(MUSIC)

Mark Masselli: This is Conversations on Healthcare I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret what a difference a week makes, things have been evolving rapidly in the wake of more American cases of Ebola. Two healthcare workers who contracted the virus from the patient have been moved and are now being treated at a highly specialized facility Emory University in Atlanta and the NIH Facility in Maryland.

Margaret Flinter: These are just a handful of cases but we know that public concern and worry of course is mounting.

Mark Masselli: And the administration in CDC are taking a much tougher approach to the outbreak.

Margaret Flinter: CDC Director Dr. Tom Frieden has issued additional guidelines on the use of the right kind of protective gear in the clinical environment if the patient have symptoms. They're recommending additional layers of protective clothing to minimize the risk of exposure to health workers and it should be noted Mark that while hospitals and healthcare facilities have protective what we called personal protective equipment. This is really very specific very protective clothing that has to be put on in a certain way taken off in a certain way and that requires training. And the nation's largest union that represents close to 200,000 nurses has issued really a stern rebuke to the healthcare system saying that, that level of training and protection just hasn't been made available to frontline nurses and the entire medical team.

Mark Masselli: Margaret you're right on target there the word training is the operative one and our hospital systems are not quipped. And top officials at Texas Presbyterian Health took responsibility for their flood initial response to the presence of Ebola in their hospital. He admits that mistakes were made but part of this is the lack of a national strategy around training hospital and healthcare workers.

Margaret Flinter: Well this one is something of a new challenge for the American healthcare system but all medical crisis have in common that there's an opportunity to learn quickly from mistakes and move to adopt best practices to prevent future breaks and to improve outcomes. And certainly it's pretty safe to say that we have a very solid healthcare delivery infrastructure here in the United States so I don't think we'll see an acceleration of outbreaks in this country but we just don't know exactly how this is going to unfold.

Mark Masselli: Meanwhile there's a epidemic of another kind that work in this country Margaret, October is national domestic violence awareness month. It's the second leading cause of death in women under 50.

Margaret Flinter: We know as people engage in primary care how complex this issue is. And we are so pleased today to have a guest who is a global expert on this topic.

Mark Masselli: That she is Dr. Jacquelyn Campbell currently serves as Co-Chair of the Institute of Medicines form on the prevention of global violence. She's developed a highly successful diagnostic tool for clinicians, law enforcement and patients determine their risk for further violence.

Margaret Flinter: The lethality assessment profile that she has developed is among one of the most highly regarded in the field Mark, Dr. Campbell has some great information on how providers as well as law enforcement might be better equipped to address the issue in their patients and in their communities.

Mark Masselli: And Lori Robertson joins us from FactCheck.org she's always on the frontline of misstatement spoken about health policy in the public domain.

Margaret Flinter: And no matter what the topic you can hear all of our shows by going to CHC Radio.

Mark Masselli: And always if you have comments please email us at chcradio.com or find us on Facebook or Twitter we'd love hearing from you.

Margaret Flinter: We'll get to our interview with Dr. Jacquelyn Campbell in just a moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

(Music)

Marianne O'Hare: I'm Marianne O'Hare with these Healthcare Headlines. The response to Ebola in West Africa and now on American shores has begun to (inaudible 3:49) up in the policy sector as well as the healthcare sector. The CDC is rethinking its approach to how best to contain infection should it become more prevalent in the US. The initial thinking was every hospital in the nation should be prepared to identify diagnose isolate and treat anyone suffering from Ebola infection. It may not be the best approach according to some experts who recently gathered at Johns Hopkins Bloomberg School of Public Health to discuss the Ebola epidemic. Now the thinking is there should be dedicated hospitals around the country who have full capacity for

isolation and quarantine as well as adequate systems to threat the illness of many if need be.

Meanwhile the scope of the outbreak in West Africa continues to confound global health officials. The World Health Organization warns there could be 10,000 new cases per week. Cuba has the largest national presence on the ground in three West African countries. Meanwhile there's a shortage of doctors in this country especially in primary care. The National Health Services Core has been around since the 1970s to address the shortage of primary care practitioners in rural settings and financial support for that program was increased to about a quarter billion dollars by 2015. But the money isn't guaranteed beyond 2015 and a number of organizations, the American Academy of Family Physicians, American College of Physicians and the American Nurses Association have all signed letters to congress urging them to keep the funding intact via next year.

And a missing link found in the quest to find a cure for Alzheimer's researchers at Mass General in Boston have grown disease brain cells being called Alzheimer's in a dish this cells can be grown quickly in a dish that allows researchers to test compounds quickly that can combat Alzheimer's its being held as a giant leap forward in the field. I'm Marianne O'Hare with these Healthcare Headlines.

Mark Masselli: We're speaking today with Dr. Jacquelyn Campbell the Anna D. Wolf Chair at the Johns Hopkins School of Nursing, she also holds -- she's an international expert on domestic and intimate partner violence and its impact on public health. Dr. Campbell is national program director of the Robert Wood Johnson Foundation Nurse Faculty, scholars she currently serves as Co-Chair on the Institute of Medicines form on the prevention of global violence. She's won numerous awards including the American society of criminology Vollmer Award and serves as Chair of the Board of Directors of Futures Without Violence. She earn her BS in nursing from Duke and her PhD nursing from the University of Rochester, Dr. Campbell welcome to Conversations on Healthcare.

Dr. Jacquelyn Campbell: Thank you I'm delighted to be with you.

Mark Masselli: Well, you know, October is National Domestic of Violence Awareness Month, an important time to examine the issues and before we dive into the assessment models you've developed could you give our listeners an analysis of the (inaudible 6:39) prevalence of domestic violence in our culture?

Dr. Jacquelyn Campbell: Well unfortunately at least 30% of women in this country have experienced physical violence and or sexual assaults or stalking from a husband, boyfriend, ex-husband, ex-boyfriend or same sex partner or ex same sex partner sometime in their lifetime, so all too common.

Margaret Flinter: Well Dr. Campbell because it's so common it is critical that in healthcare people on the frontlines be very tuned to the possibility of intimate partner violence. But how effective have we been at getting primary care providers to screen for intimate partner violence to recognize it and what are the science and symptoms beyond physical manifestations that provider should be alert for and thinking about whether a women might be at risk or experiencing violence?

Dr. Jacquelyn Campbell: Well we have found where primary care providers do assess for domestic violence we get far more disclosure of domestic violence when they actually ask. We have been successful in increasing our screen practices in primary care when first of all the providers are trained and doesn't have to be a long training but at least a some sort of a brief training about the importance of doing this, also when the providers know that there's someone in their system that they can help get an abuse women to talk to. So it's very important for them to know who within their system is able to help them if it's a very difficult kind of a situation which is often is. We also find that is helpful if there is -- in the well women's visit coverage insurance coverage for the time that you spend doing some brief counseling with someone who is abused. And you said, you know, what should we be alert for or we know that abused women are much more likely to be depressed than other women. We know that women who are abuse have a whole variety of healthcare problems especially things like chronic pain. So we find it's much more important to ask everyone and then we don't have to think about oh should I be asking this person versus that person.

Mark Masselli: Dr. Campbell during your early days working as a nurse you recognize that the healthcare and law enforcement communities needed a better risk assessment tool to intervene on behalf of battered partners and especially in determining which battered domestic partners were more likely to experience future lethal harm. And your works evolved to the development of the lethality assessment profile and what's different about this new assessment tool and how much uptake has there been in law enforcement communities around the country?

Dr. Jacquelyn Campbell: Well first I developed the danger assessment which is an instrument that a women can do herself (inaudible 9:51) there's actually an app for that, that helps her see for herself how much danger she's in. It's even better done with a domestic violence advocate at a advocacy organization or by a social worker or a nurse in the healthcare system then they would go on to have the danger assessment done with them which is very accurate and helps pinpoint the actual level of danger for each women. The LAP which is a Lethality Assessment Program was developed by the Maryland Network against domestic violence along with myself and domestic violence advocates. And it is a short form of the danger assessment that was meant to be asked by first responders law enforcement when they are called to a scene of a domestic violence incident. It's somewhat less detailed than danger assessment itself and so

therefore it's very user friendly for a first responder a police officer the officer makes the phone call to the domestic violence advocacy organization and actually helps the victim get on the phone with that organization right there, right then. What police officers usually do is give domestic violence victims a phone number to call and they often times don't follow up on that. So we know we have good day to the show that it's much more effective if the police officer actually gets the victim in touch with that domestic violence advocacy organization right then on the scene. So we have the Maryland Network has been incredibly successful at getting the LAP in use across the entire state of Maryland. We've also been very successful in getting it in use in the state of Oklahoma. So now the Oklahoma legislature has passed a law that the LAP is to be used throughout the state of Oklahoma.

Margaret Flinter: Well Dr. Campbell, Mark and I have the pleasure of leading a statewide community health center one of the very few in the country I think that also operates a domestic violence shelter and full community intervention program so I want to give a shout out to our director **Michelle Walder [PH]** who I know is been working hard in Connecticut to get the lethality assessment profile adopted here. But I like to ask you about another dimension of this issue the issue of reporting or mandated reporting I'd be so interested in your perspective on this what sort of the state of the country in terms of mandated reporting and some of the arguments against that or for that as a case maybe.

Dr. Jacquelyn Campbell: Part of the issue with that and we did a whole series of research studies both to see what abused women thought about that. And actually the majority of abused women said this, I would prefer that the healthcare provider offered to call the police but that it should be up to me and whether or not the police get called in on a case because only I know if this could be harmful to me. A lot of women of color know that their partner for instance has had some other legal action against them and if they have one more arrest for something this is going to mean significant jail time for them. She wants the abuse to end but not necessarily this abuser go to jail, so it's a complicated decision for her to make now on the other hand obviously as providers we have to obey the law. So if it is an assault with a weapon or where someone has for instance been choked or strangled to unconsciousness in those kinds of cases the police have to be called. But for other kinds of abuse in most states as you said California been the big exception also Kentucky where healthcare providers are not mandatory reporters of the whole range of abuse of tactics. As providers we need to do two things, we need to remember to offer to her to call the police for her because often times when the emergency department and the police can be brought in to talk to her in privacy. We also as providers use something like the danger assessment to see, you know, if she's at high risk for lethality then I as a clinician would be a lot more assertive.

Mark Masselli: We're speaking today with Dr. Jacquelyn Campbell the Anna D. Wolf Chair at the Johns Hopkins School of Nursing. She's an international expert on domestic and intimate partner violence and develop the lethality assessment profile use to predict ongoing risk for intimate partner violence. You know, Dr. Campbell talk to us a little bit about politics of this of how this is grabbing on, it's really about making sure as you say that the three pillars that you want to do is to improve safety health and wellbeing are all taking place.

Dr. Jacquelyn Campbell: When we look at from a national perspective for those that think that the best way to address domestic violence is through the criminal justice system. The LAP gives those locals a really good way to make sure that the criminal justice part is collaborating with the domestic violence services organization. Those two sides need to work together with the healthcare system been the third pillar. The one place where we find issues that often times do get politically driven, guns being so often the domestic violence fatality means especially the homicide suicides and when a child is also killed those are almost always with guns. So trying to address that gun removal from known abusers, abusers who have been convicted of a domestic violence offence or who have an order of protection out against them, how that can really save lives. That's a place that politics does sometimes get in the way. One of the reason that I see like the LAP has been a really important and I can't credit Maryland Network against domestic violence enough that it is a means of brining all of the sectors together through a coordinated use. And Connecticut has done a really terrific job of implementing the use principles of risk assessment throughout the various parts of the systems, so that now child protective services is involved. The family court is involve and your health department as you say so Connecticut is an excellent example of a statewide initiative and Maryland is trying to be -- and even Oklahoma is now with this risk assessment strategy the LAP's strategy that it also brings together their health department and their domestic violence services organizations.

Margaret Flinter: Dr. Campbell I'm sure it will come as no surprise to you that we are always searching for the opportunity to be further up stream in our prevention efforts. And it seems that to do that we need so much for the next generation of healthcare professionals to have as part of their education and curriculum and understanding of intimate partner violence and you play such a prominent leadership role in the country in your position as the national program director for the RWJ Foundation nurse faculty scholars. What's the state of the art around training of the next generation of healthcare professionals around this critical issue?

Dr. Jacquelyn Campbell: We've been very fortunate in the Robert Wood Johnson Foundation funding of nurse faculty scholars. We've had a number of nurse faculty scholars who are doing research on various aspects of domestic violence, children's exposure etcetera. So that's a really important piece of the nurse faculty scholar

program. And the Robert Wood Johnson Foundation is working their new initiatives are around a culture of health. They've identified addressing violence as one way of providing this culture of health for the country. I work with a number of organizations that were all interested in increasing that training making it part of every curriculum, you know, we had in the 70s and 80s some real initiatives that way. We got it into most of the nursing curricular by early 90s then that was sort of like things (inaudible 19:22) even in my own school of nursing I suspect right now with all of the national attentions that domestic violence will have another upsurge and people making sure it's in the curriculum. But it's one of those things that you have to get systematized the same thing with screening for domestic violence, you have to get it in the healthcare records, in the electronic medical records. You know, a permanent place in the curriculum.

Mark Masselli: We've been speaking with Dr. Jacquelyn Campbell the Anna D. Wolf Chair at the Johns Hopkins School of Nursing. You can learn more about her work going to dangerassessment.org, Dr. Campbell thank you so much for joining us on Conversations on Healthcare today.

Dr. Jacquelyn Campbell: You're welcome it was my pleasure.

(Music)

Mark Masselli: At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics, Lori what have you got for us this week?

Lori Robertson: We write a lot about seniors care efforts by politicians who scare seniors to get their votes. And this midterm election has included plenty of that. Nearly $50 million has been spent on television advertising in the first nine months of the year on ads mentioning Medicare with democrats outspending republicans nearly two to one. That's according to Kantar Media Intelligence Campaign Media Analysis Group. The spending maybe new but the claims are old, for instance democratic ads and several senath in-house races claim that republicans would "end the Medicare guarantee" a reference to their support of representative Paul Ryan's Medicare Plan. But Ryan's plan wouldn't ends the guarantee of Medicare benefits instead it proposes phasing in a government subsidy program in which future beneficiary from private plans or traditional Medicare. And it wouldn't take away any guaranteed benefits either it would require private plans to include the same minimum benefits as traditional Medicare. These claims about Ryan's plan and in Medicare first began in 2011 when he released a budget proposal that included a transition to a premium support system. We called the claim a (inaudible 21:49) of the year then. Three years later democrats have modified

the claim to say the plan would ends the Medicare guarantee that doesn't make it any more accurate.

And many ads feature seniors who are already on Medicare or in one case a man who says Medicare is " around the corner for him" the republican plan wouldn't kick in until those under age 55 reached Medicare eligibility, and that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

Margaret Flinter: Each week Conversations highlights a bright idea about to how make wellness a part of our communities and to everyday lives. One in six people in the world lacks access to drinking water or basic sanitation. And statistic show that diarrhea is the leading cause of death for these populations but access to clean and portable water continues to present a real challenge. In African the numbers are staggering with 46% of the residence of Sub-Saharan African having no direct access to clean water.

In 2005 artist Tracy Hawkins went to Tanzania to see what she could do about it. Clay pot water filtration has been around for several hundred years where simple clay pots lying in the bottom of silver oxide can remove up to 99% of the impurities for most water sources. But no one had undertaken a dedicated program to produce and distribute these pots. Tracy founded that the Sing'isi Pottery Project with a local activist and began making the pots with local artisans in this region of Tanzania. By 2008 she and her team were able to get a factory built so that they could increase production. The project has served multiple communities and continues to expand. Independent researchers have determine the system to be safe effective and the best part the health of entire communities has been improved significantly once each village resident is provided with a clay filtration system. The pots are inexpensive to produce, easy to handle and the factory has also created jobs for local residence. They have since change the name of the organization to Safe Water Ceramics of East Africa and have continued plans to replicate the successful model across the region. A simple easily manufactured solution that improves access to portable water for a community that previously had few options, one that improves health, wellbeing and economic conditions at the same time now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Healthcare, I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.