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Lessons about Recruiting Primary Care Practices to Domestic Violence Trainings

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INTRODUCTION

Despite a well-recognized need for domestic violence (DV) education for healthcare workers (Alpert & Cohen, 1997; Brandt, 1997; Cohn, Salmon, & Stobo, 2002; Council on Scientific Affairs, 1992; Garimella, Plichta, Houseman, & Garzon, 2000; Hendricks-Matthews, 1997; Reid & Glasser, 1997; Rosenberg, Fenley, Johnson, & Short, 1997), successfully implementing a DV training program within the realities of today's medical world can be a significant challenge. DV advocates and educators frequently voice frustration over failed attempts to

convince healthcare workers to attend training sessions. Studies evaluating the effectiveness of educational efforts have mostly taken place in medical schools (Ernst, Houry, Weiss, & Szerlip, 2000; Haist et al., 2003; Heath, Dyer, Kerzner, Mosqueda, & Murphy, 2002; Jonassen et al., 1999; Short, Cotton, & Hodgson, 1997), residency programs (Berger, Bogen, Dulani, & Broussard, 2002; Heath et al., 2002; Knight & Remington, 2000; Korenstein et al., 2003), emergency departments (Allert, Chalkley, Whitney, & Librett, 1997; Nelms, 1999), or staff-model health maintenance organizations (Thompson et al., 1998) where learners are often a "captive audience" with little choice whether or not to participate. Outside these settings, the feasibility and effectiveness of strategies to recruit health care workers for educational interventions about DV remains unknown.

A few studies have evaluated continuing medical education programs on DV, but they have generally used convenience samples and have not provided information regarding their recruitment strategies or the proportion of eligible providers that attended the interventions. (Davis, Kaups, Campbell, & Parks, 2000; Haney, Kachur, & Zabar, 2003; McCauley, Jenckes, & McNutt, 2003) In one study that did provide such information, investigators faxed invitations to 1887 physicians, of which only 121 (6%) responded that they were interested despite a \$50-\$100 incentive to participate in a short on-line program with free Continuing Medical Education (CME) credits (Harris, Kutob, Surprenant, Maiuro, & Delate, 2002).

We attempted to recruit healthcare workers from all primary care practices in

Washington County, Oregon to attend a DV training program. This paper uses our experience to demonstrate the challenges and successes of different strategies and make recommendations for future recruitment efforts.

METHODS

Training Project

Our goal was to improve primary care responses to DV by educating healthcare workers in Washington County, Oregon about DV and linking them with community resources. The project was a joint effort between the neighboring academic medical center and the local DV agency. All general internal medicine, gynecology, and family medicine practices in the county were eligible to participate regardless of profit status, affiliation, or size. Due to the heterogeneous nature of these practices, we allowed the management of each practice to decide which staff should participate in the training.

Healthcare providers and staff who enrolled in our project attended two hour-long training sessions based on the *Voices of Survivors* documentary and companion guide (Nicolaidis, 2000, 2002). The first session featured a 30-minute educational video created for primary care providers from interviews with DV survivors. The video was followed by a short discussion of participants' reactions as well as a review of statistics on the prevalence of DV and its associated morbidity and mortality. The second session consisted of a facilitated discussion on the clinical aspects of DV including assessment techniques, clinical predictors, counseling techniques, available resources, and documentation requirements. As part of the intervention, clinics also received resource materials from the local DV agency and an optional consultation to

optimize screening and documentation procedures.

Recruitment Strategies

We identified eligible primary care practices by searching a list of internists, family physicians, and gynecologists compiled by the Oregon Medical Association; lists of primary care providers accepting a variety of health plans; telephone directories; municipal Chambers of Commerce; and internet websites. No single source proved current and comprehensive enough to use exclusively.

After compiling a total list of 92 eligible clinics, we mailed invitation letters to approximately 30 providers in order to gauge a response. Each letter gave an outline of the project, listed available incentives, and included a flier promoting CME credit for physicians and physician assistants. Letters were printed on University stationery and signed by the principal investigator who identified herself as a primary care provider and the creator of the training program. A week after letters were mailed, we attempted to make follow-up telephone calls to those providers.

Faced with no response to initial mailings and phone calls, the project coordinator visited all 92 eligible practices to personally deliver an invitation letter to the office manager or other key contact person. All personal visits were followed up with one or more telephone contacts and an offer to give a short presentation about the training at a regularly scheduled staff meeting. If such attempts did not result in a scheduled training, the project coordinator made a second visit to redeliver the invitation letter along with an additional cover sheet pointing out the prevalence of DV in women who seek health care, the associations between DV

and morbidity, and the lack of response by providers.

In order to facilitate participation, we scheduled training sessions on-site at the convenience of each clinic. Clinics could choose two one-hour sessions back-to-back or on separate days. Some clinics chose to separate workshops between providers and staff. We initially set a maximum of 10 attendees per training session, but later dropped this rule to accommodate clinics that wished to use fewer sessions to train more staff. As an incentive for providers, we provided two hours of American Medical Association Category I CME credit for physicians and physician assistants. We also originally provided free lunches by soliciting nearby restaurants to donate food. As free lunches became increasingly more difficult to provide and did not appear to significantly influence whether or not practices chose to participate, we eventually discontinued this incentive.

At the end of the recruitment process, we mailed a brief survey to the managers of practices that declined to participate. The survey listed reasons why they may have chosen not to enroll in the program and asked them to mark all that applied. A choice of “other” was available where they could write in their own reason. We contacted practices that did not return the survey and asked the manager to complete it by telephone.

The entire project, including the recruitment protocol, training intervention, provider questionnaires, and non-participation survey, was approved by the University’s Institutional Review Board. Participants were asked to complete a workshop evaluation as well as pre- and post-intervention questionnaires on their knowledge, attitudes, and practices. Employees who did not complete written informed consent were

still allowed to attend the training, but did not participate in the evaluation component. Results of the evaluation component have been published elsewhere (Nicolaidis, Curry, & Gerrity, 2005).

RESULTS

We identified 92 eligible primary care practices, 31 (34%) of which enrolled in the program. Identified practices included non- and for-profit clinics, public clinics and private practices, and those located in both suburban and rural areas. The number of providers and staff at each practice ranged from one to several dozen. A total of 278 healthcare workers participated in the trainings and the evaluation study, including 70 (25%) primary care providers (physicians, nurse practitioners, or physician assistants); 121 (44%) medical support staff (nurses, medical assistants, social workers); 56 (20%) administrative staff (reception, billing); and 21 (8%) “other” employees (eg. community outreach workers). An additional 73 employees attended the trainings but did not participate in the evaluation study, most often because they had not received or had not completed the pre-intervention materials before the training session.

Mailing invitation letters to a number of eligible clinics produced no response. Telephone calls almost never reached the provider directly, and messages were rarely returned. Personal visits to the practices provided opportunities to promote the project with reception, meet spontaneously with the clinic manager, or identify a key contact person who could facilitate further communication. After these visits, several phone calls to the manager or key contact person were often necessary to ensure that the providers reviewed the letter, to clarify any

questions, and to check the status of their decision. In one case, we were invited to give a presentation for three managers who attended a health system regional meeting. On another occasion, we gave a presentation at a staff meeting of an eligible clinic. All four practices whose managers viewed the presentations enrolled in the project.

All 61 clinics responded to the brief telephone or paper survey about their reasons for declining to participate (Table 1 – *See Page 8*). Among the options provided, the most commonly marked reasons were “Could not set aside time for two-hour training” (N=16, 27%) and “Domestic violence is not prevalent in our patient population” (N=10, 16%). However, 23 managers (36%) answered “other.” Written or verbal responses as to the reason why they marked “other” almost all fell under the general theme that providers in the clinic were not interested or did not feel this training was a priority.

Discussion

Our project confirmed the general sense among DV advocates and educators that recruiting healthcare workers to participate in a training project on DV is difficult and time consuming. Despite intensive recruitment efforts, only 34% of eligible clinics participated in our project. On the other hand, we were successful in training over 300 healthcare workers from 31 separate primary care practices. As reported separately, the trainings were very well received (>90% of participants rating them excellent or outstanding) and resulted in significant improvements in participants’ sense of responsibility to assess for DV, respect for patient autonomy, empathy toward patients in abusive relationships, confidence, knowledge, and self-reported assessment behaviors (Nicolaidis et al., 2005). We are

unaware of any other published accounts of CME programs on DV that included healthcare workers from as large a number of unaffiliated primary care practices. Given the initial poor response to letters and phone calls, we believe that without our intensive recruitment efforts we would have been unable to train more than a handful of providers, if any at all.

Our experience is that providers did not respond well to mailed invitations or telephone calls. This is consistent with the low response rate seen with faxed invitations in the study by Harris et. al. (2002). Physicians receive large amounts of promotional mail and are likely to discard most of it without taking a closer look. Similarly, reception staff is often trained to take messages instead of allowing direct communication with providers. Providers typically receive many messages and are likely only to respond to those requiring prompt clinical attention. However, when accompanied by a personal visit and followed up with contact with a key staff member, the letter offered clinics a convenient introduction to our project and conveyed the professional relevance of the topic. Other incentives, such as free lunches, proved to be less effective than we had expected, potentially because clinics are accustomed to receiving lunches from pharmaceutical company representatives. Though food was always appreciated, we ultimately chose to use our limited resources to cover the personnel time required for recruitment.

Delivering an invitation letter in person allowed the project coordinator to engage the front desk staff in a dialogue. While these conversations were usually short, they provided a valuable opportunity to immediately respond to questions and counter what clinics perceived as obstacles to enrollment. For example, if staff said

the providers were too busy to participate, the project coordinator explained the option of splitting the training into shorter sessions and scheduling it during the lunch hour. When staff seemed unenthusiastic about the topic, we emphasized the prevalence of DV among primary care patients and the high ratings that participants had given our training in previous evaluations. We attempted to convey a first impression that highlighted the most appealing and least intrusive aspects of the project. The project coordinator often introduced himself as “part of a free program” sponsored by the university medical center, offering “outreach materials providing easier access to local resources” and “a free training held in your clinic and scheduled at your convenience.”

We also found that it was extremely valuable to identify a key contact person such as a clinic manager or other sympathetic employee. While providers usually decide whether a clinic ultimately participates, the clinic manager often determines if a project is worth bringing to the attention of the providers and follows through with making the necessary arrangements. A medical director may also take on this role, as can a private practitioner in a small clinic. Any staff member who is already trained on the topic or is sympathetic to DV issues in general may choose to act as an advocate. Coming across a sympathetic employee early in the recruitment process and enlisting their support can greatly increase chances that a practice participates. Often, the most important outcome of the first in-person visit was identifying such an employee. Though unlikely to grant access to a provider, front desk staff often introduced the project coordinator to the office manager or to an employee they knew had an interest in the topic.

Another important feature was maintaining a great degree of flexibility. Primary care practices are extremely heterogeneous in nature. We found that we had to be extremely flexible as to when and where we would schedule trainings, which employees we would include in the trainings, how many people we would train at a time, and how we could collect evaluation materials. A more rigid protocol would have prevented many practices from participating.

The intense recruitment efforts required by our project call into question whether or not Continuing Medical Education is a feasible way to address the need for DV training amongst healthcare providers. DV education may instead have to be incorporated into the mandatory curricula of undergraduate or graduate professional training programs or as part of employer-mandated training programs at large health systems. On the other hand, there is ample evidence that practicing providers and their staff still need continuing education about DV (Cohn, Salmon, & Stobo, 2002; Garimella et al., 2000; Reid & Glasser, 1997; Rodriguez, Bauer, McLaughlin, & Grimace, 1999; Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999).

We found that the most difficult barrier to overcome was providers' lack of interest in the topic. After participating in the program, however, over 90% of healthcare workers found the training worthwhile and stated that they would recommend it to a colleague. Our sample is biased in that they did agree to the training, but in many instances it was the office manager who made the decision and only after intense recruitment efforts by our project coordinator. It is unclear what would make providers more interested in learning about DV. One yet untested strategy is to incorporate DV

education into training programs on related issues that may be inherently more interesting to providers. Examples would include trainings on depression, anxiety, chronic unexplained physical symptoms, pain, chronic illness management, or medication adherence. If planning to conduct CME programs specifically on DV, however, one must not underestimate the challenge of recruiting participants. Projects may need to allot a significant amount of time and money to recruitment, and should plan on making multiple contacts with key office personnel before they can expect providers to agree to participate.

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TABLE 1

Reasons why practices declined to participate in training program	N (%)
Domestic violence is not prevalent in our patient's population.	10 (16%)
Our providers do not have enough time to address domestic violence.	2 (3%)
Addressing domestic violence is not within the scope of our practice.	2 (3%)
Could not set aside time for two-hour training.	16 (27%)
There are too many other trainings competing for limited time.	7 (11%)
It is unlikely that a training course would make it possible to adequately address domestic violence.	1 (2%)
Our staff has already had adequate training on domestic violence.	6 (10%)
Other* _____	22 (36%)

* The majority of write-in responses fell under the general theme that providers were not interested or did not see this topic as a priority.