STD:** Sexually Transmitted Disease

Executive Summary

Intimate partner violence (IPV) is a substantial public health problem for Americans that has reached epidemic proportions. Los Angeles is no exception, with thousands of adults and children impacted by IPV each year. The Los Angeles Police Department alone reported a total of 26,747 domestic violence crimes and the Los Angeles Sheriff Department added a total of 10,132 domestic violence incidents in 2002. According to the California Department of Justice, a total of 181 IPV criminal homicides were committed in California in 2002. Of those 31.5% (N=57) occurred in Los Angeles County, which is higher than the 30% of the state population that resides in the county.

IPV remains largely undetected in the health care setting. Although battered women frequently seek health care, fewer than one in 20 are correctly identified by health care professionals.

To facilitate physicians' intervention on behalf of abused patients, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO-1992) required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. While most states have improved the legal remedies available to IPV victims, California is one of six states – including Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island- with specific laws for health care providers on reporting suspected cases of IPV. California Penal Code, section 11160 requires that health care professionals report cases for patients whom they suspect are suffering from an IPV-related injury to law enforcement officials, with or without the patient's consent.

The Los Angeles County Department of Health Services (DHS), Injury and Violence Prevention Program (IVPP) was awarded a grant from the State Department of Health Services Epidemiology and Prevention for Injury Control (EPIC) Branch to develop a five year strategic plan to address IPV within Los Angeles County DHS.

To facilitate the strategic planning process, the IVPP convened the IPV Prevention Strategic Planning Coalition, which consisted of a broad array of service providers, DHS administrators, DHS staff, public health programs, SPAs (service planning areas), community leaders, researchers (UCLA) and community based agencies. The mission of the Intimate Partner Violence (IPV) Prevention Strategic Planning Coalition is to prevent and reduce IPV in Los Angeles County through development of IPV policies, procedures, and protocols for LAC DHS in collaboration with the community agencies of Los Angeles County. Our vision is that all patients within the DHS system are screened, identified, treated, referred and reported for IPV, leading to a safe and healthy environment in Los Angeles County, where all people can live without risk of IPV.

The strategic planning process was initiated in June 2003, and proceeded over the course of eighteen months. The main goal of the strategic planning process was to formulate a five-year comprehensive plan to implement standardized IPV policies and protocols within DHS clinics, health centers and hospitals, including a strategy to assure compliance with mandatory IPV reporting laws. We conducted a survey to assess the DHS healthcare facilities' environment related to IPV practices and policies. Information was collected from 823 staff and 104 administrators and managers.

Based upon the results of the surveys, the IPV Prevention Strategic Planning Coalition assessed internal strengths and weaknesses, as well as external opportunities and threats. These data guided us in identifying the eight key strategic areas that would be focused upon in the five-year comprehensive strategic plan to effectively address IPV within DHS healthcare facilities. The eight key strategic areas are:

- DHS Policy on Intimate Partner Violence
- IPV Policy Implementation and Systems Improvement Strategies
- Screening and Identification
- Intervention and Treatment
- Resources and Referrals
- Reporting and Law Enforcement
- Collaboration and Data Collection
- Training

As we are ready to move forward with this plan, we sincerely hope that everyone will support efforts to implement the IPV Prevention Strategic Plan, while actively engaging in on-going violence prevention efforts to make our community a better and a safer place to live.

Table 1 on the following pages provides a summary of the specific priority issues, goals, objectives, and timeframes outlined in the strategic plan.

Table 1:
Implementation Plan: Goals and Objectives

Key strategic area	**#1 DHS Policy on Intimate Partner Violence (IPV)**	**#2 IPV policy implementation & systems improvement strategies**		
Goals	To develop standardized policies, procedures and protocols to address IPV within DHS healthcare facilities	To ensure that DHS facilities have the infrastructure and guidelines necessary to implement the IPV policy		
Implementation activities	Develop standardized IPV policies	2.1.IPV policy implementation	2.2. Develop an internal promotional campaign	2.3. MyPHD & DHS web-pages
Objectives	1) By 2006, IVPP will formulate an IPV policy development team comprised of Internal Working Group members to create standardized IPV policies for DHS healthcare facilities 2) By 2006, IVPP and the IPV policy development team will develop standardized IPV policies for DHS healthcare facilities, by revising and adapting current policies from selected DHS healthcare facilities. 3) By 2007, standardized IPV policies will be approved by appropriate DHS command channels and be distributed to DHS healthcare facilities.	1) By 2006, IVPP will hire two staff members to assist with the IPV implementation activities 2) By 2006, IVPP and the IPV policy development team will create guidelines for monitoring and evaluating IPV policy implementation 3) By 2006, IVPP and the IPV policy development team will create guidelines to ensure that clinics and community-based organizations in partnership with DHS are in compliance with IPV laws 4) By 2008, 100% of DHS healthcare facilities will develop their own IPV implementation plans 5) By 2008, 100% of DHS healthcare facilities will create IPV Response Teams or designate an IPV staff member(s) to facilitate IPV policy implementation 6) By 2010, IVPP will coordinate a process and outcome evaluation of the overall IPV program within DHS	1) By 2007, IVPP will develop an internal promotional campaign to inform staff on standardized IPV policies and procedures 2) By 2008, an internal promotional campaign will be disseminated to 100% of DHS healthcare facilities to inform DHS staff on standardized IPV policies and procedures	1) By 2007, an IPV web page for MyPHD and the DHS websites will be completed. 2) By 2008, initiate on-going maintenance and perform periodic updates of IPV information on the DHS and MyPHD websites

Intimate Partner Violence Prevention Strategic Planning
Implementation Plan: Goals and Objectives

Key strategic area	#2. IPV policy implementation & systems improvement strategies	#3 Screening & Identification	#4 Intervention & Treatment	
Goals	To ensure that DHS facilities have the infrastructure and guidelines necessary to implement the IPV policy	To ensure that all patients seen at DHS healthcare facilities are screened by a culturally competent healthcare provider, who is trained to identify IPV	To ensure that all patients who screen positive for IPV will receive appropriate intervention and treatment	
Implementation activities	2.4. Advanced technology	IPV screening practices	4.1.Educational materials	4.2.IPV intervention and treatment practices
Objectives	1) By 2006, IVPP will investigate new advanced technologies for screening, referrals, reporting, and data collection 2) By 2007, IVPP will assess the feasibility of utilizing new technologies within DHS 3) By 2010, IVPP will re-evaluate technology for screening, referrals, reporting and data collection	1) By 2006, IPV standardized policy will include a recommended IPV screening instrument to be used across DHS healthcare facilities 2) By 2010, 100% of DHS healthcare facilities will routinely provide IPV screening to patients ages 13 and older	1) By 2006, IVPP will evaluate, update and distribute existing IPV educational materials 2) IVPP will continue to be a resource for updated IPV educational materials	1) By 2010, 90% of DHS patients who screened positive for IPV will have lethality assessed and documented, injuries recorded in a body map, and have a safety plan discussed 2) By 2010, 90% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.

Intimate Partner Violence Prevention Strategic Planning
LAC-DHS Injury and Violence Prevention Program (IVPP)
Implementation Plan: Goals and Objectives

Key strategic area	#5 Resources and Referrals	#6 Reporting and Law Enforcement	#7 Collaboration & Data Collection	
Goals	To ensure that IPV resources are available to all DHS healthcare providers to assist with referral of patients to appropriate resources	To ensure that all DHS healthcare providers comply with IPV reporting laws and collaborate with local law enforcement agencies to improve safety outcomes for patients identified with suspected or known IPV	To ensure prevention of IPV through the collection of data and collaboration with internal and external agencies	
Implementation activities	IPV resources and referrals	IPV Reporting and law enforcement	7.1.Collaboration	7.2.IPV data collection
Objectives	1) By 2006, IVPP will identify and update culturally and linguistically appropriate resources and referral lists 2) By 2008, 100% of DHS healthcare facilities will have culturally and linguistically appropriate resources, referral lists, and IPV prevention and intervention literature easily accessible to all DHS patients 3) By 2009, 100% of IPV Response Team (or designated IPV staff) will initiate contact and develop a working relationship with community agencies serving IPV	1) By 2006, IVPP will identify contacts within law enforcement agencies in LAC to address IPV 2) By 2009, 100% of DHS healthcare facilities will have established contact with identified law enforcement personnel in their jurisdiction by the IPV Response Team or IPV designated staff 3) By 2010, 90% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement as mandated by State law, using a standardized form	1) By 2007, IVPP will develop a collaborative plan with DHS internal program staff and community partners on training, funding, sharing of resources and data collection	1) By 2008, IVPP will develop a data collection system to collect IPV data in DHS healthcare facilities 2) By 2008, each DHS healthcare facility will appoint an IPV records keeper to submit regular quarterly reports to IVPP 3) By 2008, IVPP will train IPV records keepers to submit quarterly IPV reports beginning in 2009 of implementation 4) By 2010, 100% of DHS healthcare facilities and IVPP will implement the protocols and procedures for data collection as specified in the IPV policy 5) By 2010, IVPP will investigate the feasibility of establishing a countywide IPV data collection system, among DHS healthcare facilities, non-DHS healthcare facilities, and other community agencies.

Intimate Partner Violence Prevention Strategic Planning
LAC-DHS Injury and Violence Prevention Program (IVPP)
Implementation Plan: Goals and Objectives

Key strategic area	# 8 Training
Goals	To provide IPV and sexual violence training to DHS staff to increase staff knowledge and skills in order to address and reduce the impact of IPV in Los Angeles County
Implementation activities	IPV Training
Objectives	1) By 2007, IVPP will provide a training curriculum and an evaluation tool to be implemented within DHS 2) By 2008, 90% of administrators/managers in each DHS healthcare facility who are mandated in the IPV policy will have participated in the IPV and sexual violence training. 3) By 2010, 90% of DHS staff with direct patient care in each healthcare facility will participate in IPV and sexual violence training offered through DHS. 4) By 2009, 90% of all new DHS staff will participate in IPV and sexual violence training within one year of hire. 5) BY 2008, IVPP will evaluate initial IPV trainings and make adjustments accordingly for future training. 6) By 2010, 90% of DHS staff who provides direct patient care, and who completed initial IPV training by 2008, will attend on-going IPV and sexual violence training.

Background

Overview: Intimate Partner Violence

Intimate partner violence (IPV) is a substantial public health problem that has reached epidemic proportions resulting in serious consequences and costs for individuals, families, communities, and society.[1,2] The National Violence Against Women Survey (NVAWS) reports an estimated 5.3 million IPV victimizations occur among U.S. women ages 18 and older each year and this violence results in nearly 2 million injuries, more than 555,000 of which require medical attention (CDC, 2003). Estimates from the National Crime Victimization Survey (NCVS) indicate that approximately 1 million violent crimes are committed annually against persons by their current or former spouses, boyfriends, or girlfriends, with 85% of victims being women. On average, approximately 8 in 1,000 women and 1 in 1,000 men, age 12 or older, experienced a violent victimization perpetrated by a current or former intimate partner.[3]

The health care costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care service which accounts for more than two-thirds of the total costs (CDC, 2003).

In 2003, there were over 194,000 domestic violence-related calls for assistance to law enforcement in the State of California. Approximately 52,000 of those calls occurred in Los Angeles County. In addition, there were over 48,000 arrests for spousal abuse charges in the state of California in 2003 and of those nearly 13,000 arrests occurred in Los Angeles County.

Medical providers may be the first non-family member to whom an abused woman turns for help; thus, they have a unique opportunity and responsibility to intervene.[4] To facilitate intervention on behalf of abused patients, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO-1992) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

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[1]Bachman R, Saltzman LE. Violence against women: estimates from the redesigned survey, Bureau of Justice Statistics, Special Report. Washington, DC: US Department of Justice; August 1995.
[2]Greenfeld L, et al., editors. Violence by intimates: analysis of data on crimes by current or former spouses, boyfriends, and girlfriends. Bureau of Justice Statistics Factbook Washington, DC: US Department of Justice; March 1998. NCJ-167237.
[3] National Crime Victimization Survey, 1992 - 1996
[4] American Medical Association

In addition, most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care providers. While almost all states have laws that require reporting certain injuries, California is one of six states -- including Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island -- with specific laws on reporting suspected cases of intimate partner violence. Most of these states have provisions for protecting victim identity, obtaining informed consent, or reporting to social service agencies. However, California Penal Code, section 11160 requires that health care professionals report cases when they suspect the patient is suffering from an IPV-related injury to law enforcement officials, with or without the patient's consent. [5]

Overview: Strategic Planning Background

Until recently, several California counties, including Los Angeles, had not developed standardized policies to ensure compliance with IPV laws. To address this issue, healthcare providers, often in conjunction with advocacy and law enforcement, met in several counties to address how best to comply with IPV laws. They developed protocols, on a county-by-county basis, that attempt to comply in a manner that is ethical and protective of patients, as much as possible, without minimizing the danger and criminal nature of the event.[6] As part of this effort, the Los Angeles County Department of Health Services (DHS), Injury and Violence Prevention Program (IVPP) was awarded a grant from the State Department of Health Services Epidemiology and Prevention for Injury Control (EPIC) Branch to develop a strategic plan for implementation of policies and procedures regarding Intimate Partner Violence and compliance with California Penal Code, section 11160.

The strategic planning process was initiated in June 2003, and proceeded over the course of eighteen months. The main goal of the strategic planning process was to formulate a five-year comprehensive plan to implement standardized IPV policies and protocols within the 25 DHS clinics, health centers and hospitals, including a strategy to assure compliance with mandatory IPV reporting laws. The strategic planning process included the following five fundamental phases that allowed for flexibility and creativity, while providing a structured process for developing a comprehensive plan to address IPV with DHS healthcare facilities:

- Phase 1: Plan for Strategic Planning – During this phase, agreement was reached on initial critical issues and a detailed "plan for planning" was developed, which included process and procedures for all phases of planning, planning outcomes, activities, responsible personnel and timeframe.

- Phase 2: During phase 2, the planning committee developed a mission and vision statement.

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[5] Rodriguez M, et al. Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. JAMA. August 1999. 282: 468-474.

[6] Shaping California's Health Policy for Victims of Intimate Partner Violence. Harvard Health Policy Review. Fall 2001: 2:2.

- Phase 3: Assessed the Environment – During this phase, appropriate data was collected from the DHS healthcare facilities to provide an explicit understanding of the current IPV practices and protocols and the degree of implementation of these procedures. This information was used to analyze the internal strengths and weaknesses within DHS, and its external opportunities and threats in regard to intimate partner violence

- Phase 4: Agreement on Priorities - During phase 4, the planning committee decided on the strategies to address the previously identified issues and established goals and objectives.

- Phase 5: Composed the Strategic Plan – During phase 5, the information collected in the previous phases was synthesized into one coherent, consolidated document that will act as a detailed blueprint for action, as DHS implements policies and protocols to address IPV within its healthcare facilities.

The overall purpose of the strategic planning process was to develop a plan to implement standardized policies, procedures and protocols to screen, treat, refer and report intimate partner violence, assuring compliance with the law and to prevent and reduce intimate partner violence, through training, education, and consultation of healthcare providers and staff. The objectives of the strategic planning process were to construct a plan to:

- Develop protocols to screen, treat, refer, and report victims of IPV in all DHS healthcare facilities.

- Identify and implement a universal screening tool for victims of intimate partner violence

- Develop uniform reporting and data collection systems within LAC DHS.

- Facilitate services and resource linkages to victims of intimate partner violence.

- Prevent and minimize collateral damage that accompanies IPV.

- Raise awareness, educate and train LAC DHS healthcare staff about IPV and compliance with the law.

Overview: Intimate Partner Violence Strategic Planning Coalition

The involvement of key stakeholders leads to an increased level of commitment to the strategic plan's goals and objectives by building a vision that is shared among all participants. In order to involve key stakeholders, the IVPP convened the Intimate Partner Violence Prevention Strategic Planning Coalition, which contained two main committees consisting of key staff within DHS, community based organizations and community leaders. The External Advisory Group consisted of community-based agencies and community leaders with expertise in intimate partner violence. The External Advisory Group functioned as an oversight committee, assuring that planning efforts were strategically focused while addressing the complexities of developing a plan for IPV within DHS.

The Internal Working Group consisted of administration and staff members from DHS SPAs (service planning areas), hospitals, clinics, and public health programs. The Internal Working Group was responsible for providing leadership, oversight and resources for the project. Members of the Internal Working Group were required to participate in at least one sub-committee, which focused on a specific aspect of the strategic planning process (see Table 2). Both the Internal Working Group and the External Advisory Group ensured that the strategic plan addressed the most important elements of IPV including screening, treatment, referral and reporting.

Table 2
Internal Working Group Sub-Committees

Sub- Committee Name	Description	Time-Frame
Policy Review Sub-Committee	The Policy Review Sub-Committee was responsible for coordinating the collection of DHS facilities' IPV policies, service statistics, organizational charts, resources, and other documents clarifying the organization's mandates, history, and operating trends.	July – September 2003
Mission/ Vision Statement Sub-Committee	The Mission/Vision Statement Sub-Committee was responsible for developing the Mission and Vision Statement for the IPV Prevention Strategic Planning Coalition.	September – October 2003
Survey Sub-Committee	The Survey Sub-Committee was responsible for developing the administrator and staff surveys to assess current IPV related policies, procedures and protocols, and to assess ideas for implementation of county-wide policies, procedures, and protocols.	November 2003 – February 2004
Data Collection Sub-Committee	The Data Collection Sub-Committee was responsible for coordinating the assessment of the DHS facilities to evaluate current IPV related policies, procedures and protocols. The Data Collection Sub-Committee provided feedback on the data analysis related to the information collected during the countywide assessment. This sub-committee also assessed current IPV policies within DHS.	March – June 2004
Strategies Sub-Committee	The Strategies Sub-Committee was responsible for choosing the criteria to guide the setting of priorities, and then selected the future overall core strategies so that the IPV Prevention Strategic Planning Coalition can achieve its purpose of implementing IPV-prevention policies, procedures, and protocols within DHS facilities.	July – August 2004
Goals and Objectives Sub-Committee	The Goals and Objectives Sub-Committee was responsible for developing overall goals, as well as specific and measurable objectives regarding the implementation of IPV-prevention policies, procedures, and protocols within DHS facilities. The Goals and Objectives Sub-Committee also reviewed IPV strategic plans from other California Counties.	September - November 2004

Mission and Vision Statements

Mission Statement

The mission of the Intimate Partner Violence (IPV) Prevention Strategic Planning Coalition is to prevent and reduce intimate partner violence in Los Angeles County through development of IPV policies, procedures, and protocols for LAC DHS in collaboration with the community agencies of Los Angeles County.

External Vision Statement

A safe and healthy environment in Los Angeles County, where all people can live without risk of intimate partner violence.

Internal Vision Statement

All clients (ages 13 and older) within the DHS system are screened, identified, treated, referred and reported for IPV.

Vision of Success

The IPV Prevention Strategic Planning Coalition will be successful in meeting its purpose if implementation of the strategic plan results in the following:

- Raised awareness about intimate partner violence among healthcare providers within LAC DHS.
- Increased knowledge, understanding, and law requirements associated with intimate partner violence for healthcare providers within LAC DHS.
- Decreased economic costs associated with utilization of judicial system, law enforcement and healthcare system.
- Early identification, effective intervention and treatment, and adequate referral services for victims of intimate partner violence.
- Implementation of universal screening for intimate partner violence for all clients within LAC DHS healthcare facilities.
- Promotion of primary prevention of intimate partner violence.
- Reduction in incidence and prevalence of intimate partner violence.
- Healthier, happier and safer families and communities.

Fundamental Values and Beliefs

Prior to creating the mission and vision statements, the IPV Prevention Strategic Planning Coalition identified the fundamental values and beliefs that guide the interactions between planning participants, as well as with the community. The IPV Prevention Strategic Planning Coalition also identified the major assumptions upon which the strategic plan was developed.

We believe:

- All people have the right to healthy relationships and safe environments.
- All people have the right to be free of IPV.
- All people should feel empowered to live to their full potential without fear of IPV.

We value:

- Integrity
- Collaboration and teamwork
- Education and knowledge
- Positive behavioral changes
- Basic human rights and dignity
- Empowerment
- A holistic approach
- Health, happiness and quality of life

We assume:

- There is a need to raise awareness of the domestic violence problem.
- There is a need for prevention and treatment of IPV.
- Prevention is possible and that it works.
- Behavior can be changed.
- Developed IPV policies, procedures, and protocols will be successfully implemented.
- All healthcare workers should be educated about domestic violence.
- We can build and facilitate collaboration among LAC DHS agencies.
- We can make a difference.

Initial Key Critical Issues

The Internal Working Group identified five key critical issues that assisted in focusing the strategic planning process. In addition to identifying the issues, the IPV Prevention Strategic Planning Coalition identified the potential barriers and benefits of addressing the key critical issues in the five-year comprehensive strategic plan to address IPV within DHS healthcare facilities.

Screening/ Identification of Intimate Partner Violence

Without an initial IPV screening process, IPV victims would not be identified and prevention strategies could not be applied. Possible barriers to IPV screening include time constraints, cultural issues, personal fear, biases, attitudes and values, and lack of knowledge and information about addressing IPV within a healthcare facility. Requiring universal IPV screening of all DHS patients will result in better identification of suspected or known cases of IPV, allowing an opportunity for intervention and prevention of further harm and injury.

- Only 45% of DHS healthcare facilities reported having a policy to screen for victims of IPV.
- 21% of administrators/managers were unsure if an IPV screening policy existed in their facility.
- Only 43% of facilities reported that universal screening of men and women was required under the IPV policy.
- Of the administrators/managers working in facilities with Emergency Departments, most felt confident that IPV screening occurred there. However, of the respondents with OB/GYN facilities, 27% did not know if screening occurred in that area, and 44% didn't know if screening occurred in the outpatient department.

Intervention and Treatment

Timely intervention and early treatment can reduce the number and severity of injuries, prevent future incidents of IPV and save lives. Possible barriers to effective intervention include a lack of institutional or administrative support and training, insufficient staff, lack of bilingual staff, inadequate system to respond appropriately after identification of IPV, and a poor monitoring system for reinforcement of IPV policies.

- 33% of administrators/managers reported that their facility did not have a written policy for treating, intervening and referring IPV.

- 23% were unsure if their facility had a written policy addressing protocols for intervention with a patient identified as a victim of IPV.

- 16% of staff members reported that their facility does not have a policy for providing services to victims of IPV, while 29% were unsure if such a policy existed.

- Of the administrators/ managers who responded that their facility has an IPV policy (45%):

  - 20% of the policies do not describe how to appropriately intervene and treat a victim of IPV.
  - 35% of the policies do not describe how to document an intervention.
  - Only 24% of the policies required development of a safety plan.

Resources and referrals:

Appropriate resources may facilitate the process of breaking the cycle of violence and ensure safety for IPV victims. It may enable IPV victims to further seek what she/he needs to prevent future IPV.

- Of the 400 survey respondents whose facility provided direct services to patients, 39% of DHS staff responded that inadequate resources to help identified IPV victims was a perceived barrier to providing adequate services to victims of IPV.

- Of the administrators/ managers who responded that their facility has an IPV policy (45%), 17% do not describe how to refer victims of IPV.

- Of the 400 survey respondents whose facility provided direct services to patients:

  - 65% stated that their facility works with shelters for battered women.
  - 57% stated that their facility works with counseling service agencies.
  - 43% stated that their facility works with legal aid service agencies.

Reporting to Law Enforcement:

California Penal Code, section 11160 requires that health care professionals report cases for patients whom they suspect are suffering from an IPV-related injury to law enforcement officials, with or without the patient's consent. However, Los Angeles County DHS has not had a standardized policy to ensure mandatory reporting of IPV patients to law enforcement. Currently, there is not a judicial monitoring system to assess the effectiveness and level of implementation of this law. Other barriers to reporting may include a lack of follow-up system, slow response time, and inadequate level of support and cooperation from law enforcement.

- 37% of DHS staff were not aware of the standard countywide injury reporting form.
- Only 14% of DHS staff who were aware of the form stated that they have used this form to report IPV to local law enforcement during the past 12 months.
- 22% (183/823) of the respondents were not sure (or did not answer) if they were a mandated reporter for IPV.
- 33% (270/823) were not sure (or did not answer) if patient's consent was required to report IPV to law enforcement.
- 11% (93/823) incorrectly answered that patient's consent was required to report IPV to law enforcement.

Countywide Data Collection System:

Developing a data collection system is important because the epidemiology of IPV in Los Angeles is not completely known due to incomplete data.

- 22% (22/104) of administrators/managers stated that their facility collected IPV data. Of these:
  - 73% collect data on number of IPV cases identified.
  - 64% collect data on number of clients screened.
  - 55% collect data on number of IPV cases reported to law enforcement.

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.

Goals, Objectives and Strategies

The IPV Prevention Strategic Planning Coalition developed strategies, goals and objectives, which are essential to effectively addressing IPV within DHS healthcare facilities. The goals, objectives and strategies address our key strategic issues, and were developed in response to the data and information collected from the surveys and policy review. These data provided us with an explicit understanding of current IPV policies and procedures within DHS facilities, allowing the IPV Prevention Strategic Planning Coalition to mobilize DHS' strengths when developing this strategic plan. In order to develop the goals, objectives and strategies, the Internal Working Group accomplished the following:

- Discussed each critical strategic issue that had been previously identified, and using gaps analysis, developed the final key strategic areas that will be addressed in the DHS' five-year strategic plan. The eight key strategic areas are:
  - DHS Policy on Intimate Partner Violence
  - IPV Policy Implementation and Systems Improvement Strategies
  - Screening and Identification
  - Intervention and Treatment
  - Resources and Referrals
  - Reporting and Law Enforcement
  - Collaboration and Data Collection
  - Training
- Discussed the relationship between DHS' strengths and weaknesses and the external opportunities and threats, and determined how that interplay affects the critical strategic issues.
- Developed and assessed the various possible strategic approaches to each critical issue.
- Narrowed down the options to arrive at the primary strategies related to program, management and operational priorities.
- Developed goals and objectives to assist in implementation of IPV policies and protocols within DHS healthcare facilities and to provide a measure by which to evaluate the progress and outcomes of the IPV Prevention Strategic Plan.

Key Strategic Area #1: DHS Policy On Intimate Partner Violence

Goal:

To develop standardized policies, procedures and protocols to address IPV within DHS healthcare facilities.

Objectives:

1) By 2006, the Injury and Violence Prevention Program (IVPP) will formulate an IPV policy development team, comprised of interested Internal Working Group members, to create standardized IPV policies for DHS healthcare facilities.

2) By 2006, the IVPP and the IPV policy development team will develop standardized IPV policies for DHS healthcare facilities, by revising and adapting current IPV policies from selected DHS healthcare facilities.

3) By 2007, standardized IPV policies will be approved by appropriate DHS command channels and be distributed to DHS healthcare facilities.

Recommended Strategies:

1) Create a standardized DHS Policy and Procedure on IPV that includes, at a minimum, the following elements:

   a) Purpose

   b) Definition, background and impact of IPV

   c) Roles and Responsibilities of DHS health care providers

   d) Guidelines for implementation

   e) Standardized procedures for:

      i) Screening
      ii) Assessment and intervention
      iii) Documentation
      iv) Lethality assessment and safety plan
      v) Reporting

   f) Training:

i) IPV training is mandated for all staff with patient/client contact and recommended for all staff.
ii) IPV training will be included in new employee orientation.
iii) IPV policy will be included in annual Performance Evaluation reviews and signed by employees to indicate knowledge of their responsibility.

g) Compliance Guidelines for Policy Monitoring and Evaluation:

h) Data Collection

i) Cultural and Linguistic Sensitivity

j) Inter-agency and intra-agency collaboration

k) Timeline for implementation

Key Strategic Area #2: IPV Policy Implementation And Systems Improvement Strategies

Goal:

To ensure that DHS facilities have the infrastructure and guidelines necessary to implement the IPV policy.

Objectives:

1) By 2006, the Injury and Violence Prevention Program (IVPP) will hire two staff members to assist with the coordination and implementation of IPV activities throughout DHS, which include staff training, resource and referral management, and evaluation.

2) By 2006, the IVPP and the IPV policy development team will create guidelines for monitoring and evaluating IPV policy implementation.

3) By 2006, the IVPP and the IPV policy development team will create guidelines to ensure that clinics and community-based organizations in partnership with DHS are in compliance with IPV laws.

4) By 2006, the IVPP will investigate and document new advanced technologies for screening, referrals, reporting, and data collection.

5) By 2007, IVPP will develop an internal promotional campaign to inform staff on new standardized IPV policies and procedures.

6) By 2007, an IPV web-page for MyPHD and the DHS websites will be completed. The DHS IPV policies, reporting forms, and other community resources will be available to all DHS staff through these websites.

7) By 2007, the IVPP will assess the feasibility of utilizing new technologies within DHS healthcare facilities.

8) By 2008, 100 % of DHS healthcare facilities will develop their own IPV implementation plans based on guidelines specified by DHS IPV policy.

9) By 2008, 100 % of DHS healthcare facilities will create IPV Response Teams or designate an IPV staff member(s) to facilitate IPV policy implementation and systems improvement.

10) By 2008, an internal promotional campaign will be disseminated to 100% of DHS healthcare facilities to inform DHS staff on standardized IPV policies and procedures.

11)By 2008, initiate on-going maintenance and perform periodic updates of IPV information (i.e. policies, laws, and community resources) on the DHS and MyPHD websites.

12)By 2010, the IVPP will re-evaluate technology for screening, referrals, reporting, and data collection.

13)By 2010, IVPP will coordinate a process and outcome evaluation of the overall IPV program within DHS healthcare facilities.

Recommended Strategies:

1) Identify funding sources and submit proposals to potential funders to assure adequate financial resources to implement the overall strategic plan and IPV policy.

2) Create IPV Response Teams, with special training in IPV, who respond, during all hours of operation, when staff identify suspected IPV. The IPV Response Team members interview the patient, complete the paperwork, give referrals, and report to local law enforcement.

   a) Each CEO/Clinic Manager/Area Health Officer will identify members of the IPV Response Team (including social workers [MSWs or LCSWs] or public health nurses) and release them for training and assisting suspected IPV victims. The composition of the IPV Response Teams will be site specific for comprehensive health centers, Public Health and Personal Health clinics and county hospitals.

   b) Social workers (MSWs or LCSWs) will be included in IPV Response Team in hospitals and will attend regular meetings with IPV Response Teams in clinics without on-site social workers.

   c) Each CEO/Clinic Manager/Area Health Officer will be accountable for assuring a working IPV Response Team and for establishing linkages with local law enforcement and IPV service providers.

   d) IPV Response Teams will meet at least quarterly for training and/or systems improvement.

3) Each facility will develop its own IPV implementation plan based on guidelines specified by DHS IPV policy.

4) At each facility, the CEO/Clinic Manager/Area Health Officer will be accountable for implementing IPV policies, procedures and protocols.

5) The DHS Injury and Violence Prevention Program (IVPP) will develop guidelines for IPV policy implementation, monitoring, and evaluation, which may be incorporated

into the Management Appraisal and Performance Plan (MAPP) or existing Quality Management (QM) activities within each facility.

6) IVPP will develop guidelines to incorporate compliance with IPV laws into contracts with clinics and community-based organizations in partnership with DHS.

7) Create an IPV page for MyPHD and the DHS websites to make screening policies, procedures, protocols and reporting forms available to all. The websites will contain links to other services and have search capabilities (i.e. capacity to search specifically for services for same sex couples, teen dating violence etc)

8) Investigate new technologies for screening, referrals, reporting, and data collection. (e.g. use of handheld computer technology and/or feasibility of tapping into existing SCARS-Suspected Child Abuse Reporting System).

9) Develop an internal promotional campaign focused on:

    i) Reminding staff to screen, treat, refer, and report suspected and known IPV cases.
    ii) Informing staff of new IPV policies.

Key Strategic Area #3: Screening & Identification

Goal:

To ensure that all patients ages 13 and older seen at DHS healthcare facilities are screened by a culturally competent healthcare provider, who is trained to identify IPV.

Objectives:

1) By 2006, the IPV standardized policy will include a recommended IPV screening instrument to be used across DHS healthcare facilities.

2) By 2010, 100% of DHS healthcare facilities will routinely provide IPV screening to patients, ages 13 years and older, with the screening documentation as part of the permanent medical record.

   a) By 2008, 25% of DHS healthcare facilities will routinely provide IPV screening to patients, ages 13 years and older, with the screening documentation as part of the permanent medical record.

   b) By 2009, 75% of DHS healthcare facilities will routinely provide IPV screening to patients, ages 13 years and older, with the screening documentation as part of the permanent medical record.

Recommended Strategies:

1) Develop a protocol for routine screening of IPV, which complies with state laws and shall become part of the permanent medical record.

2) Assess existing IPV screening instruments used in clinical settings and adapt as needed to include linguistically and culturally appropriate questions.

3) Secure funding for IPV screening translation services available in target languages and sign language

4) Flag all DHS patient/client charts in which there is a suspected IPV victim or perpetrator to ensure safety and to provide timely intervention.

Key Strategic Area #4: Intervention & Treatment

Goal:

To ensure that all patients, ages 13 and older, who screen positive for IPV will receive appropriate intervention and treatment.

Objectives:

1) By 2006, IVPP will evaluate, update and distribute existing IPV educational materials.

2) By 2010, 90% of DHS patients who screened positive for IPV will have lethality assessed and documented, injuries recorded in a body map, and have a safety plan discussed.

   a) By 2008, 50% of DHS patients who screened positive for IPV will have lethality assessed and documented, injuries recorded in a body map, and have a safety plan discussed.

   b) By 2009, 75% of DHS patients who screened positive for IPV will have lethality assessed and documented, injuries recorded in a body map, and have a safety plan discussed.

3) By 2010, 90% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.

   a) By 2008, 50% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.

   b) By 2009, 75% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.

Recommended Strategies:

1) Establish IPV protocols for Intervention and Treatment. Appropriate intervention and treatment will include:

   a) Lethality assessment
   b) Treatment of current medical problems
   c) Documentation of the abuse
      i) Use of body map
      ii) Use of patient's own words
   d) Examination for the pattern and history of abuse

e) Discussion of safety plans and options
f) Appropriate referrals and resources
g) Follow-up care

2) Evaluate and update existing IPV educational materials, revising the materials to be gender neutral and meet the needs of diverse populations including:

a) Racial/ethnic/cultural groups
b) Non-English speaking groups
c) People with disabilities
d) Adolescents
e) Lesbian, Gay, Bisexual, and Transgender (LGBT)

3) Promote intimate partner violence awareness and prevention within the Department by:

a) Posting IPV awareness posters and brochures in waiting areas.
b) Showing child appropriate IPV videos or Public Service Announcements in waiting rooms.
c) Placing IPV resource materials in the exam room and/or bathrooms.
d) Other health education activities.

Key Strategic Area #5: Resources & Referrals

Goal:

To ensure that IPV resources are available to all DHS healthcare providers to assist with referral of patients to appropriate resources.

Objectives:

1) By 2006, the IVPP will identify and update culturally and linguistically appropriate resources and referral lists.

2) By 2008, 100% of DHS healthcare facilities will have culturally and linguistically appropriate resources, referral lists, and IPV prevention and intervention literature easily accessible to all DHS patients/clients.

    a) By 2007, 50% of DHS healthcare facilities will have culturally and linguistically appropriate resources, referral lists, and IPV prevention and intervention literature easily accessible to all DHS patients/clients.

3) By 2009, 100% of the IPV Response Team (or designated IPV staff) will initiate contact and develop a working relationship with community agencies knowledgeable about IPV to whom they can refer patients.

    a) By 2008, 50% of the IPV Response Team (or designated IPV staff) will initiate contact and develop a working relationship with community agencies knowledgeable about IPV to whom they can refer patients.

Recommended Strategies:

1) Provide a referral guide for professionals and the community consisting of IPV prevention and treatment agencies, mental health professionals and agencies, service providers, and other relevant violence prevention community links including the following:

    a) Child care resources
    b) Legal Aid
    c) Hotline Services
    d) Shelters for IPV Victims
    e) Victim Services Organizations
    f) Mental Health Agencies
    g) Health Organizations (e.g. hospitals, clinics)
    h) Law Enforcement Agencies

i) Organizations Connected with the Violence Prevention Coalition (VPC)
j) Domestic Violence and Sexual Assault Community Based Organizations
k) Alcohol & Drug Programs
l) 12 Step Referrals
m) Rape Crisis Centers
n) Culturally relevant resources, including community agencies serving culturally, ethnically and linguistically diverse populations
o) Lesbian, Gay, Bisexual and Transgender Services
p) Batterer's Invention Program

2) Update and distribute a pocket size IPV resource card (business card) that lists referrals in multiple languages for patients/clients and the community.

3) The DHS Injury and Violence Prevention Program (IVPP) will be responsible for coordinating IPV activities throughout DHS including:

a) Coordinating IPV training
b) Handling of referrals and requests for information from the general public.
c) Resource to IPV Response Teams and community based organizations
d) Data collection, analysis and interpretation
e) Monitoring and evaluation of IPV trainings
f) Updating and disseminating IPV educational materials to DHS healthcare providers

Key Strategic Area #6: Reporting And Law Enforcement

Goal:

To ensure that all DHS healthcare providers comply with IPV reporting laws and collaborate with local law enforcement agencies to improve safety outcomes for patients identified with suspected or known IPV.

Objectives:

1) By 2006, IVPP will identify contacts within law enforcement agencies in LAC to address IPV.

2) By 2009, 100% of DHS healthcare facilities will have established contact with identified law enforcement personnel in their jurisdiction by the IPV Response Team or IPV designated staff.

    a) By 2008, 50% of DHS healthcare facilities will have established contact with identified law enforcement personnel in their jurisdiction by the IPV Response Team or IPV designated staff.

3) By 2010, 90% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement as mandated by state law, using a standardized reporting form.

    a) By 2008, 50% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement as mandated by state law, using a standardized reporting form.

    b) By 2009, 75% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement as mandated by state law, using a standardized reporting form.

Recommended Strategies:

1) Each CEO/Clinic Manager/Area Health Officer will be held accountable for compliance with state IPV reporting laws and regulations.

2) Assure that each facility has a liaison person to maintain collaborative efforts with local law enforcement agencies to:

a) Promote safety for IPV victims and family
b) Prevent recurrence of IPV
c) Improve law enforcement's response to a report (oral and written) and better understand the protocol once reported to local law enforcement.
d) Facilitate procedures for obtaining an emergency restraining order.

Key Strategic Area #7: Collaboration And Data Collection

Goal:

To ensure prevention of IPV through the collection of data and collaboration with internal and external agencies.

Objectives:

1) By 2007 of implementation, the IVPP will develop a collaborative plan with DHS internal program staff and community partners on training, funding, sharing of resources and data collection.

2) By 2008, the IVPP will develop a data collection system to collect IPV data in DHS healthcare facilities.

3) By 2008, each CEO/Clinic Manager/Area Health Officer will appoint an IPV records keeper to submit regular quarterly reports to IVPP.

4) By 2008, IVPP will train IPV records keepers to submit quarterly IPV reports beginning in 2009 of implementation.

5) By 2010, 100% of DHS healthcare facilities and IVPP will implement the protocols and procedures for data collection as specified in the IPV policy and determined by the IVPP.

    a) By 2009, 50% of DHS healthcare facilities and IVPP will implement the protocols and procedures for data collection as specified in the IPV policy and determined by the IVPP.

6) By 2010, IVPP will investigate the feasibility of establishing a county-wide IPV data collection system, among DHS facilities, non-DHS healthcare facilities, and other community agencies.

Recommended Strategies:

1) For the purpose of IPV prevention, intervention, education and/or treatment, collaborate with agencies outside of DHS (inter-agency collaboration):

    a) Specifically collaborate with community organizations (i.e. non-profits doing IPV-related work such as shelters, rape crisis centers, hotlines), law enforcement, judges, commissioners, schools, other L.A. County departments (Department of Mental Health, Children and Family Services, Department of Public Social

Services), and agencies with expertise in dealing with IPV in specific cultures such as LGBT (Lesbian, Gay, Bisexual, Transgender) community;

b) Collaboration will focus on the following topics:

i) Training
ii) Funding
iii) Client advocacy
iv) Public policy and legislation
v) Sharing of resources
vi) Sharing of data
vii) Promotional campaigns (i.e. Prevention forums, newsletters, job listings, emails)

2) For the purpose of IPV prevention, intervention, education and/or treatment, collaborate with agencies within DHS (intra-agency collaboration):

a) Specifically collaborate with the Alcohol and Drug Program, Maternal, Child and Adolescent Health (MCAH) program, Suspected Child Abuse and Neglect (SCAN) Teams in the hospitals, Office of Women's Health, SPAs, Health Education Program, Nurse Family Partnership, Sexually Transmitted Disease (STD) Program, and the Office of AIDS Programs and Policy (OAPP).

b) Collaboration will focus on the following topics:

i) Training
ii) Funding
iii) Advocacy
iv) Sharing of resources
v) Sharing of data

3) Develop a countywide system to collect IPV victim and perpetrator data. Specifically collect data on:

a) Scope and magnitude of the problem (incidence and prevalence)
b) Trends in IPV occurrence among populations
c) Health impacts
d) Victim and perpetrator profiles and/or risk factors

Key Strategic Area #8: Training

Goal:

To provide IPV and sexual violence training to DHS staff to increase staff knowledge and skills in order to address and reduce the impact of IPV in Los Angeles County

Objectives:

1) By 2007 of implementation, the IVPP will provide a training curriculum and an evaluation tool to be implemented within DHS.

2) By 2008, 90% of administrators/managers in each DHS healthcare facility, who are mandated in the IPV policy, will have participated in the IPV and sexual violence training.

    a) By 2007, 25% of administrators/managers in each DHS healthcare facility, who are mandated in the IPV policy, will have participated in the IPV and sexual violence training.

3) By 2010, 90% of DHS staff with direct patient care, in each healthcare facility, will participate in IPV and sexual violence training offered through DHS.

    a) By 2008, 25% of DHS staff with direct patient care will participate in IPV and sexual violence training offered through DHS.

    b) By 2009, 75% of DHS staff with direct patient care will participate in IPV and sexual violence training offered through DHS.

4) By 2009, 90% of all new DHS staff will participate in IPV and sexual violence training within one year of hire.

5) By 2008, IVPP will evaluate initial trainings and make adjustments accordingly for future training.

6) By 2010, 90% of DHS staff, who provide direct patient care, and who completed initial training by 2008, will attend on-going IPV and sexual violence training.

Recommended Strategies:

1) Mandate and provide annual IPV and sexual violence training, using evidence-based curriculums and materials, in compliance with California State law.

2) Training will be provided to:

   a) All DHS staff with patient/client contact. Priority for training will be given to:
      i) Pediatric and adolescent health services providers
      ii) Emergency Departments, Urgent Care Clinics, and Comprehensive Health Centers
      iii) Prenatal and OB/GYN clinics
   b) All new DHS staff as part of new-employee orientation
   c) Administrators in each DHS facility and program

3) All training will be conducted by and/or in collaboration with:

   a) IPV experts
   b) A law enforcement professional who works with IPV and sexual violence
   c) Community based agencies providing IPV services within the community including shelters
   d) An IPV survivor

4) Training topics will include but not be limited to:

   a) Background and Enforcement of IPV Policy
   b) Definition and Prevalence of IPV
   c) Dynamics of IPV
   d) Causes of IPV
   e) Impact of IPV on victim, children, employment and the community
   f) Correlation between IPV and child abuse
   g) IPV in diverse culture, ethnic and same sex groups
   h) Health Care and IPV
      i) Identification of signs and symptoms of IPV
      ii) Screening
      iii) Intervention and Treatment
      iv) Documentation
      v) Lethality assessment and safety plan
      vi) Referrals and Resources
      vii) California mandatory reporting laws
      viii) Cultural competency in dealing with diverse IPV victims

5) Initial IPV training should be offered in-person at a DHS facility for a minimum of two hours. Web-based and interactive satellite training may only be used for on-going training.

6) Suggested training methods may include:

   a) Didactic lecture
   b) Role play
   c) Vignettes
   d) Written material
   e) Video

f) Interactive question and answer

7) DHS will collaborate with community-based organizations, with IPV expertise, to train others including law enforcement, judges and commissioners.

8) IVPP will develop an evaluation tool for IPV trainings to measure changes in knowledge, attitudes and behaviors, as well as an evaluation of the training and trainers.

Implementation Plan Timeline

Year/Activities	2006	2007	2008	2009	2010
1. Standardized IPV policies & policy implementation	1.1a. IVPP will hire two staff members to assist with coordination and implementation of IPV activities including training, resource and referral management and evaluation. 1.1b. IVPP will formulate a IPV Policy Development Team - Develop standardized IPV policies -Include recommended screening instrument -Include guidelines for policy implementation monitoring & evaluation - Include guidelines to incorporate contract terms.	2.1a. Standardized IPV policies to be approved and be distributed to DHS healthcare facilities.	3.1a. 100% of DHS healthcare facilities will develop own IPV implementation plan. 3.1b. 100% of DHS healthcare facilities will create IPV Response Team or identify designated IPV staff. 3.1c. 25% of DHS healthcare facilities will routinely provide IPV screening to patients ages 13 and older. 3.1d. 50% of DHS patients who screened positive for IPV will have lethality assessment documented, body map recorded, and safety plan discussed.	4.1a. 75% of DHS healthcare facilities will routinely provide IPV screening to patients ages 13 and older. 4.1b. 75% of DHS patients who screened positive for IPV will have lethality assessment documented, body map recorded, and safety plan discussed.	5.1a. IVPP will coordinate a process and outcome evaluation of the overall IPV program within DHS healthcare facilities. 5.1b. 100% of DHS healthcare facilities will routinely provide IPV screening to patients ages 13 and older. 5.1c. 90% of DHS patients who screened positive for IPV will have lethality assessment documented, body map recorded, and safety plan discussed.
2. Internal promotional campaign		2.2a. IVPP will develop internal promotional campaign to inform DHS staff on standardized IPV policies & procedures.	3.2a. Promotional campaign will be disseminated to 100% of DHS healthcare facilities.		

Year/Activities	2006	2007	2008	2009	2010
3. Reporting & Law enforcement contact	1.3a. IVPP will identify contacts within law enforcement agencies in LAC to address IPV.		3.3a. 50% of DHS healthcare facilities will have established contact with law enforcement personnel in their jurisdiction by the IPV Response Team or IPV designated staff. 3.3b. 50% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement.	4.3a. 100% of DHS healthcare facilities will have established contact with law enforcement personnel in their jurisdiction by the IPV Response Team or IPV designated staff. 4.3b. 75% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement.	5.3a. 90% of known or suspected IPV cases within DHS healthcare facilities will be reported to local law enforcement.
4. Training		2.4a. IVPP will develop training protocol. 2.4b. IVPP will develop evaluation tools for IPV training. 2.4c. 25% of administrators and managers in each DHS healthcare facility who are mandated in the IPV policy will have participated in the IPV and sexual violence training.	3.4a. IVPP will evaluate initial trainings and make adjustments accordingly for future training. 3.4b. 90% of administrators and managers in each DHS healthcare facility who are mandated in the IPV policy will have participated in the IPV and sexual violence training. 3.4c. 25% of DHS staff with direct patient care in each healthcare facility will participate in IPV and sexual violence training.	4.4a. 90% of all new DHS staff will participate in IPV and sexual violence training within one year of hire. 4.4b. 75% of DHS staff with direct patient care in each healthcare facility will participate in IPV and sexual violence training.	5.4a. 90% of DHS staff who provide direct patient care and who completed initial training by 2008 will attend on-going IPV and sexual violence training. 5.4b. 90% of DHS staff with direct patient care in each healthcare facility will participate in IPV and sexual violence training.

Year/Activities	2006	2007	2008	2009	2010
5. Data collection system			3.5a. Each CEO/Clinic Manager/AHO will appoint an IPV records keeper to submit reports to IVPP. 3.5b. IVPP will train IPV records keepers. 3.5c. IVPP will develop IPV data collection system within DHS healthcare facilities.	4.5a. IPV records keepers will submit quarterly IPV data reports. 4.5b. 50% of DHS healthcare facilities and IVPP will implement data collection protocols & procedures.	5.5a. Investigate the feasibility of a countywide system for data collection. 5.5b. 100% of DHS healthcare facilities and IVPP will implement data collection protocols & procedures.
6. Resources & referral lists	1.6a. IVPP will update IPV resources & referral lists.	2.6a. 50% of DHS healthcare facilities will have appropriate resources, referral lists, and IPV prevention and intervention literature accessible to all DHS patients/clients.	3.6a 100% of DHS healthcare facilities will have appropriate resources, referral lists, and IPV prevention and intervention literature accessible to all DHS patients/clients. 3.6b. 50% of the IPV Response Teams or designated IPV staff will initiate contact and develop a working relationship with community agencies with expertise in IPV. 3.6b. 50% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.	4.6a. 100% of the IPV Response Team or designated IPV staff initiates contact and develop a working relationship with community agencies with expertise in IPV. 4.6b. 85% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.	5.6a. 100% of DHS patients who screen positive for IPV will be provided with resources and referred to appropriate agencies for follow-up.

Year/Activities	2006	2007	2008	2009	2010
7. Educational materials	1.7a. IVPP will distribute IPV educational materials.				5.7a. IVPP will continue to be a resource for updated IPV educational materials.
8. Inter- & Intra-agencies Collaboration		2.8a. IVPP will outline a plan for inter- and intra- agencies collaboration.			5.8a. Efforts to seek opportunities to collaborate with inter & intra-agencies continue.
9. MyPHD & DHS web pages		2.9a. IPV web page (policies, reporting forms, community resources) completion.	3.9a. Initiate on-going maintenance of web page.		5.9a. Continue on-going maintenance of web page including update of information (policies, laws, community resources).
10. Advanced technology	1.10a. Investigation & documentation for new advanced technology for screening, referrals, reporting, and data collection.	2.10a. Assess feasibility of utilizing new technology within DHS healthcare facilities.			5.10a. Re-evaluate technology for screening, referrals, reporting, and data collection.

Post Script

"The professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue and one that profoundly affects the public health."

- Former Surgeon General C. Everett Koop

The Los Angeles County-DHS is committed to taking a leadership role in meeting former Surgeon General C. Everett Koop's challenge as it declares the mission to protect and improve the health of all Angelenos. This project provided an opportunity towards this mission by gathering DHS staff and administrators together with community leaders who shared the same vision of creating a better and safer place to live in our community. Their commitment and dedication shown for the project was invaluable and the collaboration created through the planning process was beyond what was documented in this plan.

The IPV Prevention Strategic Planning Coalition believes that violence is a public health issue because of its tremendous impact on the health and well-being of residents in Los Angeles County. The public health model to violence prevention brings a strong problem-solving approach with an emphasis on collaboration and community involvement. This approach is based on a well-defined process, which involves identifying the risk factors, designing interventions to address these factors, and evaluating the effectiveness of programmatic efforts.

Every member of the Intimate Partner Violence Prevention Strategic Planning Coalition strongly believes that prevention of intimate partner violence is possible, and that together, we can make a difference in addressing this critical issue. Each one of us can contribute to transforming the system, and united, we provide a powerful front to combating this terrible epidemic. And thus, we cordially invite you to join us by committing to fully supporting violence prevention efforts through implementation of this strategic plan within all DHS healthcare facilities.

As we move forward to manifest a common vision of a community free from the destruction of intimate partner violence, let us embrace the words of Margaret Mead (from Only One Earth):

"Never doubt that a small group of committed people can change the world. Indeed, it's the only thing that ever has."

Together, we CAN and WILL make a difference.

Appendix A

Strategic Planning Detail

Appendix A: Strategic Planning Process

The strategic planning process includes seven fundamental phases that allow for flexibility and creativity, while providing a structured process to focus the participants. This project addressed the first five fundamental phases, although it describes the last two phases so the Intimate Partner Violence Prevention Strategic Planning Coalition will have an understanding of the necessary steps involved in implementing a strategic plan. The seven phases are as follows:

Phase 1: Getting Ready

Prior to initiating the strategic planning process, the Intimate Partner Violence Prevention Strategic Planning Coalition assessed if it was ready for strategic planning at this time. The most important factor of readiness is a true commitment to the planning process amongst the key leaders. Following that determination, five things were accomplished in phase one to pave the way for an organized strategic planning process:

- Identification of specific issues or choices that the planning process should address.
- Clarification of roles of members involved in the planning process.
- Creation of a planning committee.
- Development of an organizational profile.
- Identification of the information that must be collected to assist in relevant decision-making.

Phase 1 Outcomes:

- Agreement that the Intimate Partner Violence Prevention Strategic Planning Coalition was ready to initiate a strategic planning process.
- Identification of potential members of the Intimate Partner Violence Prevention Strategic Planning Coalition, Internal Work Group, Sub-Committees and External Advisory Group.
- Detailed Plan for Planning including agreement on process and procedures for all phases of planning, planning outcomes, possible activities, personnel responsibility and timeframe.
- Knowledge about planning process and agreement on terminology by all Internal Work Group members.
- Common base of knowledge about organizational and project history and programs.
- Agreement on initial critical issues and initial plan for gathering information that will assist with strategic decisions.

Phase 2: Articulating the Mission and Vision

The mission statement communicates the essence of the Intimate Partner Violence Prevention Strategic Planning Coalition. For this phase, the mission statement described the Intimate Partner Violence Prevention Strategic Planning Coalition in the following terms:

- *Purpose:* Why the group exists and what it seeked to accomplish.
- *Business:* A description of the primary means used to accomplish the purpose.

- *Values:* The principles or beliefs that guided the group's members as they pursued the purpose.

A vision statement presents an image in words that describes the image of success. With a mission statement and a vision statement, the Intimate Partner Violence Prevention Strategic Planning Coalition had a solid understanding of what it needed to accomplish, the reasons behind the accomplishments, and what it hoped to achieve.

Phase 2 Outcomes:

- Agreement on Mission and Vision Statement

Phase 3: Assessing the Environment

During the strategic planning process, it was important for DHS to examine its current situation. During phase 3, information was collected regarding DHS' internal strengths and weaknesses, and its external opportunities and threats in regard to addressing intimate partner violence. These assessments assisted the Intimate Partner Violence Prevention Strategic Planning Coalition in determining the most critical issues to address. During phase 3, the DHS healthcare facilities were assessed to identify the current practices and protocols regarding IPV and the degree of implementation of these procedures. The Internal Work Group and the Intimate Partner Violence Prevention Strategic Planning Coalition agreed on eight critical issues around which to organize the strategic plan.

Phase 3 Outcomes:

- Compilation of information to help inform strategic decisions.
- Sufficient information about the organization and issues so as to be able to make informed choices about long and short-term priorities.
- Evaluation of current policies and procedures and degree of implementation.

Phase 4: Agreeing on Priorities

During phase 4, the Internal Work Group and the Intimate Partner Violence Prevention Strategic Planning Coalition decided on the strategies to address the eight issues and established goals and objectives. It was during this phase that the Intimate Partner Violence Prevention Strategic Planning Coalition agreed on its top priorities.

Phase 4 Outcomes:

- Agreement on core strategies and long term and short term program and administrative priorities.
- Agreement on overall program and organizational project goals.
- Agreement on specific objectives that the Intimate Partner Violence Prevention Strategic Planning Coalition wished to accomplish in the immediate and long term.

Phase 5: Writing the Strategic Plan

The information collected in the previous phases will be synthesized into one coherent, consolidated document that will be submitted for review by all of the Strategic Planning Coalition Advisory Group.

Phase 5 Outcomes:

- Approval of Strategic Plan.
- Distribution of Plan to key leaders and stakeholders.

Phase 6: Implementing the Strategic Plan

The interface between the strategic plan and the daily operations is a concise and easy-to-use operating plan. This plan should coincide with the organization's fiscal year and accommodate the need for detailed program-level planning related to funding cycles or other reporting cycles. The Intimate Partner Violence Prevention Strategic Planning Coalition will need to develop an overall operational plan, while each DHS health care facility will need to develop an implementation plan to integrate the new policies and protocols into their operations.

Phase 6 Outcomes:

- Detailed operating plan.

Phase 7: Monitoring and Evaluation

The strategic planning process should always be responsive to a changing environment. Periodic assessment will need to be conducted to determine if the Intimate Partner Violence Prevention Strategic Planning Coalition is meeting its goals and objectives and if those goals and objectives are still pertinent. An evaluation should analyze the following:

- Applicability of the current strategic plan.
- Accomplishments of goals and objectives.
- Validity of the internal and external environment of the original strategic plan.
- Current issues facing the organization.
- New priorities that need to be addressed.
- Performance targets.

Phase 7 Outcomes:

- In-depth system to monitor and evaluate implementation of the plan and achievement of success factors.
- Processes to ensure that the Operating Plan is modified as needed and that the Strategic Plan continues to provide guidance for the setting of current priorities for the following year. Evaluation will assist the Intimate Partner Violence Prevention Strategic Planning Coalition with analyzing its efficacy in meeting the needs of its clients.

Appendix B

IPV Legislation

Appendix B: Legislation-California Penal Code Section 11160

11160. (a) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows, shall immediately make a report in accordance with subdivision (b):

(1) Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.

(2) Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.

(b) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department shall make a report regarding persons described in subdivision (a) to a local law enforcement agency as follows:

(1) A report by telephone shall be made immediately or as soon as practically possible.

(2) A written report shall be prepared on the standard form developed in compliance with paragraph (4) of this subdivision, and Section **11160**.2, and adopted by the agency or agencies designated by the Director of Finance pursuant to Section 13820, or on a form developed and adopted by another state agency that otherwise fulfills the requirements of the standard form. The completed form shall be sent to a local law enforcement agency within two working days of receiving the information regarding the person.

(3) A local law enforcement agency shall be notified and a written report shall be prepared and sent pursuant to paragraphs (1) and (2) even if the person who suffered the wound, other injury, or assaultive or abusive conduct has expired, regardless of whether or not the wound, other injury, or assaultive or abusive conduct was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the wound, other injury, or assaultive or abusive conduct was discovered during an autopsy.

(4) The report shall include, but shall not be limited to, the following:

(A) The name of the injured person, if known.

(B) The injured person's whereabouts.

(C) The character and extent of the person's injuries.

(D) The identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person.

(c) For the purposes of this section, "injury" shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

(d) For the purposes of this section, "assaultive or abusive conduct" shall include any of the following offenses:

(1) Murder, in violation of Section 187.

(2) Manslaughter, in violation of Section 192 or 192.5.

(3) Mayhem, in violation of Section 203.
(4) Aggravated mayhem, in violation of Section 205.
(5) Torture, in violation of Section 206.
(6) Assault with intent to commit mayhem, rape, sodomy, or oral copulation, in violation of Section 220.
(7) Administering controlled substances or anesthetic to aid in commission of a felony, in violation of Section 222.
(8) Battery, in violation of Section 242.
(9) Sexual battery, in violation of Section 243.4.
(10) Incest, in violation of Section 285.
(11) Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, in violation of Section 244.
(12) Assault with a stun gun or taser, in violation of Section 244.5.
(13) Assault with a deadly weapon, firearm, assault weapon, or machinegun, or by means likely to produce great bodily injury, in violation of Section 245.
(14) Rape, in violation of Section 261.
(15) Spousal rape, in violation of Section 262.
(16) Procuring any female to have sex with another man, in violation of Section 266, 266a, 266b, or 266c.
(17) Child abuse or endangerment, in violation of Section 273a or 273d.
(18) Abuse of spouse or cohabitant, in violation of Section 273.5.
(19) Sodomy, in violation of Section 286.
(20) Lewd and lascivious acts with a child, in violation of Section 288.
(21) Oral copulation, in violation of Section 288a.
(22) Sexual penetration, in violation of Section 289.
(23) Elder abuse, in violation of Section 368.
(24) An attempt to commit any crime specified in paragraphs (1) to (23), inclusive.
(e) When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of violence that is required to be reported pursuant to this section, and when there is an agreement among these persons to report as a team, the team may select by mutual agreement a member of the team to make a report by telephone and a single written report, as required by subdivision (b). The written report shall be signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.
(f) The reporting duties under this section are individual, except as provided in subdivision (e).
(g) No supervisor or administrator shall impede or inhibit the reporting duties required under this section and no person making a report pursuant to this section shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established, except that these procedures shall not be inconsistent with this article. The internal procedures shall not require any employee required to make a report under this article to disclose his or her identity to the employer.
(h) For the purposes of this section, it is the Legislature's intent to avoid duplication of information.

Appendix C

Surveys

Appendix C: Surveys

Administrative Survey

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

JONATHAN E. FIELDING, M.D., M.P.H.
Director of Public Health and Health Officer

Office of Injury and Violence Prevention Program

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TEL (213) 351-7888 • FAX (213) 351-2713

www.lapublichealth.org

March 5, 2004

The Injury and Violence Prevention Program was recently awarded a grant from the State to conduct strategic planning for **Intimate Partner Violence** (IPV) prevention. Intimate partner violence refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship and it does NOT include child abuse or elder abuse. The overall goal of the grant is to develop a Department of Health Services (DHS) five-year plan to reduce and prevent IPV throughout Los Angeles County (LAC).

As a part of the initial planning process, we are conducting a survey to gather information about current IPV policies and practices throughout LAC DHS healthcare facilities. Results will be analyzed as aggregate data to support the overall strategic planning process.

Please take a few minutes to fill out this questionnaire and return it to the Injury and Violence Prevention Program by xxxxx county mail in the enclosed envelope or fax it to us at 213 351-2713. For more information or questions regarding this project or survey, please contact Billie Weiss, M.P.H. or Sung Hye Yu, Ph.D. at (213) 351-7888 or via email at bweiss@dhs.co.la.ca.us or syu@dhs.co.la.ca.us. Your cooperation and support are greatly appreciated.

_____

Billie Weiss, Director
Injury and Violence Prevention Program

Administrator survey
The first questions ask about your job and where you work.

1. Name of the facility/program where you work? _____

2. Is this a: Hospital.....1
Clinic, or... 2
Public health program?.....3

3. What is your position or title?_____
POSITION OR TITLE

4. How many years have you been working at this facility/program in this job?
_____
YEARS

The following questions ask about intimate partner violence policies and procedures at your facility or program.

5. Does your facility have a policy for screening victims of intimate partner violence (IPV)?
Yes.....1
No.....GO TO Q10.....2
Not sure.....GO TO Q10.....3

6. Does the policy require that both men and women are to be screened?
Women only.....1
Both women and men.....2
Not sure.....3

7. Does the policy require that certain age groups are to be screened?
Yes.....ANSWER Q7A.....1
No.....GO TO Q8.....2
Not sure.....GO TO Q8.....3

7A. What age groups are required to be screened for IPV?

_____
AGE GROUPS

8. Who usually does the screening? Is it:

Physicians,.....1
Nursing staff.....2
Other(s)?.....3

PLEASE SPECIFY: _____
Not sure.....4

9. The following table lists some of the places in your facility/program where clients might be screened for intimate partner violence (IPV). Please tell us whether **intimate partner violence screening** occurs in these clinics or other areas.

Clinic Area	Yes	No	Do Not Know	Not Applicable
Emergency department?	1	2	3	4
Obstetrics and gynecology?	1	2	3	4
Labor and delivery?	1	2	3	4
Adolescent Medicine or Family Practice?	1	2	3	4
Outpatient department?	1	2	3	4
Urgent care?	1	2	3	4
Psychiatric unit?	1	2	3	4
Pediatrics?	1	2	3	4
Home visits?	1	2	3	4
Walk-in clinics?	1	2	3	4
Community outreach settings?	1	2	3	4
Other clinics or areas? PLEASE SPECIFY:_____	1	2	3	4

The next questions ask about the treatments and interventions, if any, that your facility/program provides for intimate partner violence (IPV).

10. Are there written policies for treating, intervening, and/or referring for IPV?

Yes.....ANSWER Q11.....1
No.....GO TO Q 12.....2
Not sure.....GO TO Q 12.....3

11. Things that are sometimes found in written policies on IPV are listed below. Please tell us whether the written policies at your facility/program include these things.

Does your program's policies:	**Yes**	**No**	**Do not know**
Define intimate partner violence (IPV)?	1	2	3
Describe how to intervene?	1	2	3
Describe how to document an intervention?	1	2	3
Describe how to refer victims?	1	2	3
Describe mandatory reporting procedures?	1	2	3
Require training on IPV for physicians?	1	2	3
Require training on IPV for nursing staff?	1	2	3
Require training on IPV for other staff? WHO?_____	1	2	3
Require development of a safety plan?	1	2	3

12. Is there an IPV coordinator at your facility/program?

Yes.....1
No.....2
Not sure.....3

13. Does your facility/program have a standardized form that it uses to record information about known or suspected cases of intimate partner violence (IPV)?

Yes.....ANSWER Q13A-E.....1
No.....GO TO Q14.....2
Not sure.....GO TO Q14.....3

13A. Is the completed form or a copy included in the medical record?
Yes.....1
No.....2
Not sure.....3

13B. Is the name and/or relationship of the alleged perpetrator recorded on the form?
Yes, name only.....1
Yes, relationship only.....2
Yes, name and relationship.....3
Neither one.....4
Not sure.....5

13C. Does the form include a body map to record injuries?
Yes.....1
No.....2
Not sure.....3

13D. Does the form have a place to record referrals that were provided for the victim?
Yes.....1
No.....2
Not sure.....3

13E. Does the form include a place to assess victim's safety?
Yes.....1
No.....2
Not sure.....3

14.Does your facility/program offer IPV training for staff?
Yes.....ANSWER 14A-C.....1
No.....GO TO Q15.....2
Not sure.....GO TO Q15.....3

14A. Is training mandatory?
Yes.....1
No.....2
Not sure.....3

14B. Does your facility/program have ongoing training for IPV?

Yes.....1
No.....2
Not sure.....3

14C. Are staff required to attend IPV training more than once?

Yes.....1
No.....2
Not sure.....3

15.Are there posters or brochures about IPV in your facility/program?

Yes.....1
No 2
Not sure.....3

16. Some facilities and programs collect data about IPV. Does your facility/program collect any IPV data?

Yes.....GO TO Q 16A-D.....1
No .....GO TO Q 17.....2
Not sure.....GO TO Q 17.....3

16A. Some of the kinds of data that are collected are listed below. Please indicate which kinds of data are collected by your facility/program.

Types of Data Collected	Yes	No	Not Sure
Number of clients screened?	1	2	3
Number of IPV cases identified?	1	2	3
Number of IPV cases reported to law enforcement?	1	2	3

16B. Is the data that your facility/program collects reported to any agency or office?

Yes.....1
TO WHOM?_____
No.....2
Not sure 3

16C. Who is in charge of data collection at your facility/program?

NAME & POSITION_____

16D. What is done with the IPV data?_____

17.Some programs monitor the implementation of the IPV policies at their facilities; others do not. How do you monitor IPV policies at your facility/program?

18. In your opinion, what are some of your facility's (or program) strengths and/or weaknesses in implementing IPV policies?

Thank you very much for your time and please return your completed questionnaire to Injury and Violence Prevention Program

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

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Billie Weiss, Director
Injury and Violence Prevention Program

Staff survey

The first questions ask about your job and where you work.

1. Name of the facility/program where you work?_____

2. Is this a: Hospital.....1
Clinic, or.....2
Public health program?.....3

3. What is your position or title?_____
POSITION OR TITLE

4. How many years have you been working at this facility/program in this job? _____
YEARS

The following questions ask about intimate partner violence (IPV) policies and procedures at your facility/program and your experiences with the IPV related practices.

5. Does your facility/program have a policy for providing services to victims of intimate partner violence (IPV)?

Yes.....ANSWER Q 5A.....1
No.....GO TO Q 6.....2
Not sure.....GO TO Q 6.....3

5A. How familiar are you with IPV policies and procedures at your facility?

Familiar 1
Somewhat familiar.....2
Not at all familiar.....3

6. Are you aware of the standard countywide injury reporting form for reporting IPV? (Report of Injuries by a Firearm or Assaultive or Abusive Conduct)

Yes.....ANSWER Q 6A.....1
No.....GO TO Q 7.....2
Not sure.....GO TO Q 7.....3

6A. During the past 12 months, have you used this form to report IPV to local law enforcement?

Yes.....GO TO Q 7.....1
No.....GO TO Q 6B.....2

6B. If you have not used this form, what is the reason for not using it?

No IPV clients identified.....1
Form is not easily available.....2
Another form has replaced it.....3
Data is collected electronically.....4
Other (PLEASE SPECIFY)_____
_____

The following questions ask about Intimate Partner Violence (IPV) mandating reporting laws.

7. Are you aware of the laws about IPV mandated reporting requirements for health care providers?

Yes 1
No 2
Not sure.....3

8. How familiar are you with IPV laws?

Familiar 1
Somewhat familiar.....2
Not familiar.....3

9. Are you a mandated reporter for IPV?

Yes.....1
No 2
Not sure.....3

10. Is patient consent required to report IPV to law enforcement?

Yes.....1
No 2
Not sure..... 3

The following questions ask about your familiarity with IPV in general and IPV training experiences.

11. How knowledgeable do you feel about IPV such as definition, facts, types, and dynamics?

Knowledgeable.....1
Somewhat knowledgeable.....2
Not knowledgeable.....3

12. During your employment with Los Angeles County, have you attended a training session either onsite or offsite on IPV?

Yes .....ANSWER Q12A.....1
No .....GO TO Q14.....2
Not sure.....GO TO Q14.....3

12A. Was this IPV training mandatory?

Yes .....GO TO Q12B.....1
No .....GO TO Q13.....2
Not sure.....GO TO Q13.....3

12B. How frequently are you required to attend IPV training?

One time only.....1
Every _____ YEARS
Not sure.....99

13. If you ever attended a training session either onsite or offsite on IPV during your employment with Los Angeles County, please tell us whether the following contents have been covered during the IPV training session you last attended.

IPV training topics	Yes	No	Do Not Know
Dynamics of IPV	1	2	3
Mandatory reporting	1	2	3
Legal issues and options for victims of IPV	1	2	3
Clinical skills: Screening, Assessment, Intervention, and Documentation	1	2	3
Community resources	1	2	3
Cultural considerations	1	2	3
Same gender abuse	1	2	3

14. Does your facility/program have a designated staff member (or unit) to whom you refer victims of IPV?

Yes .....ANSWER Q 14A.....1
No.. .....GO TO Q 15.....2
Not sure.....GO TO Q 15.....3

14A. Please indicate name and job title (or unit) of designated staff member to whom you refer victims of IPV.

_____

15. Does your facility/program provide direct services to clients?

Yes.....ANSWER Q15A-B.....1
No .....GO TO Q16.....2
Not sure.....GO TO Q16.....3

15A. Collaborating with community resources provides an important linkage to victims of intimate partner violence. Does your facility/program work with the following community agencies in providing services to victims of intimate partner violence?

Outside resources	Yes	No	Do Not Know
Local law enforcement?	1	2	3
Shelter for battered women?	1	2	3
Legal aid service agency?	1	2	3
Counseling service agency?	1	2	3
Others (PLEASE SPECIFY)			

15B. Health care providers often encounter barriers to providing adequate services to victims of intimate partner violence. Please check ALL that apply to you.

Barriers	Yes	No	Do Not Know
Not comfortable in discussing IPV with clients?	1	2	3
Belief that IPV is a private matter, not a health concern?	1	2	3
Lack of time?	1	2	3
Inadequate training on IPV?	1	2	3
Language barrier with clients?	1	2	3
Inadequate resources to help identified IPV victims?	1	2	3
Others (PLEASE, SPECIFY)			

16. Please write down any other concerns or training needs you have in dealing with victims of IPV.

Thank you very much for your time and please return your completed questionnaire to Injury and Violence Prevention Program

Appendix D

Survey Analysis

Appendix D: Survey Analysis

Staff Survey:

Table 1: Staff Survey Respondents by Facility (N=823)

DHS Facility Category	Facility	Number of surveys data entered (%)
Hospitals (6)	Harbor UCLA	168 (20.5%)
	High Desert	86 (10.5%)
	LAC/USC	79 (9.6%)
	Rancho	39 (4.7%)
	Olive View	7 (0.8%)
	Martin Luther King/Drew	13 (1.5%)
	Sub-total for Hospitals	**392 (47.6%)**
Comprehensive Health Centers (5)	El Monte	66 (8%)
	Claude Hudson	46 (5.6%)
	H.Humphrey	52 (6.3%)
	Long Beach	14 (1.7%)
	Roybal	11 (1.4%)
	Sub-total for CHC	**189 (23%)**
Service Planning Areas (SPA1-8)	SPA 1&2	43 (5.2%)
	SPA 3&4	96 (11.7%)
	SPA 5&6	50 (6.1%)
	SPA 7&8	25 (3%)
	Sub-total for SPA	**214 (26%)**
Public Health Program (2)	Nurse-Family Partnership	18 (2.2%)
	Office of Women's Health	10 (1.2%)
	Sub-total for PHP	**28 (3.4%)**

Table 2. Staff Survey Respondents by Job classification (N=823)

Job classification	Number
Nurses Licensed Unlicensed	608 (74%) 539 69
Physicians & Dentists	126 (15%)
Social workers	33 (4%)
Others (Public health investigator, Community worker, Patient Resource worker)	56 (7%)

The following describes the responses to each staff survey question.

Q1: Does your facility have a policy for providing services to victims of intimate partner violence (IPV)?

Yes	447 (54%)
No	130 (16%)
Not sure	235 (29%)
No answer	11 (1%)
Total	823 (100%)

Q2: How familiar are you with IPV policies and procedures at your facility?

Familiar	181 (39.5%)
Somewhat familiar	236 (51.5%)
Not at all familiar	41 (9%)
Total	458 (100%)

Q3: Are you aware of the standard countywide injury reporting form for reporting IPV (Report of Injuries by a Firearm or Assaultive or Abusive Conduct)?

Yes	338 (41%)
No	302 (36%)
Not sure	154 (19%)
No answer	29 (4%)
Total	823 (100%)

Q4: During the past 12 months, have you used this form to report IPV to local law enforcement?

Yes	48 (13.6%)
No	305 (86.4%)
Total	353 (100%)

Q5: If you have not used this for during the past 12 months, what is the reason for not using it?

No IPV patients identified	219 (74%)
Form is not easily available	10 (3%)
Reported by other assigned staff	30 (10%)
Other/no answer	38 (13%)
Total	297 (100%)

Q6: Are you aware of the laws about IPV mandated reporting requirements for health care providers?

Yes	532 (65%)
No	151 (18%)
Not sure	129 (16%)
No answer	11 (1%)
Total	823 (100%)

Q7: How familiar are you with IPV laws?

Familiar	180 (22%)
Somewhat familiar	360 (44%)
Not at all familiar	268 (32%)
No answer	15 (2%)
Total	823 (100%)

Q8: Are you a mandated reporter for IPV?

Yes	527 (64%)
No	113 (14%)
Not sure	173 (21%)
No answer	10 (1%)
Total	823 (100%)

Q9: Is patient consent required to report IPV to law enforcement?

Yes	93 (11%)
No	460 (56%)
Not sure	252 (31%)
No answer	18 (2%)
Total	823 (100%)

Q10: How knowledgeable do you feel about IPV such as definition, facts, types, and dynamics?

Knowledgeable	136 (16.5%)
Somewhat knowledgeable	399 (48.5%)
Not knowledgeable	282 (34%)
No answer	6 (1%)
Total	823 (100%)

Q 11: During your employment with LAC have you attended an IPV training either onsite or offsite?

Yes	305 (37%)
No	400 (49%)
Not sure	111 (13%)
No answer	7 (1%)
Total	823 (100%)

Q12: Was this IPV training mandatory?

Yes	252 (79.5%)
No	36 (11.5%)
Not sure/no answer	29 (9%)
Total	317 (100%)

Q13: If you ever attended a training session on IPV during your employment with LAC:

Topic	Yes
Mandatory reporting ever covered?	88% (268/305)
Dynamics of IPV ever covered?	84% (255/305)
Community resources ever covered?	78% (238/305)
Clinical skills on screening assessment intervention and documentation ever covered?	77% (234/305)
Cultural considerations ever covered?	76% (231/305)
Legal issues and options for victims of IPV ever covered?	74% (223/305)
Same gender abuse ever covered?	64% (195/305)

Q 14: Does your facility have a designated staff member or unit to whom you refer victims of IPV?

Yes	241 (29.5%)
No	243 (30%)
Not sure/no answer	333 (40.5%)
Total	823 (100%)

Q 15: Perceived barriers to providing adequate services to victims of IPV:

Perceived Barriers by DHS health care providers	Yes
Inadequate training on IPV a barrier?	190
Language barrier with clients a barrier?	163
Inadequate resources to help identified IPV victims a barrier?	157
Is lack of time a barrier?	136
Not comfortable in discussing IPV with clients	72
Believe that IPV is a private matter and not a health concern	32

Administrator/Managers Survey

Table 1: Administrators/Managers Survey Respondents by Facility (N=102)

DHS Facility Category	Facility	Number of surveys data entered (%)
Hospitals (6)	Harbor UCLA	13 (12.5%)
	High Desert	8 (8%)
	LAC/USC	13 (12.5%)
	Rancho	1 (1%)
	Olive View	1 (1%)
	Martin Luther King/Drew	3 (3%)
	Sub-total for Hospitals	**39 (38%)**
Comprehensive Health Centers (5)	El Monte	6 (6%)
	Claude Hudson	5 (5%)
	H.Humphrey	2 (2%)
	Long Beach	1 (1%)
	Roybal	7 (7%)
	Sub-total for CHC	**21 (21%)**
Service Planning Areas (SPA1-8)	SPA 1&2	4 (4%)
	SPA 3&4	17 (17%)
	SPA 5&6	9 (9%)
	SPA 7&8	10 (10%)
	Sub-total for SPA	**40 (40%)**
Public Health Program (2)	Nurse-Family Partnership	1 (1%)
	Office of Women's Health	1 (1%)
	Sub-total for PHP	**2 (2%)**

Table 2: Administrators/Managers Survey Respondents by Job classification (N=102)

Job classification	Number (%)
Nurses	53 (52%)
Physicians & Dentists	29 (28%)
Social workers	4 (4%)
Others (Public health investigator supervisor, hospital or clinic administrator, Medical Director, Area Medical Director, Department chairs)	16 (16%)

The following describes the responses to each administrator/managers survey question.

Q1: Does your facility have a policy for screening victims of IPV?

Yes	47 (45%)
No	35 (34%)
Not sure	22 (21%)
Total	104 (100%)

Q2: If so, does the policy require that both men and women are to be screened?

Women only	19 (40.5%)
Both women and men	20 (42.5%)
Not sure	8 (17%)
Total	47 (100%)

Q3: Does the policy require that certain age groups are to be screened?

Yes	22 (47%)
No	17 (36%)
Not sure/no answer	8 (17%)
Total	47 (100%)

Q4: Are there written policies for treating, intervening, and referring for IPV?

Yes	46 (44%)
No	34 (33%)
Not sure/no answer	24 (23%)
Total	104 (100%)

Q5: Regarding IPV policy at your facility:

Does your IPV policy	Yes
Define IPV?	76% (35/46)
Describe how to intervene?	80% (37/46)
Describe how to document an intervention?	65% (30/46)
Describe how to refer victims of IPV?	83% (38/46)
Describe mandatory reporting procedures?	87% (40/46)
Require IPV training for physicians?	33% (15/46)
Require IPV training for nursing staff?	50% (23/46)
Require development of a safety plan?	24% (11/46)

Q6: Is there an IPV coordinator at your facility or program?

Yes	18 (17%)
No	62 (60%)
Not sure/no answer	24 (23%)
Total	104 (100%)

Q7: Does your facility have a standardized form that it uses to record information about known or suspected cases of IPV?

Yes	30 (29%)
No	48 (46%)
Not sure/no answer	26 (25%)
Total	104 (100%)

Q8: Does your facility offer IPV training for staff?

Yes	33 (32%)
No	46 (44%)
Not sure/no answer	25 (24%)
Total	104 (100%)

Q9: Is IPV training mandatory?

Yes	19 (58%)
No	6 (18%)
Not sure/no answer	8 (24%)
Total	33 (100%)

Q10: Are there posters or brochures about IPV in your facility?

Yes	29 (28%)
No	56 (54%)
Not sure/no answer	19 (18%)
Total	104 (100%)

Q11: Does your facility collect IPV data?

Yes	22 (21%)
No	47 (45%)
Not sure/no answer	35 (34%)
Total	104 (100%)

Q 12: If your facility collects IPV data,

Does it include:	Yes
Number of IPV cases identified	73% (16/22)
Number of clients screened	64% (14/22)
Number of IPV cases reported to law enforcement	55% (12/22)

ANALYSIS OF DHS DV POLICY CONTENT

	High Desert Hospital Updated 05/2002	Harbor-UCLA Med Center Updated 01/2002	MLK/ Drew Med Center Updated 10/1996	Rancho Los Amigos Updated 05/2003	SPA 1 & 2 Updated 09/2003	Olive View Updated 01/2002	Long Beach CHC Updated 12/2002	Roybal CHC Updated 04/2002	El Monte CHC Updated 05/2003	Humphrey Comp Health Ctr Updated 02/2003
1.) Screening Policy for IPV victims?	Yes, but no question	Yes	Yes	No	Yes, but no question	Yes, Limited	Yes	Yes	Yes	No
2.) Screening men & women?	Yes	No	No	No	Yes	Yes	?	No	Yes	No
3.) Screening certain age groups	No	Yes	No	No	No	No	Yes	No	No	No
4.) Written IPV policies?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
4a. Define IPV?	No	Yes	Yes	No	Yes	No	Yes	No	No	Yes
4b. How to intervene?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes
4c. How to document an intervention?	Yes	Yes	No	Yes	Yes	Yes	No	?	Yes	Yes
4d. How to refer victims?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4e. Describe mandatory reporting procedures?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4f. Require IPV training for physicians?	No	No	No	No	No	No	No	Yes	No	No
4g. Require IPV training for nursing staff?	No	No	No	No	No	No	No	Yes	No	No
4h. Require development of a safety plan?	Yes	No	No	No	Yes	No	Yes	No	No	?
5.) Standardized form to record IPV information?	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes
5a. Does form include perpetrator name/ relationship	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes
5b. Include body map to record injuries?	No	No	No	No	No	No	No	Yes	No	No
5c. Include a place to record referrals	No	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
5d. Include a place to assess victim's safety?	No	Yes	No	No	No	No	No	Yes	No	Yes
% of questions answered affirmatively	59%	71%	24%	41%	71%	41%	65%	65%	53%	59%

1) Only four policies were updated in 2003, five were updated in 2002, one in 2000, and MLK/Drew was not updated since 1996.

2) Only three policies were described as clear, or moderately clear. However, even those stated that the policies needed to incorporate training. Also, a need for an index was mentioned a few times.

3) 80% (8/10) had a screening policy for victims of IPV, but at least three were limited (e.g. excluding screening questions).

4) 40% (4/10) specifically required screening for both men and women.

5) 20% (2/10) specifically required screening for certain age groups.

6) 80% (8/10) have written policies for IPV.

7) 50% (5/10) define IPV.

8) 80% (8/10) describe how to intervene.

9) 70% (7/10) describe how to document an intervention.

10) 90% (9/10) describe how to refer victims of IPV.

11) 100% describe mandatory reporting procedures.

12) 10% (1/10) specifically require training on IPV for physicians.

13) 10% (1/10) specifically require training on IPV for nursing staff.

14) 30% (3/10) require development of a safety plan.

15) 80% (8/10) have a standardized form to record information about IPV. 55% use a standard DHS form, although 50% of those also include their own, in-house form. 46% are using their own form (although 60% of those also use the standard DHS form). 30% were not identified.

16) 80% (8/10) of the forms include the name and relationship of the alleged perpetrator.

17) 10% (1/10) of the forms include a body map to record injuries.

18) 60% (6/10) of the forms include a place to record referrals.

19) 30% (3/10) include a place to assess a victim's safety.

20) Not one policy had all of the components that we were reviewing.

21) The average percentage of affirmative responses was 55%. Seventy percent responded to more than one-half of the questions affirmatively. The range of responses went from 24% to 71%.

22) Strengths:

    a. Most policies had:
        i. Screening policy (80%)
        ii. Written policy specifically addressing IPV (80%)
        iii. Description of how to intervene, and how to document the intervention (80%, 70%)

iv. Description of how to refer victims of IPV (90%)
v. Mandatory reporting procedures (100%)
vi. Standardized form to record information about IPV, which included space to record the name and relationship of the alleged perpetrator (80%, 80%)

23) Weaknesses

a. Most policies did NOT:
    i. Specifically mandate screening for men and women (60%)
    ii. Require screening for certain age groups (80%)
    iii. Define IPV (50%)
    iv. Specifically require training for physicians or nursing staff (90%)
    v. Require development of a safety plan (70%)
    vi. Include a body map to record injuries (90%)
    vii. Include place to assess a victim's safety (70%)
b. 60% of the policies have not been updated since January 2003.
c. Only three policies (of 10) were described as clear or moderately clear, and those expressed a need to include training.

Appendix E

SWOT Analysis

Results of Worksheet 11: Perceptions of SWOT

Themes	**Strengths** (Internal Forces)	Themes	**Opportunities** (External Forces)
State and Hospital Policies on IPV	- Mandatory reporting policy and procedures (3) - Awareness of mandatory reporting (1) - Written hospital IPV policies (2)	***Standardized IPV policy and procedure***	- Create a DHS policy and procedure on IPV (4) - Develop countywide standardized screening, documentation and reporting forms (6)
Hospital Infrastructure	- Staff and administrators are used to following policies and procedures (4) - Infrastructure in place to implement a program (1)	***User-friendly policies and procedures***	- Cross referencing and/or consolidating multiple policies and procedures to make all policies and procedures user friendly (3) - Make standardized IPV policies and forms available on MyPHD, have search capacity on MyPHD (4)
DHS Infrastructure	- DHS provides a large amount of diverse services to the public (2) - DHS has infrastructure in place (1)		- Electronic standardized screening form for all patients aged 13 and up, could increase reporting because of confidentiality (2)
Standardized Form	- Most agencies have a standardized form to record info on IPV (4)	***Training***	- Use outside experts to train employees (3) - Annual training for staff (2) - Practical training on reporting and documenting (1)
Committed Staff	- Staff and admin want to be seen as helpful to patients affected by IPV (3) - Caring, knowledgeable, committed employees (1) - Willingness to address the issue (1)		- Standardized training for county (1)
		Partnerships	- Build internal partnerships (e.g. among county entities, such as law enforcement, the district attorney's office, shelter agencies, mental health, health care agencies) (5)
Referral Procedures	- PHNs have referral procedures (1) - Staff willingness to refer to other agencies (3)		- Build external partnerships (e.g. among non-county entities, such as church groups, non-profits, IPV agencies, human rights campaigns, unions) (6) - Partner with private sector groups in the areas of data collection, training, etc. (1)
Trained Staff	- Large number of employees trained and knowledgeable (3)		
		IPV Team	- Formation of IPV teams, like sexual assault response teams, which are trained and present in each facility (3)

Themes	Weaknesses (Internal Forces)	Themes	Threats (External Forces)
Staff awareness, preparedness to screen, report and refer	- Most employees are not aware of standardized forms (3) - Staff uncomfortable asking IPV screening questions (1) - Training on IPV is not up-to-date, comprehensive, or consistent, and only reaches a limited number of employees (6) - Lack of good research regarding what does and does not work, with respect to training (3) - Staff are overloaded with many policies, procedures and manuals (3) - Staff are overloaded, short of time for screening, interventions, and training (2) - Need clarification of resources (1) - Some staff are incompetent, new (3)	***Shortage of personal and county resources***	- Shortage of resources (personal and monetary resources) (1) - Budget cuts (7) - Program cuts (1) - Staff cuts (1) - Overworked staff, overloaded (1)
		Systematic threats	- County bureaucracy (3) - Consolidation of department and services
		Privacy	- Privacy issues (2)
			- Cultural issues (3)
Lack of infrastructure to respond to IPV	- Currently no DHS IPV policy (3) - No clear definition of IPV (vs. DV, child/elder abuse) (3) - No entity to specifically address IPV, need a department such as DCFS (2) - Size of DHS (1) - Geographical location, buildings distributed all over the place (1)	***Sociological Threats***	- Religious barriers (2) - Gender issues (Women still invisible, women's issues unrecognized) (1)
Administrative Accountability	- Lack of internal policy review (4) - Lack of administrative accountability (1)	***Coordination***	- Lack of communication and coordination between IPV-related agencies (i.e. law enforcement, shelters, legal, etc). (4)
Collaboration/ Communication	- Lack of internal collaboration (1) - Lack of external collaboration and communication between related agencies (law enforcement, shelters, legal, etc) (5)	***Prevention***	- Lack of prevention programs to address the needs of perpetrators (i.e. treatment for batterers) (2)
		Political agendas	- Politicians reluctant to address issues of IPV, for fear of affecting election outcomes (3) - Changes in political environment, which alter goals and slow processes (2)
Bureaucracy, slow processes	- Planning process to develop IPV policy is too slow (2) - Political changes impede the process (1)		
Prevention	- Lack of prevention programs, lack of prevention money		