Greater Milwaukee Area

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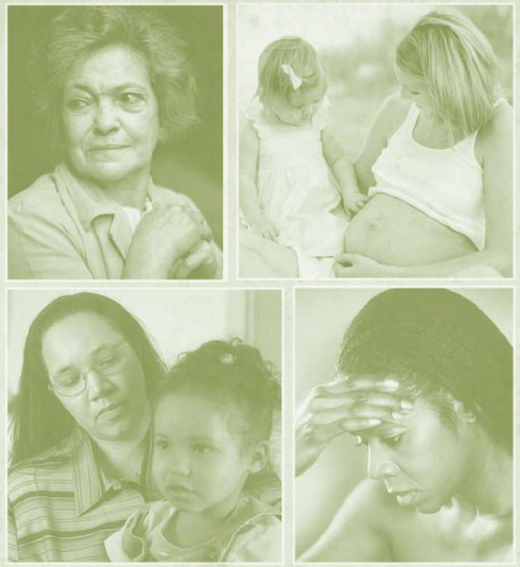

Abuse Response Services

Domestic Violence

2002-2011 ten-year report

Aurora Health Care®

Greater Milwaukee Area

2002-2011 ten-year report

Abuse Response Services
Domestic Violence

Aurora Health Care is a large, integrated health care system that spans the eastern third of Wisconsin and northern Illinois. The Abuse Response Services in the Greater Milwaukee Area (Greater Milwaukee East, South and Mid Markets) have created an organizational culture where attention to issues of intimate partner violence and sexual abuse are an expectation of all caregivers. This is consistent with the stated purpose of Aurora Health Care "We help people live well."

Interpersonal abuse and trauma have significant health consequences for people's physical and emotional well-being; and health care providers are in a unique position to make a difference. Since 1985, Aurora Health Care has provided crisis intervention, forensic exams and ongoing support via its 24/7 hotline and Sexual Assault Treatment Center (SATC) to men, women and children across the Greater Milwaukee Area.

In 2000, Aurora supported the creation of The Healing Center, which provides ongoing healing for adult victims of sexual violence at any point in their healing process. Its services include individual counseling, support groups, advocacy, survivor-led workshops and alternative therapies, such as acupuncture, massage, Reiki, as well as community education and training on prevention, risk reduction, partner/acquaintance abuse and recovery. Both the SATC and The Healing Center exemplify Aurora's understanding of sexual abuse and violence as significant public health issues.

The sexual abuse services of Aurora's SATC and The Healing Center, and those of the Milwaukee community, became formalized in the 1980s and '90s. But within Aurora, attention to the education of caregivers and the provision of services to patients experiencing domestic violence/intimate partner violence were unstructured and sporadic until 2001. As we advance our prevention agenda for the 21st century with respect to the social determinants of health identified by the U.S. Dept. of Health and Human Services[1], health care systems need to address the health implications of multiple forms of abuse. To that end, Aurora created an additional program to address the needs of patient's and employees experiencing domestic violence/intimate partner violence. This report details the development and impact of that program from 2002-2011.

2002	*Abuse R sponse Services: Domestic Violence* (DV) program aligned with the existing Sexual Assault Treatment Center and The Healing Center in the Greater Milwaukee Area. The DV Clinical N rse Specialist provides: • Education of Aurora caregivers – nurses, physicians, residents, social services and others • Crisis intervention, education, safety planning and advocacy to patients and caregivers who disclose abuse • Organizational P&P, standards of care, documentation • Local and state leadership re: domestic violence and health care
2004	Conducted and published a prevalence study of intimate partner violence and health implications for women using emergency department and primary care clinics within Aurora and Greater Milwaukee Area.
2005	Designed and implemen ed the *Safe Mom Safe Baby* program – A unique collaborative model of care for pregnant and recently delivered women experiencing intimate partner violence The Nurse Case Manager (Aurora Health Care) and Community DV Advocate (Sojourner Family Peace Center) Team provides: • Education of Aurora caregivers • Case management, education, safety planning and advocacy to diverse and socio-economically challenged women • Enhanced DV screening tools • Community education for teens and participation with ocal and regional infant mortality initiatives
2006-2011	Presentations at local, state and international conferences; four publications in peer-reviewed nursing journals; and received several honors for excellence from Aurora and State organizations.
10 Year Outcomes 2002-2011	• 2,172 referrals received from Aurora caregivers and community partners (80 clients were caregivers [employees]) • *Safe Mom Safe Baby* clients – Adopted significantly more safety behaviors and grew in their readiness to make life changes – Achieved birth outcomes *comparable* to the overall population of pregnant women delivering at Aurora Sinai Medical Center despite their increased risk for premature and low birth weight infants • Education provided to nearly 1,000 Aurora caregivers annually • Enhancement of DV screening, reporting and referrals • Standardization of documentation in the electronic health record • Reported patient experiences that are increasingly safe and supportive • Additional and timely legal and shelter services mobilized for our patients via community partnerships • Established credibility of Aurora Abuse Response Services as leaders regarding issues of health care and domestic violence
2012	Integration into Aurora Family Ser ice 2012-2016 trategic Priorities – Family Stability

See Appendix A for detailed timeline information

Notes

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Letter from the Director …

Dear Reader,

What you are holding in your hands is the story of how just a few dedicated and passionate nurses have changed the lives of hundreds of abused women – not just for this generation, but for generations to come.

Domestic Violence/Intimate Partner Violence affects nearly 1 in 3 American women, yet most American health care workers, including doctors and nurses, have little to no training in how to help women create safety in their lives.

At Aurora Health Care, there ***is*** *the education. There* ***is*** *the passion, there* ***is*** *the commitment. And as a result, there is healing and hope for victims and their families.*

No doubt the report seems long, the subject matter "heavy." If it feels too daunting, start with reading the introduction on the next page, and the summary on page 28. Then don't set it down. Check out the Table of Contents and chose one subject that draws you (e.g., Scope of Intimate Partner Violence in Pregnancy). With one-third of women living it, all of us need to learn about it, or we will never be able to stop it. Your learning can begin now.

At Aurora Health Care, we do many great things. And this is one of our best. Keeping women and their children safe is one of our top priorities. We hope this report will make it one of yours, too.

With deep appreciation to our program founder Alice Kramer, RN, CNS, and her protégé Tina Watts, RN, BSN, and to Aurora Health Care for unending support, I invite you to join us in helping us end this epidemic,

Sally Turner, RN, MS
Director Patient Experience and Abuse Response Services

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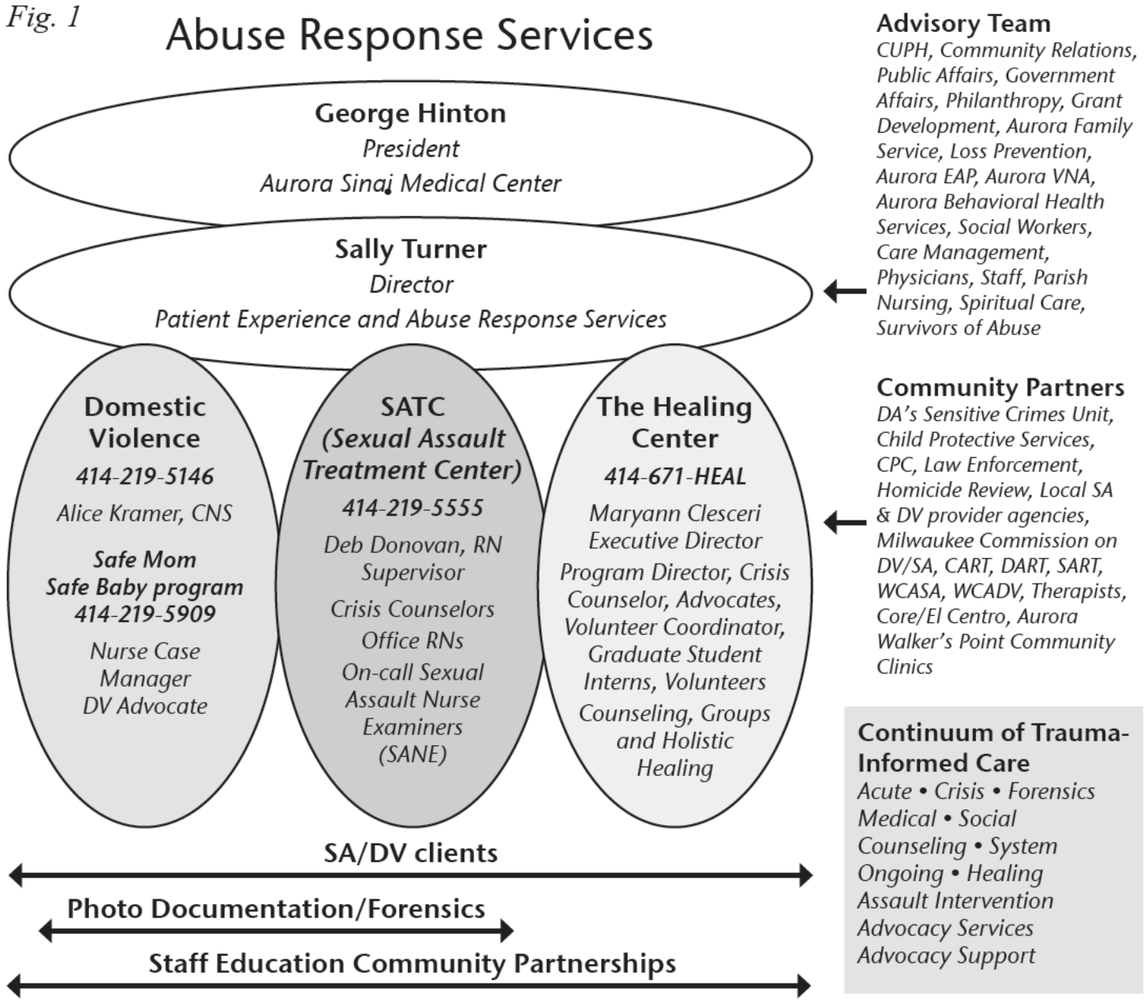
Abuse Response Services (ARS)

In 2002, the Abuse Response Services model was conceptualized together with the Sexual Assault Treatment Center and Domestic Violence staff and administrator. Based on the high prevalence rates of domestic violence in Aurora Health Care's patient population and a readiness of internal champions, the formalized domestic violence components were born. The diagram below *(Fig. 1)* depicts the integration of sexual abuse and domestic violence services. While the SATC and The Healing Center provide services to the Milwaukee community at large, the domestic violence components of ARS target education and direct services predominantly to the caregivers and patients of Aurora – their Milwaukee area hospitals, clinics and various other health settings.

Fig. 1



Extent of the problem

Intimate partner violence (IPV) is more commonly known as domestic violence (DV) and the terms will be used interchangeably at various points in this report. IPV is defined by the Family Violence Prevention Fund as a pattern of assaultive and coercive behaviors that may include: inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other[2].

Nearly one-third of American women will experience intimate partner violence in their lifetime[3]. Annually, about 4.8 million women encounter physical assaults and rapes connected to IPV[4]. In 1995, the cost of IPV for medical care, mental health services and loss of productivity was estimated at $5.8 billion. Converting that amount to costs in 2003 comes to more than $8.3 billion[5].

IPV is linked to health in a number of ways and accounts for a significant proportion of injuries and emergency room visits for women[4,6-8]. IPV is also the leading cause of female homicides and injury-related deaths during pregnancy[9].

Looking beyond the immediate and often severe health consequences of IPV, a growing body of research has also linked IPV to eight out of 10 of the Leading Health Indicators for *Healthy People 2010,* while injury/violence is one of 12 health focus areas for *Healthiest Wisconsin 2020*[10]. IPV has emerged as a significant risk factor for these chronic health problems and health risk behaviors as we learn more about the long-term impact of abuse. Women who have been victimized by an

intimate partner and children raised in violent households are more likely to experience a wide array of physical and mental health conditions including frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems and post-traumatic stress disorder[11-13].

Although there is a clear relationship between IPV and poor health outcomes, the issue has traditionally been attended to from a criminal justice perspective. In 1991, C. Everett Koop, U.S. Surgeon General at the time, acknowledged that discussing violence as a public health issue was breaking new ground. Prior to that time, when faced with domestic violence, health professions deferred to the criminal justice system[14]. This is evidenced by the efforts of legal policy created by the Law Enforcement Assistance Administration, law enforcement, judicial sanctions and state initiatives to provide training for police, court personnel, prosecutors and judges, parole and probation officers, substance abuse counselors and child protective service workers.

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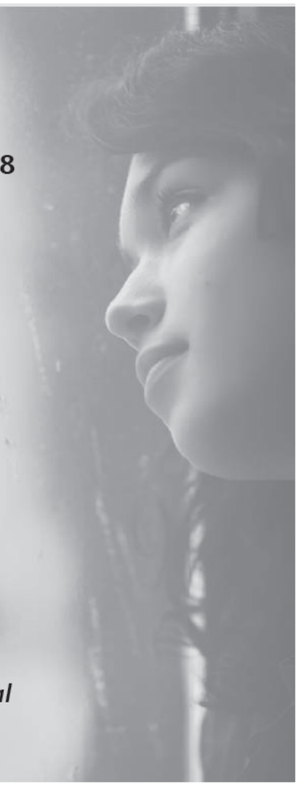
While the responsibility and response to domestic violence from the criminal justice community expanded starting in the early 1970s, the health care community's efforts were slow and often had little impact[15]. The growing body of research on the area provides strong evidence that health care settings are a vital place for intervention[4]. In a study conducted on intervention perspectives, it was found that victims of IPV believe that a health provider's inquiring about IPV is an occasion to raise patient awareness, communicate compassion and provide information and resources[16].

Screening tools have been found to be very effective in correctly identifying victims of IPV[17]. It has been predicted that abuse to women could be reduced by as much as 75% if identification and intervention were routinely done in primary care settings[18]. The opportune timing to intervene in the health care setting is often missed due to the lack of consistent IPV screening standards. One study found that only 4 out of 56 health care providers systematically screen for domestic violence[19]. The same study found that only 41% of women experiencing domestic violence during pregnancy reported it.

Aurora Health Care conducted an IRB (international review board)-approved study in 2002 to quantify the prevalence of IPV and the health implications of adult women presenting to 24 Aurora clinic sites, including 5 emergency departments (N = 1,268 adult female patients, including 75 Spanish-speaking women)[20]. Results indicated:

- *Nearly one in two (49.5%) of women in this study had experienced physical abuse in their lifetime; 11.7% had experienced physical abuse within the past year.*
- *Women in every demographic group reported instances of abuse in their lifetime; although younger, poorer and less educated women reported the highest rates.*
- *Abused women reported significantly lower health ratings than non-abused women*
- *The majority (63%-93%) of women with health problems, such as headache, stomach problems, chronic pain, STDs, substance abuse, depression and suicide thoughts, had experienced emotional/physical abuse in their lifetime.*



Results from the Aurora Health Care study, anecdotal evidence and scientific findings emerging from the professional literature alerted providers within Aurora to the need for a dedicated program addressing the complex needs of people experiencing intimate partner violence.

Program Description

In October 2001, Aurora Health Care created a dedicated clinical nurse specialist (CNS) position for the Greater Milwaukee Area to systematically educate health care providers about skillful assessment and interventions. The goal was to create safe environments where patients could disclose abuse and receive supportive services. In addition to caregiver education, Aurora provided the resources and autonomy to the CNS to provide direct services/ crisis intervention to patients and its employees.

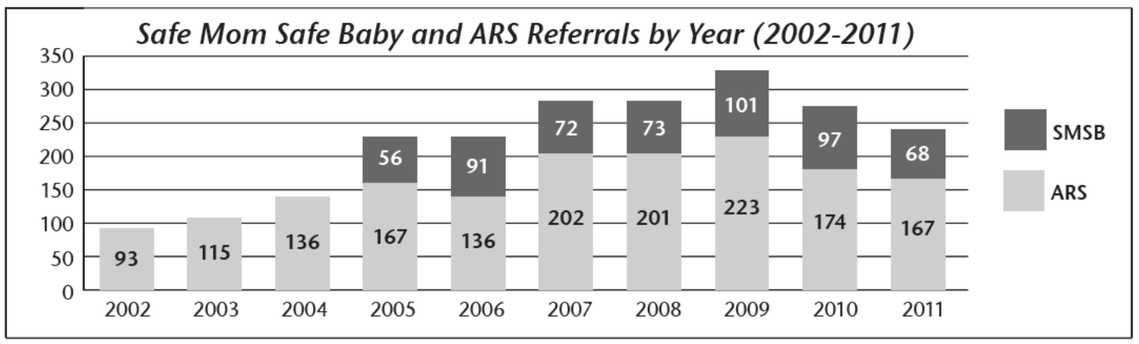
The program is guided by input of an Advisory Team of professionals and community partners (Appendix B). The CNS also works in collaboration with the Aurora EAP (employee assistance program) and managers regarding employees who are experiencing IPV to promote safe work environments and job performance. In addition, the CNS partners with Aurora social services in the Greater Milwaukee Area to respond to patients who identify domestic violence concerns and want to talk with someone. The CNS is available during business hours and relies on the 24-hour coverage of social services for after-hour response. The CNS also collaborates with the SATC and The Healing Center when clients are impacted by multiple forms of abuse, such as sexual violence. The ARS-DV office is located at Aurora Sinai Medical Center, but the CNS is available to provide education and direct services at any Aurora setting in the Greater Milwaukee Area.

Referrals to ARS

The ARS-DV program received 2,172 referrals for services over the past 10 years and has a current average rate of 225 referrals per year *(Fig. 2)*. These data include referrals to the general DV program (n = 1,614) and additional referrals to the DV *Safe Mom Safe Baby* program related to pregnant women (n = 558), which will be described later in this report.

The majority of referrals for non-pregnant women were received proportionately from the four Aurora hospitals in the Greater Milwaukee Area *(Table 1)*. Referrals originated most often from the emergency (60%), inpatient (14%) and ambulatory (7%) departments. In addition, 5% of referrals came from specialty clinical settings (i.e., rehab, pain center, prenatal care coordination, private physician offices) *(Table 2)*. Aurora caregivers who were experiencing IPV accounted for 80 referrals. Referrals were most likely made by nurses (63%), social workers (10%), other allied professionals (8%) and mid-levels/physicians (7%). Friends/ family and employers of clients and self referrals made up the remaining referrals (6%) *(Table 3)*.

Fig. 2



Tables

Figures

Appendix E: ***SMSB Client Interviews (cont.)***

Question	*Response Themes and Notable Quotes*
Was it helpful to meet during appointments?	• For all applicable participants this was very helpful and appreciated.
Why did you leave the program?	• ***With the exception of one person, most of the participants thought they were still in the program.***
Since entering the program, how has your life changed and what part did the program play in that?	• A number of the women also said they left their abusers. **Client quote:** ***"I have gotten so much more confidence than I could have ever imagined-so much confidence when it comes to my son, being myself, and working. My thing is, if not for SMSB staff I would have given my son up for adoption, I would never have known him or what it was like to be a mom. She has given me the greatest gift of all-my son-to know how to love him and be there for him and to enjoy him. I didn't know any of that before."***
What do you see in your future?	• Most of the participants had positive outlooks for the future and have begun making positive changes such as finishing school, planning to go back to school, and focusing more on children.
Is there something you would like to add that hasn't been asked or haven't had a chance to talk about?	• The program should do more outreach. • Most participants want to encourage others to give the program a chance. • All of the participants believe strongly that the program should continue. • One participant stated that the program should allow women to stay in the program longer. **Client quote:** ***"They help a lot of mothers-single mothers at that-that need it. A lot of us, it's hard for us to make it especially as a single mom. We have hard times like going to a shelter. You need that help***

Table 1
Referrals to ARS by Hospital
(2005-2011)

Hospital	Count	Percent
ASLMC	386	30%
ASMC	473	37%
AWAMC/WAMH	183	14%
AWP	16	1%
NA	67	5%
Other	56	4%
ASLSS	54	4%
Unknown	38	3%
Total	**1,273**	**100%**

Table 2
Referrals to ARS by Department
(2005-2011)

Department	Number	Percent
Ambulatory	93	7%
ED	768	60%
Inpatient	179	14%
NA	96	8%
Other	70	5%
Private Physician Offices	5	0%
Unknown	62	5%
Total	**1,273**	**100%**

Table 3
Referrals to ARS by Caregiver
(2005-2011)

Caregiver	Number of Referrals	Percent of Referrals
Self	67	5%
Friend/Relative of Client	13	1%
Mgr/Employer of Client	21	2%
Nurse	800	63%
PA/Nurse Practitioner	47	4%
Physician	41	3%
Social Worker	126	10%
Other	101	8%
Unknown	57	4%
Total	**1,273**	**100%**

Type and Extent of Services

The ARS clinical nurse specialist provided direct services such as crisis intervention, safety planning, education, emotional and situational support and advocacy to 54% of the referred clients. These services were provided in-person (19%), with in-person and follow-up phone contact (12%) or client contact by phone alone (21%) *(Table 4)*. Most client services consisted of one or two in-person and/or phone contacts. Additionally, 234 clients (22%) were assisted by the CNS via consultation and support of the referring person without actual contact with the client if it was not needed or possible. As is often the case with abused women whose living situations change frequently, contact was not made with 25% of referrals due to insufficient or inaccurate contact information.

Table 4

Number of Service Types Provided
(2005-2011)

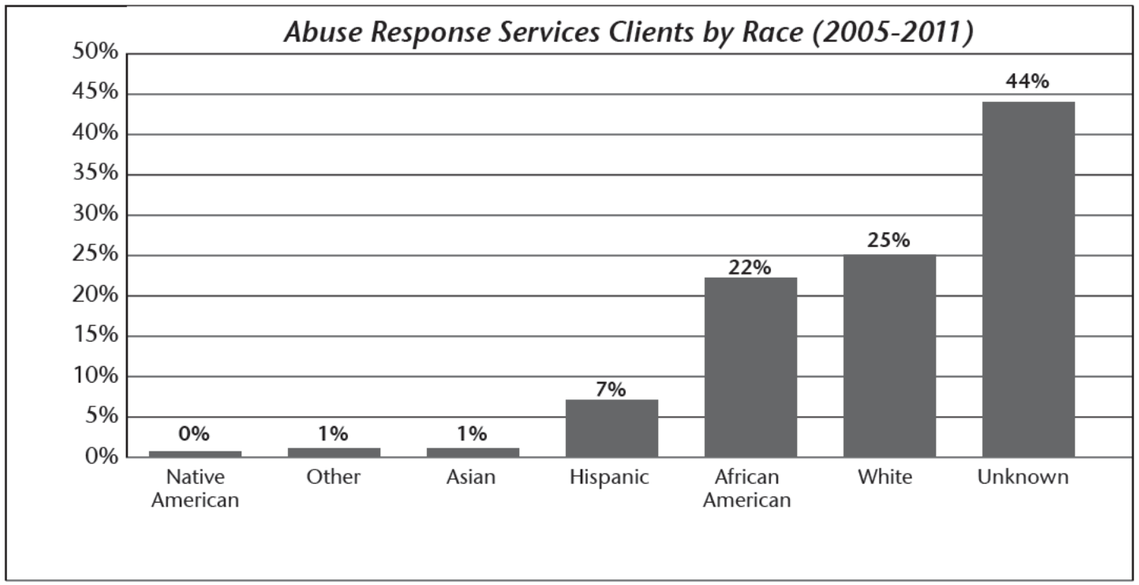
Client Contact Type	Number	Percent
1:1 only	225	19%
Phone (with 1:1)	141	12%
Phone (without 1:1)	237	21%
Advocacy (without direct client contact)	258	22%
Phone (attempts without contact)	239	21%
F/U contact refusal – client says she will call and does not	49	4%
Other	6	0%
Unknown	0	0%
Total	**1,155**	**1%**

Spheres of Influence

Clients

The ARS-DV services are available to any Aurora patient or caregiver who discloses IPV and wants to work with this program. Data from 2005-2011 indicate that the vast majority of clients were women (97%). Of the 56% of patients with known racial demographics, 25% where Caucasian, 22% African American, 7% Hispanic, 2% other *(Fig. 3)*. Clients' ages ranged from under 18 years (2%), 18-39 years (50%), 40-69 years (30%), 70+ years (4%), unknown (19%) *(Fig. 4)*. No specific income data was collected for general ARS clients. Clients reported experiencing physical and/or emotional abuse most often and sexual or financial abuse to a lesser degree. The majority (96%) of perpetrators were a significant other/partner, while the remainder was a relative or acquaintance.

Fig. 3



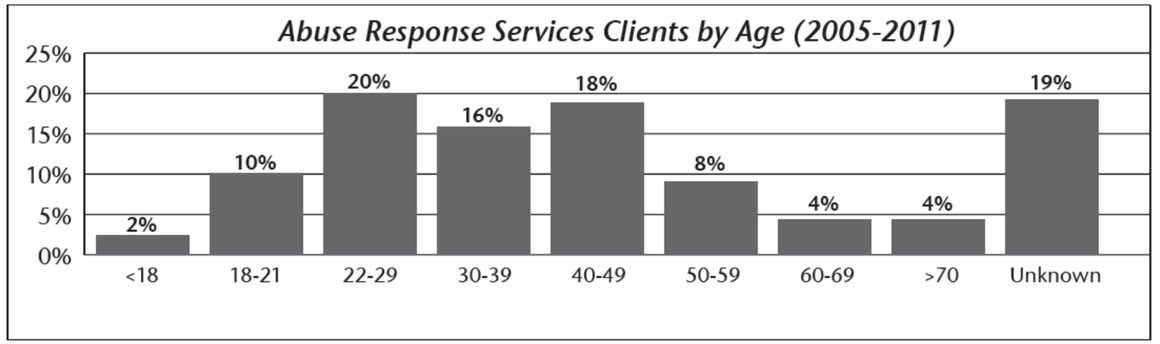
Appendix E: ***SMSB Client Interviews (cont.)***

Question	***Response Themes and Notable Quotes***
What did you need/want, but didn't get from the program?	• A few things that women wished were offered: better legal advice, employment assistance, and more housing options.
What would you have liked to be different about the program? Follow up probes: *housing, legal advocacy, medical advocacy, safety, isolation, more knowledge of safety promoting behaviors, coordination of other services, emotional support, and transportation.*	• A few of the participants did not know about all of the resources available. • One participant mentioned that it would be nice to offer opportunities for participants to meet (festivals) each other and that SMSB staff should be recognized.
How could the program change to better suit your needs?	• A few of the participants mentioned that additional outreach would have encouraged them to learn about and join the program earlier. • One woman mentioned that she felt like she was "red-flagged" in the hospital and the nurses treated her differently because of that. **Client quotes:** ***"I was red-flagged, when I was in the hospital nurses came in and wanted to talk to me and the nurses weren't nice and asked my family to leave. I didn't appreciate being treated like a victim."*** ***"I didn't know the program existed…they helped with food and Christmas toys and not many people know about it. A lot of people don't know programs like this exist."***
Was the process of the program accommodating?	• All participants agreed that the program was very convenient and accommodating. **Client quote:** ***"I didn't have to do anything- she came to me. She wasn't pushy. I liked that she didn't try to dig into my business. It was whatever I wanted to talk about, she never judged me or she just said what you do is up to you just know that your safety is what's important."***

Appendix E: ***SMSB Client Interviews (cont.)***

Question	*Response Themes and Notable Quotes*
What was it like being in the program? Follow up probes: *what was your initial visit like, what was it like coming back after the first visit, and who provided support between visits?*	• All participants said the program provided social support, often the only form of social support they received. • Other common responses said the program provided safety, stress relief, and resources. **Client quote:** ***"When I come to my meetings with her it is like a stress relief class and when I come home I feel like a different person. She made you feel like you could put all of your trust in her."***
Which resources were the most/least important to you? *(Problem solving, self care, service utilization, financial situation, stress reduction, social support)*	• The most common resources that were most important include social support, financial help, and problem solving. Stress reduction, legal services, and self-care were each mentioned twice. The most common type of financial help were often things needed for children i.e. car seats, formula, etc. • Most of the participants could not think of a resource that was not helpful with the exception of parenting classes.
What was the most helpful about the program?	• Social support was the most helpful part of the program for all participants. • The second most common response was help in obtaining things for children. **Client quotes:** ***"I would say when my child was born I didn't have the things that I needed. At this time me and the father was on very very bad terms and he didn't want to step up to the plate. The hospital provided a car seat, a bed, diapers, and formula. That there is a blessing."*** ***"I love the fact that she is in my life because I would not be the kind of mom that I am without her."***
What would you like to see continue in the program?	• The convenience of the program should continue (meeting locations and times). • Social support should continue.

Fig. 4



Caregiver

Comprehensive education of health care providers is a major component within Abuse Response Services. Formal methods of education and informal mentorship of Aurora caregivers were systematically developed over 10 years in the Greater Milwaukee Area to better prepare providers to skillfully inquire about, and respond to, clients' IPV related concerns. High levels of provider screening and client disclosure of abuse have resulted from caregiver education and ready access to IPV resources within Aurora's Abuse Response Services.

IPV was specifically incorporated into essential annual nursing education requirements in collaboration with an Interdisciplinary Advisory Team and working closely with clinical nurse specialists, nurse educators and the Aurora Professional Development and Standards Shared Governance Councils. The ARS nurse leaders work diligently to assure that the clinical practice of all interdisciplinary providers is aligned with the IPV-related recommendations of their professional organizations.

It is estimated that nearly 1,000 Aurora caregivers are formally educated about domestic violence each year.

> *"I never understood how abuse can create so many physical and emotional health problems! So I quit saying to patients, 'I have to ask this question,' and now I ask and listen more intentionally about their personal safety."*
>
> ~ Aurora Caregiver

Innovative educational programming is tailored to meet the unique learning needs of interdisciplinary providers practicing in specialized clinical areas such as perinatal clinics, emergency departments, inpatient and ambulatory settings. Workshops include discussion of IPV-related standards and offer opportunities to refine communication skills through role-playing. Video clips of IPV survivors sharing their personal experiences and perspectives on abuse-related interventions are a particularly effective component of web-based educational programming.

In 2011, four online modules were developed for family medicine and obstetrical residents related to IPV in pregnancy. The project was supported by the Picker Institute, Inc., which is an international non-profit organization that supports research in the field of patient-centered care. These modules utilize an Objective Standardized Clinical Evaluations (OSCE) approach with video clips of actual residents providing care to "standardized" patients who represent common concerns of abused

patients. These modules are available on the Aurora Graduate Medical Education website.

Currently, there is an extensive catalogue of resources available to Aurora caregivers such as:

- Online learning modules on Aurora's *iConnect* Learning Connection
- Instructor-led interactive in-services, workshops and conferences
- Customized, unit-specific education
- Consultation to the other affiliates within Aurora's footprint re: education and policies
- Onsite mentorship and informal education

Organization/Community

Aurora's Abuse Response Services-DV education, expertise and direct services are currently available to five hospitals and all clinic and ambulatory settings throughout the Greater Milwaukee Area. This program has promoted a standardized response to domestic violence in the Greater Milwaukee Area and has influenced the entire Aurora Health Care system in the following ways:

- The Metro Administrative P&P is updated regularly with current legislative, Joint Commission and practice changes
- ARS-DV provides consultation to the other Aurora affiliates
- Minimum screening standards have been developed for specific clinical settings such as emergency, inpatient and perinatal areas in the Greater Milwaukee Area
- Standardized screening questions and assessment/ intervention templates are embedded into the electronic health record (Cerner and EPIC) across Aurora Health Care's footprint

The nurse leaders of Abuse Response Services and *Safe Mom Safe Baby* have taken an active role in the dissemination of information about their collaborative model of care and integrated services. They have made podium and poster presentations at numerous local, state and international health care conferences. They have published four separate articles in nursing peer-reviewed journals and have received excellence awards from Aurora Health Care and state agencies *(Appendix C)*.

Outcomes of the Abuse Response Services – Domestic Violence Program

Process outcomes

- Identified the prevalence of lifetime abuse among its Aurora patients
- Collected descriptive data of clients, referral patterns and services (data is reported for 2005-2011 unless otherwise noted)
- Standardized education, screening, resources and referrals
- Standardized documentation in the electronic health record
- Created an organizational culture where addressing IPV in a skillful and culturally sensitive manner is expected of all caregivers
- Obtained grant and private donation funding for the program
- Received 2,172 referrals from Aurora caregivers and community partners (80 clients were employees)
- Established the credibility of Aurora Abuse Response Services' nurse leaders regarding issues of health care and domestic violence

Client outcomes

- *Safe Mom Safe Baby* clients:
  - Adopted significantly more safety behaviors ($p < .05$)
  - Grew significantly in their readiness to make life changes ($p < .05$)
  - Achieved *comparable* birth outcomes to overall population of women delivering at Aurora Sinai Medical Center despite abused women's increased risk for premature and low birth weight infants
- Patients report experiencing increasingly safe and supportive health settings and skillful caregiver responses

Appendix E: ***SMSB Client Interviews (cont.)***

Question	***Response Themes and Notable Quotes***
Who did you work with in the program?	Four of the participants worked predominantly with Tina (Nurse Case Manager) and three of the participants worked predominantly with Nancy (DV Advocate). **Client quote:** ***"They saved my life, they're great."***
How long were you in the program?	Average length: 15 months
How did you first hear about SMSB?	• Six of the seven participants heard about the program after being in the hospital. • One of the seven participants was referred while at the courthouse.
How did you make the decision to be in the program? Follow up probes: *what was the tipping point, previous resources used, first impressions, and initial concerns*	• All participants decided to join after speaking to a SMSB staff person. • Two of the participants decided to join because of the resources offered. • One participant mentioned that she did not participate until her situation escalated. • All participants said they joined for social support. • Three participants said they were hesitant about the program when they first heard about it. • One participant mentioned it was difficult for her to connect to SMSB via phone and said it took some time to get involved. **Client quotes:** ***"I thought they were there to make me do things that I didn't want to do, but the more I got involved I found out they were there to help me."*** ***"I didn't think that I fit the bill because I wasn't in the relationship anymore. Once I started getting stalked I realized that I fit the bill."*** ***"This is the only resource that I know that I have used in almost three years and I know that when I call I will get help."***

Appendix E: *SMSB Client Interviews (cont.)*

Quotables

"I thought I wasn't never gonna get off my feet. And just, real hard. (program staff) and just all of them helped me. "You know, (subject's name), you have a way of finding, you have a way of finding, finding out things to do to make yourself feel better." And she would tell me, "It's not me that's going to the job. It's you, it's you, it's you. And I still felt like it was hard and she helped me more.

I could be happy one minute and then I could break down and cry out of nowhere. And I'll call her and she would sit on the phone and talk to me. And every time I hang up I'll feel better."

"It was actually, this sounds probably bad, but it was a pregnancy that I enjoyed. I can say as many complications as I had, as far as with the baby, I was, I was still, I enjoyed it and that was something I wasn't able to do with my first one or second." (pt attributed to her involvement with the program)

"It's kind of hard to explain, but the confidence that they give you is a self-confidence. It builds you up from knowing that your strength is really what got you as far as you are now. It's that confidence that you don't recognize that got you to where you are today. So I think that's pretty much what it was, that how the program helped me. Everybody needs somebody to talk to. And I would suggest that you call up Safe Mom and Safe Baby and talk to whoever that answer the phone 'cause they will listen. But this program helped me so much that now I just… I don't know, I wake up with a smile instead of wake up thinking this the end, it's over for me. Now I wake up feeling good about waking up."

"By encouraging me to keep going out there, to find different resources to, you know; help myself get back on my feet. Because I didn't have anyone that was there and just being by myself, not being in a relationship, I didn't have mother and father, it was just like … the smallest thing happened to me and I think my whole life was falling apart because a lot did fall apart within seven months. It was like I was losing everything."

Safe Mom Safe Baby

The domestic violence components of Abuse Response Services were significantly expanded in 2005 with the creation of the *Safe Mom Safe Baby* program. The SMSB program was funded in large part by two consecutive 3-year Wisconsin Partnership Program grants (totaling nearly $850,000) from the University of Wisconsin School of Medicine and Public Health. Grants awarded through the Community-Academic Partnership Fund are used to promote the goals of Wisconsin's health plan, Healthiest Wisconsin 2010, and the mission, vision and guiding principles of the Wisconsin Partnership Program (WPP)[21].

The SMSB program has advanced the Wisconsin Partnership Fund's mission and vision by building upon the long and successful collaboration between Aurora Abuse Response Services, Sojourner Family Peace Center and numerous other community organizations to expand their outreach to Milwaukee's pregnant and postpartum women who are victims of IPV. Further, the engagement of two academic partners (obstetrician and nurse midwife) who are passionate about improving perinatal care and outcomes in Milwaukee, a Sustainability Planning process and the evaluation expertise of the Center for Urban Population Health gives SMSB significant academic research strength. This breadth of academic assistance to the program has enhanced our understanding of effective interventions, generated new knowledge and contributed to public policy discussions.

The first WPP grant in 2005 supported the design, implementation and evaluation of this innovative and collaborative program linking health care and community efforts toward addressing IPV. In 2008, SMSB received an additional three-year WPP grant to expand and sustain the program. Matching funds were provided by Aurora Health Care and our community partner, Sojourner Family Peace Center.

Sojourner Family Peace Center is the largest DV program in Wisconsin. It provides education, advocacy and resources to keep people safe. They operate a 42-bed shelter that has provided safety and support services to thousands of women and children. Other programs include a 24-Hour Domestic Violence Hotline, Domestic Abuse Victim Advocates in the Milwaukee District Attorney's Office, Belle Resource Center for Women and Children, Courthouse Advocacy and Restraining Order Clinic, Legal Emergency Assistance, Children's Advocacy, Ending Violence through Education and Beyond Abuse – a batterers' group for men and women seeking alternatives to abusive behavior. Sojourner Family Peace Center is committed to creating communities where people live peacefully.

Additional funding for the Abuse Response Services-*Safe Mom Safe Baby* program was received from the Office of Justice Assistance – a STOP Violence Against Women 1-year grant ($42,500), private donors including a long-standing community supporter and Aurora caregivers. In total, over the past 10 years Abuse Response Services secured over $1M in private and federal grants and individual donations *(Appendix D)*.

Scope of IPV Related to Pregnancy

One of the most comprehensive studies of IPV on maternal and neonatal health was based on data from 118,579 women in the 2000-2003 Pregnancy Risk Assessment Monitoring System[22]. Women reporting IPV in the year prior to pregnancy were at increased risk for high blood pressure or edema, vaginal bleeding, severe nausea and vomiting or dehydration, kidney infection or urinary tract infection, hospital visits related to such morbidity and delivery preterm of a low birth weight (LBW) infant and an infant requiring intensive care unit compared with those not reporting IPV. A meta-analysis of eight studies concluded that IPV victims are 1.4 times more likely to have a LBW baby when factors of prenatal care, substance use and income are controlled for[23-25].

In a Canadian study, many women reported that their abuse began or escalated during pregnancy and continued afterward[26]. Coercion and control over the female partner may include refusal to use or allow contraceptive use, restricted abortion option, limited access to health care or use of pain medications during labor. Plichta's review of research findings from 1993-2003 confirms that IPV is associated with increased mortality, injury and disability, worse general health, chronic pain, substance abuse, reproductive disorders, and poorer pregnancy and fetal outcomes[27]. IPV is also associated with an over-use of health services and unmet need for services, as well as strained relationships with providers.

IPV during pregnancy is common with prevalence rates of 0.9% to 20.1% being reported in the United States. Most studies report a range of 3.9% to 8.3%[28,29]. Taking an average of 8% means that one in 12 pregnant women may be experiencing IPV. Abuse occurs among all socioeconomic groups but is more reported among the most disadvantaged women and higher reported rates are found in adolescents[30-32] and in clinical settings that serve predominately poor women[33-35].

Bohn et al. found that abuse is not related to income per se, but rather associated with the variables of education and ethnicity[36]. Women with less than a high school education are at greatest risk of abuse. Women of racial and ethnic minority groups face tremendous social, economic, cultural and other barriers to achieving optimal health – they are in poorer health, use fewer health services and suffer disproportionately from premature death, disease and disabilities[37]. In addition, African American women's rates of IPV are often higher than every other group's, except American Indian women[38].

Milwaukee is a large and ethnically diverse urban setting in Wisconsin. According to the 2007 Big Cities Health Inventory, the City of Milwaukee ranks 7th worst for infant mortality among the 53 largest cities in the U.S., and the difference or disparity between Milwaukee's infant mortality

Appendix E: *SMSB Client Interviews*

First impression of the program

"I was real comfortable the first time. Even the second time that I talked to her, she made me feel real comfortable. She told me, you know, it's okay. It's not my fault and nobody understands why … made him getting into it when it never got into him before. She let me know, you know, don't blame myself. It's not my fault. Because that's how I'm feeling from being pregnant."

Initial concerns about program

"I think I considered Safe Mom/Safe Baby, but I might not get involved in it, 'cause I don't really want them in my business.

I thought you know, with the program, because of what I was going through, you know what I'm saying, that they would probably put the social services in my business, you know? You know, that happens a lot, you know? and that's why I was kind of hesitant not to get involved within the program, because I didn't want them to think my children was being abused and she's allowing this guy to do this and that to her, you know."

Coming back for visits

"I felt a relief, a sense of comfort 'cause when you go into they office you don't have to just be uptight and feel like you gotta walk on egg shells and watch what you saying. You could actually be yourself around her. And I liked the fact that I could actually be myself around her, 'cause around everybody else I know I gotta watch what I say so I don't offend this person, I just tell her what's going on in my life, how I'm feelin, and she gives to me real."

"That she, as busy as she was and is, and if she promised something or said she was gonna do it, she did it. She made it a point to mare sure that she got it done no matter what it took. You know she just, she worked 110% to always, with everything, you know."

"I just enjoy the fact that she just made me look at a lot of stuff in a totally different way."

"She kind of noticed that I was like having a problem, and I was depressed, and going through a lot of things in my life, so she introduced me to a therapist."

What was helpful

"It's like it's hard to pick out just one thing that stands out because everything is just so helpful. Everything is so beneficial. I guess being able to actually vent to somebody, being able to talk to her. That's the only thing I can really think of. Being able to talk to her whenever I can, whenever I feel like it, whenever I want so I could leave her a message and she call me right back. You know, just … I guess just being there to talk to her."

Appendix D: *Abuse Response Services and SMSB Funding*

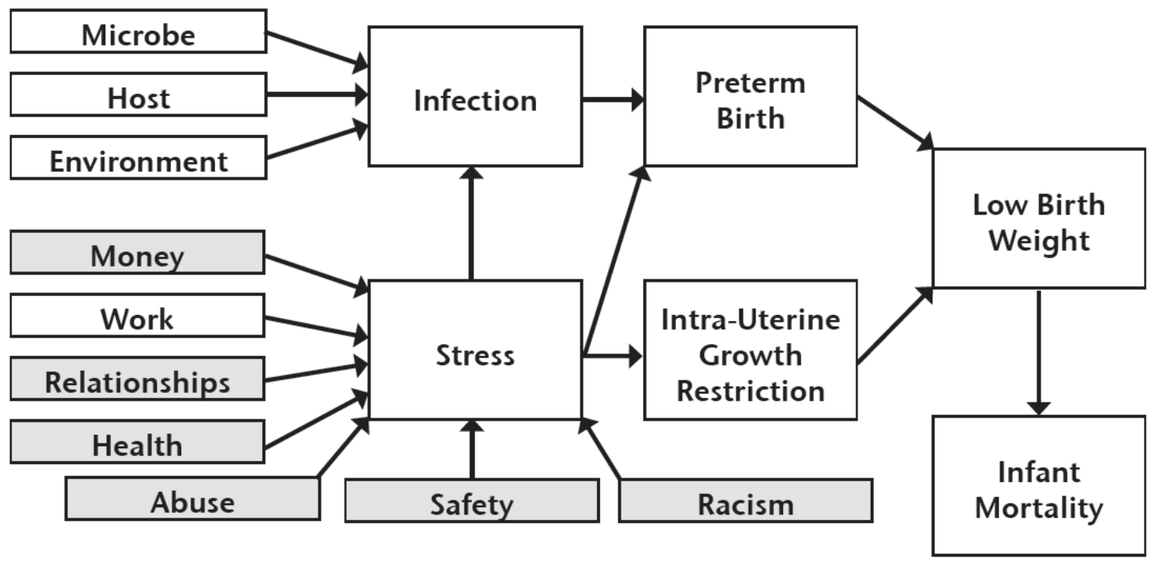
Funding Interval	*Source*	*Amount*
2002-present	**Victims of Crime Act (VOCA)** – Federal grant funding .15fte of CNS position	$216,186
2005-2011	**Wisconsin Partnership Program** – University of Wisconsin School of Medicine and Public Health. Two consecutive 3-year grants funding the majority of the nurse case manager & DV advocate positions	$849,502
2010-2011	**Office of Justice Assistance** – Violence Against Women (OJA-VAWA) STOP grant funding .5fte nurse case manager position for 1 year	$42,415
2009-2010	**The Pickar Institute, Inc.** – An international non-profit based in Massachusetts that supports research in the field of patient-centered care. ARS/ SMSB were subcontracted to develop and provide education to OB residents	$13,500
2008	**Private donation from the Davis Family Foundation** – $25K divided between Aurora Health Care and Sojourner Family Peace Center for use of SMSB program	$12,500
2005-present	**Aurora Partnership Campaign** – Various donor sources and employees donate an average of $5K per year	$81,561
	Total	**$1,215,664**

rates for African Americans and whites is one of the worst in the nation[39]. Milwaukee's infant mortality rates (IMR) in 2008-2010 were 14.3/1000 births for non-Hispanic Blacks, 5.1/1000 for non-Hispanic whites and 8.4/1000 for Hispanics[40]. The black infant mortality rate is worse than the overall rate of at least 35 countries around the world. Compare these to the national IMR of 6.75/1000 in 2007[41] and the Healthy People 2020 target of 6.0/1000[10].

The innovative, nurse-led *Safe Mom Safe Baby* program is committed to enhancing the safety, perinatal care and outcomes for this vulnerable population of abused pregnant women. SMSB focuses on many of the stress factors in the pathway to preterm birth that can be exacerbated by issues of money, work, relationships, health, abuse, safety and racism. Psychosocial stress can lead to behavioral risk factors which impact on biological risk factors and increase the likelihood of preterm birth.

Fig. 5

Pathways to Preterm Birth



Pathways to Preterm Birth *(Fig. 5)* were described by Sheri Johnson, PhD, Wisconsin State Health Officer, and Murray L. Katcher, MD, PhD, Wisconsin Chief Medical Officer, in a recent presentation to the Wisconsin Partnership Fund Oversight and Advisory Committee[42]. Both infection and stress can lead to preterm birth, low birth weight and infant mortality – serious health issues, especially among the socioeconomically disadvantaged population in the city of Milwaukee. Factors that exacerbate stress include: money, work, relationships, health, abuse, safety and racism. (**Note:** The shaded boxes in this model are all impacted in some way by the SMSB program.) Psychosocial stress can lead to behavioral risk factors which impact on biological risk factors and increase the likelihood of preterm birth. Taking a proactive approach to reducing the impact of IPV on pregnancies, thus increasing safety and reducing abuse and stress, can be an important piece of the large puzzle of improving birth outcomes in Milwaukee.

IPV may also be a significant risk factor for maternal and neonatal mortality. Homicide is a leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31% of maternal injury deaths[43-45]. State and local statistics indicate the prevalence of intimate partner violence. The 2010 Wisconsin Coalition Against Domestic Violence Homicide report identified 58 deaths in Wisconsin related to family violence, with the majority (72%) of victims being female. Two homicides and one near-homicide in 2010 involved pregnant women and other children[46].

Health care providers seldom have a working knowledge of the myriad of pragmatic needs that an abused pregnant woman has related to her safety. Prior to SMSB, perinatal health care providers simply gave the patient a phone number for the local DV agency. And in turn, DV agencies seldom knew how to help a pregnant woman if she had medical needs. SMSB offers a unique collaborative model of care that helps abused pregnant women navigate both within the health settings and the community to receive effective, trauma-informed care.

Program Description

Partnering Across the Care Continuum

> *"My past experience with domestic violence reveals that providers will not ask or pursue an obvious problem, if they know there are no services available for the patient. If SMSB were not here, the care of women would suffer hospital-wide."*
>
> ~ Obstetrician

The *Safe Mom Safe Baby* interdisciplinary team is led by a clinical nurse specialist (CNS) who serves as the grant program director. Team members include a registered nurse (RN) case manager and a bilingual (English/Spanish), bicultural domestic violence advocate. The SMSB program collaborates with two academic faculty members (obstetrician and certified nurse midwife) and an interdisciplinary advisory team from both Aurora Health Care and the community *(Appendix C)*.

Realizing that health care systems alone could not have sufficient impact on the safety of abused pregnant women, the SMSB program incorporated concepts of nursing case management and partnered them with community-based domestic violence advocacy. The SMSB program removes system barriers and silos of service by creating a seamless continuum of care in the Greater Milwaukee Area for a pregnant woman within outpatient/inpatient health settings, as well as within the community in which she lives.

Client empowerment is the foundation of all SMSB initiatives. The mission and philosophy are informed by the Empowerment Model, a theoretical framework used by researchers investigating intimate partner violence[47-50]. When interacting with potential clients, the SMSB registered nurse and domestic violence advocate offer a wide range of assessments and direct services *(Fig. 6)*. Following this initial discussion and entry into the program, the client directs the development of her personal safety plan. She identifies her readiness to engage in various service options which might include crisis intervention, emotional support, advocacy within various health care and community settings, and assistance with specific safety strategies.

The SMSB team provides evidence-based services using a synergistic dyad model. More details regarding the scientific evidence that informed the

Appendix C: *Presentations, Publications and Awards*

Presentations

Numerous unit specific and workshop educational offerings each year for in-patient, emergency and ambulatory caregivers across Aurora Health Care-predominantly in Greater Milwaukee Area.

- **Kramer, A., & Watts, T. (2007,April). *Violence threatens health of pregnant women and newborns: A toolkit for developing effective responses in perinatal settings.* Podium presentation at Wisconsin Assoc of Perinatal Care (WAPC) Madison, WI.**
- **Kramer, A., & Watts, T. (2007,October). *Safe Mom Safe Baby collaborative model of care for pregnant women experiencing intimate partner violence – 2 year summary.* Podium presentation at Nursing Network on Violence Against Women International (NNVAWI) Conference. London, Ontario, Canada.**
- **Kramer, A. (2008, Sept). *Health care responds: The prevention and treatment of IPV perinatal settings.* Paper presented at the International Conference on Violence, Abuse, & Trauma. (IVAT) San Diego, CA.**
- **Watts, T. (2009, Oct). *SMSB collaborative model of care for pregnant women experiencing IPV: Expanding and sustaining.* Poster presentation at National Family Violence Prevention Fund-Health Care (FVPF) Conference. New Orleans, LA**
- **Kramer, A., & Watts, T. (2010, Oct). *Healthcare and domestic violence advocacy partnerships.* Paper presented at Wisconsin Coalition Against Domestic Violence (WCADV): Advocacy in Urban Communities Summit.**
- **Kramer A. Watts T. (2011) *SMSB: A Collaborative Model of Care for Pregnant Women Experiencing IPV.* Poster presentation at the 13th Annual Southeastern Wisconsin Nursing Research Conference-Dispelling myths with research evidence. Marquette University, Milwaukee, WI**
- **Kramer A. and Watts T. (2012) *SMSB: A Collaborative Model of Care for Women Experiencing IPV.* Accepted to co-present podium presentation at National Assoc of Clinical Nurse Specialists (NACNS) Chicago, IL March 9, 2012**

Publications

- **Kramer, A. (2002). Domestic violence: How to ask and how to listen. *Nursing Clinics of North America, 37(1),* 189-210.**
- **Kramer, A. Lorenzon, D. & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency department and primary care clinics. *Women's Health Issues,* 14(1), 19-29.**
- **Kramer, A. (2007). Stages of change. Surviving intimate partner violence during and after pregnancy. *Journal of Perinatal and Neonatal Nursing, 21(4),* 285-295.**
- **Kramer, A. (2009) *EMS Response to Domestic Violence.* WEMSA December.**
- **Kramer A., Nosbusch J. Rice, J. (2011) Safe Mom Safe Baby: A Collaborative Model of Care for Women Experiencing IPV. Accepted for publication to the *Journal of Neonatal and Perinatal Nursing.* (In press)**

Honors/Awards

- **Kramer, A (2005) Aurora Health Care: *Nursing Excellence Award-Patient/Client***
- **Kramer, A. (2006). *Champion in Women's Health-Domestic Violence.* Wisconsin Women's Health Foundation. This award recognizes extraordinary leadership in women's health. Madison, WI.**
- **Kramer, A. (2009). *Significant Achievement in Domestic Abuse.* State of Wisconsin's Governor's Council on Domestic Abuse. Madison, Wisconsin**
- **Watts, T. (2011) Aurora Health Care Mid – Market: N*urse Excellence Award for Community Achievement***

Appendix B: *SMSB Interdisciplinary Team*

SMSB Team Members

Grant Program Director

- Clinical Nurse Specialist – *Abuse Response Services*

Grant Academic Faculty

- Physician and Director of Obstetrical Residency Program
- Midwife and Manager of Midwifery and Wellness Clinic

Community Partner

- Co-executive Director of Sojourner Family Peace Center (SFPC)

***Safe Mom Safe Baby* Staff**

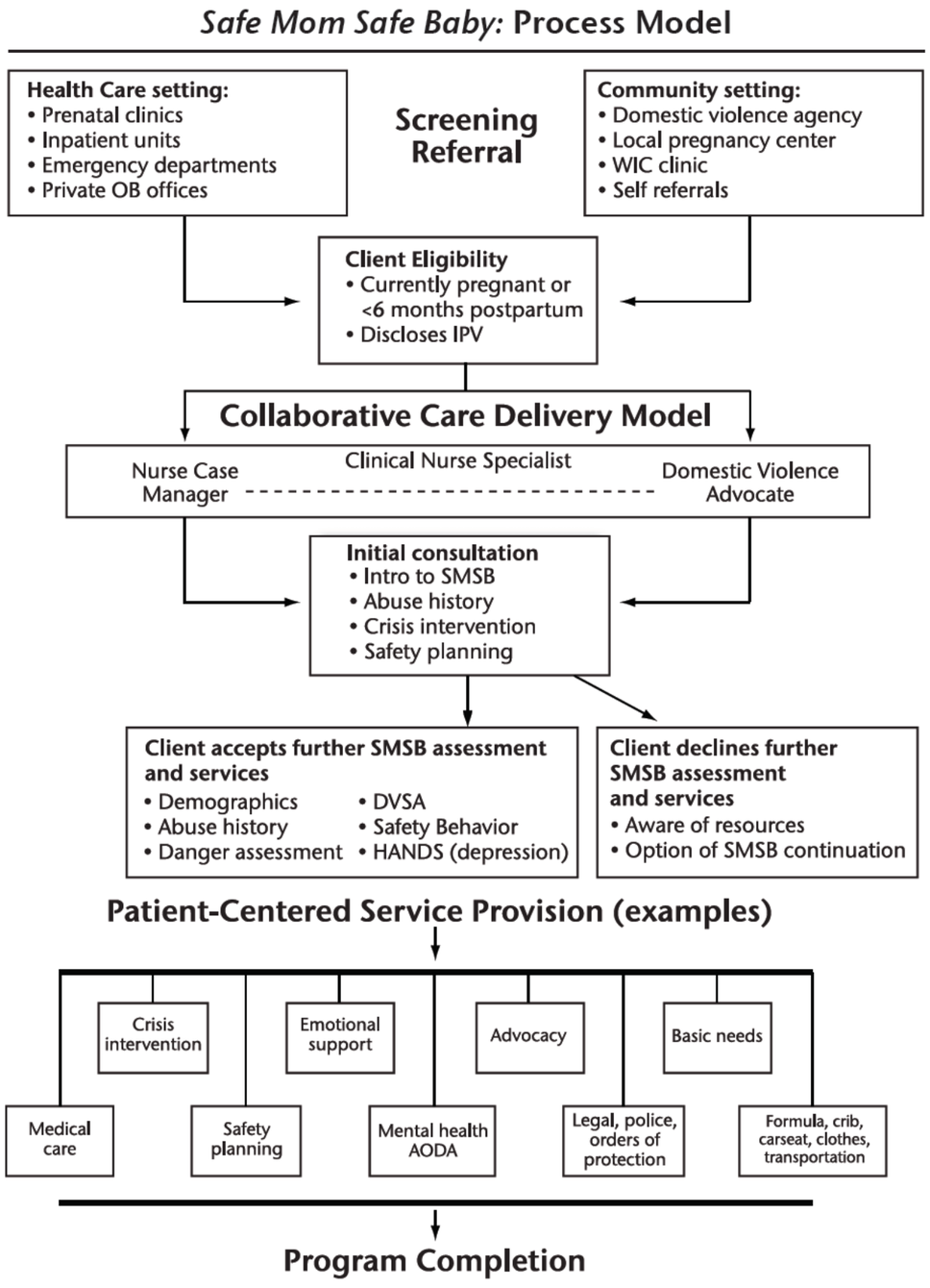
- Nurse Case Manager
- Domestic Violence Advocate (SFPC)
- Center for Urban Population Health Assistant Researcher

Interdisciplinary Partners

- Aurora Administration and nursing leaders
- Clinical staff from perinatal areas, emergency departments
- OB attending and residents
- Social workers
- Security/Loss Prevention
- Grant development and philanthropy
- Private donors

***Safe Mom Safe Baby* Client Interviews**

Fig. 6



program design, roles of the nurse case manager/ domestic violence advocate and outcomes of this program can be found in the recently published article in the *Journal of Perinatal and Neonatal Nursing*(in press),[51].

Referral Patterns

The primary target population of *Safe Mom Safe Baby* is pregnant and newly delivered women in the Milwaukee metro area who self-disclose IPV. Clients are eligible for SMSB services while they are pregnant and up to six months postpartum. Some exceptions are made to work with clients longer if they have ongoing high risk medical and safety needs. SMSB received 558 referrals during 2005-2011, bringing the total number to 2,172 of ARS-Domestic Violence referrals. Information presented in the following sections is based on the evaluation of program data collected from 2005-2011.

Table 5
SMSB Referrals from Aurora Health Care settings (2005-2011)

AHC Referral Site	Number	Percent
ASMC WHC	70	22%
ASMC UWMC	32	10%
ASMC Labor and Delivery	63	20%
ASMC Post Partum	32	10%
ASMC NICU	7	2%
ASMC ER	40	13%
ASMC OB Triage	25	8%
ASMC EFW	3	1%
AWP Labor and Delivery	7	2%
AWP Post Partum	16	5%
AWP NICU	2	1%
AWP ER	6	2%
AWP OB Triage	9	3%
Total	**312**	**100%**

The SMSB services are provided both in health care settings and in the community. Program staff interacts with clients in emergency departments, perinatal clinics, private offices, labor and delivery units, a restraining order clinic or a variety of community-based agencies. On limited occasions, the DV advocate may interact with clients in the client's home after assuring their own safety. Program staff also maintain business hours at offices at Aurora Sinai Medical Center and at our partner community agency, Sojourner Family Peace Center.

Referrals to the SMSB program at its inception originated predominantly from high volume Aurora Health Care prenatal and inpatient settings in the Greater Milwaukee Area (ASMC 87%, AWP 13%) *(Table 5)*.

Referral patterns changed as health care providers and community partners became familiar with SMSB. Currently, over 60% of the referrals originate from self referrals, clients of Sojourner Family Peace Center and some non-Aurora health settings*(Table 6)*. The majority of these patients did, however, deliver their baby at Aurora Sinai Medical Center.

Referrals from within the Aurora Health Care system were predominantly from nursing staff in collaboration with their obstetrician and midwife, prenatal clinics, inpatient nursing units, private offices and emergency departments. The referral process for SMSB begins when the nurse case manager is called or paged and arrangements are made for her to meet individually with the patient that same day in the health setting or at a later time/ place that is safe and agreeable to the patient *(Fig. 6)*.

Appendix A: ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012) (cont.)***

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/ Publication*
2012	**SMSB integrated into ARS-DV overall** (to be determined)	1.0 CNS/NC	Founding CNS retiring April, 2012 and 1.0 FTE becomes a consolidated position for both DV general and perinatal services General – continues to collaborate with AHC social services and EAP SMSB - continues to collaborate with DV advocate to provide a team of services Future Integration with: • Trauma-Informed Care • Integrated Medicine • Holistic Nursing	Funding: 1.0 CNS/NC – AHC 1.0 DV Advocate - SFPC (Each system funds its own staff person)	Pending: Kramer A., Nosbusch J. Rice, J. (2011) *Safe Mom Safe Baby:* A Collaborative Model of Care for Women Experiencing IPV. Accepted for publication to the *Journal of Neonatal and Perinatal Nursing.* Kramer A. and Watts T. SMSB: *A Collaborative Model of Care for Women Experiencing IPV.* Accepted to co-present podium presentation at National Assoc of Clinical Nurse Specialists Chicago, IL March 9, 2012

Appendix A: ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012) (cont.)***

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/Publication*
2008-2011 cont.			Ongoing involvement with: • Wisconsin Coalition Against Domestic Violence (WCADV) • Statewide DV Health Care Task Force • Milwaukee Consortium of Healthcare Response to IPV • SE Wisconsin and Milwaukee Public Health Dept Initiatives re: Infant Mortality		Kramer A. Watts T. (2011) SMSB: A Collaborative Model of Care For Pregnant Women Experiencing IPV. Poster presentation at the 13th Annual Southeastern Wisconsin Nursing Research Conference-Dispelling myths with research evidence. Marquette University, Milwaukee **Honors** • Kramer, A (2005) AHC Nursing Excellence Award-Patient/Client • Kramer, A. (2006). *Champion in Women's Health-Domestic Violence.* Wisconsin Women's Health Foundation. Award recognizes extraordinary leadership in women's health. Madison, WI. • Kramer, A. (2009). *Significant Achievement in Domestic Abuse.* State of Wisconsin's Governor's Council on Domestic Abuse. Madison **Honors:** • Watts, T. (2011) AHC Mid Market Nurse Excellence Award for Community Achievement

Table 6
SMSB Referral Site by Year (2005-2011)

	Year the client entered SMSB						
	2005	2006	2007	2008	2009	2010	2011
Aurora Health Care	48	63	52	43	59	37	21
	85.7%	70.0%	74.3%	59.7%	59.6%	42.0%	31.3%
Sojourner Family Peace Center	0	6	8	10	25	40	39
	.0%	6.7%	11.4%	13.9%	25.3%	45.5%	58.2%
Other	8	21	10	19	15	11	7
	14.3%	23.3%	14.3%	26.4%	15.2%	12.5%	10.4%

If referrals are made from Aurora clinical sites after business hours, a message is left for SMSB and the nurse attempts initial contact with the patient via phone. These referrals have a much higher rate of loss to follow up than with clients in which the team can make initial contact in person.

In a similar fashion, referrals that originate from the community are made by staff at Sojourner Family Peace Center (SFPC) *(Fig. 6)*. The agency staff contacts the SMSB advocate by phone or pager and she arranges to meet with the client at a service site, i.e., restraining order clinic, SFPC office or at a later time/place that is safe and agreeable to the client. This might include the patient's home or a local restaurant or library. A small number of referrals come directly to either of the team's offices from non-Aurora health settings, private physician offices and/or self referrals.

Participation in the program is voluntary, and refusal to participate does not affect any other care or treatment. There is no cost to participate in the program, and all women referred to *Safe Mom Safe Baby* are eligible to receive services.

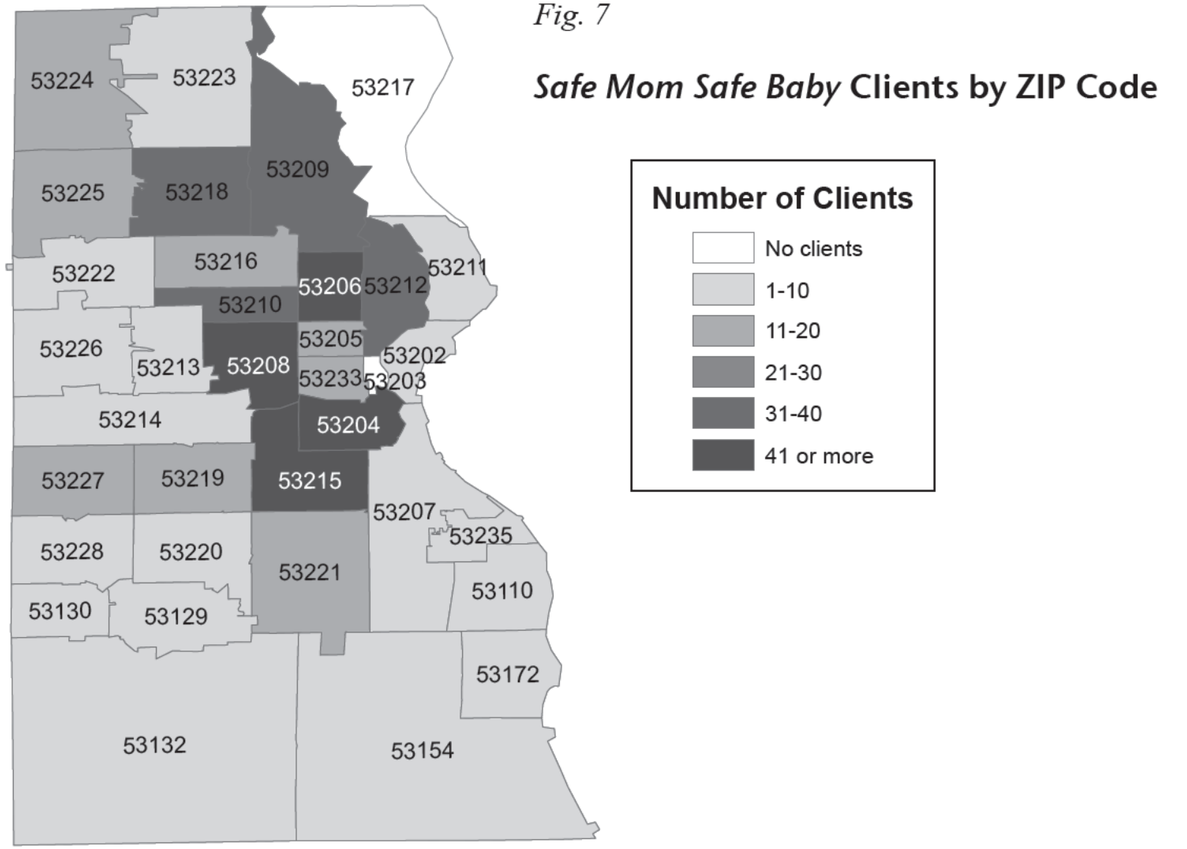
Description of Clients

Intimate partner violence (IPV) affects women of all ages, races, socioeconomic groups and religions. The demographics of clients referred to the general ARS-DV program were quite different than those referred to *Safe Mom Safe Baby*. The ARS-DV program served clients from teen to 70+ years of age and a wider range of income, while SMSB predominantly addressed the needs of a particularly vulnerable population of child-bearing aged (20-40 years), socioeconomically challenged women *(Table 7)*.

The majority of clients referred to SMSB were non-white women (63% African American, 11% Hispanic) with limited economic resources (84% T19) and high school education or less (60%). The majority of SMSB clients lived in Milwaukee ZIP codes with the highest infant mortality rates[39,40] *(Fig. 7)*.

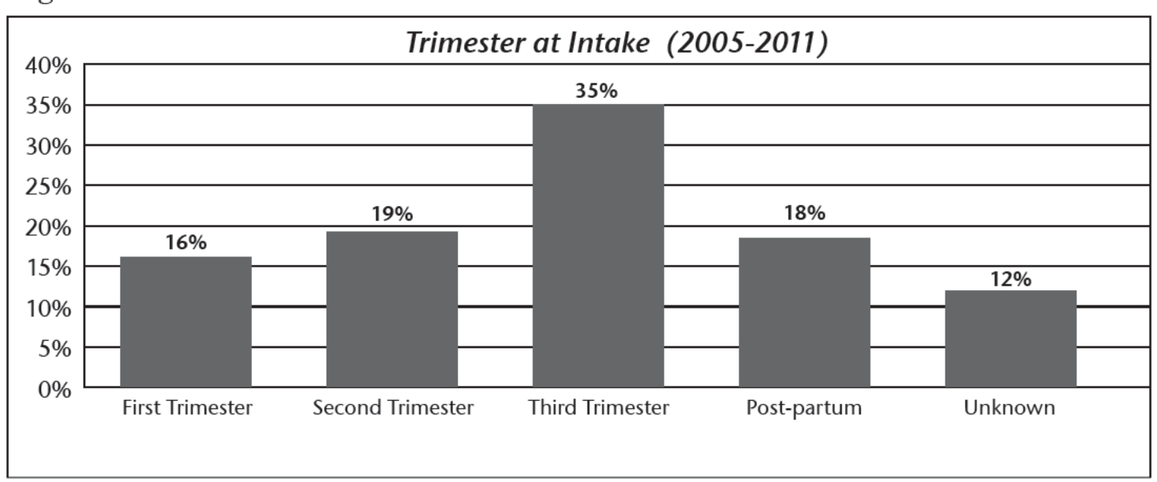
The SMSB clients reported experiencing multiple forms of abuse: physical, emotional and to a lesser degree sexual and financial abuse. Despite efforts that encouraged women to disclose abuse and enter SMSB early in their pregnancy, the majority of clients disclosed abuse and/or agreed to enter the program in their third trimester of pregnancy *(Fig. 8)*.

Fig. 7



Safe Mom Safe Baby Clients by ZIP Code

Fig. 8



Appendix A: ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012) (cont.)***

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/ Publication*
2008-2011	**SMSB**	1.0 FTE CNS (.2 fte in-kind to SMSB) (Alice Kramer) SMSB: .5-1.0 FTE NCM (Tina Watts) and 1.0 FTE DV Advocate (bilingual and bicultural) (Connie Medina) Faculty Advisors: MD/ Midwife (Tina Mason Jackie Tillet)	Scope: Expand SMSB services and create sustainability plan Referrals: 50% AHC 50 % SFPC (but nearly 90% deliver at AHC) Expansion of referrals from clinics, pvt OB offices, WIC, W2, Pregnancy Centers Direct Services – Streamlining the case management model Education • Caregiver – Adding Resident online modules • Community – More Teen and Faith-based relationship abuse presentations Organizational – create AHC culture with expectation to address IPV • EPIC templates to document Preliminary integration with • Trauma-Informed Care • Integrated Medicine • Holistic Nursing Electronic Health Records • Cerner- Admission Database • EPIC - NEW – screening template NEW – assessment & intervention template	Funding: 3 yr grant #2 from UW Madison School of Medicine and Public Health – WI Partnership Program (WPP) WPP - $362,691 In-kind: ~$230,000 • AHC • SFPC Limited funding from: • Office of Justice Assistance $40,000 • Private Donor $25,000 • Pickar Institute- OB Residency education $13,462 • Aurora Partnership Campaign $6,000	Kramer, A. (2008, Sept). *Health care responds: The prevention and treatment of IPV perinatal settings.* Paper presented at the International Conference on Violence, Abuse, & Trauma. San Diego, CA. Watts, T. (2009, Oct). *SMSB collaborative model of care for pregnant women experiencing IPV: Expanding and sustaining.* Poster presentation at National Family Violence Prevention Fund-Health Care Conference. New Orleans. Kramer, A., & Watts, T. (2010, Oct). *Healthcare and domestic violence advocacy partnerships.* Paper presented at Wisconsin Coalition Against Domestic Violence: Advocacy in Urban Communities Summit.

Appendix A: ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012) (cont.)***

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/ Publication*
2005-2008	ARS – DV added the *Safe Mom Safe Baby* (SMSB) components Advisory Team: Admin, Nursing, MD, SW, Loss Prevention, Philanthropy, Grant Development Faculty Advisors: MD/Midwife	1.0 FTE CNS (.2 fte in-kind to SMSB) (Alice Kramer) SMSB: 1.0 FTE NCM (Tina Watts) and 1.0 FTE DV Advocate (Nancy Wilkinson)	Scope: Design and Implement SMSB services to pregnant and recently delivered abuse women Second ARS office at ASMC near Women's Health Clinic & Office at SFPC also (see below) Collaborative model of care – Team of nurse case manager (AHC) and DV advocate from community DV agency (Sojourner Family Peace Center) Referrals: 80% perinatal areas in AHC hospitals, clinics, pvt offices & 20% community (SFPC) Continuum of care across • healthcare settings • criminal justice, police, social service agencies • community and home settings Education: • Perinatal caregivers • Community - teens Organizational • Infant Mortality Initiatives • Advanced screening tools	Funding: 3 yr grant #1 from UW Madison School of Medicine and Public Health – WI Partnership Program (WPP) WPP - $448,529 IN-kind: $155,836 • AHC • SFPC	Kramer, A. (2007). Stages of change. Surviving intimate partner violence during and after pregnancy. *Journal of Perinatal and Neonatal Nursing,* 21[4], 285-295. Presentations by: Kramer, A., & Watts, T. – (2007, April). *Violence threatens health of pregnant women and newborns: A toolkit for developing effective responses in perinatal settings.* Wisconsin Assoc of Perinatal Care Madison, WI. - (2007, October). *Safe Mom Safe Baby collaborative model of care for pregnant women experiencing intimate partner violence – 2 year summary.* Nursing Network on Violence Against Women International Conference. London, Ontario, Canada.

Program Processes and Services

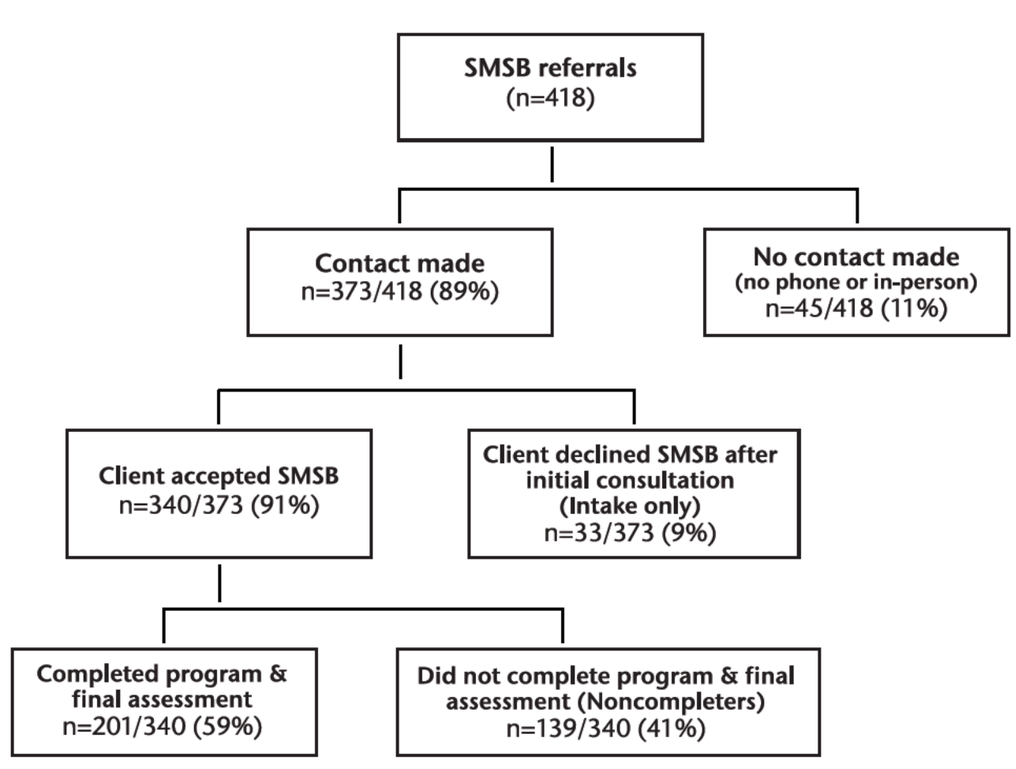
Client empowerment, emerging thorough assessments and mutually-determined interventions are the focus of the SMSB program. In essence, the client is in charge of the process, with her autonomy and strengths acknowledged and respected. She decides the level of assessment and intervention that she is willing to engage in with SMSB team members.

The participation of clients within the SMSB program varied *(Fig. 9)*. Of the 561 referrals to SMSB, 494 (88%) clients were contacted. No contact was made with 12% of the clients due to the referral being made after hours when the SMSB staff had not made personal contact with the patient at the beginning, and/or the client had no phone or means for being contacted. Ninety percent of those 494 clients agreed to enroll in SMSB and received an initial consultation and intake assessment. All were then offered the full range of SMSB services. Ten percent of clients (n-48) declined further services beyond assessment and one-time advocacy/crisis intervention (intake only).

Of the 446 women electing additional SMSB services, 237 (53%) received a comprehensive assessment and completed the full SMSB program (completers), while 209 (47%) received various aspects of the program but declined further services at some point without completing a final assessment

Fig. 9

Safe Mom Safe Baby: Client Participation 2005-2010



(non-completers). The completion rates were similar whether the client referral originated through a health care (nurse case manager) or community setting (DV advocate).

A comprehensive assessment process includes a discussion of the nature and extent of the abuse. This seven part assessment is guided by the use of five instruments with established reliability and validity *(Table 8)*. Several instruments used in SMSB are based on the groundbreaking work of nurse researchers such as Dr Judith McFarlane and Dr. Barbara Parker, reported in *Safety Behavior Checklist*[18] and *Abuse Assessment Screen (AAS)*[46]; Dr. Jacquelyn Campbell, reported in *Danger Assessment*[52], and Dr. Jacqueline Dienemann, reported in *Domestic Violence Survivor Assessment*[17]. To promote the privacy and safety of women served, all client-specific data are treated as confidential.

The comprehensive assessment usually reveals a myriad of stressors, risk factors and challenges in the pregnant woman's life. The SMSB team and client work together to identify the stressors needing immediate attention; they also identify stressors that can be addressed later. The stressors associated with poor birth outcomes, such as IPV, insufficient food, lack of transportation, addiction and mental illness are usually identified by clients as priorities in need of change.

Every client of SMSB, regardless of their initial referral source, has the benefit of both the nurse case manager and advocate services. A time study was conducted in 2008 to better understand the unique and overlapping roles of this effective and efficient partnership *(Fig. 10)*. The nurse case manager provided direct services to clients within health settings and had more responsibilities for caregiver education and program development while the DV advocate provided predominantly direct service and advocacy to clients within the community. This pattern of role accountability continues within the program. The distribution of SMSB services to individual clients is determined by appropriateness, expertise, and availability. Team members communicate regularly to assure timely, comprehensive and integrated services.

Table 7
SMSB Clients Demographics
(2005-2011)

	Number	Percent
Under 18	16	2.9
18-19	51	9.1
20-21	91	16.2
22-25	164	29.2
26-30	131	23.4
31+	89	15.9
African American	355	63%
White	97	17%
Hispanic	63	11%
Unknown	32	6%
Other	10	2%
Pacific Islander	3	1%
Native American	1	0%
Unknown	19	3.4
Less than HS	119	21%
HS or GED	216	39%
Some College	64	11%
College	9	2%
Unknown	153	27%
Private	25	4%
Medicare	4	1%
Medicaid (T-19)	473	84%
None	5	1%
Unknown	54	10%

Appendix A: ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012) (cont.)***

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/ Publication*
2002	Advisory Team: Admin, Nursing, MD, SW, Loss Prevention, Philanthropy		Research Study (2002) re: Intimate Partner Violence (IPV) at AHC IRB-approved study with two primary objectives. #1 quantify the prevalence of IPV within AHC patients (n = 1,268) accessing 5 emergency dep and 19 primary care clinics. #2 increase knowledge about the impact of IPV on the health of adult women. Survey results, anecdotal data, and scientific findings emerging from the professional literature alerted ARS leaders to the need for a dedicated program addressing the complex problems of women experiencing IPV.	AHC – Marketing and Business Development	Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency department and primary care clinics. *Women's Health Issues,* 14[1], 19-29.

Appendix A: *Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012)*

Year	*Programs*	*Personnel*	*Scope*	*Funding*	*Dissemination Presentation/ Publication*
1991-2000	Informal DV services at ASLMC		Developing champions w/ Ed Howe (Aurora CEO), Social Services & MWC-Safe At Home Grant		Unit specific education at ASLMC and SAH workshops Metro Region
October 2001	**Domestic Violence** components of ARS formalized and integrated with SATC and HC	1.0 CNS (Alice Kramer)	Office at ASMC with SATC Referrals from caregivers, managers, social workers and physicians, self-referrals Services across Mid Market to hospitals, ED, clinics, home care • Direct Care (crisis intervention and advocacy) to patients/ employees • Collaboration with Social Services and EAP Caregiver education • Formal presentations • Unit specific mentorship • E-learning Organizational leadership • Policy & Procedures • Standards of Care	.85 FTE AHC .15 FTE VOCA	Kramer, A. (2002). Domestic violence: How to ask and how to listen. Nursing Clinics of North America, 37[1], 189-210.

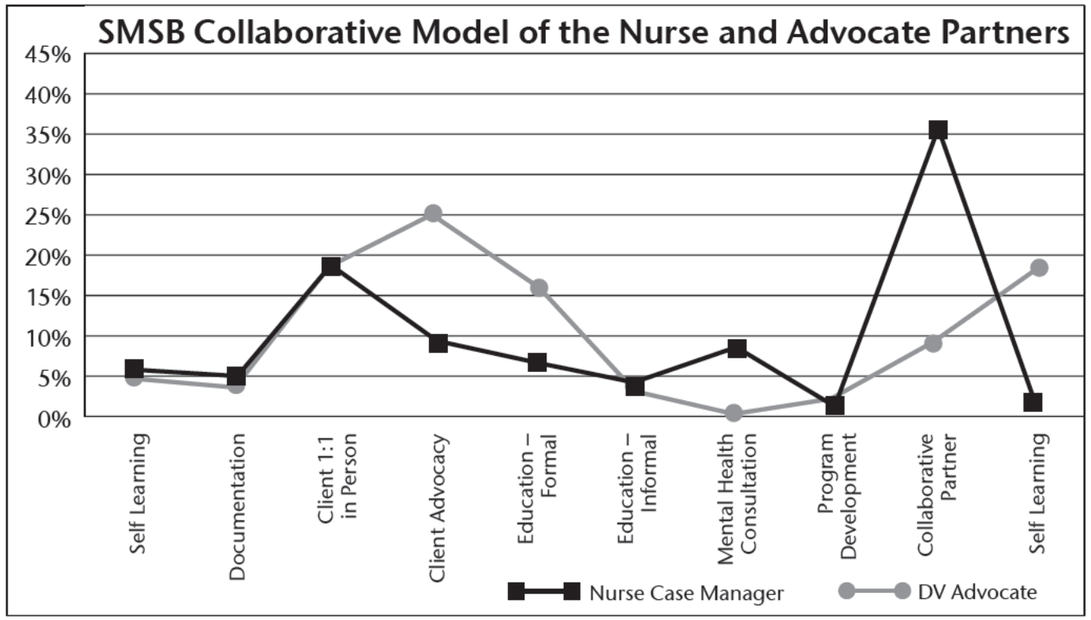
Table 8

SMSB Data Collection

Instrument	Description
Intake Form	Captures demographics, abuse history, risk factors and support services currently used.
Data base	Database is shared by CNS, RN case manager, domestic violence advocate, and statistician.
Abuse Assessment Screen[19] (AAS)	Five questions for use with pregnant women experiencing IPV. Determines the frequency, severity, perpetrator and body site of injury that occurs within a stated period of time. It has reliability, criterion-related validity and content validity with minority women.
Danger Assessment (revised)[52] (DA)	A valid instrument designed to assess the likelihood of lethality, or near lethality, occurring in a case of IPV. The DA is meant to be a collaborative exercise between SMSB staff and the client, as her perception of risk is important in developing a safety plan.
Safety Behavior Checklist[18] (adapted) (SB 1 & 2)	Determines the woman's use of safety behaviors. It was expanded for SMSB. Scoring is based on the number of items applicable to an individual client at the time. The safety checklist is discussed informally with clients and safety planning is done frequently to ensure that the client is aware of all their options as their safety situation changes. The number of times that a safety plan is discussed is directly related to their individual situation.
Domestic Violence Survivor Assessment[17] (DVSA 1 & 2)	A reliable and valid instrument used to guide abused women and caregivers as they traverse the decision-making process of seeking safety and non-violence. It provides measure of intermediate goals to demonstrate the effectiveness of interventions. DVSA delineates five stages of readiness for change (i.e., pre-contemplation, contemplation, preparing, action and maintenance). Range of scores is 1.0 to 5.0. Comparative scores are assigned at beginning and end of SMSB services.
HANDS[53]	The purpose of the HANDS screening (10 items; range of scores is 0-30) is to provide early detection, education and intervention for clients who may be experiencing symptoms of a depressive disorder. The screening asks participants if they have experienced any of the following conditions within the past two weeks. Participants can then choose from a series of four responses for each item that best describes their personal experience and enter a mark in the corresponding box.

Note: Instruments are presented in the order used during client encounters.

Fig. 10



The nurse case manager is an expert nurse with strong perinatal caregiver relationships that make her ideally suited to assist with the client's medical needs and create safety plans within health care settings. Additionally, the DV advocate has extensive experience in the field of adult and child abuse and helps the client navigate the myriad of legal and social service systems in the community. Both SMSB partners are comfortable providing services within health care and community settings. The nurse case manager is of African American descent; the advocate is Latina and speaks English and Spanish. Both team members live and work within the communities where most SMSB clients reside. Their insights into the diverse needs of clients, and their skillful formal and informal communication with interdisciplinary providers, have greatly enhanced the providers' cultural and ethnic sensitivity and overall program effectiveness.

By design, most clients complete the SMSB program by six months post-delivery. Some exceptions are made, however, to work with clients longer if they have ongoing high-risk medical and/or safety needs. A small number (n = 20) have returned to the program with another pregnancy and were in the same or new abusive relationship.

The extent of *Safe Mom Safe Baby* services for each client depends how early in their pregnancy the client enters the program and the complexity and urgency of her needs. Approximately half of SMSB clients received intensive and frequent contact (2-3 times per week for months). The remaining half had needs that spanned the continuum *(Table 9)*. For example, some clients' needs were addressed successfully through occasional phone conversations, while other women needed a one-time, day-long involvement that helped them relocate to emergency shelter out of state. All clients received in-person services with either/both the nurse or the advocate.

Appendices

- **Appendix A:** ***Abuse Response Services (ARS) – Domestic Violence Overview Timeline (1991-2012)***
- **Appendix B:** ***SMSB Interdisciplinary Team***
- **Appendix C:** ***Presentations, Publications and Awards***
- **Appendix D:** ***Abuse Response Services and SMSB Funding***
- **Appendix E:** ***SMSB Client Interviews***

Summary

Aurora Health Care is proud of the dedication and vision of its nurse leaders and change agents in the design, implementation and ongoing success of Abuse Response Services and the *Safe Mom Safe Baby* program. They have sensitized and embedded a cultural expectation within our organization for recognition and response to this critical public health issue.

Different from other disciplines, nursing brings a holistic perspective to the lived experience of people who are impacted by abuse and violence. The nurse leaders of ARS-Domestic Violence and the *Safe Mom Safe Baby* program have been able to bring their insider knowledge and experience of health systems together with their collegial relationships with community intimate partner violence partners to create trauma-informed environments of skilled health care and agency providers. These nurse leaders are exquisite in their ability to mentor and educate all levels of providers and communicate across systems. The management style continues to be inclusive, participative and client centered. The nurse case manager has completed her BSN, completed the Aurora Leadership Academy and begun her graduate studies in nursing during her six years with SMSB. The grant program director received two state recognitions for leadership in women's health and domestic violence.

The image of nursing is greatly enhanced throughout our community because of this collaborative model of care. The ARS-DV clinical nurse specialist and the nurse case manager have been diligent in sharing their findings and experience and have a known presence at the local, state and national level of nursing. See *Appendix E* for summary of publications and presentations. The *Safe Mom Safe Baby* program can be replicated using a toolkit, and their experience with the sustainability planning process will be useful to the larger public health community.

This track record demonstrates a commitment to communicating to the public health and nursing communities. Further, the engagement of two academic partners (physician and certified nurse midwife), Aurora's Nurse Research Center, a sustainability planning process and the evaluation expertise of the Center for Urban Population Health gives the Abuse Response Services *Safe Mom Safe Baby* program significant academic research strength and increases the understanding of effective interventions, generates new knowledge, and contributes to public policy discussions.

Examples of SMSB team interventions include:

- Collaboration with financial assist to secure insurance coverage, eligibility for services
- Quick assess to a perinatal provider, medical excuses, medications, flexible office visits based on unique client safety needs
- Transportation for health visits and to resource centers to get clothes, furniture
- Accompaniment to appointments (i.e., WIC clinic, court dates)
- Unique safety plans within the health care setting that respect the patient's decision-making while enhancing the safety of staff and the newborn
- Assisting patient to determine her own plan of care when abusive partner is interfering with decisions related to use of pain meds during labor, breastfeeding, future birth control
- Securing a restraining order from the bedside in the hospital or clinic
- Assistance to find affordable housing or a DV shelter
- Rapid response to relocate client and newborn out of state
- Coordinating community meetings with Child Protective Services, school counselors, public health nurses, guardian ad litem on behalf of teen mother being abused by parent
- Emergency funds for clothing, portable crib, rent, moving expenses
- Supportive services to children who have witnessed abuse
- Securing housing for other children while mother is in labor
- Advocating with police when their services have not been helpful or protective
- Accessing client to support groups, counseling, addiction and mental health services

Table 9
SMSB Services (2005-2011)

Intensity/Frequency 2008-2010 *Closed cases only (n = 186)*		
	Limited/ Episodic	**Consistent/ Continuous**
Minimal/ Infrequent	1 (60%)	1 (1%)
Consistent/ Complex/Intense	17 (9%)	57 (31%)

Spheres of Influence: Outcomes

Each quarter, the *Safe Mom Safe Baby* team formally evaluates program-related processes and assesses the extent to which the program is achieving its mission and purpose. The goals of the program are threefold:

1. Create a supportive healthcare environment with skillful and compassionate caregivers
2. Enhance client safety
3. Influence organizational and community policy that enhances the health and well-being of abused women

It is a challenge to evaluate the impact of clinical programs like SMSB designed to address complex, client-specific, multi-faceted issues among highly mobile and vulnerable women. Despite this challenge, the SMSB team remains committed to collecting data and considering data trends when making decisions for this clinical program. Descriptive statistics and client interviews from the perspectives of both the clients and providers are used to illustrate outcomes of the SMSB program.

An example of one client's situation and services provided by the SMSB team:

T was a 19-year-old first-time mother being seen in one of Aurora's women's health clinics. After being asked about abuse, she finally felt safe enough to tell her provider that the father of her baby was hitting and screaming at her. She agreed to speak with the Safe Mom nurse who met with her in the clinic for an hour. Together they identified an immediate need for transportation to her prenatal visits since her boyfriend was unreliable and often told her she didn't need to go to the doctor so much. T was deeply ambivalent about her feelings for her boyfriend; however, she was willing to work closely with the nurse to develop a safety plan in her home and begin a discussion about the pending delivery and safety of the baby. The advocate arranged transportation for the client and low cost clothing for the baby. The nurse assisted the nursing staff on the L&D unit with safe visitation of the baby by the abusive father without contact with the mother, per her request. After the birth of her healthy newborn and seeing that the boyfriend was becoming even more controlling, T identified the need for more protection. The advocate helped her obtain a temporary restraining order from the bedside in the hospital. They were able to help her find safe housing outside of the abusive relationship after discharge. T now has hope of a future without abuse.

Caregiver Outcomes

It is crucial that providers integrate assessment of IPV into perinatal care for all women. Several research studies indicate that abuse during pregnancy may be more common than gestational diabetes, neural tube defects, and pre-eclampsia, yet less than half of reproductive health care providers routinely screen for domestic violence or sexual assault[4,7,8,11,16]. Health care affords critical opportunities to promote safety in women, and abuse survivors state a willingness to engage in this discussion. Education and ready access to SMSB resources have resulted in high levels of perinatal provider screening and client disclosure of abuse.

The SMSB program has embedded the recommendations of the American College of Obstetricians and Gynecologists for screening abuse at least at every trimester and postpartum. The effectiveness of a two-minute screening, the Abuse Assessment Screen (AAS,) for early detection of abuse of pregnant women has been established[19]. IPV screening takes skill, commitment to prevention and persistence on the part of the health care provider, as it may take as

Organization/Community Outcomes

Safe Mom Safe Baby nurse leaders have created structures that bring people together and they are actively engaged with initiatives looking to affect policy change to expand abuse response services to women of all life stages, both in Milwaukee and statewide. The SMSB grant program director has been a board member on the Wisconsin Coalition Against Domestic Violence and is an active member of their statewide Health Care Task Force, as well as a member of the Office of Justice Assistance – Violence Against Women Advisory Team. She is a founding member of the leadership team to develop the *Milwaukee Consortium of Health Care Systems Responding to IPV* where all five health systems in Milwaukee participate. The SMSB nurse case manager is an active member of the United Way of Greater Milwaukee – Teen Pregnancy Prevention Oversight Committee and the Wisconsin DHFS Advisory Committee on Racial Disparities on Birth Outcomes.

Realizing that health care systems alone could not have sufficient impact on the safety of abused pregnant women, SMSB designed its services to provide coordinated services across the continuum of outpatient/inpatient health settings and the community in which the pregnant woman lives. Partnership is a core value of the SMSB program – centered on the client and collaborating with physicians, residents, midwives, nurses, students, social workers, security and other caregivers, as well as IPV agencies, criminal justice, law enforcement, etc.

The continuous quality improvement team includes the expertise of statisticians/researchers in the Center for Urban Population Health. The team utilizes chart reviews, analyzes other relevant sources of secondary data, collects primary data via key informant interviews with both providers and clients, tracks referral patterns of providers, conducts a quality improvement process, manages SMSB data, performs statistical analysis, and reports progress on an annual basis to the advisory team. Cost-effectiveness is evaluated via data about time/effort by staff members and client utilization of the program's services. The *Safe Mom Safe Baby* program can be replicated using a toolkit, and their experience with the sustainability planning process will be useful to the larger public health community.

Conclusion

The *Safe Mom, Safe Baby* program has made gains in addressing the complex problem of intimate partner violence during pregnancy. These gains reflect the impact of the collaborative care delivery model, particularly how the model supports clinical integration and promotes synergy among the unique resources and skill sets of the health care system and community domestic violence agency. Positive health and safety-related outcomes for women and their infants are being achieved, and the staff of health care and domestic violence organizations are benefitting from the program's consultation and educational services.

These encouraging birth outcomes may relate to the priorities of the SMSB team. The nurse case manager and domestic violence advocate focus their interventions on many of the stress factors in the pathway to preterm birth that can be exacerbated by issues of money, work, relationships, health, abuse, safety and racism *(Fig. 5)*. These providers understand that psychosocial stress can lead to behavioral risk factors, and that behavioral risk factors impact biological risk factors and increase the likelihood of preterm birth. Taking a proactive approach to reducing the impact of IPV on pregnancies, thus increasing safety and reducing abuse, appears to be an important piece of the complex puzzle of improving birth outcomes in this community.

Client Feedback

As part of the SMSB process improvement program, two IRB-approved qualitative studies were conducted with 13 SMSB clients[61,62] *(Appendix E)*. Key informant interviews were conducted to provide program process evaluation and assess the extent to which the program is carrying out its intended purposes. Clients perceived that the most useful aspects of the program were the ability to speak candidly about their abuse experiences, the establishment of trusting relationships with SMSB staff, increased social support, and reliable linkages to needed resources. The women also expressed that they appreciated the SMSB staff's ability to help them better understand the dynamics of the abusive relationship. Clients perceived that this increased understanding enabled them to take action. Overall, clients were highly satisfied with their SMSB

Table 12

Birth outcomes for SMSB at ASMC and AWP (2008-2011)

Low Birth Weight (less than 2400 grams)

	Safe Mom Safe Baby	Aurora Sinai Medical Center	Aurora Women's Pavilion	City of Milwaukee
2008	3 7.5%			1128 9.97%
2009	8 13.3%	405 13.90%	224 6.50%	
2010	3 15.8%	364 13.60%	199 6.77%	

Preterm Births (less than 37 weeks)

	Safe Mom Safe Baby	Aurora Sinai Medical Center	Aurora Women's Pavilion	City of Milwaukee
2008	5 12.5%	392 14.0%	308 9.1%	1626 14.4%
2009	8 13.3%	403 13.87%	298 8.65%	
2010	3 15.8%	381 14.05%	301 8.67%	

experiences and believed strongly that the program should continue. They also recommended expanding program resources and heightening visibility of program services within the community.

> *"The SMSB program has proven invaluable for our patients and for our midwives. We know that when a woman discloses a problem with violence, we have a coordinated team to assess her needs and offer her help and safety. The midwives are more productive and the patients are better served. Asking about interpersonal violence ... increases patient engagement. ... All women feel safer and better served in an environment that appreciates the lives that women live."*
>
> ~ Nurse Midwife

many as six interactions with a health care provider for an abused woman to disclose the violence.

Prior to SMSB, health care providers stated that the lack of readily available support services was a major deterrent to their willingness to screen for IPV. Effective screening requires follow-up with the interventions provided by SMSB that empower clients to engage in planning to reduce risks and increase safety.

Table 10

Domestic Violence Survivor Assessment (DVSA) Scores: Entry vs. Close

	Number of Clients	DVSA score at Entry	DVSA Score at Close
All years combined	239	2.86	3.56*
2005	15	3.34	3.99
2006	32	3.15	4.39*
2007	40	2.7	3.65*
2008	38	2.99	3.89*
2009	64	2.65	3.15*
2010	38	2.73	3.01
2011	12	3.18	3.39

**Significant at p<0.05*

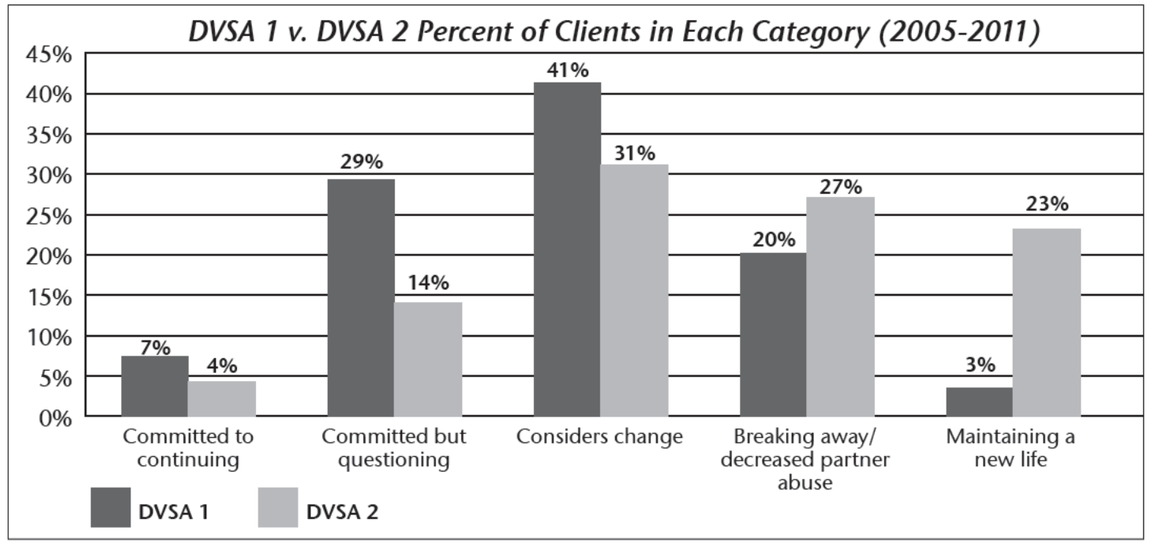
Provider education, a simple, effective screening tool, evidence-based approaches and accessible SMSB referral services predisposes Aurora providers to screen for IPV. Screening predisposes abuse survivors to increase awareness, self-efficacy, movement from pre-contemplation to contemplation regarding IPV and adoption of more safety behaviors.

Client Outcomes

It is important to note that SMSB team members elect not to use outcome measures related to re-victimization rates such as injury rates or danger assessment scores. Re-victimization rates and danger assessment scores often measure the behaviors of the perpetrator, not the victim. Instead, SMSB staff looks at client feedback and measures of client behaviors that indicate changes in the woman's readiness for change and adoption of safety behaviors. These indicators have proven useful in guiding program interventions, and help the SMSB team focus on the clients' safety-enhancing behaviors.

Given the myriad of challenges that women experience within an abusive relationship, evaluating a woman's readiness for change is complex. Prochaska and DiClemente offered the *Transtheoretical Model,* also known as stages-of-change, as a useful way to understand the

Fig. 11



experience of individuals considering major life changes, modifying a problem behavior, or acquiring a positive behavior[54,55]. Creating change within an abusive relationship has only recently been conceptualized within the context of the stages-of-change model[56-60] and has provided practical utility in several recent studies, as well as SMSB when considering stage-based interventions that assist women toward healthier behaviors and lives free of abuse.

The program's impact on clients' readiness to initiate significant life changes is measured using the Domestic Violence Survivor Assessment (DVSA) instrument[17] which clients complete when entering and completing the program. Two hundred and thirty-nine clients had scores for the DVSA at entry and at completion. The median for DVSA stage-of-change readiness at program entry was 3; the median DVASA stage at program completion was 4. This change from 3 to 4 is statistically significant when measured using a Wilcoxon Signed Ranks test (T = 264.5, p = .000, r = -0.58) and suggests that clients receiving SMSB services grow in their readiness to initiate significant life changes. This pattern has continued over the years of the SMSB program *(Table 10)*. In Fig. 11, you can more visually appreciate the significant progression of clients from contemplation toward action, a shift to the right.

Over half of *Safe Mom Safe Baby* clients completing both an entry and exit DVSA progressed one to four levels toward action and maintenance of violence-free relationships. The remaining 46% remained at their entry stage of readiness and 3% reverted to an earlier stage. It is important to note, however, that reversion to earlier stages of change or lack of forward progress is not indicative of women's lack of desire to achieve safety. Rather, this outcome may relate to long-held dreams, individual life circumstances, and the need to create change according to the client's timeline. Over time, SMSB team members have gained increased understanding of the complex dynamics of IPV during pregnancy: the tensions between women's illusions of their partner and home, and the reality of their intimate partner's abusive behaviors.

It is apparent in client interviews that they value the interventions of SMSB *(Appendix E)*. However, since the economic downturn began in 2008, program staff have noticed that clients are tending to increasingly prioritize their basic needs of housing, transportation and child custody over their willingness or ability to take action regarding their abusive relationship.

The complexity of client cases continues to unfold with multiple personal and social issues adding to the time, energy, resources and length of time that is spent with each client. The cumulative effects of a lack of stable income, housing, transportation and adequate system response, compounded by abuse, only increase the challenges for pregnant women. A period of only a few months of SMSB contact with abused pregnant women may not be enough to deal with problems that took years to develop. However, the progress that most clients do make toward safety, self-efficacy and empowerment attests to the value of *Safe Mom Safe Baby* interventions.

Adoption of Safety Behaviors

Since 2009, the Safety Behavior Checklist[18] (modified) has been used to calculate the total number of safety behaviors employed by the client at the time of SMSB program entry and program completion. Based on their experience and knowledge of the IPV-related literature, SMSB team members added 16 additional safety behaviors to the original 15-item instrument. This expanded instrument reflects the safety behaviors commonly used by abused women in their home, work setting and community. Scores on the Safety Behavior Checklist (modified) can range from 0 to 31.

Close monitoring of DVSA and Safety Behavior serves as a guide for the nurse case manager to adapt interventions to enhance the clients' willingness and ability to progress toward action and maintenance of safety. Overall, clients completing the Safety Behavior Checklist at the beginning and conclusion of SMSB services were performing an average of 24.9 safety behaviors at intake compared to 27.7 behaviors when leaving the program (p<.05) *(Table 11)*.

Table 11

SMSB Safety Behavior (SB) Checklist Scores (2005-2011)

Maximum score = 31

	Number of Clients	SB score at Entry	SB Score at Close
All Years combined	126	24.9	27.7*
2008	33	22.9	28.9*
2009	61	24.3	26.6*
2010	21	29.3	29.5*
2011	11	26.0	26.9

**Significant at p<0.05*

Birth Outcomes

Birth-related data were not available to SMSB team members for clients delivering at a hospital outside of Aurora Health Care due to data sharing restrictions. However, data from the Aurora birth certificate database related to gestational age and infant weight at delivery were available for 128 of the 418 closed cases. Nine of these clients with no program contact were deleted. Data was analyzed for the remaining 119 SMSB clients. Newborns weighing less than 2400 grams were coded as low birth weight. Infants with an estimated gestational age of less than 37 weeks were coded as preterm. Data in Table 12 indicates that SMSB clients are achieving comparable birth outcomes to the overall population of women delivering at Aurora Sinai Medical Center despite their increased risk for premature and low birth weight infants.