Effectiveness of Intimate Partner Violence Screening of Women Between the Ages of 14 and 65 in a Family Practice Setting

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Abstract

Intimate partner violence (IPV) is a prominent problem in Utah that affects the lives of one in every three women. Utah has a higher prevalence of IPV than anywhere else in the nation. There is an IPV related murder in Utah every 33 days. IPV victims can experience negative effects from exposure to abuse and violence for a lifetime. These victims often do not know who they can reach out to for help. For many IPV victims their medical professionals are their only sources for help. The purpose of this project is to compare the number of IPV cases that are reported with IPV screening to those that are reported without IPV screening. In a three-month period prior to implementation of this project only two women sought assistance in finding IPV resources at a family medicine residency clinic that averages 2,500 patients each month. This project included implementation of a standardized interview-style IPV screening process in a family practice residency setting. Positive IPV screenings were tracked for three months post screening implementations. During this time there were 18 positive IPV screenings. This was an 800% increase in IPV reporting with screening when compared to IPV reporting without screening.

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Chapter One: Introduction

Intimate partner violence (IPV) is a public health issue that affects the lives of nearly one in every four women in the United States (National Coalition Against Domestic Violence [NCADV], 2019). However, in Utah, IPV is even more prevalent and affects one in every three women (Utah Department of Health, 2019). IPV can occur in relationships of individuals of any socio-economic status, race, religion, or age. IPV victims comprise up to 74% of murder-suicide victims, and of those murdered, 94% are female (NCADV, 2019). IPV is a significant risk factor for impaired health of women of childbearing ages; that risk factor can be modified if appropriately addressed in a team-based care setting.

Background and Significance

There are many different components to IPV that can present in various ways depending on the patient's circumstances. IPV is defined as "the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as a part of a systematic pattern of power and control perpetrated by one intimate partner against another" (NCADV, 2019). Physical, sexual, psychological, financial, and emotional abuse are included in this definition (Valpied & Hegarty, 2015).

According to the Centers for Disease Control and Prevention (CDC, 2019) over 43 million women experience at least one incidence of IPV in their lifetime. IPV can occur throughout the lifespan and can start during the teen years (CDC, 2019). There are long-term negative impacts of IPV both physically and mentally. The CDC (2019) states that there are a range of negative health impacts of IPV including heart, digestive, reproductive,

musculoskeletal, and psychological conditions. IPV does not negatively impact just the patient's health, there is a significant cost to society related to IPV. IPV associated costs include healthcare for IPV injuries, lost productivity from work, and criminal justice costs that equal $3.6 trillion (CDC, 2019). Female IPV victims cost directly associated with the results of IPV are on average $103,767 (CDC, 2019).

IPV is a modifiable risk that can be reduced or eliminated if women are willing to report the abuse and seek help through community resources (Yakubovich et al., 2018). In 2013, the United States Preventive Task Force (USPTF) released a recommendation for healthcare professionals to screen patients for IPV (USPTF, 2013). The USPTF has not given directives on the most effective screening method. Screening is still implemented by clinics using methods that are most appropriate for that area's patient population. In 2018, the USPTF updated the recommendations for IPV screening. The update states that there is a moderate level of certainty that screening women for IPV will have a positive benefit to reduce the incidence of IPV (Curry et al., 2018).

Gómez-Fernández, Goberna-Tricas, and Payă-Sănchez (2019) stated that standardized screening of women in childbearing ages with a reliable tool helps to identify at-risk women, who become able with supportive resources to remove themselves from an IPV situation. Valpied and Hegartry (2015) stated that effective IPV screening might include the following questions: do you feel safe at home, what needs to happen to make you feel safe at your home, have the aggressive behaviors worsened, are there weapons in the home, is the perpetrator obsessive or jealous, and do these episodes occur in front of children? In the case of a positive screening women were referred to the appropriate community resources (Valpied & Hegarty, 2015). Some of these community resources include women's shelters, local victim advocacy

groups, police related victim's advocacy groups, ecclesiastical groups, or local legal groups that help with victim advocacy.

Screening for IPV in the health care setting creates a venue for women to find help if they are in a relationship that is dangerous and harmful. The effectiveness of a screening process can be improved by implementing an evidence-based screening tool with a standardized clinic process. There are currently no screening best practice guidelines that give direction on how to screen women for IPV.

Needs Assessment

A review of the strengths, weaknesses, opportunities, and threats (SWOT) of the dynamics of the clinic and community was completed. It was found that currently in Utah, the largest healthcare organization owns and operates 23 hospitals and 180 clinics (Intermountain Healthcare, 2019). At the time of this paper, one obstetrics/gynecology clinic in the system is screening for IPV. All labor and delivery hospital units in the hospitals are screening for IPV. Despite the recommendations from USPTF and the strong evidence of the impact of violent relationships on the quality of lives of women and the increasing evidence that screening is effective, many clinics are still resistant to implementing a screening process. There are several reasons that clinics are resistant to screening. Some of these barriers are lack of time, lack of resources, limited knowledge of IPV, and limit knowledge of mandatory reporting instances.

A strength of this project is that this primary care clinic is currently working in a team-based care setting. Team-based care provides the best setting for IPV screenings. Team-based primary care settings that are a part of this healthcare system have the personnel that are trained and available to assist with patients who are experiencing IPV. These staff members were

utilized to help patients find the appropriate community resources that meet individual needs of each patient who screened positive for IPV.

Utah has a higher incidence of IPV episodes than any other state (Utah Department of Health, 2019). In 2008 alone, there were 169,156 reported instances of IPV-related assaults and rapes (Utah Valley University, 2017). In Utah, women of childbearing age are at an increased risk for IPV. This risk can be modified and prevented by identifying women who are experiencing IPV and assisting them in finding the resources they need to either leave or resolve the situation.

There are many barriers to effective IPV screening by primary care clinics. These barriers include but are not limited to the lack of time, inadequate training, lack of understanding of the importance of screening, and concerns about the accessibility of resources for women who screen positive for IPV. These barriers can stem from concerns about the effectiveness of screening, the time it takes to screen patients, what to do with positive screening, the comfort level of clinicians, and the lack of a standardized screening process (Pagels et al., 2015). Another barrier that must be considered is that there are no other primary care clinics in the healthcare system currently screening for IPV other than this clinic. This means that a system-wide best practice guideline does not exist.

Problem Statement

In Utah, one in three women experiences IPV in their lifetime. The Utah Department of Health (2019) stated that one woman dies from IPV every 33 days. This is a significant increase in IPV in Utah and above average for the United States (Utah Department of Health, 2019). The USPTF has recommended that women of childbearing age should be routinely screened for IPV. However, in the largest healthcare system in Utah, only one specialty clinic is screening. The

problem of absent or ineffective screening in a family practice setting is a barrier to the implementation of a standardized, evidence-based process of screening for IPV. By developing, implementing, and demonstrating the effectiveness of the IPV screening tool, providers may be more likely to implement the screening process into their respective practices.

Project Aim

This project aimed to gain a better understanding of the effectiveness of screening for IPV in a family practice setting. The SMART goal for this project was to compare the number of positive IPV screenings before and after the implementation of a standardized IPV screening process using a standardized IPV screening tool over a three-month time frame. The number of IPV victims identified for three months before screening implementation was compared to the number of IPV victims identified three months after the implementation of screening. The timeline for this project was determined based on the time frame for project completion.

Research Question PICOT

In women of childbearing age, 14-65 years old, does screening for IPV increase the number of patients with positive IPV findings within three months of implementing a screening tool in a family practice residency clinic when compared to not screening for IPV? In compliance with the USPTF recommendations for IPV screening, women ages 14 and older were screened for IPV yearly during an appointment for a physical, obstetric visit, or well-woman exam. For females between the ages of 14-17, they were screened when they were being seen for a well-child check or obstetric related visits. Screening women for IPV will help to identify women who need referrals for community resource assistance.

Congruence with the Organization's Strategic Plan

This project is in line with the healthcare system's strategic plan, mission, and value statements. The healthcare systems, (2019a) mission statement is, "Helping people live the healthiest lives' possible". IPV has been proven to have a negative impact on the lives of women who are victims. It is believed that by screening all women of childbearing age for IPV, these individuals can receive resources earlier and potentially reduce the long-term effects of violence exposure.

Another of the system's vision statements is that they will be involved in community stewardship and strive to meet the needs of the people in the communities they serve at the lowest possible cost (Intermountain Healthcare, 2019). Adding IPV screening will not incur significant additional expenses to either the system or the patient. This project is a low-cost approach to reduce the cost of long-term IPV exposure, injury, and possibly death.

The healthcare system also has a strong team-based primary healthcare plan. This plan helps to provide patients with a team-based approach to healthcare as well as collaboration with community resources. This structure aligns with the aim of this project.

Search Process

A search of literature utilizing CINAHL, PubMed, Google Scholar, Cochrane library, Health Source-Nursing/Academic Edition, and EBSCOhost was completed. Keywords for the searches included: intimate partner violence, domestic violence, provider impressions of IPV screening, IPV screening tool, effectiveness of IPV screening, incidences of IPV, IPV statistics, USPTF recommendations, risk factors for IPV, and the consequences of IPV. The Bradley University Librarian was contacted to obtain several articles that were not readily available in full-text format online. The total number of articles retrieved was 543. Five-hundred-three were

discarded because they were greater than five years old, not in English, or not available in full text, leaving 40 articles. Fifteen of those articles were duplicates and were removed, which left 25 articles for final review.

Synthesis of Evidence

As articles were compiled and reviewed, there were four main themes of the results of the studies. Some examined the risk factors for IPV or the incidence of IPV, while others examined the effectiveness of evidence based IPV screening tools and the short and long-term effects of IPV screening in the family practice setting or the emergency department. The USPTF, Utah Department of Health, and National Violent Crime registries were reviewed. Most articles reviewed showed a definite benefit of screening for IPV in the family practice setting and several pointed to the positive impacts of IPV screening in the emergency department setting.

Incidence of IPV

The incidence of reported IPV is very high in the United States, and even higher in Utah (Utah Department of Health, 2019). There are several factors that can influence the rates of IPV in different locations throughout the country. The factors in the incidence of IPV are based on geographical location, local demographics, social-economic situations, and religious beliefs in the geographic location. Understanding the incidence of IPV in any specific location can be an encouragement to a provider's resistance to screening. When providers understand the severity of a condition or a situation, they are more likely to advocate for this condition. Also, this understanding can also help to identify the most effective method of screening for that clinic or hospital.

The incidence of IPV in the United States is much higher than most providers assume that it is. The Survey for Violent Deaths-National Violent Death Reporting System, 27 states

(2015) showed that IPV factored into 47.6% of homicides in women in 2015 in the United States. Sprague et al. (2016) found that between 38 and 59% of women who seek care in any healthcare setting have experienced IPV within their lifetime. These statistics can be daunting; however, it is important to know what the incidence of IPV is in order to assess the effectiveness of IPV screening in any setting.

Risk Factors for IPV

Risk factors for IPV should be assessed when evaluating the effectiveness of IPV screening. Understanding these risks may also help to identify the population of women who are in the most need for screening. Risk factors include low social-economic status, history of childhood maltreatment, alcoholism, substance abuse, and women of childbearing age (Clark et al., 2019; Li, Zhao, & Yu, 2019; Yakubovich et al. 2018).

There are several cultural factors that can increase the risk of IPV in a relationship. Clark et al. (2019) stated that women in cultures that are based in a patriarchal structure are more at risk for IPV than those who are not. Utah has a predominantly patriarchal-based family culture, which could contribute to its higher instances of IPV.

Capaldi, Knoble, Shortt, and Kim (2012) completed a systematic review of the risk factors for IPV, which, revealed that age, social-economic status, substance abuse, and culture could increase the risk for women of childbearing age to experience IPV (Capaldi et al., 2012). These factors could also play a key role in the higher instances of IPV in Utah. Capaldi et al., (2012) stated that women who are in relationships at a young age have a greater risk for experiencing IPV. Women tend to get married at a young age in Utah, which can be a contribution to the higher rates of IPV in the state.

Another risk factor of IPV is childhood trauma such as experiencing abuse or witnessing abuse during childhood. Li, et. al. (2018) completed a meta-analysis reviewing the correlation of childhood mistreatment and IPV, which concluded that adult women who had exposure to childhood maltreatment had a significantly higher incidence of IPV reports than those who did not.

Screening Effectiveness

When implementing an evidence-based screening process, it is essential to understand what methods and tools have been successful in the past. Further understanding the best way to ask the questions for IPV screening is critical to effective screening methods. Ghondour, Campbell, and Lloyd (2015) stated that IPV screening should be interview style questions that are completed at every routine visit and that system-level support increases the effectiveness of screening. Gómez-Fernăndez, Goberna-Tricas, and Payă-Sănchez (2019) found that interview-style screening with a gold standard screening tool in a primary care setting is the most effective form of IPV screening. Interview style IPV screening for IPV is the gold standard screening method because it helps to identify more women who are experiencing IPV than other methods of screening.

Barbosa, Verfoef, Morris, et al. (2018) found that IPV screening is a low-cost intervention tool that is effective at preventing future care costs for victims of IPV. Interview style screening does not have a financial cost. The only perceivable cost is the time of either the medical assistant or the provider who are doing the screenings. The screenings are not difficult and generally not take more than two to three minutes.

Prakash, Prevot, Kola, and Wood (2019) stated that IPV screening is more effective if the screening tools are directed to a broad range of specific cultural needs. IPV screening can be

completed in any language. IPV screening can be adjusted to meet the patient's cultural beliefs if needed. This finding indicates that screening is more effective if the screening tool has the ability to be adjusted to meet the individual cultural needs of the population that is being screening at any specific location.

Alvarez, Debnam, Clough, Alexander, and Glass (2018) completed a qualitative study that included information from 17 healthcare staff members from clinics that served between 1,500 and 45,000 patients found in high-income areas. Participants were physicians, nurse practitioners, midwives, registered nurses, and social workers. These participants expressed that screening patients with an electronic application is more effective in higher-income areas, whereas screening with interview style questions is more effective in lower-income neighborhoods. The article also identified the providers' inadequate feelings of preparedness to respond to positive IPV screening as possible barriers to screening (Alvarez et al., 2017). Pagels et al. (2014) had also found that the provider's perception of preparedness and understanding of cultural considerations proved to hinder the effectiveness of screening.

Feltner et al. (2018) published recommendations with the USPTF stated that IPV screening of women of reproductive age shows a significant benefit and allows the opportunity to provide care and referrals for future care for positive IPV victims. At this time, there are no recommendations to screen men for IPV. Men are at a significantly lower risk for IPV scenarios.

Miller, McCaw, Humphreys, and Mitchell (2015) found that effective IPV screening in a primary care setting requires training, adequate electronic health record collaboration, system support, and best practice guidelines. With these in place, IPV screenings can help to identify more women who need resources for IPV care. Sharpless, Nguyen, Singh, and Lin (2018) completed a comprehensive retrospective chart review in eight primary care settings and found

that when the medical assistant (MA) screened for IPV, there was a significantly higher percentage (78%) of women of childbearing age being screened than when a physician screened (22%). However, they stated that the #metoo movement has helped to improve awareness of IPV and has increased the number of women who will disclose IPV situations. Both Miller et al. (2015) and Sharpless et al. (2018) found that screening in a primary care setting is an effective form of IPV screening. Sharpless et al. (2018) stated that MA-lead screening was statistically more effective. However, Miller et al. (2015) noted that provider-led screening is more effective than MA-lead screening.

O'Doherty et al. (2014) completed a systematic review and a meta-analysis of trials that reviewed the effectiveness of screening and found that in high-income countries, such as the United States, the likelihood of identifying IPV victims was ten times higher compared to low-income countries. This could be from difference in culture, socioeconomic status, the number of resources available, or the effectiveness of standardized screening (O'Doherty et al., 2014). This review also found that screening was more effective in antenatal and primary care settings as compared to the emergency department or specialty settings. Limitations of this review include the differences in documentation standards between providers, the willingness to use interview-style questions, and the interview screening techniques utilized by each provider (O'Doherty et al., 2014).

There are many potential barriers to screening for IPV. Pagels et al. (2014) found that primary care providers were less likely to screen for IPV because they felt IPV was not a concern, there were no resources identified to where they can refer positively screened IPV victims, or that there was no time for effective screening. Other limitations of screening can include the screening method, accuracy of documentation, and cultural or language barriers. If

MAs are not following suggested screening methods, it would be difficult to assess the quality of a specific screening measure. Accuracy of documentation can limit tracking positive reports of IPV. Cultural or language barriers limit the effectiveness of screening because these barriers may limit the understanding of the questions that are being asked.

Results of IPV

IPV results in many long-term complications and risks. Many of the articles reviewed showed evidence that IPV can cause lifelong adverse effects. Wright, Hanlon, Lazano, and Teitelman (2019) found that IPV victims have an increased risk of suicide and depression. Brown and Seals (2019) completed a qualitative and quantitative review of Kentucky Violent Death Reporting databases and found that manipulative IPV increases suicide and self-harm risk. Valpied and Hegerty (2015) stated that IPV has life-long severe health consequences such as suicide, depression, chronic pain, chronic gastrointestinal complaints, and multiple psychological and social-economic issues.

Cost-effectiveness of IPV screening and ethics of IPV screening

Barbosa et al. (2018) completed a study of the cost-effectiveness of IPV screening and its effectiveness in a primary care setting. Barbosa et al. (2018) found that there was no significant increase in the cost of care in the primary care setting. The study found that there was a substantial decrease in the cost of community resource utilization and the long-term cost of caring for IPV victims (Barbosa et al., 2018). This cost reduction will be seen in a decrease in caring for and assisting victims of IPV in relation to the negative long-term consequences of IPV.

There are many ethical concerns related to screening for IPV. Concern such as is it appropriate to screen for IPV, what are the risks to the women being screened, and is screening

for IPV negatively impacting women's autonomy? Mannell and Guta (2018) stated that the moral decision-making process of women experiencing IPV could be disproportionally altered. Therefore, screening can be beneficial to help these people identify the cause of their inner moral conflict.

Theoretical Framework

IPV can cause a significant disruption in the relationships of each IPV victim. Duffy gave permission to use the Quality-Caring Model© (CQM©) (Appendix A) This model states, that when caring relationships are incorporated into a nurse's practice there are valuable human connections that can positively influence the patient's health outcomes and improve the professional relationships of caregivers (Duffy, 2015). This theory focuses on relationship-centered encounters. These relationships can be between the nurse and patient, nurse and other health professionals, nurse and patient's families, and the nurse and self (Duffy, 2015).

Duffy's QCM© (2015) has several assumptions related to caring and caring relationships. Duffy's assumptions are that humans are involved in many relationships at one time (Duffy, 2015). These relationships can be with patients, other staff, doctors, or family members. Another assumption is caring has several processes that are functioning independently and interdependently continuously. These caring processes can be processes created by the nurse or process the nurse is involved in. Caring is a part of the daily work of a nurse is Duffy's (2015) next assumption. Other assumptions include caring can be measured, caring is a benefit for both the cared for, as well as the person that is caring, and caring is a positive emotion (Duffy, 2015). As the nurse improves his or her caring relationships, the nurse improves the care of the patient and the care of each relationship in which the nurse is involved. Duffy's QCM© (2015) can also be directly applied to the victims of IPV. These women can have a disruption of relationships

both before and after reporting IPV. The care providers need to understand that this disruption may occur, and the patient may need further support.

By gaining a better understanding of Duffy's QCM© (2015), the caregivers who are assessing patients for IPV better understand the importance of this screening and assisting patients in finding the resources needed for follow up care. The caregiver can also understand the potential impact of IPV on the patient and their positive human connections. This understanding will help the caregiver to have more empathy in the care of the women who are suffering from IPV.

Chapter Two: Methodology

Project Design

This project was a pilot quality improvement project that introduced a process to routinely screen for IPV using a standardized screening tool in the first participating family practice clinic in the healthcare system. This project model was also based on an already implemented standardized screening tool being utilized in an obstetrics/gynecology clinic. Pilot projects can be implemented for a variety of reasons. Moran, Bruson, and Conrad (2017) stated that pilot projects do help to identify the appropriate level of intervention, to see if the intervention has adverse effects, or to determine if the intervention can be applicable on a larger scale.

Setting

This project took place in a family practice residency clinic in Provo, Utah. This clinic has nine faculty physicians, 23 residents, one nurse practitioner, and a full care management team. Nine providers are scheduled to work each day. About 100-150 patients are seen in the clinic daily.

This clinic is a patient-centered medical home clinic that utilizes a team-based care approach with a care manager and two healthcare guides involved in the team-based care approach. The care management team works to connect patients to community resources that will assist them to address their needs. The clinic is located next to a large hospital and works closely with the hospital's social work team. This location helps to add interdisciplinary approach to managing

Population/Sample

This project took place in a family practice residency located in Provo, Utah. This clinic sees, on average, 100-150 patients each day. There is a wide variety of patients who are seen in this clinic. According to the clinic's demographic report, 60% of these patients are female, 75% are Caucasian, 20% are Hispanic or Latino, the other races in this clinic include Pacific Islanders, Asian, and African Americans (Intermountain, 2019b). The top three languages spoken are English, Spanish, and Portuguese (Intermountain, 2019b).

The payor mix of this clinic varies widely. There are 56% of patients with commercial insurance, 15% with Medicaid, 20% with Medicare, and 11% self-pay (Intermountain, 2019b). This clinic does offer discounted rates for self-pay or non-insured patients. Knowing the payer status of the clinic helps to understand the overall demographic of the population being screened.

For this project, women ages 14 and above were screened for IPV. The target population for the project equaled about 88% of the total clinic population (Intermountain, 2019b). The project did only report about women between the ages of 14 and 65 who screened positive for IPV. Women were only screened when they were alone and if they consented to screening. All other women were excluded.

Tools

The screening was completed using a standardized screening tool written by the healthcare system's IPV workgroup (Appendix B) and was used with permission from the healthcare system (Appendix C). This screening tool was based on the recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Obstetrics and Gynecology (ACOG). The CDC's assessment tool includes six questions that include assessment for emotional, physical, and sexual abuse, as well as a diagram for the patient to draw injuries (CDC, 2007).

ACOG's recommended IPV screening tool is a four-question interview-style tool that addresses reproductive and sexual abuse (ACOG, 2012). This tool did not fit the needs of women who are being seen in a family practice setting. This tool only focused on sexual abuse and did not evaluate for physical and emotional abuse.

The screening tool used for this project consisted of a brief discussion of the statistics of IPV in Utah. There was a disclosure that informs patients that Utah is a mandatory reporting state, and identifies which situations are considered reportable. The tool then asked questions related to emotional, physical, and sexual abuse. The final question asked is about the history of abuse and violence. This question is used to assess the need for emotional support as a result of past abuse.

Project Plan

The goal for this project was to evaluate the effectiveness of an interview-style four-question IPV screening tool that can be utilized in a family practice setting. Before implementing IPV screening in the clinic, the providers, both faculty and residents alike, attended a two-hour didactic session about IPV incidence, reporting mandates, documentation, and community resources. This training involved experts from local police departments, Division of Child and Family Services, Adult Protective services, Utah County Department for Aging Services, and the local health department.

The front desk staff and nursing staff attended a one-hour educational lunch that discussed when to screen patients, how to use the screening tool, and when to report findings to the provider or care management team. This educational lunch was presented by the project manager and a provider from an OB clinic in the region who is currently screening for IPV and works on the system IPV workgroup. Arrangements were made to add a button in the electronic

health record on the MA intake documentation form that indicates whether IPV screening is positive or negative. Also, the providers were to document the status of IPV screening and interventions in their note. Once training was completed with all staff and providers and the IRB was been approved, IPV screening was implemented.

When patients were being checked in to the clinic, the front desk staff educated the patient on the clinic standard of each provider seeing each patient over the age of 14 alone for a brief part of the visit. Notifying patients of confidential alone time with the provider at the time of check in, helped to set expectations early in the appointment for this patient to have confidential time with the provider at some point in the session.

For patients 18 and older, the screening was performed once a year during well-woman exams, new patient visits, initial obstetric visits, 20-week obstetric visits, and the 36-week obstetric visit. Female children ages 14-17 were screened during well-child checks and obstetric appointments. This screening was only completed when the patient was alone in the exam room. Patients were screened alone to allow them the chance to answer honestly if the perpetrator was with them during the visit and to ensure confidentiality. The screening tool included an explanation of the statistics of IPV in Utah as well as a disclosure statement related to reportable events. The screening tool was laminated and handed to the patient. The MA read the questions to the patient and reported any positive screenings to the provider.

Any answer of “yes” to one of these questions was considered a positive screening and was reported to the provider caring for the patient. The provider then evaluated the positive screen and referred all positive screenings to care management for further support and tracking if indicated. Care management did report the incident to local law enforcement agencies and other applicable community resources if the incident fell within mandatory reporting statutes. Care

management kept a secured and password protected log of any patient that was referred to this team with a positive IPV screening.

Potential barriers to data collecting included patients not consenting to care management referral, a provider's failure to notify care management of a positive screen, or time involved in reporting a positive screen. Providers and MAs were educated on the importance of reporting positive screenings. If patients do not consent to screening, it may decrease potential positive screens. If providers do not notify care management of positive screens these screens will not be tracked.

This project was determined to be sustainable and was evaluated frequently throughout the timeframe defined for the project. The project was evaluated by observing screening, asking MAs how they felt screening was going, and discussing with providers if they were getting feedback from the MAs related to IPV screening. If patients were not being screened appropriately, providers and MAs could be re-educated on the IPV screening process. The IPV screening process was written and posted in the clinic's official process book. The process book helped to train new staff members and providers who may not remember the screening process.

Data Analysis

The care management team was a key component in collecting data for this project. Care management has been logging any IPV related cases in a password protected Excel spread sheet for the past three months due to requirements from the healthcare organization. There was a retrospective care management log review done to identify the number of patients referred for IPV prior to screening implementation. These numbers were deidentified and entered onto a password-protected Excel spreadsheet stored on a password protected device. This spreadsheet was entitled *IPV Tracking Tool*.

In the case of a positive screen, the provider referred the patient to the care management team for assessment, continued support, and community resource referral. After the implementation of screening, care management did de-identify any IPV referrals and tracked the number of referrals. These numbers were also entered into the password-protected spreadsheet as a post-implementation referral.

The comparison of the retrospective log review and the post-implementation log review did show the difference of IPV screening will have on the number of IPV patients in the family practice setting. Only the number of referrals was tracked. No patient identifying information was tracked.

Institutional Review Board and Ethical Issues

An application for Institutional Review Board (IRB) was submitted through the healthcare system's IRB department. An application for IRB approval was also submitted to Bradley University's IRB department. Implementation of IPV screening was held until approval from both IRB boards was granted. The only information tracked was the number of positive IPV screenings. There was no patient health information tracked for this project. This information was tracked by the project leader on a password-protected spreadsheet on a secure device.

This project was a minimal risk project with few ethical considerations. All women were screened using a standardized screening tool. All women who had a positive IPV screening were offered the same options for community resources. Providers, nursing staff, and front desk staff were all informed and educated related to the project, screening process, and referral plan prior to the implementation of the screening tool. No personal health information was tracked.

Chapter Three: Organizational Assessment and Cost-Effective Analysis

Organizational Assessment

This healthcare system is the largest healthcare organization in Utah. Over the past two years, the organization has had a major change in reporting structure and management. With new leadership, there is a greater focus on outpatient care and community health improvement initiatives. There is a workgroup that is focused on IPV and has focused its efforts in the obstetrical and emergency departments. The need to expand the focus of the IPV workgroup to include family practice setting was identified. This change was helpful to encourage providers to be more engaged in screening for IPV in the family practice setting.

This healthcare system also has a large network of providers and community resources. This network will aid in creating a collaborative relationship with community resources that help care for women who have positive IPV screenings, which helps to encourage providers to screen patients. Understanding the role and scope of community resources will help to ensure that women who screen positive will receive the proper community referrals.

One potential barrier to implementation was employee burnout from frequent organizational changes over the past two years. The healthcare system has gone through a restructuring process that has created a large amount of stress within the system. This amount of tension has caused burnout due to the frequent changes and the implementation of new programs throughout the system's reorganization process. Burnout can decrease the staff's willingness to learn and implement new processes into their current practice. This can have a negative impact on the overall effectiveness of IPV screening. Careful attention was paid to the engagement of healthcare providers and clinic staff. If there is limited engagement those individuals can have a discussion with the project coordinator to discuss concerns.

This project required interprofessional collaboration. The project included front desk staff, providers, MAs, care managers, healthcare guides, and in some cases social workers and law enforcement. The healthcare system has encouraged these interprofessional collaborations and relationships.

Cost Factors

There were few costs associated with this project. An outline of the project budget can be found in Appendix D. Costs included patient education posters that discuss IPV, IPV risk factors, IPV resources, and catering a lunch for the staff lunch and learn. All costs were approved by the clinic manager. Other items used for this project were in place at the time of project implementation and provided by the organization. No additional costs associated with equipment, information technology, or technical equipment were identified. The cost of staff time to complete IPV screening and gather information was negligible.

It is difficult to identify the cost savings of IPV screening. Any cost savings will be long term and related to the long-term implication of patients enduring IPV situations. Barbosa et al. (2018) did state that effective IPV screening does reduce long term costs of healthcare in the community. These cost savings will be seen with a reduction of cost in overall care for women and families who experience IPV.

Chapter Four: Results

Analysis of Implementation Process

The implementation of the IPV screening process went well. There was excellent support from the key stakeholders (MAs, providers, mentors, and clinic administration) in the project. All project expectations and objectives were explained to the stakeholders prior to implementation. The project was well supported, and no resistance to screening was noted prior to the implementation of the project. All stakeholders agreed to the implementation date of October 1, 2019.

The providers, MAs, and front desk staff were trained related to the new process and start time of screening. The expectations of screening, method of screening, the importance of screening, IPV screening began on October 1, 2019. Many of the MAs asked clarifying questions and wished to review scenarios of positive screening and questionable screening results. These scenarios were provided in a staff meeting prior to October 1, 2019. After additional clarification, training, and information were provided, the MAs agreed that they were comfortable with implementing IPV screening into their routine. Neither the providers nor front desk staff had any further questions or concerns after the initial training was completed.

Analysis of Project Outcome Data

Positive IPV screenings from October 1, 2019, to December 31, 2019, were tracked. In the three months prior to the implementation of IPV screening, there were two positive IPV cases reported to the care management staff. Between October 1 and December 31, 2019, there were 18 positive screenings reported to the care management staff.

Chapter Five: Discussion

Findings

The goal of the project was to compare the effectiveness of screening for IPV in a family practice setting versus not screening for IPV in a family practice setting. A retrospective chart review of care management cases during a three-month timeframe was completed. During this timeframe, there were only two cases referred to care management for IPV resource assistance.

The implementation of a standardized IPV screening tool was completed on October 1, 2019. Any answer of "yes" to one of the four screening questions was considered a positive screen for IPV. The positive screening was then deidentified and reported to the care management team. The care management team only tracked the date of a positive screen. During the three-month trial timeframe in question, there were 18 positive screens. Identifying 18 positive cases in three months is an increase of 16 or an increase of 800% after implementation of IPV screening. This does indicate that standardized interview-style IPV screening in a family practice setting is an effective tool.

Limitations or Deviations from Project Plan

There were three limitations to this project that will be discussed. The first limitation would be the length of time IPV screening was tracked. Tracking a process during a limited timeframe of three months could have decreased the statistical significance of the outcomes. This timeframe also limits the sample size of the project. Monitoring standardized IPV screening positive reports for a more extended timeframe may increase the significance of the finding.

The second limitation of the project was the high MA turnover rate during the time of data collection. The family practice clinic employs 12 MAs; eight are full time while the other MAs are either part-time or only as-needed employees. During the time of data collection, five

new MAs were hired and trained in the clinic. This proved to be a limitation because of the lack of standardized orientation and training of MAs in the clinic. To decrease this limitation, orientation and training of new MAs in the clinic should include the same IPV training MAs received prior to implementation.

Another limitation includes a new system wide social determinant of health screening implemented during the data collection time. This new screening asked similar questions, but not the same questions the IPV standardized screening tool uses for screening. Some of the providers requested that their MAs do not complete both screenings to reduce the time it takes to room the patient for the visit.

Implications

The findings of this project indicated that implementation of IPV standardized interview-style IPV screening does help to identify victims of IPV who are cared for in a family practice setting. Although there are several limitations, the findings did show a significant increase in positive screenings. These findings indicate that standardized IPV screening is effective in the family practice setting.

Future research can be useful after implementing an MA orientation education for new hire MAs. This may help to increase the number of positive IPV screenings. Other future research could monitor IPV screening over a greater period to identify barriers to reporting IPV and completing IPV screening in the family practice setting.

Another future research question would be, does mandatory healthcare provider reporting of IPV cases impact the woman's willingness to report active IPV? Knowing the impact of mandatory reporting is crucial to understanding barriers of women reporting IPV. This

understanding could help to create new regulations related to the reporting of IPV to law enforcement.

Chapter Six: Conclusion

Value of the project

This project did show that standardized IPV screening in a family practice setting is an effective technique to identify IPV victims. The aim of the project to was to evaluate the effectiveness of the screening tool. This evaluation showed that screening for IPV does help family practice providers to identify IPV victims and refer them to organizations ready to provide resources for these individuals.

Implementation of IPV screening in a family practice setting tested a tool used for IPV screening in a family practice setting. The tool used in the project was created by a system workgroup. The tool was based on other nationally recognized tools but was changed to meet the needs of the population in many different settings throughout the healthcare system. This tool was useful in identifying IPV victims.

DNP Essentials

The American Association of Colleges of Nursing (AACN) identified eight core competencies that a DNP prepared nurse practitioner should have before they work as an advanced practice nurse. These essential competencies are skills that will help the DNP be successful throughout his or her career.

This DNP project relates to many of these essential competencies. The first essential that is related is *Essential II: Organizational and Systems leadership for Quality Improvement and Systems Thinking* (AACN, 2006). This project correlated to this essential because of the need to work closely with leadership in the system to identify a best practice model for the implementation of the IVP screening.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice states that the DNP has the knowledge to identify evidence-based research from a variety of databases and implement that information to improve patient outcomes (AACN, 2006). To complete this project, a variety of evidence-based materials was reviewed and used to identify IPV victims. Knowing how to utilize evidence-based information was a key component of the project.

Essential V: Health Care Policy for Advocacy in Health Care, VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes, and *Essential VII: Clinical Prevention and Population Health for Improving Nation's Health* were all utilized to complete this project. This project required working with community resources, system leadership, information technology specialists, and government officials to identify the best way to assist IPV victims once they have been identified. Gaining an understanding of working with other professionals helped to implement a screening process that was sensitive to all those involved in the project. Along with understanding the role of other professions, this project required a collaborative working relationship with many professionals from other roles. Working in this collaborative setting helped to improve the overall strength of the IPV screening process and referring patients who had a positive IPV screen to community resources.

Plan for Dissemination

The project will be presented to the DNP project team during a live video conference utilizing a PowerPoint presentation. This will take place at a time scheduled through Bradley University utilizing the university's website. Secondly, the scholarly paper will be added to the DNP repository that is accessible to practicing APRNs and APRN students. Finally, the project

and result of the project will be shared with the family practice setting, as well as any key stakeholders during a staff meeting.

Attainment of Personal and Professional Goals

My professional goal with this project was to identify a way that women who are suffering from IPV can have an opportunity to ask for help. IPV has impacted my life and the lives of my family. I felt it was important to find a way to increase awareness and understanding of the severity of IPV. I also wanted to identify a method that would help to identify women who are impacted by IPV and offer community resources for them. Based on the results of this project, standardized IPV screening does provide an opportunity for women to ask for help and potentially remove themselves from an abusive situation.

The other goal of this project is to raise awareness of this significant social issue that impacts the lives of women and children daily. This project opened up opportunities for me to get more involved in working to improve the lives of women and children by educating people around me about IPV and the impact IPV has on our communities.

When I started working on this project, I just wanted to meet the requirements needed to get my Doctor of Nursing Practice degree. A year later, I realize that this project has taught me much more than I thought possible. I have gained the confidence I need to advocate for vulnerable individuals. Ultimately, I have learned the importance of being an advocate for my patients in the community as well as in the clinical setting.

Conclusion

IPV is a growing social issue that influences the lives of women throughout the world. IPV is more prevalent in Utah than in many other areas of the country. IPV screening can help to identify IPV victims and prevent long-term negative impacts of IPV. A significant barrier to

receiving assistance in leaving an IPV relationship is notifying someone who can guide victims through the process. The question asked by this project was is screening for IPV in a family practice setting an effective way to identify IPV victims? The results of the project showed an 800% increase in identifying IPV victims over not screening at all.

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Appendix A

Personal Correspondence

Leslie Forbush <lforbush@mail.bradley.edu> Fri, Mar 22, 1:09 PM (8 days ago)

to jrduffy

Dr. Duffy,

My name is Leslie Forbush. I am currently in a DNP FNP program at Bradley University. I am in the process of writing the proposal for my doctorate project and would like to utilize concepts of your Quality Caring Model to describe the theoretical framework of working with and identifying victims of intimate partner violence (IPV). I would need your permission to cite this theory for this project. May I cite your theory in my work?

Thank you,

Leslie Forbush, RN, MSN
lforbush@mail.bradley.edu
(435) 633-5525

Duffy, Joanne R. Wed, Mar 27, 2:50 PM (3 days ago)

to me

Hello Leslie - The Quality-Caring Model is published and in the public domain, so you have permission to cite it in your project. Be sure to use the most recent version - published in 2018 - *Quality-Caring in Nursing and Health Systems.* Good luck in your program, Dr. Duffy

Joanne R. Duffy PhD, RN, FAAN
Visiting Professor
Indiana University School of Nursing
1111 Middle Drive
Indianapolis, IN 46202

Appendix B

One in three women in Utah experience very unhealthy relationships with an intimate partner in their lifetime. Since this affects their health (and children's health) and identifying the problem and offering resources decreases violence and improves health outcomes, we ask all female patients about this issue.

Disclosure on reportable events: (events can be reported either verbally or in writing by MA, RN, NP, or physician)

- By law, some things are reportable to the police or to the division of child and family services. Some of these events are:
    - If we are treating, you for an injury today caused by someone else
    - If you tell me children are experiencing or witnessing abuse
    - If you tell me your partner has threatened, you with a lethal weapon.
- Screening questions:
    - Are you in a relationship now in which you are often emotionally hurt by your partner such as being frequently insulted, put down, or controlled?
    - Are you in a relationship now in which you are physically hurt by your partner such as being hit, shoved, kicked, or choked?
    - Are you in a relationship now in which you are forced by your partner to do anything sexually that you do not want to do?
    - If no to all the above, have you ever been in a relationship with a partner who hurt you emotionally, physically, or sexually in any of these kinds of ways or who scared you?

Appendix C

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Leslie Forbush 229 S. 400 E. American Fork, UT 84003	IHC Health Services, Inc. Attention: Intellectual Property Director 36 S. State Street, 8th Floor Salt Lake City, Utah 84111
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Appendix D

Project Budget

Items	Quantity	Cost	Subtotal	Total
IPV posters	10	$1	$10	$10
Lunch for staff	1	$10 per person	$180	$190