Implementing a Universal Education Approach to Intimate Partner Violence in a Patient Centered Medical Home

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DNP Final Project

Abstract

Background: Intimate partner violence (IPV) is a serious, preventable health problem causing significant morbidity and mortality in the United States. Unfortunately, numerous barriers prevent healthcare settings from implementing focused screening and referral support for IPV services, as recommended by the US Preventative Services Task Force (USPSTF) (O'Doherty et al., 2015; Rees & Silove, 2014; Sprague et al, 2012; Rose et al., 2011; USPSTF, 2013). Evidence is growing for a universal education approach that overcomes many of the cited barriers by providing information about relationship health with patients, regardless of disclosure, and through increasing referral access to a community IPV advocate (Miller et al., 2011; Miller et al, 2013; Miller et al., 2015; Miller et al., 2017; Tancredi et al, 2015). **Methods:** This paper focuses on the implementation of this universal education approach in one patient centered medical home. Implementation was tracked through use of a QI/QA tool, counting referrals, and reviewing use of the protocol in the electronic health record. Effectiveness of training health care providers on the model was evaluated through surveys at set intervals: pre-training, immediate post training, and six months after training. **Results:** Results included self-reported changes in provider knowledge, confidence, and practice. Additionally, changes were demonstrated through referral numbers, disclosures, use of materials, use of the protocol, and collaboration with community partners. However, there were no statistically significant mean differences in reported behavior when comparing pre-training and six months follow up surveys. **Conclusion:** This evaluation adds support to a universal education approach to addressing intimate partner violence. Plans for integrating IPV advocate partners onto the healthcare team provide opportunity for further evaluation.

Intimate partner violence (IPV) is a serious, preventable health problem causing significant morbidity and mortality in the United States. An "intimate partners" can be anyone whom someone has or has had a close personal relationship with, and IPV includes physical violence, sexual violence, stalking and psychological aggression (such as coercive acts and expressive aggression; Center for Disease Control [CDC], 2016). In their lifetime, at least one in four women and one in seven men report experiencing severe physical violence by an intimate partner (CDC, 2017). As many as one in three women and one in four men experience IPV including physical violence, sexual violence, or stalking, and nearly half of persons, of all genders, experience psychological aggression by a partner in their lifetime (CDC, 2011). IPV is an all too common problem.

Extensive literature demonstrates the health impacts of IPV. Serious health consequences of IPV include, but are not limited to, increased rates of asthma, headaches, recurrent kidney infections, fibromyalgia, sexually transmitted infections, unintended pregnancy, medication non-compliance, anxiety, depression, suicidal behavior, injury, and death (CDC, 2015; Hampanda, 2016). More than half of all female homicide victims are killed by an intimate partner (Petrosky et al., 2017). An estimated 34% of IPV survivors who have injuries seek medical care for those injuries (Truman & Morgan, 2014), but many more are seeking care for commonly associated health issues without disclosing IPV.

Persons who are experiencing IPV may not seek health care services specifically for disclosed IPV (Truman & Morgan, 2014), but they may be more likely to utilize healthcare services (Bonomi, Anderson, Rivara, & Thompson, 2009). Unfortunately, numerous barriers prevent healthcare settings from implementing focused screening for IPV and addressing the impact of intimate relationships on health. Public health advocates and primary care providers

need an easily delivered, preventative approach to IPV that can impact population health and overcome barriers associated with traditional direct screening.

An educational tool developed by *Futures Without Violence* (FWV) and funded by the Department of Health & Human Services (DHHS), provides primary prevention through education and awareness building. Research is demonstrating that this brief intervention in health care clinics is helping women leave unhealthy relationships, regardless of disclosure (Miller et al., 2011; Miller et al, 2017). The tool implements a universal education model, providing education about how healthy and unhealthy relationships impact health, along with information about resources. Universal education is a process that normalizes conversations about IPV and provides information to all, not just those who are suspected of or disclose experiencing IPV.

Review of Literature

Relevant Literature

Interventions and screening for IPV in primary care settings is evidence-based practice. A meta-analysis of 17 studies found that a majority of studies could demonstrate health-related benefits of interventions including reductions in future violence, increased safety behaviors, and increased utilization of resources (Bair-Merrit et al, 2014). A systematic review of intimate partner violence screening found that accurate screening instruments exist and that screening caused minimal to no harm (Nelson, Bougatsos, & Blazina, 2011). The review noted additional health benefits associated with screening were significant, including improved birth outcomes, reduced violence, and reduced reproductive coercion. Another systematic review, this one looking at successful implementation of IPV screening, found provider self-efficacy to be imperative to successful implementation. This self-efficacy is best supported through

institutional support, effective protocols, initial and ongoing training, and rapid access to referral services (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). Patient satisfaction and improved outcomes are associated with interventions that focus on patient empowerment and community referral to an advocate (Bair-Merrit et al, 2014; Miller, 2017). In summary, effective protocols for screening or talking about IPV in primary care is supported in the research, particularly when paired with referrals to community advocates.

Clinical Guidelines

Based on the evidence available, clinical guidelines from the US Preventative Services Task Force (USPSTF), Institute of Medicine (IOM), and the American Academy of Family Physicians (AAFP) all provide strong recommendations that screening adolescent and adult women for IPV in the primary care setting should be standard of care (USPSTF, 2013; IOM, 2011; Dicola & Spaar, 2016). The Women's Prevention Services Initiative (2016) and Health Resources & Services Administration (HRSA), both expand their recommendation for IPV screening to include adolescents and women of all ages, and also recognizes the increased indication to screen lesbian, gay, bisexual, transgender, and gender non-conforming individuals. To truly provide an inclusive protocol, health centers may focus on interventions for all adolescents and adults through a universal approach, providing education and resources to all regardless of gender, relationship status, or direct disclosure of abuse.

Gaps in Literature and Practice

Despite clinical guidelines promoting screening and intervention in primary care, patient and provider barriers contribute to ineffective and insufficient implementation (O'Doherty et al., 2015; Rees & Silove, 2014). Barriers to screening for intimate partner violence by health care providers have been identified as time constraints, a lack of protocols and policies, lack of

training, lack of support, and providers' perceptions or attitudes about IPV (Sprague et al, 2012). Patient-related barriers include knowledge gaps about what is abuse, fear of not being believed, fear of social service involvement, the partner's presence at visit, confidentiality concerns, self-blame, immigration status, and gender or sexual orientation factors (Rose et al., 2011).

In order to impact health outcomes, health care providers need to provide information on resources and help available. Just screening for IPV, without a referral or intervention, has an insufficient impact on health outcomes (Hegarty & Glasziou, 2011; Jewkes, 2013; Rees & Silove, 2014). While several screening instruments have been identified as having high sensitivity and specificity for identifying IPV in health care settings (AHRQ, 2015; Nelson, Bougatsos, & Blazina, 2012), traditional screening that relies on direct disclosure of IPV may miss opportunities with persons who fear reporting their experiences, as well as with those who are unaware that their experience is considered abuse (Miller et al., 2017). Barriers associated with direct screening are reducing the use and utility of validated screening instruments in clinical settings.

Proposed Solutions

Randomized controlled trials support the practice of addressing IPV through preventative health strategies. For example, providing education to youth populations defining healthy and unhealthy relationships during a well adolescent visit resulted in fewer youth staying in unhealthy relationships (Miller et al, 2015). Further, programs that educate young men on healthy relationships reduce perpetration of dating violence (Miller et al, 2013). Early detection can be achieved through screening, and tertiary prevention is possible through referral and harm reduction strategies. Reproductive coercion, for example, can be decreased through harm reduction strategies such as assisting patients with birth control options that cannot be interfered

with and providing referral to local domestic violence providers (Miller et al, 2011; Tancredi et al, 2015).

Compared with direct disclosure based screening, patients and health care providers respond favorably to a universal education approach (Miller et al., 2017). The universal education method involves use of an educational brochure, folded into the size of a business card, as a tool for providers to deliver patient education on IPV and its' impact on health. This card also serves as a resource for free, confidential national hotlines (FWV, 2017).

Universal education has been found by providers, administrators, and patients alike to be an effective tool. In one study of this intervention provided to all women at a reproductive health clinic, administrators found the intervention and training feasible, affordable, and straightforward to administer (Miller et al., 2017). Providers reported increased confidence in discussing IPV with patients, facilitated by the tool, and increased capacity to help their patients. Patients found the intervention to be informative, supportive, and empowering; and patients reported holding on to the cards for themselves, as well as sharing them with friends or family (Miller et al., 2017).

Summary of Project

This project sought to replicate a quality improvement initiative addressing IPV in a health site through universal education. The aim was to increase provider confidence in addressing IPV, increase patient access to resources, and work towards preventing IPV and related health consequences. The project aim was to examine the relationship between training of health care providers in a particular IPV educational model, along with a collaborative partnership with an IPV advocate organization, on providers' comfort and practice providing IPV education and referrals. Building on prior research supporting this model (Miller et al., 2013; Miller et al., 2015; Miller et al., 2017), this project sought to increase the generalizability of the

findings by applying the intervention to adolescents and adults of all genders, compared to only adult women of reproductive age (thereby also supporting the gender diverse clinic population). The project further sought to build upon prior research supporting a collaborative relationship with an IPV advocate organization to improve utilization, satisfaction, and effective referrals (Bair-Merrit et al, 2014; Miller, 2017; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

Approach to the Conduct of the Project

Setting

The project was implemented in one clinic site and with one advocate partner. The clinic, OHSU Family Medicine at Richmond, is a certified patient centered medical home (PCMH), federally qualified health center (FQHC), and is affiliated with an academic medical center. The PCMH focuses on providing a full range of primary care services to a SE Portland, Oregon community, including pharmacy, behavioral health, laboratory and x-ray, walk-in/urgent care, reproductive healthcare, addiction medicine, transgender healthcare, geriatric care, sports medicine, and other life span primary healthcare.

The population served includes nearly 15,000 patients across the lifespan (16% children and 10% over 65). Payers include 44% Medicaid, 17% Medicare, 8% Uninsured, and 31% Commercial. Approximately 75% of patients have incomes below 200% FPL and about 4% are homeless. The patient population is primarily Caucasian (75%) and about 10% require interpreter services.

The partner advocate site, Home Free, is a service of Volunteers of America. Home Free offers free and confidential services to the Portland metropolitan area. Specific services include safety planning, emergency and permanent housing, emotional support, referral coordination,

long term advocacy support, child welfare support, teen groups, and assistance with legal procedures, advice, and support through legal processes (Volunteers of America, 2017).

Organizational/systems and Population Readiness to Change

The project initiative was supported by clinic leadership and the patient advisory council. However, results of a pre-survey of current clinical practices indicated a significant gap between current practices and proposed practice. Prior assessment of clinic readiness revealed the top three identified provider barriers to be lack of protocol, difficulty getting the patient alone, and inadequate training (Hallock-Koppelman, 2014). Other barriers, consistent with research, included inadequate resources, lack of time, and lack of confidence to address IPV as an issue, but at lower rates than anticipated (Hallock-Koppelman, 2014). The survey revealed that the majority of providers never considered screening for IPV with correlated health conditions such as hypertension or coronary artery disease, and nearly half never screened for IPV with chief complaints of headaches or irritable bowel syndrome. Prenatal care and depression/anxiety were more likely to trigger evaluation of IPV, but not routinely (Hallock-Koppelman, 2014).

Participants/Population

The populations of focus were the clinic and the partner advocate sites, the clinic health care providers (HCPs) and medical assistants (MAs), and patients. HCPs include Nurse practitioners (NP), physician assistants (PA), medical doctors (MD), registered nurses (RN), and behavioral health consultants (BHC). Patients served by the clinic, age 12 and up, were the recipients targeted to receive the intervention. Twelve years old was chosen as a starting point as this is the age that youth begin receiving a well adolescent visit. The sole inclusion criterion was clinic HCPs', MAs', or patients' willingness to participate. There were no exclusion criteria.

Sample size and rationale

The goal was to capture survey responses from at least 30% of clinic providers, including a mix of HCPs and MAs, expecting a typical internal survey response rate of 30-40%. The clinic currently has 37 fulltime equivalent HCPs and 27 MAs.

Recruitment, protection of participants, & ethical considerations

Recruitment occurred through internal emails with a survey link. The pre-training survey was emailed two weeks prior to training. Participants were invited to complete a post training survey two times: 1) either in person immediately following the training session or via an emailed link within two weeks post training, and 2) six months post training. No identifying data were collected, protecting participants through anonymity. A trauma informed approach to the FWV-developed training sought to protect trainees and clinical trainers alike by providing a training that acknowledges the impact of trauma and actively seeks to avoid re-traumatization (SAMHSA, 2015). The universal education approach serves as both education and resource to providers, clinic staff, and patients alike. Research supports that discussing IPV in a supportive environment produces minimal to no harm (Nelson, Bougatsos, & Blazina, 2011).

The universal education model provided by FWV helps overcome barriers and ethical risk such as fear of legal repercussion, child services involvement, and deportation by providing resources universally and not requiring disclosure. Through the collaboration, the advocate partners agreed to provide a dedicated advocate for clinic patients, with access through a dedicated phone line and capacity to with patients in the clinic, giving patients increased opportunity to connect with that advocate without their partner's knowledge. Advocate partners can provide confidential services and, in some states like Oregon, do not face the mandatory

reporting requirements of health care providers (National Network to End Domestic Violence, 2011).

Implementation of the project

Evolution of the Project over Time: Plan Do Study Act (PDSA)

Plan. The IPV clinic work group set out to implement a process of addressing intimate partner violence through universal education and improved referral access to IPV advocates. The group aimed to achieve this outcome by supplying the clinic with the educational materials, collaborating with a partner advocate agency, and providing clinic training on the universal education model. Participants received surveys, developed by FWV, on practices and attitudes at set intervals: prior to the training, immediate post training, and six months after training. The goal was to provide descriptive information about practices and the impact of training, as reported through these surveys. Additionally, six questions on the pre-training and six months follow up survey were repeated, and the hope was that the six month follow up survey may assess for attitude and behavioral changes over time. The plan also included collecting referral numbers through our partner advocate site, Home Free, as an additional data point.

Do. A quality improvement/quality analysis tool (appendix E), provided by FWV, was used as a guiding tool for the work group and its implementation benchmarks were reviewed prior to initial training, three months post training, and one year post training. In the year since planning to bring training from FWV, the work group was able to provide training to a majority of health care providers, medical assistants, and administrative leadership. The referral process focused on a direct phone line to our partner advocates, with a goal of increasing patient access.

Educational Materials. The primary educational materials were a 4-panel double-sided brochure that folds up to the size of a business card (3.5″ x 2″) and was designed for persons

receiving health care services (FWV, 2017). The card helps readers recognize how their relationship impacts their health as well as the health of their children, and provides information on safety planning. The safety card lists specific health problems that may be the result of chronic stress from an abusive relationship. The backside of the card refers people to national domestic violence hotlines for further support, which will also aid in connecting the patient to local resources. The cards are available in exam rooms and also in restrooms with associated educational posters.

The Collaboration. Developing a collaborative relationship with Home Free facilitated the initiative, supporting a goal to improve provider confidence in accessing supportive services. The clinic was given direct telephone access to an advocate when needed for referral or emergency support with the opportunity to bring the advocate on site to the clinic. Similarly, Home Free clients needing to connect with a health clinic site were to be offered rapid access to these services. Efforts were made to inform all staff at both sites about the relationship.

Clinic Training. Ensuring all providers were trained and had access to reminders, prompts, and re-training was considered essential to the success of this project. Half day training sessions were conducted at both the clinic and advocate sites, with a general focus on recognizing health consequences of IPV, utilizing the universal education model, and how the partner organizations could better work together to achieve these aims. Addressing implicit biases about who may or may not be experiencing abuse was addressed in the training, as well as through the initiative's focus on universal intervention, rather than screening by indication or suspicion only. The training also sought to expand participants' knowledge on health indicators that suggest IPV as part of the differential diagnosis. Administrators, HCPs, and MAs were recruited through email to attend the training at the clinic.

Use of Information Systems and Technology. A significant barrier encountered was how to best integrate the screening in the electronic health record (EHR) with an implementation that simultaneously addresses patient privacy needs, assists providers with adequate prompting, and provides for data tracking. Documenting the intervention and disclosures without alerting intimate partners who could potentially access the patient chart is essential to the protection of patients. A saved process in the EHR known as a "smart phrase" was developed. Providers or MAs can now enter this smart phrase into the EHR to remind them how to follow the protocol and the smart phrase includes language reminding providers to make the note private so the note will not be visible from a patient access portal. Further, during the implementation of this project, the capacity to merge this smart phrase with one developed by the EHR allowed for more effective EHR prompting and the ability to monitor use of the protocol.

Study. Measurements included 1) pre-training and post-training survey of providers (see appendixes A-D); 2) pre- and post-implementation use of a quality improvement/quality assurance (QI/QA) tool evaluating clinic progress with protocol (see appendix E); and 3) recording the number of referrals between Richmond and VOA post implementation (baseline was 0 recorded). Sixty-two pre-surveys were collected, 38 immediate post surveys, and 31 six-month follow up surveys, for follow up completion rates of 61% and 50% respectively.

Additional tracking included obtaining referral numbers, use of a QI/QA tool, and tracking EHR use. Referral numbers from Home Free were obtained in January and late April. VOA staff added the question "who referred you?" to their intake process and counted the number of referrals from the clinic. The aim was to demonstrate improved patient access to services through increased referral. The QI/QA tool was completed by the IPV clinical work group prior to initial training, 4 months post training, and one year after initial training.

Additionally, an EHR function emerged during implementation that could both encourage and record each use of the smart phrase developed for IPV screening. These numbers were also collected.

Benefits of this implementation process included a simple survey design and use of implementation science to evaluate a developed model of care across another health system, assessing effectiveness and generalizability. Limitations include risk for recall bias, response bias, nonresponse bias, and observer bias.

Act. The evolution of this work led to more opportunities. In December, 2017, an application was submitted for a grant opportunity "Victims of Crime Act (VOCA)- Support services & training grant" (Oregon Department of Justice, 2017), in support of collaborative services between the partner advocate site and the clinic, specifically to support mental health related services for survivors. The grant was awarded in April, 2018, for $36,550. In late February, 2018, another grant application was submitted for "VOCA- Community based advocates and health care partnerships" (Oregon Department of Justice, 2018), which focused more specifically on expanding the established collaboration and project. This second VOCA grant was awarded in April, 2017 for $496,844. The grant will fund additional training support and two on-site IPV advocates, one from our original partner and a new advocate partner, to work across the FQHC settings (which include the main clinic, urgent care, and a school based health center). The continuous implementation and improvement process will be sustained at least 30 months through this support, with new champions stepping into the leadership of the project. The grant includes funding to evaluate this project.

As mentioned, the clinic was able to utilize EHR tools that encouraged screening and use of the protocol. As the clinic is transitioning to a new EHR, these tools will be transferred to and

modified for the new process of having on site advocates. The result of this project implementation, ultimately, was opening doors to these opportunities to fund, evaluate, and further implement this intervention.

Unintended Consequences

Addressing employee health. When including for psychological aggression, nearly half of all adults experience some form of IPV in their life. Given these numbers, we know that many health care providers and clinic staff are survivors or also may currently be experiencing IPV. The clinic set out to address IPV experienced by our patients with a trauma informed approach. Much of the information provided about relationship health and related resources was new to employees, and providing the information was at times emotionally triggering to employees. Several employees identified themselves as survivors, as experiencing IPV, and as knowing someone personally they were concerned about. Even brief discussion needed to include a warning statement and review of self-care strategies to utilize. Health care sites looking to replicate or implement a similar project may want to first focus on providing the education and resource support to employees.

Gatekeepers & champions. The plan was to empower medical assistants (MAs) to include providing universal education in their scope of practice. While enthusiasm was mixed among medical assistants, many emerged as key champions of this work. Unfortunately, key leadership became a gatekeeper for including the universal education model as a part of the MA workflow. It is possible this difference in workflow impacted survey results, though the number of medical assistants participating in the follow up survey was not significant enough to run a comparison. Alternatively, participation in follow up surveys may have been influenced by less engagement in the intervention.

Many champions of the work did emerge, however, including administrative and clinical leadership who were essential to facilitating time for training and finalizing agreements for the grant based collaboration with community partners. Anecdotally, health care providers who identified as champions appeared more likely to change their practice.

Missing data or information

Surveys did not include identifiers. Thus, it is impossible to assess how any specific participant changed over time, and only to observe group changes. Further, since attendance was not recorded at all training sessions, and survey responses were anonymous, it remains unknown if anyone who completed the pre-survey did not actually complete the training. The surveys were sent to all providers and medical assistants, asking that only those who attended the training complete it. Additionally, all "n/a" responses and skipped responses were not included in the analysis.

Key Findings

Comparing pre-survey and six months follow up. No significant changes were noted between mean responses on questions 1-5, and question 7 on the pre-and six months post training surveys. Lack of significance remained when looking at the May and November trainings alone.

Electronic Health Record data ("Health maintenance"). At the time of implementation (November 2017) more than 12,000 patients were eligible for IPV screening based on our criteria (ages 12+, all genders). As of April 26th, 2018, 529 patients had documented IPV screening through use of the health maintenance smart phrase.

Referral numbers. Prior to partnering with VOA Home Free, our partners were unaware of any referrals from the clinic, and the assumed baseline was 0. Between August 2017 and the end of April 2018, at least 73 referrals were generated. Interestingly, but not statistically

significant, more referrals (46 vs. 28) came through the hotline after hours than were generated within the clinic (see Table 1).

Table 1. Referrals to VOA Home Free

Richmond Clinic Direct

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1	3	6	5	3	0	1	2	6

Home Free Hotline Referral

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
3	2	10	15	8	2	0	1	5

Total N=73.

Descriptive data from post training surveys.

Immediate post training (Appendix A). The response to training was favorable. Respondents overwhelmingly endorsed increased understanding about IPV and its' health impacts. They further endorsed increased knowledge on how to discuss confidentiality, provide universal education about relationship health, assess for IPV and reproductive/sexual coercion (RSC), and working with their local IPV advocate partner. Following the training, the majority of respondents agreed (53% strongly agree, and 37% agree) that they would be more likely to provide universal education on healthy relationships to patients, and that they would be more likely to conduct direct inquiry for IPV with any patient (8% were undecided, only one respondent disagreed).

However, some respondents were undecided around changing their practices following the training. While about 70% either agreed or strongly agreed that they would be more likely to discuss confidentiality limits, as many as 18% were undecided (with another 5% disagreeing and 5% answering "n/a"). Similarly, 18% of respondents' remained undecided about committing to

assessing patient safety and discussing ways to stay safe in relationship (76% agree or strongly agreed). Providers were most committed to offering patients materials on IPV, and a majority committed to some practice change, but only 18% responded they were ready to commit to offering universal education and IPV screening *regularly*. Describing support needed to incorporate the universal education model, respondents suggested clinic policy changes, adequate materials, and on-going training.

Descriptive results of the pre-survey and six months follow up (Appendix B). As stated, there were no statistically significant differences in reported behavior pre training and six months post training in any of the correlated questions. Both pre training and six months following training, there was significant variance reported in the practice of discussing IPV with patients, assessing safety, and discussing confidentiality (See appendix B). While the percentage of persons who endorse talking to patients about IPV "most of the time" increased from 13% to 27%, there was overall no statistically significant difference between respondents in the pre-training and six month post training surveys. Six months following training, a majority of respondents still endorsed talking to patients about RSC rarely or not so often (less than 25% of the time).

Interestingly, while not statistically significant, 60% reported rarely or "not so often" referring to their DV organization six months later, compared to only 45% in the pre-assessment. There were differences in confidence around referrals, though the net differences were not significant. For example, 60% felt "somewhat confident" in referring to their IPV partner organization following training, compared to 39% in the pre-training assessment. However, "complete" confidence dropped from 28% to 13%, while a complete lack of confidence ("not at all") also dropped from 26% to 13%.

Several questions on the six month follow up survey did not directly correlate to the pre-training assessment. These self-report measures describe respondents' perceived changes in comfort, confidence, and behavior (see appendixes C & D). Overall, providers endorsed increased confidence in responding to disclosures (20% strongly agree; 53% agree). A smaller majority endorsed feeling more comfortable supporting clients making phone calls to IPV advocates (58%), and increased frequency of talking to their patients about healthy relationships six months after the training (57%). About one third of participants reported an increase in making referrals to advocate partners and half reported experiencing more disclosures. In contrast, 50% reported their practice unchanged around making referrals or receiving disclosures. Asked more specifically about contact with a local DSV agency, a small majority (55%) reported their practice remained the same and about 20% reported an increase in contact. Six months after the training, the vast majority of respondents were aware of available resource materials in the clinic.

V. Outcomes

Comparison of findings to literature and expected results

The findings of this project evaluation are consistent with prior research on training providers on IPV screening, interventions, and referral. A systematic review by Zaher, Keogh, and Ratnapalan (2014) on the effect of domestic violence training overall found that training increased provider referrals to IPV support resources primarily only when paired with system support interventions. Training alone was found to increase knowledge and change perceptions, without necessarily having a significant impact on behavior. Similarly, in this evaluation there were reported changes in attitude, confidence, and knowledge. However, these changes did not

correlate with significant change in reported behavior frequency, though a small majority did report increased use of the universal education intervention (57%).

Consistent with prior evaluations of the universal education model, health care providers responded favorably to this specific universal education approach (Miller et al., 2017; Miller et al., 2013; Miller et al., 2015). Evaluations of 35 health care professionals who received the same training by FWV in Oregon's Clatsop and Columbia Counties, endorsed an increased understanding of the intersections of health and IPV as well as increased comfort in addressing the topic (Guanciale et al., 2017). These findings were supported by this evaluation as well.

System changes, such as the developing of an EHR incentive and the ability to provide a direct referral to a partner advocate, did appear to have some impact on behavior change. Referral numbers and documentation of screening demonstrated implementation of the protocol, though there is no base comparison to test for significance. Prior research supports a collaborative relationship with an IPV advocate organization increasing utilization, satisfaction, and effective referrals (Bair-Merrit et al, 2014; Miller, 2017; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). Prior findings on the impact of EHR prompts or incentives specific to IPV screening or general to health screenings were not found.

Understanding differences between expected and observed results

Several factors may contribute to lack of statistically significant behavior changes. A majority of participants reported increased confidence responding to disclosures, but there were no statistically significant differences in reported screening and referral. Small sample size could have impacted significance (N= 62 pre-survey, N=38 immediate post surveys, and N=31 six-month follow up survey). One clinic related factor could be related to having a robust behavioral health team. Thus, the questions may fail to capture the reality that providers defer more in depth

assessments and referrals to their behavioral health colleagues. Further, low levels of commitment in the immediate post training survey to providing universal education/screening (18%), is consistent with lack of behavioral change. It would be useful to understand more what prevented providers from feeling able to commit to education/screening, compared to their willingness to provide the materials alone (53%).

Prior assessment of clinic readiness revealed top provider identified barriers to be lack of a protocol, difficulty getting the patient alone, and inadequate training (Hallock-Koppelman, 2014). We cannot conclude from this assessment if training was "adequate", but training was provided and a protocol now exist. Difficulty getting the patient alone, as well as discussing confidentially, remained identified barriers. Future efforts to change clinic policy to address this issue is a necessary component to improving successful implementation, and is also a requirement of the VOCA grant received that funds on site advocates.

Use of the quality improvement tool to guide the work group suggests there is much work still to be done to have a fully integrated change in practice, but also highlights progress that has been made (see appendix E for a comparison of the QI tool in May 2017 and May 2018). As the clinic addresses the impact of IPV on staff, seeing patients alone, working with advocates on site, and other facilitators to addressing IPV in a primary care setting, we may hope to observe more provider behavior change over time.

Impact of project on system including costs

Practice impacts are noted by increased implementation (QI/QA tool, appendix E), increased referrals, use of the EHR, and increased recognition of available materials onsite. In pursuit of expanding implementation through a grant funding onsite advocates, space implications were weighed heavily. The clinic space is already considered inadequate for the

services offered, with plans for future expansion to resolve some of this burden. The clinic culture, however, is highly supportive of innovation and flexibility.

Financial cost to implementing this project was minimal, as staff volunteered time during lunch hour for the clinical work group, and materials could be ordered in bulk for free (with only a $10 shipping fee). The initial training and support from FWV was funded by Oregon Safer Futures and the Department of Justice. The estimated cost of the training and support services were between $7000-$1100 (cost is an estimate due to the total cost of $3200 being split across three clinic sites across the state). The clinic spent $100 on a donation to the training location (a community church), and $350 on food and supplies.

Universal education training booklets, universal education cards, posters, implementation toolkits, and training materials are funded by HRSA and provided by FWV free of charge to download or order printed materials (there is a flat $10 shipping fee; FWV, 2017). On-going costs to the clinic may be considered as approximately $10/month of shipping and employee time related costs for additional training and work group time. Funding a training session for trainers is an approximate cost of $300 per trainee, available at the biannual conference put on by FWV on Health & Domestic Violence.

Addressing financial incentives and disincentives is essential to sustainable healthcare interventions. IPV screening and counseling is currently covered under the Affordable Care Act as a prevention service, specifically, it is a billable service for health care organizations with no co-pays or deductible for patients (Women's Preventative Services Initiative [WPSI], 2016; healthcare.gov, n.d.). In Oregon, IPV services are recognized as an essential social determinant of health and thus of value for reimbursement to Coordinated Care Organizations under Medicaid (Keefe, 2016).

VI. Practice-related implications/recommendations/limitations

Recommendations

The PCMH has an opportunity to be a leader in addressing relationship health through this innovative approach pairing universal education and embedding on site IPV advocates. They will be the one of the largest clinical sites to integrate this approach thus far and, as an academic medical center, there are unique opportunities to evaluate this model, make improvements, and demonstrate effectiveness to other health centers across the country.

The research consistently demonstrates the importance of supported referral to community advocates to benefit survivors. While integrating IPV advocates into the health care team remains in the innovation stage, recent collaborations have been able to demonstrate impact on reducing health care related costs and cost sustainability beyond grant funding (Futures without violence, 2017; Guanciale et al., 2017). These advocates offer support, information, safety planning, referrals, assistance with protective orders, emergency housing support, and trauma informed system navigation with legal, medical, and community resources. Advocate services are associated with increasing survivor safety, self-efficacy, and reducing the impact of traumatic stress (Guanciale et al., 2017). The hope is that by further integrating advocates, providers will increase their identification of IPV and its health consequences, connecting survivors to advocates in a quick, effective, and confidential manner. Providers can then focus in on the related health sequelae with enhanced understanding. Further, providers can continue to utilize the universal education approach to share knowledge with patients, young and old, about the importance of healthy relationships. This will hopefully improve patient knowledge and increase healthy relationship behaviors, thereby serving as prevention and improving health.

Limitations

Several limitations of this project evaluation are notable. Self-report measures are subject to issues of social desirability bias, recall issues, comprehension of the question, and control of sample. For example, there was a comment made to the researcher that the phrasing of responses, such as "all the time" was confusing, unclear of just how often the questioned behavior or experience was expected to occur.

For most measures, there is only the ability to provide a description of self-reported changes. There is a noted discrepancy between descriptive self-reported changes and the lack of significant difference in response to being asked about current behaviors pre and six months post training. Unfortunately, this evaluation did not assess for individual change over time. Generalizability may be limited by unique clinic resources (i.e. behavioral health team, culture of innovation and QI experience, academic medical setting), however, results were comparable to follow up evaluations of the same training in smaller clinics without those resources (Guanciale et al., 2017).

While referral numbers and EHR utilization may represent behavior change, the baseline of 0 referrals was assumed only, since this information was not previously gathered. Since EHR incentives did not exist prior to training, it is not possible assess for difference pre and post training on use.

Conclusions

Training clinic health care providers, medical assistants, and administrators on a universal education approach to addressing relationship health has been impactful. While survey responses have not demonstrated meaningful behavioral change, the clinic has changed in a number of observable ways. The exam rooms and bathrooms are stocked with IPV materials that

need monthly re-stocking. Referrals by both providers and the patients to our advocate partner are happening. Disclosures are taking place, evidenced both in the referrals and the use of EHR tools. Partnerships between the healthcare site, community advocate partners, and funders, have been forged and continue to evolve.

The training started with funding support and through continued collaboration with funders and community leaders, this project will be expanded on and sustained another 30 months. Over the next two and a half years, the collaborative partners can demonstrate the capacity for integrating IPV advocate partners onto the healthcare team, increasing access to this life saving resource, improving survivor health, and reducing IPV healthcare associated costs.

VII. Summary and Next Steps

Several lessons were learned during implementation. Health care sites looking to replicate or implement a similar project may want to first focus on providing universal education and resource support to employees. Likewise, moving forward, this PCMH will also need to further address this. One thing that was learned from tracking referrals was the significant number of calls from patients that happened outside of their clinic visit. Given that most patients were only given the referral number if there was a concern for IPV, moving forward the clinic protocol will include providing all patients with the referral number regardless of disclosure. Finally, it is essential that the clinic develop a policy around meeting with patients alone to ensure the opportunity for patients to safely disclose or connect with an advocate.

This evaluation adds support to a universal education approach to relationship health, paired with IPV advocate partnership, as a solution to the many barriers that have impeded implementation of clinical guidelines. Several opportunities for additional evaluation can be considered moving forward, including the impact of on-site advocacy on factors such as patient

satisfaction, patient safety and health outcomes, provider satisfaction and practice changes, cost-effectiveness, and other evolutions of this project not yet imagined.

Advance practice nurses with a doctorate of nursing practice (DNP) can play an important role in developing clinic protocols, coordinating between partner organizations, addressing program finances, and in advocating for innovations. The implementation of this project has evolved through problem solving and collaboration, facilitated by leaders who appreciate the impact of IPV as a social determinant of health, and through their willingness to be at the forefront of healthcare innovations. Relationships are essential to our health and also essential to impacting practice and organizational change.

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Appendix A: IPV post training survey results

Q1. The training increased my understanding of: The impact of intimate partner violence (IPV) and reproductive and sexual coercion (RSC) on health.		
Answer Choices	Responses	
Strongly Agree	63.16%	24
Agree	36.84%	14
Undecided	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q2. The training increased my understanding of: How to discuss the limits of confidentiality with my patients		
Answer Choices	Responses	
Strongly agree	42.11%	16
Agree	47.37%	18
Undecided	5.26%	2
Disagree	0.00%	0
Strongly disagree	2.63%	1
n/a	2.63%	1
	Answered	38
	Skipped	0

Q3. The training increased my understanding of:How to provide universal education and assess for IPV		
Answer Choices	Responses	
Strongly agree	44.74%	17
Agree	47.37%	18
Undecided	7.89%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q4. The training increased my understanding of:How to assess for reproductive and sexual coercion (RSC).		
Answer Choices	Responses	
Strongly agree	39.47%	15

Agree	52.63%	20
Undecided	5.26%	2
Disagree	2.63%	1
Strongly disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q5. The training increased my understanding of: How to work with your local DV/IPV partner to facilitate patient access to advocacy services.		
Answer Choices	Responses	
Strongly Agree	47.37%	18
Agree	36.84%	14
Undecided	13.16%	5
Disagree	2.63%	1
Strongly Agree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q6. Following the training, I am more likely to: Provide universal education on healthy relationships to all patients		
Answer Choices	Responses	
Strongly Agree	52.63%	20
Agree	36.84%	14
Undecided	5.26%	2
Disagree	0.00%	0
Strongly Disagree	0.00%	0
n/a	5.26%	2
	Answered	38
	Skipped	0

Q7. Following the training, I am more likely to: Conduct direct inquiry for IPV with any patient		
Answer Choices	Responses	
Strongly Agree	42.11%	16
Agree	44.74%	17
Undecided	7.89%	3
Disagree	2.63%	1
Strongly Disagree	0.00%	0
n/a	2.63%	1

	Answered	38
	Skipped	0

Q8. Following the training, I am more likely to: Discuss the limits of confidentiality with my patients before asking about coercion or violence.		
Answer Choices	Responses	
Strongly agree	36.84%	14
Agree	34.21%	13
Undecided	18.42%	7
Disagree	5.26%	2
Strongly Disagree	0.00%	0
n/a	5.26%	2
	Answered	38
	Skipped	0

Q9. Following the training, I am more likely to: Assess patients' safety and discuss ways to stay safe in an unhealthy or abusive relationship.		
Answer Choices	Responses	
Strongly Agree	42.11%	16
Agree	34.21%	13
Undecided	18.42%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
n/a	5.26%	2
	Answered	38
	Skipped	0

Q10. Please mark at least one action item that you intend to do differently following the training:		
Answer Choices	Responses	
Put up posters about IPV and RSC	0.00%	0
Offer materials on IPV and sexual coercion inclusive of diverse relationships including for sexual minorities, LGBTA clients	52.63%	20
Offer an in-service training for all my staff on IPV and RSC	5.26%	2
Call my IPV partner program with patients	5.26%	2
Commit to offering universal education and assessing for IPV and RSC regularly	18.42%	7
Attend, or help lead, another IPV or RSC training	2.63%	1
Review the new protocol for assessing for IPV and/or RSC	7.89%	3
Other (please specify)	7.89%	3

	Answered	38
	Skipped	0

Q11. What on going support do you need to confidently incorporate discussion of IPV and RSC in all your encounters?	
Answered	19
Skipped	19

Response themes:

Ongoing Training Practice Clinic Materials Cards

Q12. The presentation was helpful and informative.		
Answer Choices	Responses	
Strongly Agree	63.16%	24
Agree	36.84%	14
Undecided	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q13. I have learned something new about intimate partner violence and reproductive coercion		
Answer Choices	Responses	
Strongly Agree	68.42%	26
Agree	26.32%	10
Undecided	2.63%	1
Disagree	2.63%	1
Strongly disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

Q14. The presenters were organized and prepared		
Answer Choices	Responses	
Strongly Agree	60.53%	23
Agree	34.21%	13
Undecided	2.63%	1
Disagree	2.63%	1
Strongly Disagree	0.00%	0

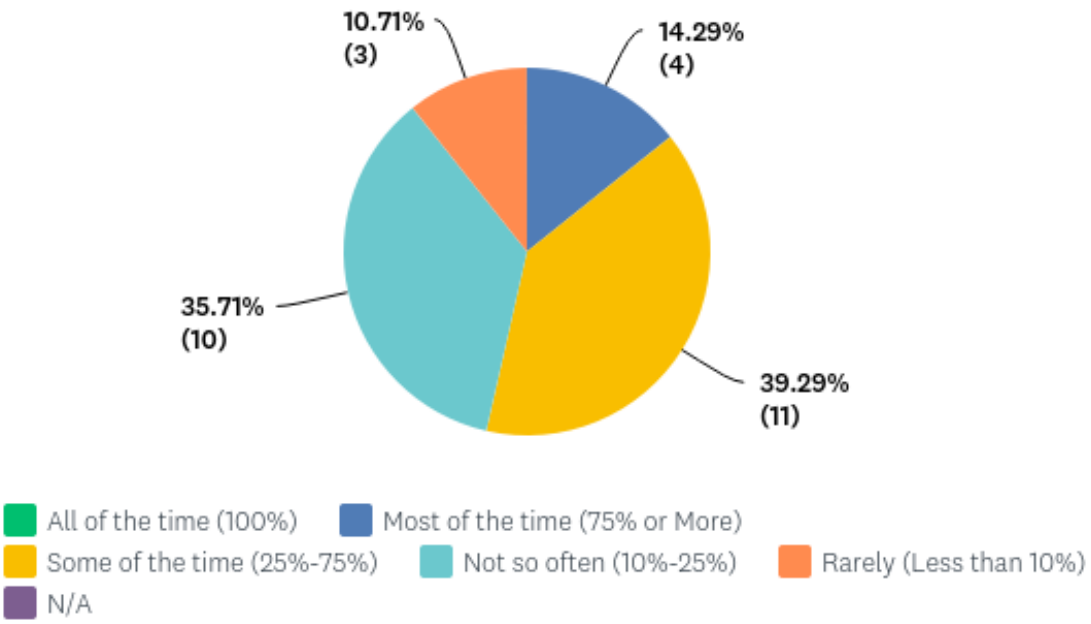
n/a	0.00%	0
	Answered	38
	Skipped	0

Q15. I was able to understand the presenters		
Answer Choices	Responses	
Strongly Agree	68.42%	26
Agree	31.58%	12
Undecided	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
n/a	0.00%	0
	Answered	38
	Skipped	0

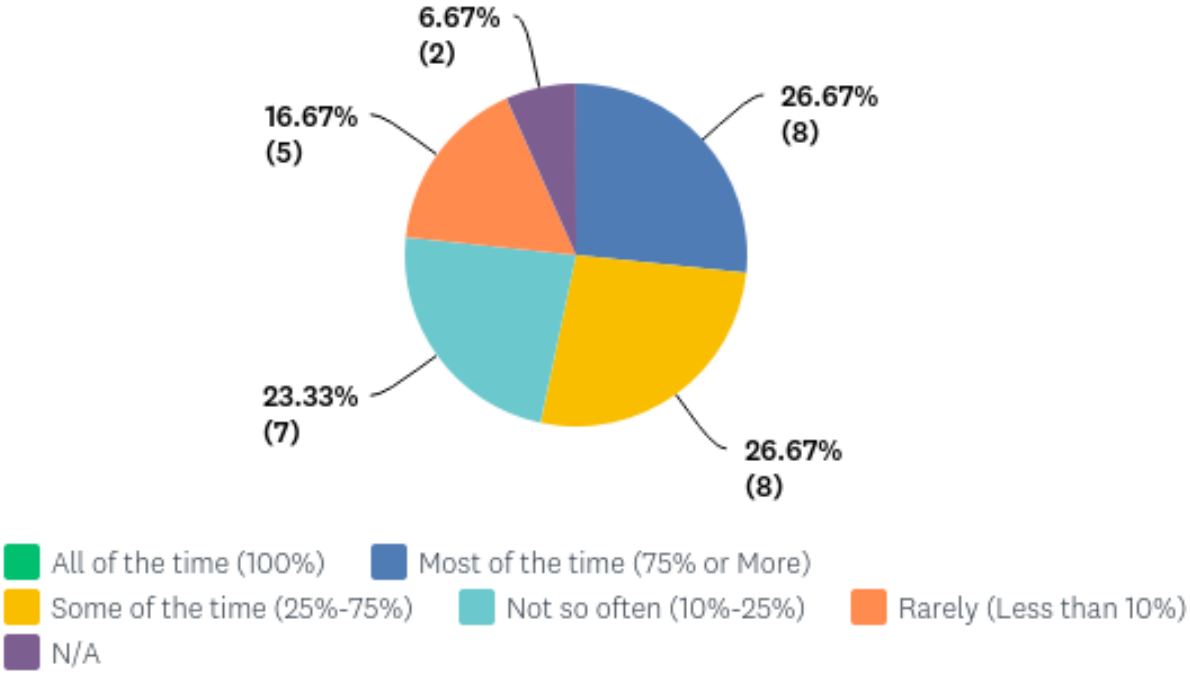
Appendix B: Comparing pre-training and six months post training results

Q1: How often do you talk to your patients about intimate partner violence (IPV)?

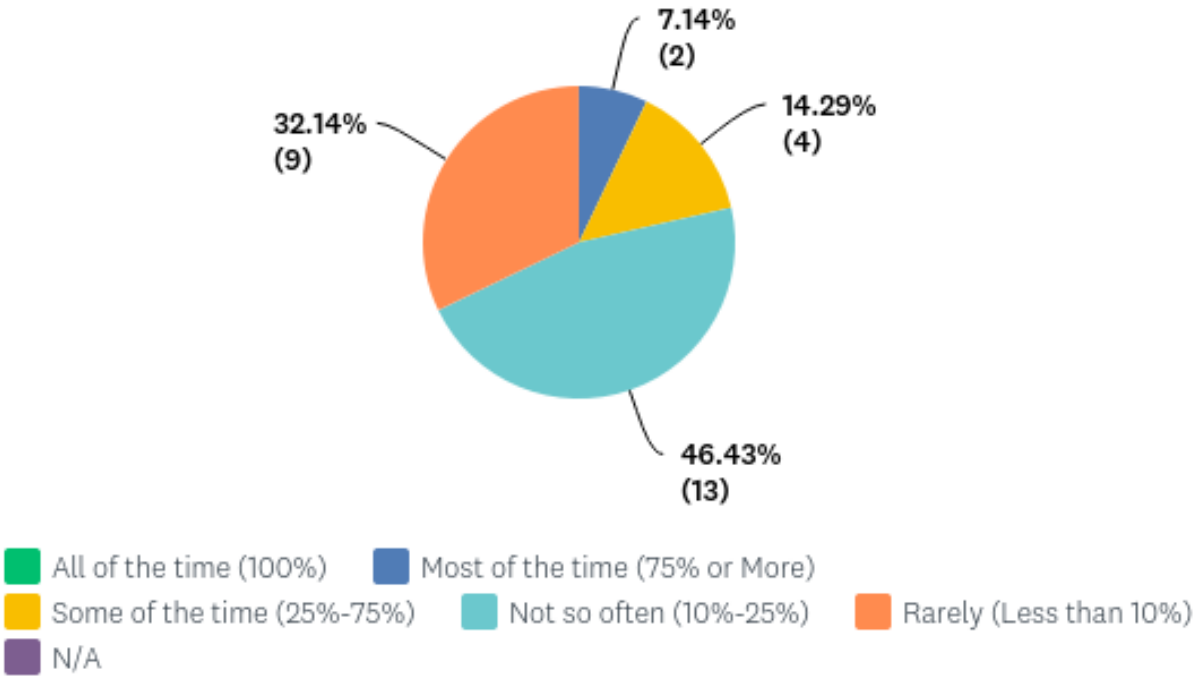
Pre-survey



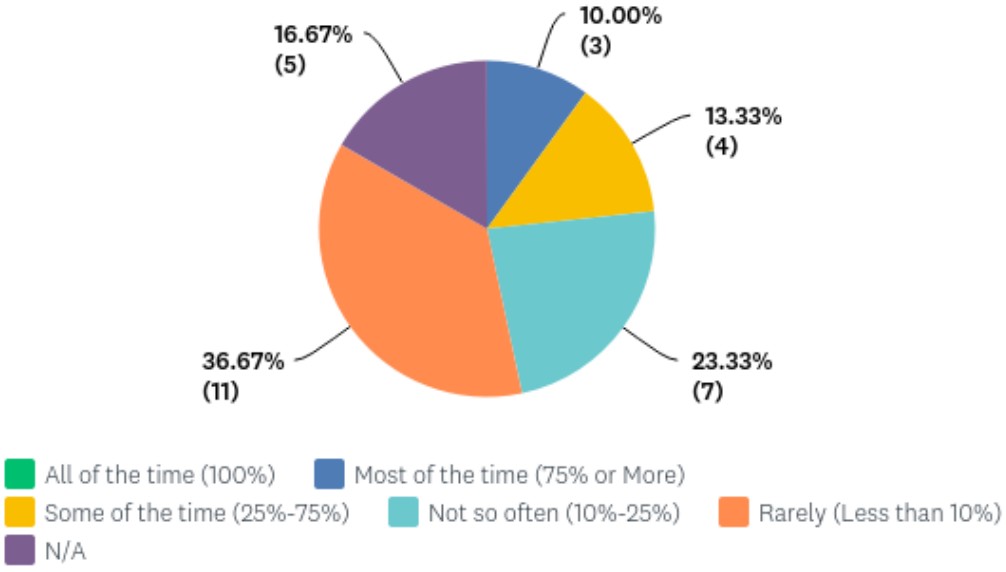
6 month follow up survey



Q2: How often do you talk to your patients about reproductive and sexual coercion (RSC)?
Pre-Survey

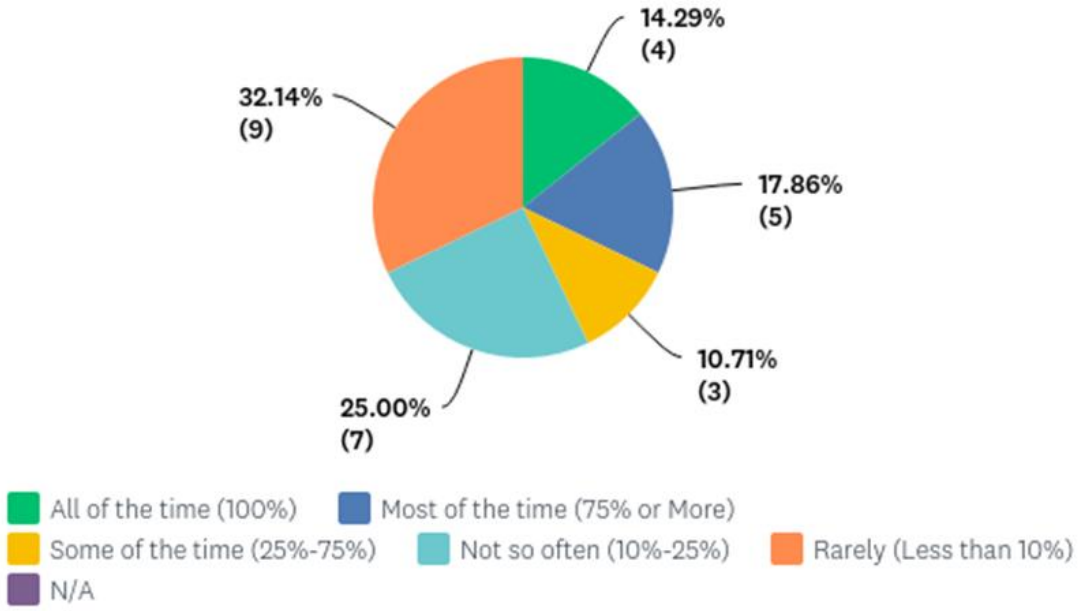


6 month follow up survey

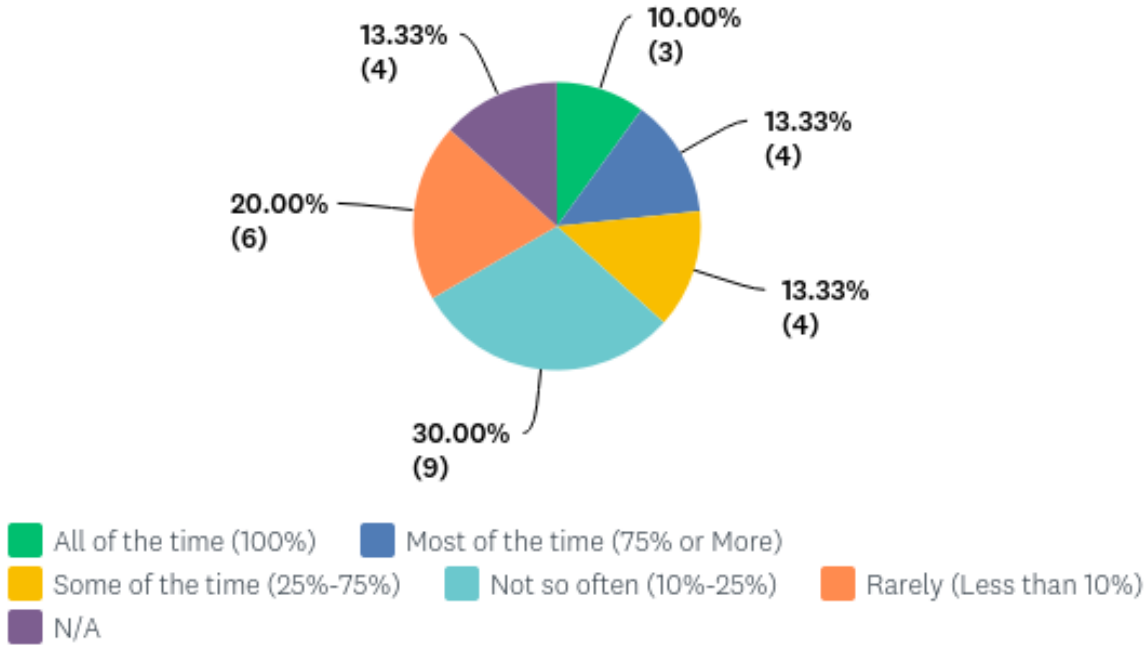


Q3: How often do you review the limits of confidentiality with your clients before asking about IPV or RSC?

Pre-Survey

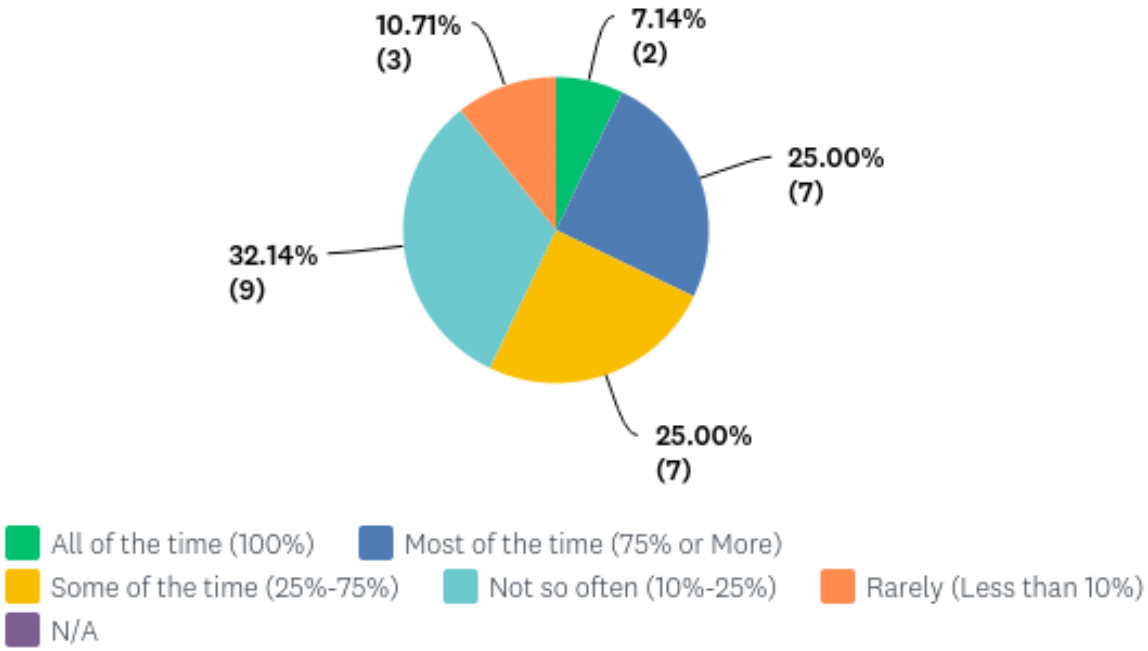


6 Month follow up survey

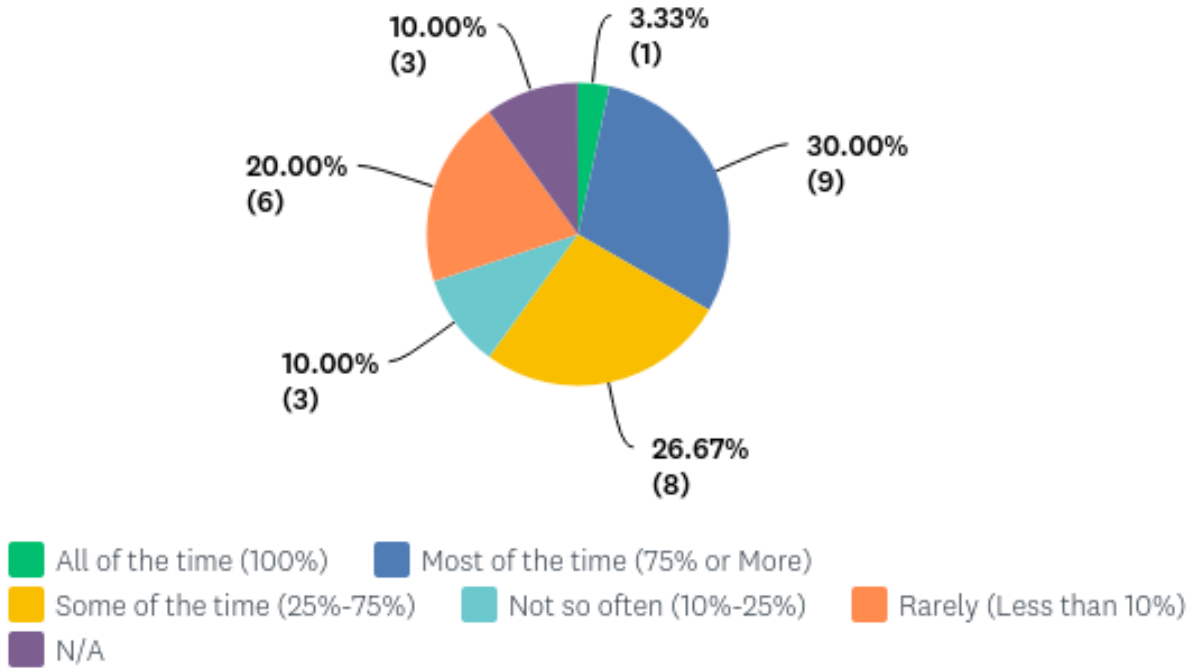


Q4: How often do you assess clients' safety and discuss ways to stay safe in an unhealthy or abusive relationship?

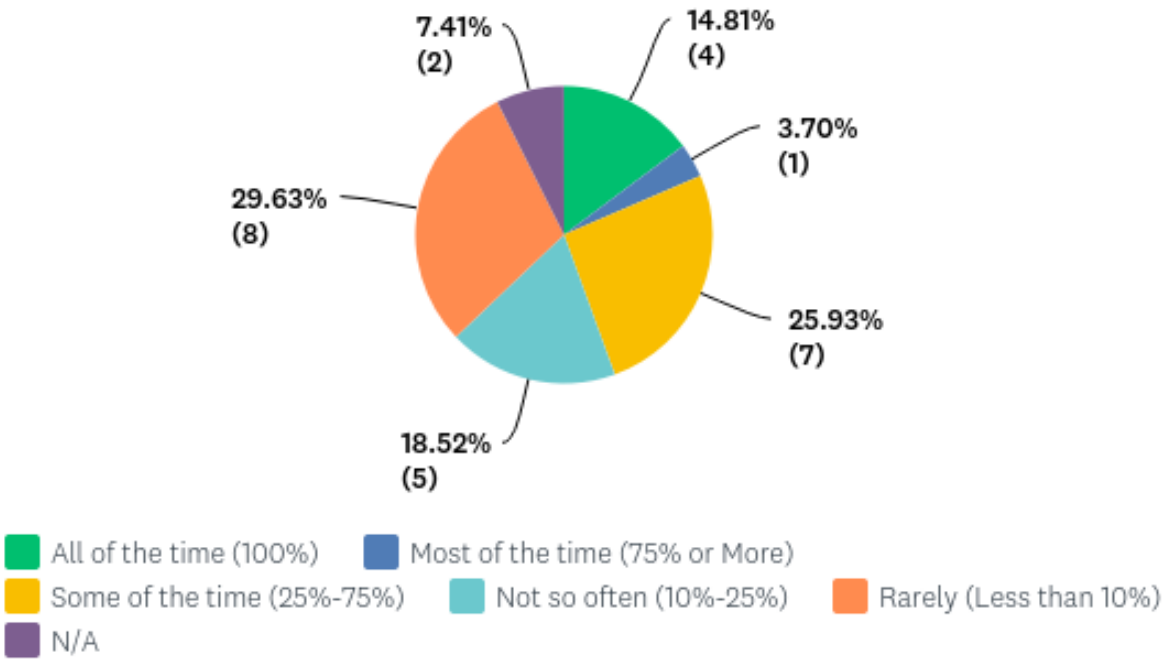
Pre-survey



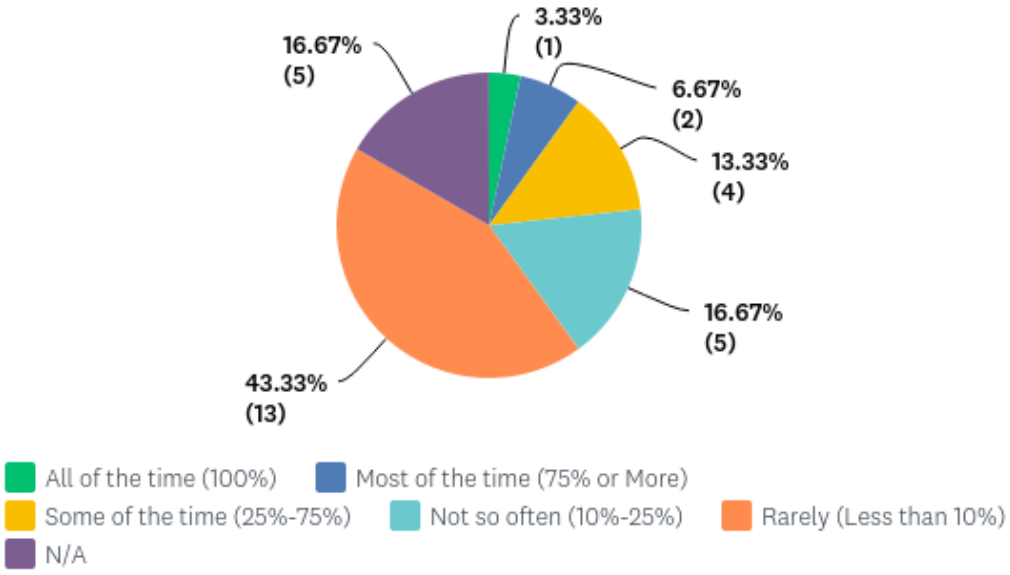
6 month follow up survey



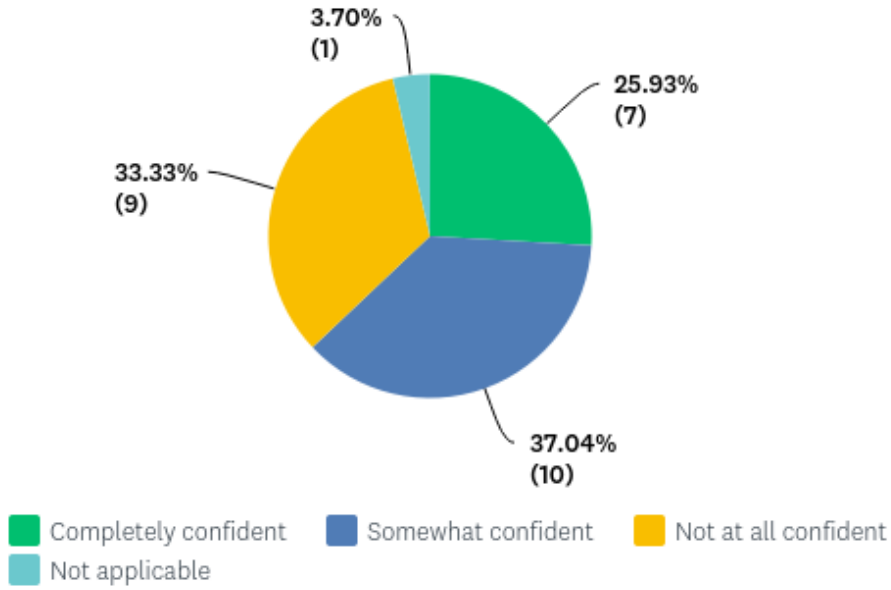
Q5: How often do you refer clients to your IPV/DSV partner organization?
Pre-survey



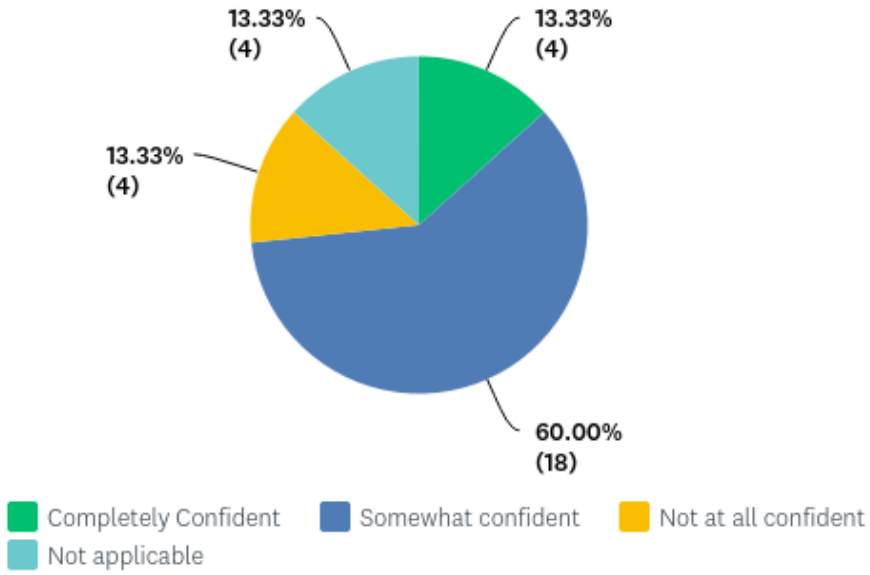
6 month follow up survey



Q7: How confident are you in referring a client to your partner organization?
Pre-survey



6 month follow up



Appendix C: Pre-survey questions 6, 8-13

Q6. What are reasons that you may not address domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) during a clinic visit? (Mark all that apply)		
Answer Choices	Responses	
Not enough time	70.73%	29
The partner is present for the visit	60.98%	25
Worried about upsetting the client	9.76%	4
Not sure what to say if they disclose an abusive/violent relationship	17.07%	7
Not knowing where to refer them to	21.95%	9
Worried about mandated reporting	7.32%	3
Have already screened them at past visit	26.83%	11
Does not apply to my patient polulation	2.44%	1
Other (please specify)		19
	Skipped	**21**

Q8. Does your clinic/practice have: (Mark all that apply)		
Answer Choices	Responses	
Brochures, cards or information about DSV and RSC	94.23%	49
Posters about DSV and RSC displayed	73.08%	38
A list of Violence-related resources and who to call with questions	46.15%	24
Prompts inserted into charts to remind providers to assess for DSV and RSC	28.85%	15
In Service trainings for all clinic staff on DSV and RSC	53.85%	28
Other (please specify)		6
	Skipped	**10**

Q9. Are educational materials available on domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) in the languages most commonly spoken in your setting?				
	Yes	No	Not applicable	Don't Know
	54.84%	11.29%	3.23%	30.65%

Q10. Are the available materials on DSV and sexual coercion inclusive of diverse relationships including for sexual minorities, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) clients?					

	Yes	No	Not applicable	Don't Know	Total
	59.02 %	8.20%	4.92%	27.87 %	61

Q11. What organization do you work for?		
Answer Choices	Responses	
OHSU FM at Richmond	59.68%	37
OHSU FM at Scappoose	1.61%	1
OHSU FM at Gabriel Park	6.45%	4
OHSU FM at Waterfront	6.45%	4
OHSU FM Beaverton	1.61%	1
OHSU other	9.68%	6
VOA	1.61%	1
Other (please specify)	12.90%	8

Q12. Optional: Please answer the following question. This information will help us better understand who we are reaching with these trainings. What is your training Backround? (Mark all that apply)		
Answer Choices	Responses	
Reproductive health specialist/family planning counselor	4.65%	2
Community health worker	0.00%	0
Nurse practitioner (Specify Specialty area under Other)	25.58%	11
Physician Assistant (Specify Specialty area under Other)	6.98%	3
Nurse (Specify Specialty area under Other)	6.98%	3
Clinic Administrator/Practice Manager	2.33%	1
Medical Assistant	11.63%	5
MD or DO	41.86%	18
Other (please comment)		25
	Skipped	**19**

Q13. I attended the May 31st, 2017 training by Futures without violence		
Answer Choices	Responses	
Yes	37.93%	11
No	62.07%	18

Appendix D: Six month follow up, Questions 6 & 8-17

Q6. Since the training, I am more comfortable responding to clients who disclose abuse in their relationships.		
Answer Choices	Responses	
Strongly Agree	20.00%	6
Agree	53.33%	16
Undecided	10.00%	3
Disagree	0.00%	0
Strongly Disagree	6.67%	2
Not applicable	10.00%	3

Q8. Since the training, I am more comfortable helping and supporting a patient to make phone calls to violence related agencies and services.		
Answer Choices	Responses	
Strongly Agree	20.69%	6
Agree	37.93%	11
Undecided	24.14%	7
Disagree	6.90%	2
Strongly Disagree	3.45%	1
Not applicable	6.90%	2

Q9. Since the training, has the frequency changed with which you are discussing healthy relationships?				
	Increased since the training	Stayed about the same since the training	Decreased since the training	Not Applicable
	56.67%	30.00%	0.00%	13.33%

Q10. Since the training, has the frequency changed with which you are referring patients to local domestic violence/sexual assault resources?				

	Increased since the training	Stayed about the same since the training	Decreased since the training	Not Applicable
	33.33%	50.00%	0.00%	16.67%

Q11. Since the training, have you encountered more patients disclosing IPV and/or RSC experiences in the clinic?		
Answer Choices	Responses	
More disclosures than before the training	33.33%	10
About the same number of disclosures	56.67%	17
Fewer disclosures than before the training	0.00%	0
Not Applicable	10.00%	3

Q12. Does your clinic/practice have: (mark all that apply)		
Answer Choices	Responses	
Brochures, cards or information about IPV and RSC	93.55%	29
Posters about IPV and RSC displayed	77.42%	24
A list of violence-related resources and who to call with questions	54.84%	17
Prompts inserted into charts to remind providers to assess for IPV and RSC	54.84%	17
In-service trainings for all clinic staff on IPV and RSC	74.19%	23
Other (please comment)		0

Q13. Since the training, has the frequency with which you have contact with your local domestic and sexual violence related service providers changed?		
Answer Choices	Responses	
Increased since the training	19.35%	6
Stayed about the same since the training	54.84%	17
Decreased since the training	0.00%	0
Not applicable	25.81%	8

Q14. Are educational materials available on IPV and/or RSC in the languages most commonly spoken in your setting?		
Answer Choices	Responses	
Yes	61.29%	19
No	12.90%	4
Not applicable	0.00%	0
Don't Know	25.81%	8

Q15. Are the available materials on IPV and sexual coercion inclusive of diverse relationships including for sexual minorities, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) patients?		
Answer Choices	Responses	
Yes	83.87%	26
No	3.23%	1
Not applicable	0.00%	0
Don't know	12.90%	4

Q16. I attended the May 31st, 2017 training by Futures without Violence		
Answer Choices	Responses	
Yes	61.11%	11
No	38.89%	7

Q17. Optional: Please answer the following question. This information will help us better understand who we are reaching with these trainings. What is your training background? (mark all that apply)		
Answer Choices	Responses	
Medical Assistant	13.79%	4
Behavioral Health consultant	10.34%	3
Nurse practitioner (specify specialty area in comments)	13.79%	4
Physician assistant (specify specialty area in comments)	3.45%	1
Nurse (specify specialty area in comments)	27.59%	8
Physician (specify specialty area in comments)	24.14%	7
Clinic administrator/Practice manager	6.90%	2
Other (please specify)		7
	Skipped	**2**

Appendix E: See attached PDF QI/QA tools

FUTURES WITHOUT VIOLENCE®

Domestic Violence Quality Assessment/Quality Improvement Tool for Clinics, Hospitals and other Health Systems

The following Domestic Violence (DV) Quality Assessment Tool was developed in 2016 by Futures Without Violence and Dr. Elizabeth Miller, University of Pittsburgh. It is intended to provide health care facilities some guiding questions to assess quality of care related to the promotion of healthy relationships and intervention related to DV within health care delivery. The information may be used as a benchmark for each program to engage in ongoing quality improvement efforts. Complete the tool as honestly and completely as you can—there are no right or wrong answers, and your clinic/hospital shouldn't be penalized for identifying areas for improvement. For questions that you respond yes to, it may be helpful to attach and review corresponding forms, policy, tools, etc.

We recommend that you complete the tool twice: once at the beginning and before you begin making any changes; and again in 6 months after the first completion and once you initiate making improvements.

We hope that this tool will help provide guidance on how to enhance your clinic/hospital's response to intimate partner violence.

For more information, client brochures, posters and resources visit http://www.healthcaresaboutipv.org/

Completed by (title only): T. O'Connor, PMHNP; Erin Kirk, Quality manager; Hallak-Kuppelman, FNP

Health Center Name: OHSU Richmond

Date: May 17th, 2017

Protocols

Does your health center have a written protocol for assessment* and response to:

	Yes (If so, please attach)	No	N/A	Don't Know
Intimate partner violence (IPV)?	☐	☒	☐	☐
Sexual violence (SV)?	☐	☒	☐	☐
Reproductive coercion (RC: birth control sabotage, pregnancy pressure and coercion, and STI/HIV risk)?	☐	☒	☐	☐

Are there sample wording, scripts, prompts, questions, or information on medical/health history/risk assessment forms or EHR for staff to:

Explain to patients why they are being screened for IPV?	☐	☒	☐	☐
Inform patients about confidentiality and any mandated reporting requirements?	☐	☒	☐	☐
Ask patients about IPV/SV/RC (with sample questions)?	☒ needs impact.	☐	☐	☐
Educate patients about impact of IPV/SV/RC?	☐	☒	☐	☐
Discuss ways to stay safe in an unhealthy or abusive relationship?	☐	☒	☐	☐

Do your protocols instruct providers to assess for intimate partner violence (IPV) during:

	Yes	No	N/A	Don't Know
A visit addressing alcohol or other drug use	☐	☒	☐	☐
A visit addressing depression or suicidality	☐	☒	☐	☐
Any primary care visit	☐	☒	☐	☐
Any reproductive or sexual health visit	☐	☒	☐	☐
A wellness visit/annual exam/preventive care	☐	☒	☐	☐

*Throughout this document, we refer to assessment—rather than screening—for intimate partner violence, sexual violence, and reproductive coercion. Screening refers to stand alone questions or a self-administered checklist, while assessment includes conversation with the provider that includes anticipatory guidance on healthy relationships, direct questions about IPV, and harm reduction strategies and a warm referral to IPV services if abuse is disclosed.

Does your health center:

	Yes	No	N/A	Don't Know
Provide patients with a written explanation of confidentiality and limits of confidentiality when they check-in?	☐	☒	☐	☐
Have a place to speak with clients privately?	☒	☐	☐	☐
Have a privacy screen on the computer to protect the contents of the electronic health record from being viewed by others?	☒	☐	☐	☐
Have a policy to ensure that providers ask about IPV when the patient is alone?	☐	☒	☐	☐

Assessment Methods

How are patients assessed for IPV?

	Yes	No	N/A	Don't Know
Patients answer questions on a medical/health history form	☒	☐	☐	☐
Staff review the medical/ health history form and ask follow-up questions	☐	☒	☐	☐
Staff ask the patients questions	☐	☒	☐	☐
Staff offer a palm-size safety card[1] with information about how violence can impact health (see example below)	☐	☒*	☐	☐
Assessment occurs in a private place	☒	☐	☐	☐

Which staff are primarily responsible for assessing patients for IPV? (please pick one)

- ☒ Counselor
- ☐ Medical Assistant
- ☒ NP/RN
- ☒ MD
- ☒ Other (Please explain) PA

[1] Futures Without Violence General Health Safety Card. To order, visit: http://bit.ly/1ydEXO1

How often are patients asked about IPV/SV/RC?

- ☐ With each new sexual partner
- ☐ At least every six months
- ☐ At least once a year
- ☒ No established time interval

Documentation of Assessment and Response

On the medical/health history/assessment form(s) are the following steps documented?

	Yes	No	N/A	Don't Know
A palm-size safety card was offered and discussed	☐	☒	☐	☐
Harm reduction strategies were shared	☐	☒	☐	☐
Referral to a domestic violence agency or advocate provided	☐	☒	☐	☐

Intervention Strategies

Does your staff:

	Yes	No	N/A	Don't Know
Have sample wording or scripts about what to say and do when a patient discloses IPV/SV/RC?	☐	☒	☐	☐
Have sample or scripted tools and instructions on how to do safety planning with patients who disclose current IPV?	☐	☒	☐	☐
Have instructions on how to file a mandated report when needed?	☐	☒	☐	☐
Know an advocate or counselor who can provide on-site follow-up with a patient who discloses IPV?	☒	☐	☐	☐
Know the national hotlines and how they can support underserved or minority communities (e.g. non-English/Spanish speakers, the hearing impaired, LGBTQ patients)?	☐	☒	☐	☐
Have a safe place where the patient can use a phone at your health center to call a national hotline or to talk to a local violence advocate?	☒	☐	☐	☐

Do your staff have resource lists that:

	Yes	No	N/A	Don't Know
Identify referrals and resources such as shelters, legal, advocacy, for patients who disclose IPV/SV/RC?	☒	☐	☐	☐
Identify referrals and resources that are specifically relevant to your community's underserved population?	☒	☐	☐	☐
Identify referrals and resources for perpetrators of IPV/SV/RC?	☒	☐	☐	☐
Include a contact person for each referral agency?	☐	☒	☐	☐

Is there a staff person responsible for updating these lists?

Not yet, but we have research specialists who may take on role

Are these lists updated at least once a year?

No

Networking and Training

Within the last year, has your staff had contact with representatives from any of the following agencies (contact means--called to refer a patient, called for assistance with a patient, called for information about program)?

	Yes	No	N/A	Don't Know
Domestic violence advocates or shelter staff	☒	☐	☐	☐
Child protective services	☒	☐	☐	☐
Batterer's intervention group	☒	☐	☐	☐
Legal advocacy/legal services + MLP	☒	☐	☐	☐
Law enforcement	☒	☐	☐	☐

Are there any staff who are especially skilled/comfortable dealing with IPV that other staff can turn to for help?

☒ Yes ☐ No

If Yes, please include staff title/position:

Do your protocols advise staff on what to do if they do not feel comfortable or adequately skilled to help a patient when IPV is disclosed? (Example: Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)

☐ Yes ☒ No

Do any of your staff participate in a local domestic violence task force or related subcommittee?

☐ Yes ☒ No

If yes, please identify staff and describe task force/subcommittee:

Is there a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence with a patient?

☐ Yes ☒ No

If yes, please describe:

We are in process of creating w/ de-escalation

Within the last two years, have representatives from any of the following agencies either been contacted to schedule a training or come to your health center and conducted a training for your staff?

	Yes	No	N/A	Don't Know
Domestic violence program	☒	☐	☐	☐
Rape crisis center program	☐	☒	☐	☐
Child protective services	☐	☒	☐	☐
Law enforcement (e.g., DV unit)	☐	☒	☐	☐
Legal services/legal advocacy	☒	☐	☐	☐

What type of training(s) do new staff receive on intimate partner violence (IPV)?

New yet

Does your staff receive booster training on assessment and intervention for IPV at least once a year?

☐ Yes ☒ No ☐ N/A ☐ Don't Know

Self-Care and Support

Does your health center:

	Yes	No	N/A	Don't Know
Have a protocol for what to do if a staff person is experiencing IPV?	☐	☒	☐	☐
Have a protocol for what to do if a perpetrator is on-site and displaying threatening behaviors or trying to get information?	☒	☐	☐	☐
Provide individual clinical supervision for staff where they can discuss any concerns/ discomfort related to IPV cases?	☐	☒	☐	☐

Provide other types (group supervision, case presentation) of opportunities for staff to discuss any concerns/issues/etc relating to difficult cases?	☒	☐	☐	☐
Have an employee assistance program (EAP) that staff can access for help with current or past victimization?	☒	☐	☐	☐

Data and Evaluation

Does your health center:

	Yes	No	N/A	Don't Know
Record the number of patients assessed for IPV?	☐	☒	☐	☐
Record the number of patients who disclose IPV?	☐	☒	☐	☐
Record use of longer-acting contraceptives among patients experiencing reproductive coercion?	☐	☒	☐	☐
Annually review all health center protocols relating to DV (both patient and staff related)?	☐	☒	☐	☐
Discuss with patients where and how their confidential information will be handled?	☐	☒	☐	☐
Do any of your patient satisfaction surveys include any questions soliciting patient's opinions about assessment and intervention strategies for IPV?	☐	☒	☐	☐
Provide regular (at least annual) feedback to providers about their performance regarding IPV assessment?	☐	☒	☐	☐

Education and Prevention

Does your health center:

	Yes	No	N/A	Don't Know
Provide information to patients on how violence can impact women's health?	☒	☐	☐	☐
Provide information to patients on healthy relationships?	☒	☐	☐	☐
Sponsor any client or community education to talk about healthy relationships or indicators of abuse?	☐	☒	☐	☐

Environment and Resources

Does your health center have any of the following?

	Yes	No	N/A	Don't Know
Brochures or information about IPV that patients can take	☒	☐	☐	☐
Brochures, cards, information for patients about how violence exposure affects children	☒	☐	☐	☐
Posters about IPV, SV and reproductive coercion displayed	☒	☐	☐	☐
Adolescent focused brochures, cards or information about adolescent relationship abuse	☒	☐	☐	☐
Information specific to LGBTQ violence?	☒	☐	☐	☐
Brochures/cards/posters placed in an easily visible location	☒	☐	☐	☐

Has your health center adapted any materials to make them more culturally relevant for your patient population?

☒ Yes ☐ No

If yes, please describe:

Who is responsible for stocking and ordering materials including safety cards, pregnancy wheels and posters?

Please identify staff by title: Diane Nery, BHRC

Additional Comments and Observations

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Domestic Violence Quality Assessment/Quality Improvement Tool for Clinics, Hospitals and other Health Systems

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We recommend that you complete the tool twice: once at the beginning and before you begin making any changes; and again in 6 months after the first completion and once you initiate making improvements.

We hope that this tool will help provide guidance on how to enhance your clinic/hospital's response to intimate partner violence.

For more information, client brochures, posters and resources visit http://www.healthcaresaboutipv.org/

Does your health center:				
	Yes	**No**	**N/A**	**Don't Know**
Provide patients with a written explanation of confidentiality and limits of confidentiality when they check-in?	☐	☒	☐	☐
Have a place to speak with clients privately?	☒	☐	☐	☐
Have a privacy screen on the computer to protect the contents of the electronic health record from being viewed by others?	☒	☐	☐	☐
Have a policy to ensure that providers ask about IPV when the patient is alone?	☐	☒	☐	☐

Assessment Methods

How are patients assessed for IPV?

	Yes	**No**	**N/A**	**Don't Know**
Patients answer questions on a medical/health history form	☒	☐	☐	☐
Staff review the medical/ health history form and ask follow-up questions	☐	☒	☐	☐
Staff ask the patients questions	☒	☐	☐	☐
Staff offer a palm-size safety card[1] with information about how violence can impact health (see example below)	☒	☐	☐	☐
Assessment occurs in a private place	☒	☐	☐	☐

Which staff are primarily responsible for assessing patients for IPV? (please pick one)

- ☒ Counselor
- ☐ Medical Assistant
- ☒ NP/RN
- ☒ MD
- ☐ Other (Please explain) _____

[1] Futures Without Violence General Health Safety Card. To order, visit: http://bit.ly/1ydEXO1

Do your staff have resource lists that:

	Yes	No	N/A	Don't Know
Identify referrals and resources such as shelters, legal, advocacy, for patients who disclose IPV/SV/RC?	☒	☐	☐	☐
Identify referrals and resources that are specifically relevant to your community's underserved population?	☒	☐	☐	☐
Identify referrals and resources for perpetrators of IPV/SV/RC?	☒	☐	☐	☐
Include a contact person for each referral agency?	☒	☐	☐	☐

Is there a staff person responsible for updating these lists?

Yes - Social Determinants coordinator

Are these lists updated at least once a year?

No

Networking and Training

Within the last year, has your staff had contact with representatives from any of the following agencies (contact means--called to refer a patient, called for assistance with a patient, called for information about program)?

	Yes	No	N/A	Don't Know
Domestic violence advocates or shelter staff	☒	☐	☐	☐
Child protective services	☒	☐	☐	☐
Batterer's intervention group	☐	☒	☐	☐
Legal advocacy/legal services	☒	☐	☐	☐
Law enforcement	☐	☒	☐	☐

Are there any staff who are especially skilled/comfortable dealing with IPV that other staff can turn to for help?

☒ Yes ☐ No

If Yes, please include staff title/position: IPV work group, BHCs

Do your protocols advise staff on what to do if they do not feel comfortable or adequately skilled to help a patient when IPV is disclosed? (Example: Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)

☐ Yes ☒ No * This is important to address

Do any of your staff participate in a local domestic violence task force or related subcommittee? NO

Provide other types (group supervision, case presentation) of opportunities for staff to discuss any concerns/issues/etc relating to difficult cases?	☐	☒	☐	☐
Have an employee assistance program (EAP) that staff can access for help with current or past victimization?	☒	☐	☐	☐

Data and Evaluation

Does your health center:

	Yes	No	N/A	Don't Know
Record the number of patients assessed for IPV?	☒	☐	☐	☐
Record the number of patients who disclose IPV?	☐	☒	☐	☐
Record use of longer-acting contraceptives among patients experiencing reproductive coercion?	☐	☒	☐	☐
Annually review all health center protocols relating to DV (both patient and staff related)?	☒	☐	☐	☐
Discuss with patients where and how their confidential information will be handled?	☐	☒	☐	☐
Do any of your patient satisfaction surveys include any questions soliciting patient's opinions about assessment and intervention strategies for IPV?	☐	☒	☐	☐
Provide regular (at least annual) feedback to providers about their performance regarding IPV assessment?	☐	☒	☐	☐

Education and Prevention

Does your health center:

	Yes	No	N/A	Don't Know
Provide information to patients on how violence can impact women's health?	☒	☐	☐	☐
Provide information to patients on healthy relationships?	☒	☐	☐	☐
Sponsor any client or community education to talk about healthy relationships or indicators of abuse?	☐	☒	☐	☐