

Intimate Partner Violence Screenings: A Quality Improvement Project to Enhance Trauma Informed

Services at an Integrated Primary Care Clinic

Doctor of Nursing Practice Project - Final Report

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Introduction

Behavioral health conditions are common in the United States (U.S.). Nearly 59 million adults, or 25% of Americans, had a mental illness or substance use disorder in the previous year (Substance Abuse and Mental Health Services Administration [SAMSHA], 2013). This population has high rates of lifetime trauma. Indeed, trauma is an “almost universal experience” for people with behavioral health disorders (SAMSHA, 2014, p. 2). Trauma includes wide-ranging experiences such as interpersonal violence, disaster, accidents, war, and childhood events that are “physically or emotionally harmful or life threatening... [with] lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMSHA, 2014, p. 7). Behavioral health clients deserve care that is trauma-informed, meaning that it recognizes the impact of trauma and strives to prevent trauma perpetuation (SAMSHA, 2014). Intimate partner violence is a specific form of trauma for which those with psychiatric and substance use disorders are at significantly increased risk (Chang et al., 2011).

Intimate partner violence (IPV) is a concerning public health issue not just for those with mental illness and addiction, but across the entire population. The four main types of IPV are physical violence, sexual violence, psychological aggression and stalking (Breiding et al., 2015). In the U.S., 24 people per minute are sexually assaulted, physically attacked, or stalked by an intimate partner (Black et al., 2011). More than one in three American women – nearly 36% - and one in four men experience lifetime IPV (Black et al., 2011; Breiding, Chen & Black, 2014). IPV is clearly a pervasive problem, and health care providers are well-positioned to identify IPV via routine screening. The purpose of the project described here was to improve trauma-informed practices by piloting the implementation of IPV screenings in an integrated primary care and behavioral health clinic that provides services to marginalized individuals.

Literature Review

One of the most salient risk factors for IPV is female sex. Women are at least three times more likely to be injured from IPV compared to men (Spivak et al., 2014). Nearly 30 million, or one in four,

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American women have survived severe physical injury inflicted by an intimate partner (Breiding et al., 2014). One in five American women is raped in her lifetime, and intimate partners commit over half of these heinous crimes (Black et al., 2011). In addition to women, individuals with childhood trauma are at greater risk for IPV (Widom, Czaja & Dutton, 2014). Those affected by mental health problems are especially vulnerable as well. Among clients receiving psychiatric services, 63% of women and 32% of men recounted IPV victimization (Chang et al., 2011). In a systematic review and meta-analysis of 41 studies, Trevillion et al. (2012) report that median lifetime prevalence rates of IPV were 46% in women with depressive disorders and 61% in women with post-traumatic stress disorder. Cases et al. (2014) found that the lifetime prevalence of IPV was a staggering 80% among women with serious mental illness. Besides psychiatric illness, other risk factors for IPV include substance abuse, social isolation, unemployment, poverty, homosexuality and living in a disadvantaged neighborhood (Buller, Devries, Howard, & Bacchus, 2014; Capaldi et al., 2012; Smith, Homish, Leonard & Cornelius, 2012).

Intimate partner violence can have grave consequences, most notably death. Numerous research studies have demonstrated that IPV is associated with bodily injury, worse physical health, poor mental health, reduced quality of life and increased disability (Black, 2011; Hegarty et al., 2013a; Plichta, 2004; Rees et al., 2011). Physical health consequences more likely to occur in those affected by IPV include joint disease, asthma, sleep problems, chronic pain, sexually-transmitted infections, reproductive health dysfunction, gastrointestinal disorders, cigarette smoking, and heavy alcohol use (Black, 2011; Breiding, Black & Ryan, 2008; Plichta, 2004; Sugg, 2015). Mental health complications are also common. Individuals who experience IPV are far more likely to have new onset of psychiatric disorders (Okuda et al., 2011) and female survivors of IPV have greater depressive symptoms over time (Illangasekare et al., 2013; Watkins et al., 2014). Further, survivors are at increased risk for suicide, as IPV is one of the strongest and most consistent risk factors for suicide attempts by women worldwide (Devries et al., 2011; Iverson et al., 2013). On top of adverse health outcomes, the economic impacts of

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IPV are striking. IPV is associated with job instability, economic hardship, and homelessness for female survivors (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Sormanti & Shibusawa, 2008). The financial cost of IPV perpetuated against women in the U.S. was estimated to be over \$8.3 billion as of 2003 (Max et al., 2004). This cost includes increased health care fees, as IPV survivors have significantly increased utilization of health services, including emergency care (Hegarty et al., 2013a).

Consideration of these consequences leads naturally to questions about screening for IPV, particularly in those populations most susceptible. Although some authors conclude that there is insufficient evidence to support universal screenings for all women (O'Doherty et al., 2014), numerous experts in interpersonal violence call for just that (Decker et al., 2012; Ghandour, Campbell & Lloyd, 2015). Others recommend screening all women ages 16-46 years and women older than 46 years if they have pertinent risk factors such as behavioral health problems, unexplained pain or somatic complaints, negative reproductive outcomes, and/or high health care utilization (Singh, Peterson & Singh, 2014). Routine inquiry improves identification of IPV and several studies have demonstrated that screening has both clinical benefits and minimal adverse effects (Nelson, Bougatsos & Blazina, 2012). The United States Preventive Services Task Force (USPSTF) upholds that detection of IPV and early intervention can reduce violence, lessen physical or mental harms, and decrease mortality (Moyer, 2013).

Many IPV screening tools of varying length are tested and available for use in diverse clinical settings (Basile, Hertz & Back, 2007), although data on psychometric properties are mixed and there is limited evidence to endorse one tool as better than others (Haggerty, Hawkin, Fontenot, & Lewis-O'Connor, 2011; Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Recommended tools include the Ongoing Abuse Screen (OAS) and the Hurt Insult Threaten Scream (HITS) screening (Moyer, 2013). Self-administered screens on computer are associated with improved disclosure while no difference in disclosure rates has been found between face-to-face and self-administered written screens (Hussain et al., 2015). Clinicians should always frame questions with statements about relevant mandatory

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reporting law, the reason for screening (i.e., IPV is common) and permission not to answer (Futures Without Violence [FWV], 2015; Singh et al., 2014; Spangaro, Poulos & Zwi, 2011).

It is not sufficient to screen for IPV without connecting women to appropriate services (Moracco & Cole, 2009). Several authors have published protocols for interventions to deliver in response to a positive screen. Shavers (2013) asserts that primary care providers (PCP) should screen, safety plan, provide resources and education, refer to counseling or intervention programs, and document. Similarly, Singh et al. (2014) proposes the “SAID” acronym, or Screen, Assess, Intervene and Document. Response to affirmative screens should include interventions that are linked with positive outcomes, such as counseling, information cards, and referral to resources (Moyer, 2013). Brief interventions for IPV identified in primary care are shown to reduce future violence, improve safety behavior and increase use of community resources (Bair-Merritt et al., 2014; Moyer, 2013). In a randomized control trial on women with positive IPV screens in primary care, clients who received brief supportive counseling from a physician had significantly less depressive symptoms at 12 months compared to women who were not counseled (Hegarty et al., 2013b). In another study, data collected six months after IPV screening show that 34% of women who screened positive described the screening as valuable, with the two most cited reasons as prompting to re-evaluate their situation and reduced isolation (Spangaro et al., 2010).

Insights on IPV screening facilitators are extracted from successful efforts. For example, the New South Wales (NSW) Department of Health implemented routine IPV screenings in clinical settings across the state (NSW, 2004). Study of the implementation process revealed several enabling factors, primarily utilization of only two brief and scripted questions; having questions on a form, which offered visual cues and enabled quick documentation; and provider training (Spangaro et al, 2011). Another effective screening program has been implemented by Kaiser Permanente (KP). In the KP model, providers are reminded to assess for IPV in the electronic medical record (EMR) and “[t]heir role is clear and limited: ask, affirm, assess, document, and refer” (Decker et al., 2012, p. 1224). Behavioral health clinicians are

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available for safety planning and assessment when clients screen positive. KP's model has resulted in a 6 fold increase in IPV identification over 10 years (Decker et al., 2012). Based on analysis of KP's and other efforts, a 2012 symposium designed an IPV prevention systems model founded on principles of direct inquiry and referral, supportive clinical environments, on-site services, and community links (Decker et al., 2012). Similar systems approaches emphasize development of IPV advocates; staff trainings; clearly defined procedures; use of the EMR to prompt screening and track outcomes data; provision of resources and decision support tools; ongoing quality improvement (QI); and collaboration with local agencies (Ambuel et al., 2013; Miller, McCaw, Humphreys & Mitchell, 2015). Successful IPV screening programs use comprehensive methods which encompass institutional support, protocols, training, and instant access to referrals/resources (O'Campo, Kirst, Tasmis, Chambers & Ahmad, 2011).

Barriers to IPV screenings are described in the literature and include time constraints; provider discomfort or lacking confidence in communication skills; limited resources for support, advocacy and referral; clinician fear of offending the client or getting police involved; perception that abuse is rare or outside the scope of clinical role; and absence of screening policies and procedures (Daniel & Milligan, 2013; Hamberger, Rhodes & Brown, 2015; Sprague et al., 2012). Other barriers are the presence of partners at office visits, provider frustration when women do not accept help, and conflicts between protection of client privacy while also abiding by mandatory reporting law (Spangaro et al., 2011). Although some evidence on barriers and facilitators for IPV screening is available, implementation studies are rather limited (Decker et al., 2012; Ghandour, Campbell, & Lloyd, 2015). Additional research gaps include missing data on disease pathways from IPV to adverse health outcomes, screening and intervention procedures for co-occurring health conditions, and extension of practices to diverse populations (Ghandour et al., 2015). Further, the literature lacks data on which explicit content should be included in clinician trainings on IPV (Mason and O'rinn, 2014).

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National agencies have published recommendations for IPV screening. The Family Violence Prevention Fund (FVPPF) issued guidelines calling for routine violence screenings for all women (2004). Likewise, an Institute of Medicine (IOM) consensus report declares that women's clinical preventive services should include universal screening for interpersonal violence (IOM, 2011), and the USPSTF recommends IPV screening for all women of reproductive age (Moyer, 2013). Recent reforms in U.S. health care policy are especially relevant, as the Affordable Care Act mandates insurance coverage of domestic violence screening and counseling for women as preventive service (Burke, Simmons & U.S. Department of Health & Human Services, 2014). Defining these services as reimbursable may provide financial incentive for health systems to implement universal IPV screening and counseling.

The clinical setting of interest is engaged in a variety of efforts to enhance alignment with a trauma-informed approach to care. A QI project aiming to increase IPV screenings fit well into this larger mission, as recognition of trauma is central to a trauma-informed model (SAMSHA, 2014). The clinic serves a low-income population with high rates of mental illness, substance use, trauma and homelessness. As established in the research, this disadvantaged community is at far greater risk for IPV. Yet the clinic, as in many similar primary care settings (Kamimura et al., 2014), does not routinely ask about IPV and there is no policy or procedure in place for screening. The purpose of this project was to pilot implementation of universal IPV screenings for women within primary care visits. Insights from the project were used to develop recommendations for practice changes to better address the issue of IPV.

Setting and Participants

The project setting is a Federally Qualified Health Center and patient-centered medical home that delivers integrated primary and behavioral health care services on a sliding fee scale in one convenient location. Each year the clinic provides care to over 4,500 low-income clients, the majority of whom have multiple chronic diseases, including medical, psychiatric and substance use disorders (Englander & Solotaroff, 2014). The clinic utilizes a multidisciplinary team-based structure, and each of

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five care teams is composed of a nurse care team manager, several PCPs, one psychiatric mental health nurse practitioner (PMHNP), two health assistants, several medical assistants (MA), a licensed clinical social worker (LCSW), and an outreach worker. PCPs include physicians, nurse practitioners, physician assistants and naturopathic doctors. The clinical atmosphere is bustling and dynamic. Continuous change is the norm, as new and evolving practice improvement projects are implemented frequently. In some ways constant change facilitated the project, as PCPs are accustomed to engaging in QI and adapting practices accordingly. Major practice modifications, like newly required suicide screenings at each primary care visit, did serve as a barrier, though, as PCPs were in an uncomfortable state of flux and perhaps slightly resistant to even more screening-related transformation.

Participants in the project were two PCPs and female clients. Because the research literature has predominantly focused on women, who are at higher risk for IPV, only female-identified clients were included. There were no other inclusion/exclusion criteria. PCPs were instructed to screen all female-identified clients over two weeks, with the goal of screening between 30 to 50 women. While the larger vision is to implement IPV screenings clinic-wide, the initial priority and exclusive purpose of the Doctor of Nursing Practice (DNP) project was to screen a limited number of clients. Beginning on a smaller scale allowed for trouble-shooting, process evaluation, and manageable change before expanding to broader implementation. All clients were assigned a non-identifiable number and, to protect privacy, data was recorded and stored on a secure computer using this number. The project and its procedures, including protection of personal health information, were reviewed by the university's Institutional Review Board (IRB) and deemed exempt from IRB oversight.

Implementation Procedures

Much happened before screenings were implemented. The DNP student conducted and PCPs participated in a 90 minute training session on IPV epidemiology, risk factors, health consequences, screening procedures, nonjudgmental response to positive screens, danger assessment, safety planning,

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resource/referral options, mandatory reporting law and appropriate documentation. During the educational session, the DNP student assessed PCP preferences for the screening process. To foster investment and offer some control over how to conduct screenings, PCPs were given options on number/types of questions to include in screenings. Based on feasibility and timeliness, both PCPs preferred one broad screening question that encompassed all forms of IPV. Training included instruction on how to initiate “warm hand-off” to a behavioral health clinician if a client was in crisis or the PCP was unsure of how to respond. Safety planning cards and printed lists of IPV resources, available in both English and Spanish, were placed in exam rooms for immediate access during visits. The DNP student developed “quick texts” and entered them in the EMR so that PCPs could immediately produce a scripted introduction, the screening question and danger assessment questions, as well as easily document interventions delivered in response to both negative and positive screens.

After the above was complete, IPV screenings were conducted by PCPs during office visits over a two week period. PCPs have therapeutic relationships with clients, and such relationships are assumed to nurture client comfort and sense of safety when responding to personal questions. For this reason, it was determined that screenings should be performed by PCPs rather than by MAs, who ask most of the other screening questions associated with the clinic’s QI projects (such as substance use, depression and suicide screenings). To be inclusive of individuals with literacy challenges or vision problems, and also to promote a meaningful interpersonal exchange between provider and client, the screening was administered verbally/face-to-face. The screening process aligned with recommendations on how to frame IPV screens (FWV, 2015; Singh et al., 2014; Spangaro et al., 2011). PCPs began with normalizing introductory statements explaining that because IPV is so common, they are asking about safety in intimate relationships. Clients were reminded that they do not have to answer the question and can choose if or how to respond. Next, situations that require alert of authorities, critical information for survivors to consider when deciding whether to disclose abuse, were reviewed. Reinforcement of the

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right to decline answering and notification of mandatory reporting policy were practices intended to promote client empowerment in the screening process.

The screening question asked for a yes/no response and was reviewed by three PMHNPs for face validity. Considering the time constraints inherent in a fast-paced primary care clinic, the DNP student agreed with PCPs that it was most practical to begin with just one screening item and follow up with additional questions as indicated for positive screens. The screening question was:

- Within the last year, have you experienced physical, sexual, verbal or emotional abuse from a partner or ex-partner? [Yes or No]

This question was purposefully designed to screen for IPV within the prior 12 months rather than lifetime IPV for several reasons. In light of available research data, it was expected that rates of lifetime IPV would be quite high for the population of interest. Screening for recent IPV narrowed the focus to women who are more likely to have current safety risks, health problems directly related to partner violence, and/or a present need for intervention.

Clients' responses were recorded in the EMR note. Those who screened negative were directed to safety plans and IPV resources if interested. When a client screened positive, PCPs clarified what type of violence was experienced. As needed, PCPs assessed for immediate danger using the following questions, which were adapted from FVPF (2004) guidelines and available in quick text:

- Has the physical or sexual violence increased over the past 6 months? [Yes or No]
- Has your partner or ex-partner used a weapon or threatened you with a weapon? [Yes or No]
- Do you believe your partner or ex-partner is capable of killing you? [Yes or No]
- Is it safe for you to leave the clinic? [Yes or No]

PCPs responded to positive screens with supportive, nonjudgmental and validating statements, as reviewed in training. They engaged clients in safety planning and provided a list of IPV resources and services, including shelter options, legal assistance, peer support, and 24-hour crisis lines. As indicated, clients were offered on-site supports, such as referral to a LCSW for counseling, a LCSW for support with accessing resources, and/or a PMHNP for psychiatric evaluation and treatment.

Measures and Outcomes Evaluation

Rates of IPV screening and positive/negative responses were the primary quantitative outcomes. An informal review of 25 charts showed that PCPs were not conducting/documenting any IPV screens prior to the project. Rates of documented IPV screening and positive/negative responses during the project were determined via chart audit of eligible visits. Demographic data, such as age, race, housing status, employment, and education, as well as behavioral health diagnoses were recorded without client identifiers in spreadsheets on a secure, password-protected computer.

Provider input on barrier and facilitators to the implementation process was also collected. Feedback was elicited using both open-ended prompts and questions answered with Likert rating scales. PCPs were asked to offer responses to the following questions:

- What challenges or barriers did you encounter when screening for IPV?
- What enabling factors or facilitators did you encounter when screening for IPV?
- How helpful did you find the IPV training? [Likert scale from very unhelpful to very helpful]
- How could the IPV training be improved or adapted to better meet provider needs?
- What is your comfort level with performing IPV screenings? [Likert scale from very uncomfortable to very comfortable]
- What would help you feel more comfortable or confident in screening for IPV?
- What is your comfort level with responding to positive IPV screens? [Likert scale from very uncomfortable to very comfortable]
- What would help you feel more comfortable or confident in responding to positive IPV screens?
- What ideas do you have for expanding and/or improving IPV screenings going forward?

Questions were asked and responses obtained via an online and anonymous questionnaire delivered through agency email. The DNP student also met with PCPs in person to discuss, via an unstructured interview, their experience with conducting IPV screenings. Hand-written notes from interviews were kept in a locked drawer at the clinic that only the DNP student could access.

Project Outcomes

Chart review revealed that 85 female-identified clients were seen by providers throughout the project's duration. Of the eligible visits, 39 IPV screenings were performed (with 38 individual clients, as

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one woman was screened twice) for an overall screening rate of 46%. Client demographics (see Appendix A, Table 1) include an average age of 48.2 years. Three-quarters of clients were Caucasian, 16% were Hispanic and 5% were African American. Data show that 79% of clients were unemployed and nearly 20% lacked stable housing. Over 97% of the women - all except for one - had one or more psychiatric diagnoses, and 66% had substance use disorders. These findings demonstrate high rates of known risk factors for IPV among screened clients, including behavioral health disorders and poverty (Capaldi et al., 2012). Chart review exposed a few instances in which screening was not conducted despite relevance due to report of IPV-associated conditions, i.e., vague pain, unexplained injury and painful intercourse (Singh et al., 2014). In two visits, women presented with chief complaints of injury inflicted by an ex or current intimate partner, signifying the salience of this issue for a couple of clients.

Screening results show that six of the 38 clients, or 15%, disclosed IPV within the last 12 months. No clients reported risk factors for homicide/imminent harm during danger assessment. It is noteworthy that the ages of clients who screened positive (see Appendix B, Table 2), which ranged from 40 to 59 years, were older than the group of women deemed at-risk in some practice guidelines. Four of the six IPV cases would have been missed entirely if USPSTF recommendations to screen all women of reproductive age, or 14 to 46 years, were followed (Moyer, 2013). Each of the women with affirmative screens had both substance use disorders and mental illness, a finding which replicates existing reports that behavioral health problems significantly increase risk of IPV (Smith et al., 2012; Trevillion et al., 2012). With one exception, all clients who screened positive were already engaged in mental health care. The individual client who was not yet engaged was scheduled for a same-day appointment with an outreach worker to discuss recovery and housing options, referred for an intake with a PMHNP for psychiatric treatment, and promptly introduced via warm hand-off to a LCSW for safety planning, crisis intervention and counseling. PCPs delivered interventions in response to positive screens (see Appendix C, Table 3), including initiation of warm hand-offs to behavioral health clinicians for three of six clients.

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All women were offered IPV resources, and five of the six clients were engaged in safety planning. The one client who was not engaged in safety planning had already separated from her abuser and recently created a safety plan with her PMHNP. Overall, providers successfully delivered interventions as planned in the IPV training.

While initially a 15% IPV prevalence appears low compared to much higher rates reported in the literature, one must differentiate between lifetime IPV and past-year IPV. A 15% rate of recent IPV is actually slightly greater than some researchers have found. A survey conducted with 176 low-income and underserved clients who access primary care at a free clinic, individuals similar in many ways to the population served in the project setting, found that the prevalence rate of current IPV was 11% (Kamimura et al., 2014). When evaluating positive screening rates, it is crucial to recognize that IPV often goes unreported (Moyer, 2013). There are many valid reasons why clients may choose not to report past-year IPV. For example, women may have more pressing concerns to address with their medical provider or simply find it unnecessary to discuss such matters. IPV survivors describe re-traumatizing experiences during interactions with legal/protective services, and women are less likely to divulge abuse if they know it must be reported (Sullivan & Hagen, 2005). Thus, providers' review of mandatory reporting requirements before screening could have, understandably, deterred clients from disclosing partner violence.

PCPs identified inadequate time as a substantial barrier to screening for IPV (see Appendix D, Table 4), a finding that mirrors the research data (Sprague et al., 2012). Another barrier was medical complexity, including the need to address multiple and sometimes immediate health concerns within the span of short visits. Other challenges involved finding a screening style that feels natural, and the fact that reviewing mandatory reporting responsibilities prior to screening was cumbersome. Both providers discussed adapting their style to conduct screening in the middle or near the end of visits, after more urgent issues had been addressed and they felt "in tune" or connected with the client. This

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indicates an opportunity to prioritize rapport and comfort within the provider/client interaction before screening. Providers reported IPV training as the primary facilitator. Additional enabling factors were readily available safety cards/printed resources and quick texts for prompts and documentation. One PCP described that early positive experiences, in which women reacted favorably and expressed interest in safety cards, facilitated IPV screens. Reported facilitators in this project match those conveyed in the literature, mainly provider training, positive client reactions during screening, and prompt access to resources (O'Campo et al., 2011; Spangaro et al, 2011).

Providers found the training very helpful and were at minimum comfortable with conducting screens and responding to affirmative responses. PCPs' feedback on how to increase their comfort and confidence with IPV screenings consisted of the following: defining a clearer procedure for warm hand-offs, including having all behavioral health providers immediately available; ensuring that all exam rooms are well-stocked with safety cards and printed resources in both English and Spanish (there were a few instances in which the supply was depleted); inclusion of more role playing activities in the training; and simply more practice. PCP suggestions for expanding and/or improving IPV screenings were educational training for all providers and integration of IPV screening as a required standard element of well-woman exams. Interestingly, one PCP recounted an inclination to also screen male-identified clients throughout the project rather than just women. During unstructured interviews, both providers described enhanced awareness of the pervasiveness of IPV, better understanding of how IPV impacts health, and increased attentiveness to IPV in their daily practice. One PCP described that IPV was "more on my radar" following the project, and both indicated likelihood to screen for IPV more frequently.

Practice Implications and Conclusions

This study's results confirm that the clinic of interest can manage broader implementation of IPV screenings as part of ongoing QI efforts. Some procedures need fine-tuning, such as involvement of every behavioral health clinician in warm hand-offs and weekly checks to ensure that plentiful written

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materials in both Spanish and English languages are available in all exam rooms. Though some key system-level facilitators are already present within the setting, namely availability of on-site behavioral health care and quick access to relevant resources (Decker et al., 2012), considerable work remains to promote additional enabling factors. Greater institutional support and improved partnership with local IPV agencies are warranted, and the DNP student has arranged meetings with clinic leadership to discuss plans for tackling these issues. Even before gaps in systems-level supports are fully addressed, the process of expanding IPV screening across the clinic can continue. Because the vast majority of individuals who receive care at the clinic have relevant IPV risk factors, eventually all clients should be routinely screened for IPV regardless of gender identity. In light of available research literature, evidence-based practice guidelines, and national policy on coverage of IPV screening as preventative care for women, however, it is most practical to initially focus on screenings for female and transgender clients of all ages. Several next steps are recommended.

First, project leaders should work with information-technology staff to develop an IPV screening form within the EMR. Creation of such a form is not only feasible but also familiar, as similar templates have been designed for other projects and are now utilized broadly in the clinic. The new IPV screening form will facilitate visual reminders, easier access to scripted screening questions/interventions, quicker documentation, less burdensome data collection, and superior outcomes tracking. Next, all providers should partake in mandatory training on IPV. The same training session conducted in the DNP project can be delivered in an upcoming provider education meeting to accommodate varying work schedules and assure satisfactory attendance. After training, IPV screenings should be expanded one team at a time until all care teams are included in the QI project. A team by team implementation process allows for provision of extra support to each team during its early involvement. Further, this approach enables project leaders to promote high-quality screening practices by offering focused attention and guidance to small groups of providers as they begin implementation. Advancing the project one team at a time

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also creates opportunity to cultivate IPV champions on each team through close collaboration and personalized encouragement during team members' initial participation.

Project leaders should aim to achieve target screening rates which increase at regular intervals. A preliminary goal to achieve an IPV screening rate of 30% is reasonable based on project findings. The author recommends against clinical policy that requires universal IPV screenings at every visit. Instead, the aim of QI efforts should be to foster providers' genuine investment in the project's vision and sincere commitment to addressing IPV. Mandatory inquiry about IPV is likely to intensify screening fatigue and contribute to questions being asked in a manner that is re-traumatizing for clients. Indeed, IPV screenings can be harmful when done poorly. The survivor experience in violent relationships is one of disempowerment, and it is crucial ensure that this is not also their experience when interacting with health professionals. If providers fail to frame screenings thoughtfully, rush the process of inquiry and intervention, or inadvertently show dismissive or judgmental reactions, there is legitimate potential for harm. Screenings that threaten client autonomy, disrupt survivors' sense of safety, and/or damage the therapeutic alliance are simply detrimental. When, for any number of reasons, IPV screening cannot be conducted using a supportive, empowering and trauma-informed approach, providers should have freedom to defer the screen based on their clinical judgement. In such instances, it is strongly advised that PCPs provide universal education on IPV in place of screening (FVW, 2015). Even brief educational interventions can normalize IPV and, by incorporating written information on safety planning and advocacy services, connect survivors to resources without directly screening for abuse (FVW, 2015).

The QI project described in this paper had numerous beneficial outcomes. While universal IPV screening was not achieved, a screening rate of 46% is a remarkable improvement from apparent absence of screening prior to project implementation. The very act of screening communicated to clients that the clinic is a safe space to talk about IPV, and interventions delivered in response to each affirmative screen provided women with information, resources, and support to reduce their risk for

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ongoing trauma. Of the six women who screened positive, four subsequently took meaningful steps to increase safety, access treatment, and break the cycle of violence. One client entered respite care to engage in intensive mental health services, a decision that allowed opportunity for psychiatric stabilization, distance from a precarious situation, and time to develop future plans. Following years of desire to leave a relationship yet uncertainty on how to do so, one client began to sever financial ties by removing her abuser from a car insurance policy. Another survivor took the important action of filing a restraining order against her violent ex-partner. Finally, a woman who was homeless and struggling with addiction chose to enter long-term residential substance use treatment, a breakthrough which provided not only months of safe shelter but also much needed clinical intervention. In addition to promising results for clients, the project generated value for PCPs, including greater awareness of how IPV impacts health and increased comfort in screening for IPV. Project outcomes encompass wide-reaching favorable effects, and thus envisioned aims were met if not exceeded. In conclusion, IPV screenings enhanced trauma-informed services in the clinic of interest. Other similar agencies may benefit from using this study as a model for introducing IPV screenings to clinical practice.

Summary

Intimate partner violence is a pervasive form of interpersonal trauma that affects individuals with behavioral health disorders at alarming rates. Prominent risk factors for IPV include female sex, childhood trauma, mental illness, substance use, and socioeconomic hardship. IPV has serious adverse health and financial consequences, particularly for women who are at greater risk for partner violence. Informed by systems models and existing programs described in the literature, a quality improvement project was developed to address IPV in an integrated primary care and behavioral health clinic that serves a vulnerable population. The project aimed to implement universal IPV screenings for a limited number of female-identified clients. PCPs were assisted in their implementation of IPV screens via

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supportive procedures such as training, quick texts, and provision of written materials on safety planning and relevant resources.

The screening rate for 85 eligible visits was 46%. Demographic characteristics of the 38 women who were screened show an average age of 48 years and high prevalence of IPV risk factors, including low socioeconomic status and behavioral health disorders. The rate of positive screens was 15% and PCPs delivered interventions in each case. Clients who disclosed IPV were offered resources, engaged in safety planning, and/or provided behavioral health support. Most of the women with affirmative screens demonstrated significant progress in their journey to freedom from partner violence. PCPs' input, collected via questionnaire and unstructured interviews, revealed insights on the implementation process. Primary barriers were time constraints and clients' complex medical needs, while key facilitators included training and access to readily available resources. Project outcomes demonstrate that the clinic is well-suited to implement IPV screenings on a larger scale. Recommendations for advancing this QI effort are incorporation of a screening form within the EMR, further training to include all providers, and expansion of screening procedures across care teams. The project enhanced alignment with a trauma-informed approach to care by cultivating awareness of how trauma impacts health, improving identification of IPV, increasing delivery of interventions to reduce trauma perpetuation, and empowering survivors in their pursuit of safety.

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Appendix A

Table 1

Client Demographic Data (N = 38)			
Age		Years	
	Minimum	28	
	Maximum	63	
	Average (mean)	48.2	
		n	%
Race			
	Caucasian	29	76.3
	African American	2	5.2
	Hispanic	6	15.8
	Asian	1	2.6
Employment			
	Unemployed	31	81.5
	Employed Part-Time	5	13
	Employed Full-Time	2	5.2
Education			
	Elementary school	2	5.2
	High school/GED	12	31.6
	Some college	5	13
	Associates degree	4	10.5
	Unknown	15	39.5
Housing			
	Housed	31	81.5
	Homeless	4	10.5
	Shelter/Transitional	3	8
Substance Use Disorder			
	Yes	25	65.8
	No	13	34.2
Psychiatric Diagnosis			
	Yes	37	97.3
	No	1	2.6

Appendix B

Table 2

Demographics of Clients with Positive Screens (N = 6)			
Age		Years	
	Minimum	40	
	Maximum	59	
	Average (mean)	51	
		n	%
Race			
	Caucasian	6	100
Employment			
	Unemployed	6	100
Housing			
	Housed	4	67
	Homeless/Shelter	2	33
Substance Use Disorder			
	Yes	6	100
Psychiatric Diagnosis			
	Yes	6	100
Engaged in Behavioral Health Care			
	Yes	5	83
	No*	1	17

*Warm hand-off to LCSW for safety planning/to establish care and referred to PMHNP

Appendix C

Table 3

Interventions Delivered in Response to Positive Screens		
	n	%
Offered IPV Resources	6	100
Safety Planning	5	83
Warm Hand-Off to Behavioral Health Clinician	3	50
Referral to Behavioral Health	1*	17

*All others already engaged in behavioral health care

Appendix D

Table 4

Provider Feedback
Barriers to Screening
<ul style="list-style-type: none"> • Insufficient time to perform screens <ul style="list-style-type: none"> ○ Concern about ability to appropriately respond to positive screens given time constraints • Level of client complexity <ul style="list-style-type: none"> ○ Many medical needs to address in short visit • Finding a screening style that feels natural • Need to state reporting requirements before screen is cumbersome
Facilitators to Screening
<ul style="list-style-type: none"> • Training • Quick texts • Positive experience with initial screens <ul style="list-style-type: none"> ○ Clients responded favorably and expressed interest in taking safety card • Safety cards and printed resources readily available
Provider IPV Training
<ul style="list-style-type: none"> • Rated as very helpful • Could be improved with more role playing <ul style="list-style-type: none"> ○ Practice screening questions in Spanish language
Comfort
<ul style="list-style-type: none"> • Somewhat comfortable or comfortable performing screenings and responding to positive screens • Ways to increase provider comfort level and sense of preparedness <ul style="list-style-type: none"> ○ Clearly defined procedure in place for warm hand-offs <ul style="list-style-type: none"> ▪ Have all mental health providers readily available for hand-offs ○ Ensure all exam rooms have safety cards/resources available ○ Ongoing practice <ul style="list-style-type: none"> ▪ As conduct more screenings, easier to integrate into appointment structure ○ More time
Suggestions for Expanding Screenings
<ul style="list-style-type: none"> • Train all providers <ul style="list-style-type: none"> ○ More education/awareness • Make IPV screening a standard element of all well-woman exams