Florida MIECHV Initiative
Intimate Partner Violence Charter

Introduction

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative funds three evidence-based home visiting models: Healthy Families America (HFA), Nurse-Family Partnership (NFP) and Parents as Teachers (PAT). The Florida MIECHV Benchmark Plan includes three measures on domestic violence: screening within six months, referrals and safety planning for participants with a positive screen. While the measures are the same for all local implementing agencies (LIAs), each model selected the screening tool they would use. The NFP model uses the NFP Relationship Assessment, Healthy Families Florida (the statewide HFA system) selected the HARK and PAT LIAs chose the Relationship Assessment Tool. Because of the difficult subject matter and results of the year one IPV benchmark measures, which are shared below, the Florida MIECHV State Continuous Quality Improvement (CQI) Team determined a more comprehensive approach is needed for programs to fully support families experiencing domestic violence and that it would be the first topic selected for a Learning Collaborative. After meeting with the Learning Collaborative faculty, the decision was made to focus on intimate partner violence (IPV), specifically. The CDC defines IPV as "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner." The purpose of this document is to lay out the importance of devoting the time and resources to this topic, and what is expected of everyone involved. It also describes what we hope this Learning Collaborative will achieve and how this will be accomplished.

Problem Statement

Intimate partner violence is a silent epidemic. Nearly 1 in 3 women and 1 and 4 men have been physically harmed by an intimate partner, according to the CDC *National Intimate Partner Violence and Sexual Violence Survey: 2010 Summary Report*[1]. Unfortunately, children are often witnesses to the violence. Based on data from the 2008 *National Survey of Children's Exposure to Violence*[2], Hamby et al (2011) concluded that within the previous 12 months:

> *1 in 15 children were exposed to IPV between parents (or between a parent and that parent's partner). During their lifetimes, 1 in 4 were exposed to at least one form of family violence. Of the children exposed to IPV, 90 percent saw the violence, as opposed to hearing it or other indirect forms of exposure.*

When IPV occurs, there may be detrimental physical and mental health effects on women, infants and young children (the primary population served by home visiting programs).

- Women who experienced IPV in the year prior to pregnancy were at increased risk for preterm labor. Additionally, their infants were at greater risk of having a low birth weight and requiring intensive care compared to women that did not experience IPV during that time (Silverman et al, 2006)[3]
- Preterm labor and other pregnancy complications are greater for women experiencing IPV during pregnancy, when compared with women that did not experience IPV, even when they did not experience IPV prior to pregnancy (Silverman et al, 2006)[4]
- Violence during pregnancy and the postpartum period has been linked to elevated levels of various emotional health problems, including depression, anxiety, Posttraumatic Stress Disorder (PTSD), and other forms of psychological distress (Martin et al, 2012)[5]
- Infants who hear or see unresolved angry conflict or witness a parent being hurt may show symptoms of PTSD, including eating problems, sleep disturbances, lack of typical responses to adults and loss of previously acquired developmental skills (Carpenter and Stacks, 2009)[6]

Gap

Evidence suggests that incorporating comprehensive IPV prevention, screening, and intervention (connections with appropriate supports) into home visitation programs can help improve the trajectory for families experiencing IPV. Yet, few programs fully integrate adequate IPV training and supervisory support into their work. Without proper training on IPV, and the policies and program structure to support it, the full benefits of these home visitation programs may not have an effect on some of the families most in need. At worst, participants and their children may be placed in increased danger as a result of well-meaning, but inadequately prepared home visiting staff. Of additional concern is that, in some cases (21 percent according to one large scale survey; CAEPV, 2005), the staff are IPV survivors, which means supervisors and organizations must factor this in to the services they provide to employees and the families they serve.

Across the Florida MIECHV home visiting programs, there is a wide variation in screening and follow-up practices across Florida's MIECHV sites.

- The statewide average percent of women screened for IPV within 6 months of enrollment was 69% in 2014 (with a range of 34-100%).
- The statewide average of women who screened positive for IPV with an appropriate referral documented within 7 days was 0%.
- The statewide average of women who screened positive for IPV and had a safety plan in progress or in place within 30 days was 79% (with a range of 0-100%).

In the middle of a difficulty lies opportunity. — Albert Einstein

Opportunity

At the time Anna enrolled in a home visiting program, she was a 31-year old mother of a 16-year old teenager and an infant who just turned one. While she had experienced a series of abusive relationships, Anna had never received help from any family members, formal system, or community-based agency to help her. Instead, she faced the violence alone, fearing her family's judgment and feeling ashamed about what was happening to her. In the sixth month of her pregnancy with her third child, her boyfriend – the father of her unborn baby – beat Anna unconscious and left her on the street. She awoke in the emergency room with serious multiple injuries. When she was released from the hospital, a social worker asked Anna if she would like a home visitor to help her with the birth of her baby. She agreed.

During one of those early home visits, the home visitor asked Anna about the father of her baby and whether she felt safe in their relationship. This critical question and her growing relationship of trust with the home visitor convinced Anna to tell her story. Over time, the home visitor provided support to Anna and her children, specifically linking them to community-based intimate partner violence resources. Anna's relationship with the home visitor helped her get the support she needed.

This is a true story adapted from *Realizing the Promise of Home Visitation: Addressing Domestic Violence and Child Maltreatment*[7]. Families with very similar stories are participating in many of Florida's home visiting programs right now. What if Anna's home visitor had not asked her about her relationship or had not developed a safe environment in which she would open up to her? What if she had not known exactly what to do when she shared what had happened to her? What might have happened to her children?

Mission: What are we trying to accomplish?

The mission of this 10-month Learning Collaborative is for participating LIAs to test best practices that will lead to a significant improvement in, not just screening women for IPV, but staff having the knowledge and confidence to effectively support families that are experiencing IPV through appropriate referrals and safety planning. From August, 2015 through May, 2016, eight LIAs will learn strategies from faculty and share their experiences with each other in an effort to achieve breakthrough improvement.

Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishment toward organizational objectives. It is the fuel that allows common people to attain uncommon results. – Andrew Carnegie

Learning Collaborative Aims and Measures: How will we know that a change is an improvement?

- By May 31, 2016, at least 90% of women will be screened within six months of program enrollment.
- By May 31, 2016, at least 85% of women will be referred to a certified DV center or other appropriate IPV services within seven days of screening positive or disclosing IPV (if not already receiving appropriate services).
- By May 31, 2016, at least 85% of women will have a safety plan in progress within 30 days of screening positive or disclosing IPV.

To measure progress towards these shared aims, we will use a common group of both process and outcome measurements. LIAs will collect monthly data for these measures and program staff will discuss this data to determine if the strategies being tested and implemented are moving them in the right direction. Participants will learn how to create and interpret run charts to promote the sustainability of using data for ongoing improvement efforts. The monthly data will be graphed on run charts and shared via Groupsite, along with a summary of monthly testing, to promote shared learning across the LIAs. Home visitors will also periodically complete a short, online questionnaire that will assess their knowledge and confidence when working with families experiencing intimate partner violence.

Methods: What changes can result in an improvement?

The IPV Learning Collaborative central document is a "Change Package" that provides ideas for testing based on evidenced-informed strategies and best practices. Recognizing that testing and making improvements takes time, each organization is expected to develop a project aim statement that includes a specific goal they want to work on during the first 90 days of the Learning Collaborative. When accomplished, new short-term aims will be identified. It is anticipated that accomplishing these short-term aims will lead to achieving the Learning Collaborative aims by the end of the 10 months.

LIAs will identify a "travel team" (3-5 individuals recommended), most likely the CQI team, to help guide the work. There will be three two-day Learning Sessions focused on bringing together LIAs and faculty to learn and exchange ideas in person. The travel team will communicate what was learned with the "home team" (staff that do not attend). Between Learning Sessions, the LIAs will engage in Action Periods during which changes will be tested using rapid Plan, Do, Study, Act (PDSA) cycles. After each test, the CQI team will decide whether to adapt the strategy to conduct another test, abandon the idea, or adopt it for implementation. Implementation occurs only after enough testing has been conducted to

be reasonable assured the change will work for everyone and a plan is in place to ensure the change is sustained. While the CQI team will lead the efforts, all MIECHV staff will participate in the IPV Learning Collaborative virtual activities and assist in executing the tests of change.

Collaborative Expectations

The Learning Collaborative faculty will:

- Share their knowledge about the best evidence related to the topic area.
- Participate in planning calls and, as time permits, webinars and Learning Sessions.
- Review the draft Driver Diagram and Change Package (specific ideas to test) and make recommendations.
- Assist Learning Collaborative staff with developing agendas for Learning Sessions and webinars.
- Coach individual LIAs, as needed, on testing changes related to IPV.
- Support the work of the IPV Learning Collaborative by sharing their knowledge with LIA staff during webinars and/or Learning Sessions.

Learning Collaborative staff will:

- Set goals and execute tasks necessary to maximize opportunities for achieving the Learning Collaborative's aims.
- Develop all Learning Collaborative documents and tools needed to support the success of the LIAs.
- Work closely with the faculty to strengthen documents and activities for the Learning Collaborative.
- Create well-defined measurements related to the Learning Collaborative's aims, and plot the results monthly for the duration of the Learning Collaborative.
- Conduct an IPV Learning Collaborative Orientation webinar for LIAs to understand expectations.
- Facilitate relationship-building between LIAs and between LIAs and faculty.
- Offer coaching to LIAs to facilitate PDSA testing and skill development in CQI techniques.
- Consult State CQI Team in preparation for and as needed, throughout the Learning Collaborative.
- Share information with the State CQI Team, faculty and LIAs on progress towards the Learning Collaborative aims.
- Present the IPV Learning Collaborative experiences and results at the final Learning Session to celebrate success.
- Prepare for and facilitate spread of changes to organizations outside the Learning Collaborative.

Local Implementing Agencies will:

- Identify local CQI team members, including extending an invitation to the local certified domestic violence center, that will attend Learning Sessions.
- Develop aim statements and PDSAs to work towards Learning Collaborative aims.

- Conduct at least monthly tests of change using PDSA rapid cycle methods during Action Periods.
- Hold CQI team meetings at least monthly to review data, discuss tests and plan for future tests.
- Review monthly data as a staff to encourage a culture of inquiry that will inform future testing.
- Implement and sustain changes after a series of successful tests.
- Commit to sharing transparently successes and failures to facilitate learning amongst peers.
- Submit monthly reports via Groupsite on tests of change and data, as well as any resources developed and any questions for faculty or other teams that will facilitate shared learning.
- Cover travel for 3-5 CQI team members to participate in the Learning Sessions.
- Participate as a team in monthly calls/webinars with peers, Learning Collaborative staff, and faculty to review data, engage in learning and problem-solve barriers.
- Present their experience and results at Learning Sessions and/or webinars to celebrate success and prepare for spread of changes to others.

Works Cited

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[3] Silverman J, Decker M, Reed E, Raj A (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: Associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology*; 195(1):140-8.

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