Standardizing Antepartum Screening for Intimate Partner Violence: A Quality Improvement Project

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Abstract

Intimate partner violence (IPV) is a significant public health issue with severe consequences for maternal and neonatal health. Despite professional recommendations for universal screening, IPV screening is not consistently implemented in the prenatal care context. This quality improvement (QI) project aimed to standardize antepartum IPV screening and education in a community hospital women's health clinic in the Pacific Northwest by implementing a confidential, evidence-based screening and education process. The project integrated trauma-informed care principles and the CUES (Confidentiality, Universal Education & Empowerment, and Support) intervention framework into clinic workflows. The intervention included confidential screening at the new obstetric (NOB) visit using the 5Ps screening tool, provider education, and universal patient education with IPV safety cards. Two Plan-Do-Study-Act (PDSA) cycles were conducted to refine implementation. Data collection included electronic health record (EHR) chart reviews and stakeholder feedback. Baseline data showed that only 13.8% of NOB visit charts documented IPV screening. After project implementation, screening documentation increased significantly to 86.2% ($p < 0.0001$), with 14.6% of patients screening positive for current or past IPV. Confidential screening documentation improved to 81.5%, and universal education was documented in 69.2% of charts. Stakeholder feedback indicated that the intervention facilitated meaningful patient-provider discussions but highlighted workflow challenges. This QI project significantly improved IPV screening rates and established a standardized process for confidential screening and education in prenatal care. Future efforts should focus on expanding screening throughout pregnancy and addressing workflow barriers to ensure sustainable, universal implementation.

Problem Description

Intimate partner violence (IPV) is a leading cause of injury among reproductive-aged women and can have severe consequences when experienced during pregnancy (Kapaya et al., 2019; Zapata-Calvente et al., 2022). IPV is defined as any physical, sexual or psychological violence by a current or former partner, including stalking and controlling behaviors (CDC, 2022). It is estimated that 1 in 3 women worldwide have experienced IPV (Drexler et al., 2022). The prevalence of IPV in pregnancy has been estimated to be as high as 6.5%-20% (Chisholm et al., 2017a; Drexler et al., 2022), while the World Health Organization (WHO) has reported that over 5% of women worldwide have experienced IPV during at least one pregnancy (2005). Experience of IPV in pregnancy is associated with increased risk of adverse maternal and infant health outcomes, including morbidity and mortality (Chaves et al., 2019; Drexler et al., 2022; Kozhimannil et al., 2023).

Pregnancy is a time during which many people interact with the healthcare system more than any other time in their lives, and pregnant people may be more likely than nonpregnant people to disclose IPV (Drexler et al., 2022). Prenatal care provides regular follow-up appointments and the opportunity to build long-term therapeutic relationships between patients and providers (LoGiudice, 2015). As such, prenatal care represents an opportunity for screening patients for IPV and referring to support services, providing trauma informed care and decreasing the risk of morbidity and mortality related to IPV (Drexler et al., 2022; Lu et al., 2023). Routine, universal screening for IPV is recommended by the US Preventive Services Task Force (USPSTF et al., 2018), American College of Nurse-Midwives (ACNM, 2021), American College of Obstetrics and Gynecologists (ACOG, 2022) and numerous other organizations

(Drexler et al., 2022; Kapaya et al., 2019). However, IPV screening is not consistently conducted in the prenatal setting (Chisholm et al., 2017b; Kapaya et al., 2019).

This project took place at a community hospital women's health clinic that is affiliated with an academic medical center in the Pacific Northwest. At the start of this project there was not an effective process for universal IPV screening in the antepartum period at this clinic. The goal of this quality improvement project was to implement a universal IPV screening and education process that ensured patients were screened confidentially in early pregnancy and empowered providers with the knowledge and resources they needed to effectively support patients experiencing IPV.

Available Knowledge

A search of the extant literature was conducted using the PubMed database. Search terms included "intimate partner violence OR domestic violence" AND "screening OR questionnaire OR intervention OR tool" AND "pregnancy OR prenatal OR antepartum OR perinatal." Article language was limited to English and publication dates were limited to the last 10 years. Additional sources were found on the reference lists of selected studies. Sources were selected based on pertinence to populations in the United States and relevance to the clinical question. A discussion of the literature is as follows.

Prevalence and Outcomes

To determine the prevalence of IPV in the perinatal period in the United States, Kozhimannil et al. (2023) analyzed data from the Pregnancy Risk Assessment Monitoring System (PRAMS), a large representative sample of recently postpartum people from across the United States. Of note, the most recent PRAMS survey included only physical and emotional IPV and did not include sexual IPV. According to the most recent PRAMS data available, 3.5%

of respondents who gave birth in the United States between 2016-2019 reported IPV by a current or former partner before or during pregnancy (Kozhimannil et al., 2023).

A number of studies have demonstrated that IPV in pregnancy can have severe consequences for pregnant people and neonates alike. Perinatal experience of IPV is associated with increased risk of miscarriage, placental abruption, preterm birth, low birth weight, infant NICU admission, lower breastfeeding rates, postpartum depressive symptoms and perinatal death (Chaves et al., 2019; Chen et al., 2017; Drexler et al., 2022; Kozhimannil et al., 2023). Studies have also found increased risk of limited or delayed initiation of prenatal care, poor nutrition, and smoking and alcohol use among those who experience IPV around the time of pregnancy (Chen et al., 2017; Alhusen et al., 2014). Furthermore, risk of homicide by an intimate partner is increased in pregnancy and postpartum, with the greatest risk for IPV-associated homicide in the first trimester (Drexler et al., 2022) and almost two thirds of all perinatal homicides related to IPV (Kozhimannil et al., 2023).

Racial and ethnic disparities exist in both the experience and consequences of IPV during pregnancy. Research has shown that Black and Hispanic people are at a significantly greater risk of experiencing IPV during pregnancy than white people (Campbell et al., 2021; Kivisto et al., 2022). Furthermore, a recent analysis of nationally-representative inpatient data in the United States showed that among those who experience IPV in pregnancy, Black and Hispanic individuals are at a higher risk than their white counterparts for preterm birth, intrauterine fetal demise, fetal growth restriction, hypertensive disorders of pregnancy and gestational diabetes (Greely et al., 2022). Disparities in pregnancy-associated intimate partner homicide rates are equally striking. Non-Hispanic Black and American Indian/Alaska Native people experience higher rates of IPV-associated homicide than other racial groups (Kozhimannil et al., 2023), with

Black women experiencing IPV-related homicide rates more than 3 times those of white and Hispanic women (Kivisto et al., 2022).

Screening in Pregnancy

With such dire consequences of IPV for both pregnant people and neonates, routine IPV screening during the prenatal period is essential. Universal screening and brief counseling for IPV are free, required preventative health services under the Affordable Care Act and should be implemented appropriately and effectively through the healthcare system, including during pregnancy (Miller et al., 2015). The American College of Nurse-Midwives (ACNM) (2021) recommends that midwives regularly screen for current or past experience of IPV using best practices and validated instruments, but does not specify the frequency or timing of screening during pregnancy. However, the American College of Obstetricians and Gynecologists (ACOG) (2022), widely considered the authority on obstetric practice, recommends screening for IPV during the first prenatal visit, at least once per trimester, and at a postpartum visit.

Multiple written and verbal screening tools exist that accurately detect IPV (Lee et al., 2019), and research has shown that self-administered screenings are as effective as clinician interviews (ACOG, 2022). However, there is currently no established standard IPV screening tool (Lee et al., 2019). The act of screening is more important than the specific tool used, as any form of screening is preferable to no screening (Drexler et al., 2022). Screening has been found to increase identification of people experiencing IPV (Lu et al., 2023), and while screening itself has not been found to cause harm, screening without intervention does not reduce the incidence of IPV or improve survivors' quality of life (Miller et al., 2017; O'Doherty et al., 2015).

Despite professional recommendations and general agreement on the importance of screening, universal IPV screening is not consistently conducted by providers in the prenatal setting. Kapaya et al. (2019) and Kozhimannil et al. (2023) utilized PRAMS data to investigate IPV screening frequency in pregnancy. Results from both studies show that while screening frequency has improved over time, a shockingly low number of pregnant people are screened for IPV during prenatal care. From 2009-2015, almost 50% of respondents who experienced physical IPV in the perinatal period were not asked about IPV in prenatal care (Kapaya et al., 2019). In contrast, from 2016-2019, 26.9% of respondents who experienced physical or emotional IPV perinatally were not screened for IPV during pregnancy (Kozhimannil et al., 2023). Although this represents a significant increase in prenatal screening for IPV, these results also demonstrate that the goal of universal prenatal screening is not yet standard practice.

Furthermore, there are disparities in who is more likely to be screened for IPV by obstetric care providers. Pregnant people who identified as non-Hispanic Black, were lower income and had lower educational attainment were more likely to be asked about IPV (Kapaya et al., 2019), while rural residents, pregnant people who identified as non-Hispanic white, and those with private insurance were less likely to be screened (Kozhimannil et al., 2023). Additionally, results from Kozimannil et al. (2023) show that Spanish-speaking Hispanic people who experienced IPV were less likely to be screened in the preconception period because they lacked a healthcare visit in the 12 months before pregnancy. However, over 98% of all respondents who experienced IPV during pregnancy attended at least one prenatal care visit, indicating that very few were not screened because of lack of prenatal care.

Barriers and Facilitators

While most healthcare institutions and providers are aware of and endorse the importance of IPV screening, evidence suggests that universal IPV screening is not yet standard practice in the prenatal clinic setting. In light of this discrepancy, multiple studies have investigated the implementation of prenatal IPV screening. One such study, a systematic review by Lu et al. (2023), aimed to examine systemic and provider barriers and facilitators to IPV screening among physicians working in prenatal care settings. Frequently cited systemic barriers to IPV screening in the prenatal setting include lack of provider time and workload pressures (Lu et al., 2023). Another systemic barrier identified by Lu et al. (2023) was the ability to provide an appropriate, private environment for screening, in which the patient is alone and not accompanied by family. Provider bias has been found to be a significant provider-level barrier to IPV screening. Lu et al. (2023) found that biases held by providers about whether the patient will want to or be able to leave their current circumstances influenced the likelihood of screening. Additionally, some providers feel that screening for or addressing IPV is outside of their scope of practice (Lu et al., 2023).

Importantly, Lu et al. (2023) also identified a number of systemic facilitators that reduce barriers to IPV screening, including staff and institutional support, established systems and provider training and education. Provider familiarity with IPV and related issues was significantly associated with willingness to screen (Lu et al., 2023). Provider familiarity with the subject of IPV is also a provider-level facilitator of increased IPV screening in the prenatal context. According to Lu et al. (2023), obstetricians who had received training on IPV screening and felt confident in their ability were more likely to screen for IPV. Another factor associated with increased IPV screening was the existence of a therapeutic patient-provider relationship (Lu et al., 2023).

Other studies in obstetric care environments have echoed these same barriers and facilitators to IPV screening. Additional systemic barriers identified include lack of policies or workflows to guide screening and lack of collaboration between healthcare and community organizations that support people experiencing IPV (Greely et al., 2022). Provider barriers influencing the likelihood of screening included limited incentive for providers to conduct screening (Greely et al., 2022), personal beliefs held by providers regarding the type of patient who is at risk for IPV (Kozhimannil et al., 2023), and lack of provider self-efficacy in their ability to respond to a positive screen effectively (Kapaya et al., 2019). It is evident that healthcare providers need additional training, tools, and systemic support in order to effectively screen for and address IPV.

Patient Perspectives

Qualitative research has demonstrated that the vast majority of women support universal screening and want their healthcare providers to ask about IPV (Dienemann et al., 2005). Patients feel that screening for IPV itself can be therapeutic, as this demonstrates that providers care about their health and safety (Decker et al., 2017). Even if they are not ready to disclose IPV, survivors share that asking about IPV creates important opportunities for information and resource sharing (Chang et al., 2005; Dichter et al., 2021). Most pregnant people do not consider being asked about IPV to be offensive or embarrassing (Kapaya et al., 2019), and instead find screening for IPV to be appropriate within prenatal care (LoGiudice, 2015; Lu et al., 2023), particularly as part of normal history taking (Chang et al., 2005).

However, screening without adequate or appropriate provider response can be harmful (Decker et al., 2017; Dichter et al., 2021). Patients express that active, nonjudgmental listening and respect for patient autonomy are essential (Dienemann et al., 2005; Dichter et al., 2021; Tarzia et al., 2020). Survivors have described the healthcare provider's role as "planting the seed" by providing options, encouragement and support and allowing the individual to make their own choices about disclosure or action instead of telling them what to do (Tarzia et al., 2020).

Universal Education

Recent literature regarding best practices for addressing IPV in the clinical setting has begun to move away from an emphasis on screening with the goal of IPV disclosure and instead focus on the provision of education and resources to all patients regardless of IPV disclosure. In contrast to “disclosure-driven practice,” which leaves those who are not ready to disclose or feel unsafe disclosing without resources and support, universal education involves the provision of information and resources regardless of disclosure (Miller et al., 2017).

Research on universal education as a means of addressing IPV in various clinical settings has shown that this approach positively impacts both providers and patients. In a cluster randomized control trial (RCT) of 4,009 women ages 16 to 29 seeking care at family planning clinics, Miller et al. (2016) demonstrated that although universal education did not significantly decrease reproductive coercion or IPV, this intervention did improve awareness of IPV resources and self-efficacy in implementing harm reduction strategies. In a follow-up study (Miller et al., 2017), providers, administrators and patients at the 11 clinical sites randomized to the intervention arm of the RCT were engaged in semi-structured interviews about their experiences with the universal education intervention. Providers reported that the intervention increased their self-efficacy in addressing IPV with patients and expressed that asking patients to share the educational information with other people in their lives helped to facilitate the discussion. Patients reported that the intervention made them feel supported and the educational materials provided them with essential information that empowered them to help others. The generalizability of these results may be limited by a number of factors, as both studies took place within clinics in Western Pennsylvania that serve predominantly rural, white women. Additionally, providers that elected to participate in semi-structured interviews may be biased towards those who felt positively about the intervention.

A smaller (n = 142) quasi-experimental study by Decker et al. (2017) also explored the feasibility and acceptability of universal IPV assessment and education in family planning clinics in Baltimore, MD. The intervention involved a provider-led discussion about IPV and providing patients with a small card with IPV information and support resources. Patients in this study reported that clinic-based IPV assessment was useful regardless of IPV history. The intervention also increased patients' perception that their providers cared about them and increased their confidence in providers' ability to respond to IPV disclosures.

The results from these studies illustrate the positive effects of universal IPV education interventions on both patients and providers. While some patients may be ready to disclose IPV through in-clinic screening, there are others who choose not to disclose and would still benefit from education and access to resources (Miller et al., 2017). Providing universal education not only improves provider comfort with discussing IPV, but also informs patients that if and when they are ready to disclose, they will be met with a compassionate and knowledgeable provider.

The sum of evidence presented in this literature review points to the need for healthcare providers to routinely address IPV in their work, particularly during pregnancy when the risk of IPV increases and patients interact frequently with providers. As the research demonstrates, a universal approach to IPV screening and education is not only feasible and acceptable, but is also beneficial for patients and providers. The evidence-based intervention utilized in this DNP project centered on a standardized process for universal IPV screening and education in the prenatal care clinic setting.

Rationale

The theoretical framework of this project was based on the guidelines for a trauma-informed approach to care published by the Substance Abuse and Mental Health Services Administration (SAMHSA). Trauma-informed approaches to care recognize that many people have experienced or are experiencing trauma, defined by SAMHSA as the experience of a physically or emotionally harmful event or series of events that has lasting effects on an individual's function and wellbeing (SAMHSA, 2014). SAMHSA's concept of trauma-informed care at the program, system or organization level is based on four major assumptions: 1) realizing the widespread impact of trauma; 2) recognizing the signs and symptoms of trauma in patients, families, staff and others; 3) responding to trauma or disclosures by incorporating knowledge of trauma into policies, procedures and practices; and 4) actively resisting re-traumatization (SAMHSA, 2014). The trauma-informed approach to care is also grounded in the following six principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and context (SAMHSA, 2014). In establishing these guidelines, SAMHSA sought to develop standardized trauma-informed care principles and facilitate the uptake of trauma-informed care approaches at the organizational and systems levels. Furthermore, these guidelines help providers to shift their perspective from asking patients what is wrong with them to instead desiring to understand what happened to them. While this framework is not specific to pregnancy care, trauma-informed care approaches have already been applied in the prenatal care setting. Trauma-informed care is a particularly useful framework for addressing IPV in pregnancy. Using this framework, prenatal providers should understand that anyone may have experienced trauma and should be trained to appropriately screen patients for IPV, respond to disclosure with understanding and empathy and engage in shared decision-making regarding referral to support services (Drexler et al., 2022). This approach not only communicates to patients that they are safe and cared for, but also decreases the risk of retraumatization which can lead patients to avoid seeking care in the future (Decker et al., 2017). As regular prenatal care is important for maternal and fetal wellbeing regardless of IPV exposure, a trauma-informed approach to prenatal care is essential.

This project was also guided by the CUES intervention, an evidence-based framework for addressing IPV in the healthcare setting developed by Futures Without Violence (Futures Without Violence, 2018). CUES is a mnemonic that stands for Confidentiality, Universal Education & Empowerment, and Support (see Appendix A). Confidentiality consists of seeing patients alone for at least part of a visit and disclosing any limits of confidentiality, such as mandated reporting requirements. Universal education and empowerment includes providing safety cards to patients to initiate a conversation about relationship safety and health. Support consists of knowing how to support someone if they disclose IPV, making referrals to support services and offering health promotion strategies and safety planning. The CUES framework is grounded in the principles of trauma-informed care and universal education, and the building blocks of CUES have been evaluated in reproductive, college and adolescent health settings (Futures Without Violence, 2018). This project was grounded in the assumption that a midwifery practice at a community hospital affiliated with an academic health center in the Pacific Northwest may benefit from applying the CUES intervention framework to their prenatal care clinical processes, resulting in improvements in IPV screening, education, response and intervention.

The quality improvement (QI) aspect of this project was guided by the Institute for Healthcare Improvement (IHI) Model for Improvement. The IHI Model for Improvement accelerates QI in healthcare by offering a framework for preparing for and testing change in a real-world setting (Institute for Healthcare Improvement, n.d.). The Model guides healthcare professionals to set aims, establish measures and identify interventions. Once an intervention has been chosen, the MFI model involves initiating Plan-Do-Study-Act (PDSA) cycles to guide the test of change in the clinical setting. PDSA cycles are iterative processes involving small scale tests of change and repeated adjustment and re-testing within a specific healthcare setting. This project utilized PDSA cycles to quickly evaluate improvements within the prenatal midwifery practice related to implementation of universal screening and education for IPV.

Specific Aims

The overarching goal of this project was to establish a standardized, evidence-based, trauma-informed process for universal IPV screening and education within prenatal care at the project site in order to reduce preventable morbidity and mortality associated with IPV. The first PDSA cycle took place from September 30 – October 27 and the second PDSA cycle took place from November 4 – December 1. The following list of specific aims was developed to provide structure and guidance toward the project objectives:

By September 16, 2024, 100% of medical assistants, obstetricians, midwives and student midwives (hereafter referred to as “midwives”) involved in antepartum care will receive access to training via a PowerPoint presentation describing the project.

By September 30, 2024, 80% of medical assistants, obstetricians and midwives who received access to the PowerPoint presentation will have viewed the training.

By October 28, 2024, 50% of patients attending new OB visits during the first PDSA cycle will have documentation of confidential IPV screening and education in their chart.

By December 2, 2024, 80% of patients attending new OB visits during the second PDSA cycle will have documentation of confidential IPV screening and education in their chart.

Context

This project was implemented in the prenatal clinic at a community hospital in the Pacific Northwest. The clinic is located in a suburban city and draws patients from the surrounding rural, suburban and urban counties. A collaborative team of obstetricians (OBs) and certified nurse-midwives (CNMs) provides obstetric and gynecologic care for patients across the lifespan, with midwives providing most of the prenatal care and intrapartum management. Midwives supervise and educate student nurse-midwives (SNMs), who are also involved in patients' antepartum, intrapartum and postpartum care. In 2023, the practice had 469 deliveries, including 143 (30.5%) cesarean births. From 2021 to 2023, 25% of patients identified Spanish as their preferred language, and 51% of respondents identified as Hispanic, Mexican, Mexican American, Latinx, Puerto Rican, or of Spanish origin. Thirty-nine percent of respondents identified as non-Hispanic white, with the remaining 10% of the community was composed of patients who identify as non-Hispanic Black, African American, Asian, or Pacific Islander. The majority of patients received Medicaid health insurance coverage.

Patients initiating prenatal care at the clinic completed intake paperwork prior to their first visit, and this paperwork was scanned into their chart. The first appointment in the clinic was typically an Early Pregnancy Assessment Clinic (EPAC) visit with an OB, during which the OB completed a dating ultrasound. In most cases, this was immediately followed by a brief intake visit with a clinic registered nurse (RN), which included a review of the patient's history and chart, as well as patient education. If the patient decided to continue the pregnancy after this first visit, their next appointment was a new obstetric (NOB) visit at approximately 12 weeks' gestation. The majority of NOB visits were conducted by midwives, with a small portion conducted by OBs.

In the development of this project, interviews with OBs, CNMs, RNs, MAs, and the clinic Practice Manager were conducted to understand the current workflow and status of IPV screening in pregnancy at this clinic and to identify potential interventions. Interviews were also conducted with staff at local IPV community organizations to better understand how healthcare institutions can best respond to and support patients who have experienced IPV.

Prior to the initiation of this project, IPV screening was attempted at three timepoints during prenatal care at this clinic: via a written question on the intake paperwork, verbally by the RN during the OB intake visit, and verbally by the provider at the NOB visit. However, a number of gaps existed that resulted in ineffective or nonexistent IPV screening during prenatal care (see Appendix B). Patients completed intake paperwork prior to their first appointment that included a broad question regarding history of trauma (see Appendix C), but many providers were unaware that this paperwork existed and had been scanned into the patient chart. As a result, providers were not consistently reviewing a patient's reported history of trauma before the initial prenatal visit. At the OB intake, RNs asked patients a series of questions about healthy relationships (see Appendix C) and documented this in the Social Documentation section of the History tab in the patient chart. Providers were prompted by the note templates in the electronic health record (EHR) to ask patients about IPV at the NOB visit (see Appendix C). However, the clinic did not have a process for patients to be seen alone at any point during pregnancy, and many patients were accompanied by their partners. This resulted in deferral of IPV screening to future visits, and since there was no process for follow-up to ensure patients were eventually screened, many patients completed their pregnancy without ever being screened for IPV. In informal interviews with providers at this site, some providers revealed that they felt comfortable discussing IPV with their patients and were prepared to offer support and resources in the case of disclosure, while others expressed hesitancy. Additionally, there was no standardized education about IPV shared with patients.

Baseline chart review data showed that from July 1, 2024 to August 25, 2024, providers at this clinic conducted 58 NOB visits, of which eight (13.8%) charts included documentation of IPV screening by the provider at the NOB visit and two of these eight (25.0%) screened positive for IPV. Of the remaining 50 (86.2%) NOB visits in which the provider did not screen the patient for IPV, 12 (24.5%) charts documented deferring screening due to lack of confidentiality ("unable to perform – partner present"), while 39 (78.0%) charts documented deferring screening because the patient had been previously screened during their OB intake visit with an RN ("negative – previously screened in OB phone intake"). Eight (16.0%) charts listed both confidentiality and previous screening as reasons for deferral. However, of the 39 charts that documented previous IPV screening at OB intake as the reason for deferring screening at the NOB visit, 23 (59.0%) charts did not include documentation of IPV screening at OB intake. Per one provider at the clinic, this was possibly due to an error in the NOB note templates that automatically checked "negative – previously screened in OB phone intake," resulting in inaccurate documentation of negative screening when there was in fact no documentation of IPV screening in the chart. If these charts were not considered a negative screen and instead were considered to be lacking documentation of IPV screening, only 24 (41.4%) charts actually included documentation of IPV screening at or prior to the NOB visit. In summary, prior to this project, less than half of patients at the clinic were successfully screened for IPV in early pregnancy.

Interventions

The project began with a brief in-person presentation at the collaborative practice meeting for midwives and OBs. This presentation introduced the project and highlighted the proposed workflow changes. Following this meeting and prior to the start of the PDSA cycles, an educational PowerPoint presentation was distributed to front desk staff, MAs, midwives and OBs involved in antepartum care. This PowerPoint included an overview of the project and new clinic workflow, as well as principles of trauma-informed care and an acknowledgement that IPV is common and may impact employees as well as patients.

In collaboration with a co-occurring QI project focused on substance use screening in pregnancy, an adapted version of the Institute for Health and Recovery Integrated 5Ps screening tool was used by providers to verbally screen patients at the NOB visit. The 5Ps screening tool is a validated screening tool designed specifically for use in pregnancy that asks non-judgmental questions about substance use and IPV. This screening tool was integrated into an updated NOB note template with a provider script so that providers were prompted to screen patients during the NOB visit (see Appendix D).

In addition to implementing the use of a consistent screening tool, this project sought to implement a clinic-wide response to IPV through the use of the CUES intervention framework. The CUES intervention was implemented as follows:

- **Confidentiality:** Clinic workflow was adjusted so that MAs roomed patients alone at the start of the NOB visit, creating an opportunity for confidential screening and history-taking by the provider. Front desk staff were provided with a standardized script (see Appendix E) to alert patients that they would be brought back to the exam room alone at the start of the visit and that their support person could join them for the rest of the visit after the confidential portion had concluded. As part of the screening process, providers were prompted by the NOB note template in the EHR to discuss the limitations of confidentiality with patients, such as mandated reporting requirements.

- **Universal Education & Empowerment:** When patients were roomed alone by the MA, they were handed a clipboard with the EPDS/GAD7 screenings and two safety cards from Futures Without Violence (see Appendix F). The MA shared that the safety cards were handed out to every patient because relationship violence is so common, and that they were welcome to take the cards with them, share with others in their life, or leave the cards in the exam room. A sample script was provided to MAs (see Appendix G) to standardize the universal education approach. These safety cards were then used by the provider to initiate a conversation about healthy and unhealthy relationships. Safety cards were also placed in exam rooms and bathrooms so that patients were able to privately choose whether or not to take one with them.
- **Support:** While disclosure of IPV is not the goal of the CUES intervention, disclosures inevitably happen, and providers must be prepared to respond appropriately and supportively. Via the pre-intervention educational PowerPoint presentation, providers received training in trauma-informed care and the use of shared decision-making to determine how patients would like to proceed after a disclosure. When providers documented a positive screen in the NOB note template, the EHR populated a script that offered language for responding to the disclosure and recommendations for next steps, including referral to local resources and safety planning.

A flowchart demonstrating the new clinic workflow (see Appendix H) was printed and posted above computers at the MA desk and provider offices to offer guidance. If patients or partners were resistant to this new process for any reason, MAs were directed to defer rooming the patient alone and alert the provider so the protocol deviation could be documented and the appropriate follow-up completed. The Practice Manager at the clinic served as a project champion among the clinic staff and disseminated information about the new workflow and served as a resource to MAs and front desk staff throughout the project.

Documentation of universal IPV screening and education was completed through the use of a standardized note template in the EHR. During the history-taking portion of the NOB visit, providers were prompted by the NOB note template to document the 5Ps screening results. The NOB note template also prompted providers to document the provision of universal IPV education, confirm that the visit was confidential, and track any follow-up needed for a positive screen. A smart phrase was created that included a list of local resources (see Appendix I), which providers could reference in conversation with patients and print or include in the patient's after visit summary (AVS), as long as this did not create safety concerns for the patient. If a provider was unable to screen a patient for any reason, it was requested that they include clear documentation in the note explaining why the patient was not screened and what the plan was to screen them at a future visit.

This QI project was studied using pertinent chart review data collected from the EHR. Baseline chart review data was collected from July 1 – August 25 from all NOB visit charts during this eight-week period. This chart review included demographic data and whether or not IPV screening was completed and documented in the NOB visit note. At the conclusion of each PDSA cycle, chart review data was collected from NOB visit charts during that cycle period. Patients were deidentified and information was collected from the NOB visit note. Chart review included documentation of IPV screening, whether the patient was seen confidentially, whether the patient received universal education, and any follow-up or resources provided to patients who screened positive for IPV.

Study of the Interventions

Two PDSA cycles were conducted over the course of this project, each lasting 4 weeks and culminating in a period of chart review, stakeholder interviews and modifications for the next cycle.

- PDSA 1: September 30 – October 27
- PDSA 2: November 4 - December 1

Preparation that took place before the first PDSA cycle included the development of a brief in-person presentation at the collaborative practice provider meeting and an educational PowerPoint presentation emailed to staff and providers, safety card acquisition, flowchart and script development, EHR template and smart phrase creation, and data storage and collection strategy confirmation.

Data collection was done in partnership with project leads from two co-occurring DNP projects focused on substance use screening at the NOB visit, whose project shared the same patient sample as this project. Each PDSA cycle involved daily chart review (Monday-Friday) by a project lead to identify patients attending NOB appointments who need to be screened for IPV and receive universal education. A project lead also added a note to the appointment slot for every eligible patient prior to each clinic day, which served as a reminder to MAs and providers that the patient needed to be roomed alone, screened and receive universal education. Informal stakeholder interviews took place throughout each PDSA cycle, with additional feedback collected via weekly DNP project update emails. Additionally, the project lead attended a virtual midwifery practice meeting at the beginning of the second PDSA cycle to request verbal feedback about the intervention from midwives at the clinic. Together, the quantitative data from chart review and qualitative data from stakeholder feedback informed revisions that were made during the second PDSA cycle, and staff and providers involved in the project were notified of any changes by weekly DNP project update emails. Cumulative results compiled at the end of the project implementation were used to inform recommendations for the future.

Measures

This project used a set of measures to determine quality improvement progress. The primary outcome measure was the percentage of patients attending NOB visits who were screened for IPV. The secondary outcome measure was the percentage of positive screens among those who were screened. These outcome measures were assessed by looking at the percentage of NOB charts documenting IPV screening in the updated NOB note template.

Secondly, the project looked at process measures, or steps in the system that performed as planned or that needed improvement. For this project, process measures reflected the components of the CUES framework, including the percentage of patients attending NOB visits who were seen confidentially, the percentage of patients who received universal IPV education and the percentage of patients who received resources or referrals if they screened positive for IPV. These measures were assessed by looking at the percentage of NOB charts documenting completion of each of these components in the updated NOB note template.

Finally, this project considered balancing measures, or measures not directly related to the specific aims but that could be used to assess whether changes designed to improve one aspect of the system resulted in problems or benefits elsewhere in the system. Balancing measures included increased workflow burden on providers and MAs. Data for this measure was collected through informal stakeholder interviews with providers and clinic staff to understand the impact of the intervention on clinic processes and/or patient experience.

Analysis

Inferences were drawn from run chart data to assess change over time. Data analysis used percentage as the primary statistical measure to describe how the intervention utilization in each PDSA cycle compared to baseline data. Additionally, a proportion test of significance was conducted to describe the statistical significance of intervention implementation. Qualitative data from stakeholder interviews and additional chart review was analyzed using narrative and content analysis to draw conclusions and identify recurrent themes.

Ethical Considerations

Ethical considerations for stakeholders, such as midwives and clinic staff, included the potential for added workload while implementing this QI initiative. This was accounted for by developing an efficient, standardized workflow for project implementation and incorporating stakeholder feedback throughout the project. Additionally, since the impact of IPV is widespread and midwives and staff involved in this project may have had their own experiences of IPV, this project introduced the possibility of retraumatization. This was addressed by including an acknowledgement in all trainings and meetings that employees may also experience IPV and encouraging employees to take care of their own needs throughout this project. These efforts were intended to reduce shame and isolation around the experience of IPV and to provide employees with resources and support.

Ethical considerations for patients included the use of protected health information (PHI) generated from the medical record and the protection of patient confidentiality. To address this concern, all patient information was deidentified to ensure the anonymity of each individual, and the project was submitted to the OHSU Institutional Review Board (IRB) for approval. Additional ethical considerations for patients included the limits of provider confidentiality and mandated reporting. Although the benefits of screening for IPV have been shown to outweigh risks (O'Doherty et al., 2015), patient disclosure of IPV and associated chart documentation may expose patients to additional risk. While mandated reporting is intended to protect individuals from harm, it may jeopardize the individual's safety (ACOG, 2022). This was accounted for by providers stating the limits of their confidentiality and mandated reporting requirements prior to IPV screening. Furthermore, since chart notes are automatically shared electronically with patients when the provider signs the note, documentation of IPV in a patient's chart may be visible to anyone with access to their patient portal, including a partner. This was addressed by providers offering to hide patients' visit notes that include IPV disclosure from their personal medical record, so they would not be visible in their patient portal.

Results

Prior to the start of this QI project, 21 of 21 (100.0%) MAs, OBs and midwives involved in antepartum care received access to an educational PowerPoint describing the project. However, only six of 21 (28.6%) responded to a poll confirming that they viewed the PowerPoint.

As shown in Tables 1-3 (see Appendix J), a total of 65 patients attended NOB visits from September 30, 2024 to December 1, 2024. Of those 65 patients, 56 (86.2%) had documentation of IPV screening at the NOB visit in their chart and eight (14.6%) screened positive for IPV. Compared to the baseline screening rate of 13.8%, this represents a statistically significant increase in IPV screening ($P < 0.0001$, 95% CI [0.5472, 0.9000]). The screening rate increased from 80.7% in the first PDSA cycle to 91.2% in the second PDSA cycle, indicating improved intervention uptake over time (see Figure 1). Figure 2 shows the percent of charts documenting IPV screening by week compared to baseline. Even when compared to the 41.4% of patient charts included in the baseline data analysis that had documentation of IPV screening at some point in early pregnancy (OB intake or NOB visit), this represents a statically significant increase in IPV screening documentation ($P < 0.00001$, 95% CI [0.2787, 0.6167]).

Figure 1

NOB Charts Documenting IPV Screening

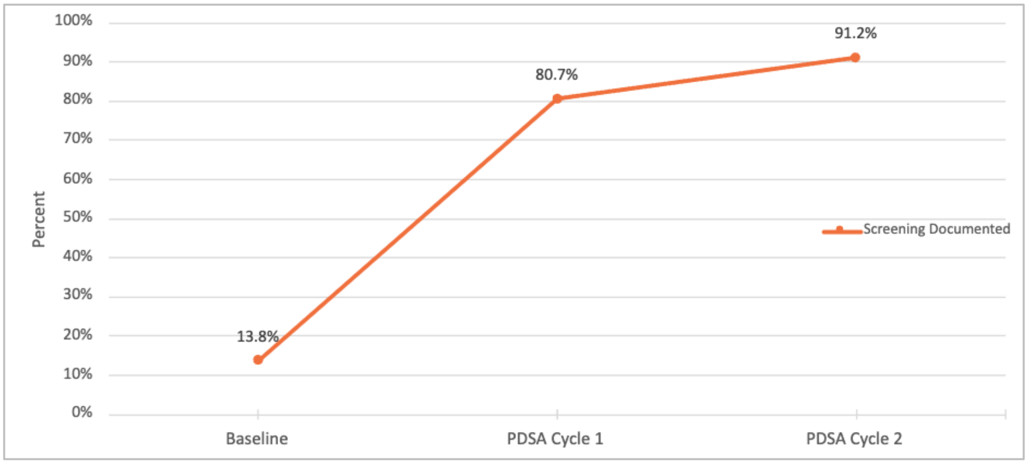


Figure 2

NOB Charts Documenting IPV Screening Compared to Baseline Screening Rate

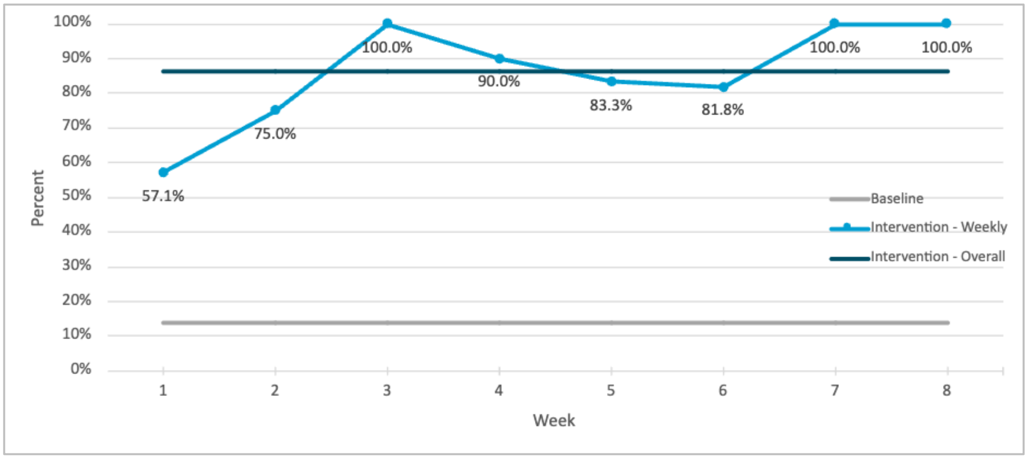
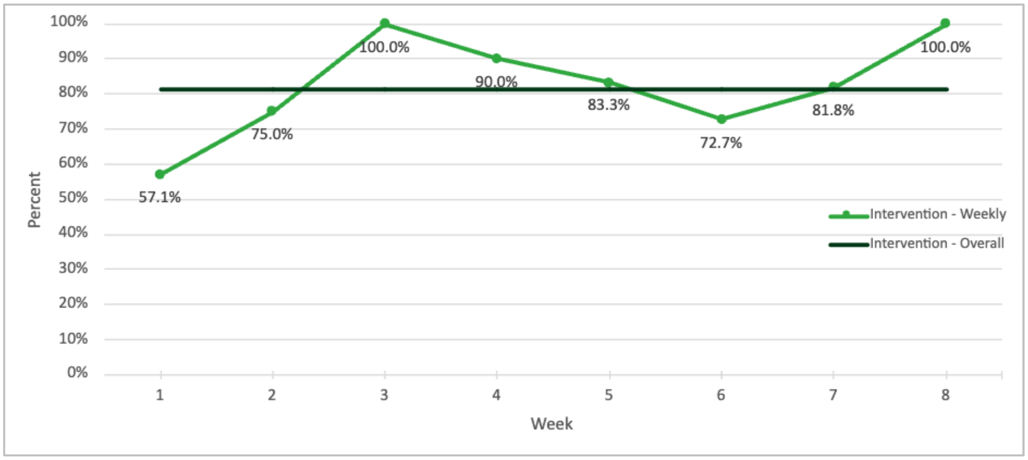


Figure 3

NOB Charts Documenting Patient Was Seen Confidentially



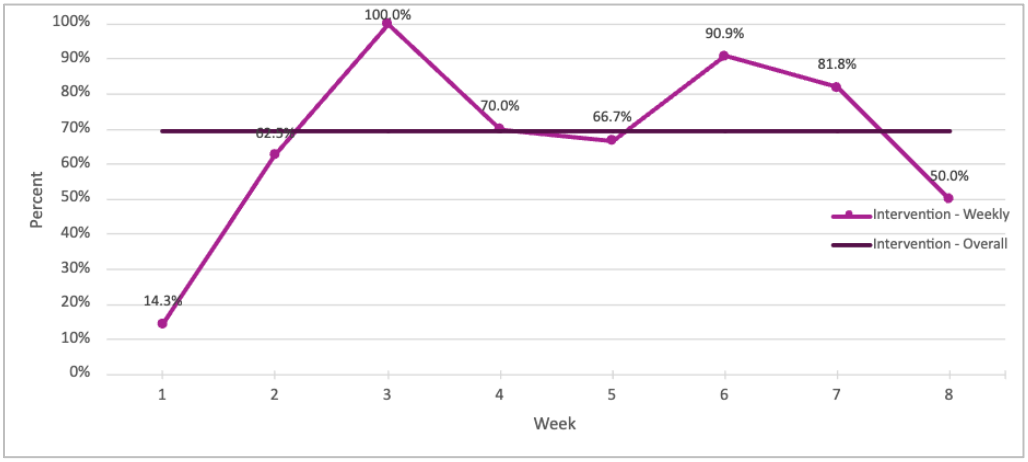
For the 65 patients attending NOB visits during this project, 53 (81.5%) patient charts included documentation that the patient was seen confidentially, two (3.1%) documented that the patient was not seen confidentially, and 10 (15.4%) did not include any documentation. In cases where there was no documentation, it was noted that this section of the NOB note template had been deleted by the provider. The percentage of charts documenting that the patient was seen confidentially increased from 80.7% in the first PDSA cycle to 82.4% in the second PDSA cycle. Figure 3 shows the percent of charts documenting that the patient was seen confidentially each week during the project implementation.

Of the 65 patients attending NOB visits during this project, 45 (69.2%) patient charts included documentation of universal education, nine (13.8%) documented no universal education, and 11 (16.9%) did not include any documentation. Again, in cases where there was no documentation, it was noted that this section of the NOB note template had been deleted by the provider. The percentage of charts documenting that the patient received universal education increased from 61.3% in the first PDSA cycle to 76.5% in the second PDSA cycle. Figure 4 shows the percent of charts documenting that the patient received universal education each week during the project implementation.

Stakeholder feedback collected throughout the project implementation via weekly project update emails and the virtual midwifery practice meeting was largely positive. Multiple providers shared that the 5Ps screening opened up deep and meaningful conversations with patients that they otherwise may not have had. One provider reported that patients particularly loved the safety cards provided as part of universal education. Another provider reported that they had not had any issues with patients being roomed alone, but that the MAs had mentioned this being an occasional issue. Some midwives expressed that while the intervention processes felt “clunky” at first, particularly documentation of screening in the EHR, it was manageable to implement. One provider shared that if a patient had not done an intake visit prior to the NOB, they were “inundated with essential care” and had to complete many more tasks in the time allotted for the appointment, making them unable to complete the 5Ps screening.

Figure 4

NOB Charts Documenting Universal Education



In response to stakeholder feedback and initial trends identified in the data, one primary project modification was made to the NOB note template to improve documentation consistency. Initially, documentation of IPV was broken up into two sections in the note. During data collection for the first PDSA cycle, it was noted that there were discrepancies in documentation between these two sections. For example, some providers documented that a patient responded “Yes” to the 5Ps screening question “Are you currently or have you ever been in a relationship where you were physically hurt, threatened, controlled, emotionally abused or made to feel unsafe?” but documented “No” to “Did the patient screen positive for Violence?”. Some providers also requested that the two sections be combined in the note template for easier access. Based on this feedback, the two sections were merged to streamline documentation. This modification was intended to be made in the week between the first and second PDSA cycles, but the change was not finalized until the second week of the second PDSA cycle (sixth week of the intervention).

During the first PDSA cycle, it was noted that some providers were still using an older NOB note template that did not include 5Ps screening. The project team considered adding the 5Ps screening tool to the older template, but after discussion with stakeholders it was determined that the clinic goal was to transition to the newer template, and they decided not to make changes to the older version.

Discussion

Summary

The specific aims of this project were largely met. The first specific aim, delivery of an educational PowerPoint presentation to 100% of MAs, OBs and midwives involved in antepartum care at the practice, was achieved. However, the second specific aim, to have 80% of recipients view the PowerPoint by September 30, 2024, was not met, as only 28.6% responded to a poll to report that they viewed the PowerPoint.

The third specific aim, to have 50% of patients attending NOB visits during the first PDSA cycle have documentation of confidential IPV screening and education in their chart, was achieved. Throughout the first PDSA cycle, 80.7% of patient charts included documentation of IPV screening, 80.7% of patient charts included documentation of confidentiality, and 61.3% of patient charts included documentation of universal education.

The final specific aim, to have 80% of patients attending NOB visits during the second PDSA cycle have documentation of confidential IPV screening and education in their chart, was largely met, with the exception of universal education. During the second PDSA cycle, 91.2% of patient charts included documentation of IPV screening and 82.4% of patient charts included documentation of confidentiality. However, only 76.5% of patient charts included documentation of universal education, falling just short of the 80% aim.

Despite this shortcoming, strengths of this project included the integration of the 5Ps screening tool into the standard NOB note template used by providers at the practice, as well as the development of a clinic workflow for rooming patients alone at the NOB visit to allow for confidential history taking and screening. Together, the results from this project helped affirm the importance of IPV screening for the practice, established a process for confidential IPV screening and education, and highlighted multiple avenues for improvement.

Interpretation

This QI project contributed a standardized process and screening tool to the prenatal care practice that has the potential for long-term use and possible adaptation at multiple time points during prenatal care. With this tool and clinic workflow, providers were able to increase confidential IPV screening rates in pregnancy and provide universal education to patients about healthy relationships. These improvements are in contrast to the lack of consistency in IPV screening and absence of confidential visits or universal education within the practice prior to the implementation of QI interventions.

During this project, providers documented screening 86.2% of patients for IPV at the NOB visit. While this falls short of the ACOG (2022) recommendation for universal IPV screening at the first prenatal visit, it represents a statistically significant increase in IPV screening at this practice. Potential barriers that contributed to less than universal screening included variation among providers regarding which NOB note template was used. Within the prenatal care practice, two main NOB note templates were used the majority of the time, only one of which included the 5Ps screening, provider scripts, and prompts for documentation of universal education, visit confidentiality and patient-specific follow-up. In eight out of nine (88.9%) cases in which IPV screening was not documented, screening was missed because the intervention NOB note template was not used. In one case, the provider documented that the patient’s visit was cut short due to childcare challenges and IPV screening was deferred to the next prenatal visit.

Of patients screened at the NOB visit during this project, 14.6% screened positive for current or past IPV. This is in stark contrast to the most recent national data showing that 3.5% of postpartum individuals experienced physical or emotional IPV before or during pregnancy (Kozhimannil et al., 2023). This dramatic finding indicates that the prevalence of IPV may be higher among patients at this practice than among a national sample, further emphasizing the need for universal, confidential screening and education at this practice.

A review of the extant literature identified barriers and facilitators that contributed to successful IPV screening in pregnancy, and many of these same factors were reflected in the qualitative feedback received throughout this project. A key systemic barrier to screening included provider time constraints (Lu et al., 2023), a perspective echoed by one provider who struggled to accomplish IPV screening at the NOB visit if the patient had not had a prior OB intake. Other systemic barriers identified in the literature were directly addressed in the development of this project intervention. First, the lack of workflow to guide screening (Greely et al., 2022) was directly addressed with the creation of a new clinic workflow for all NOB visits. This new workflow, in which patients were roomed alone at the start of the NOB visit, also addressed the barrier of providing a private environment for screening in which the patient is alone (Lu et al., 2023). Systemic facilitators that have been shown to reduce barriers to IPV screening were intentionally included in the development of this project. Throughout the development and implementation of the intervention, the project lead garnered staff and institutional support (Lu et al., 2023) by including stakeholders in the project planning phase, regularly requesting feedback throughout the project, and implementing changes to address identified issues.

A primary provider-level barrier identified in the literature was providers feeling that screening for or addressing IPV was outside of their scope (Lu et al., 2023), a sentiment echoed by one provider who felt that IPV screening did not fall into the category of "essential care" during the NOB visit. Provider-level facilitators that have been found to reduce barriers to IPV screening were also deliberately incorporated in the development of this project. The project lead disseminated provider training and education to stakeholders with the goal of increasing provider familiarity with IPV and related issues and increasing provider confidence in their ability to address IPV (Kapaya et al., 2019; Lu et al., 2023). Only 28.6% of stakeholders receiving this training and education confirmed that they had viewed the materials, indicating that this aspect of the intervention may not have been as successful as intended.

Limitations

This QI project had several limitations. First, the project was unsuccessful in gathering robust data related the balancing measure of clinic workflow burden. The project design called for informal stakeholder interviews with the MAs to assess workflow burden, but despite attempts to organize these interviews, these were unable to be completed in the time allotted for the project. MAs were asked to communicate any issues with rooming or workflow to the provider for documentation in the chart, but no documentation was identified on chart review. Absence of feedback from MAs also meant that no feedback was collected on the process of rooming patients alone. Therefore, this project missed valuable feedback that could be used to evaluate the success of this component of the intervention and inform next steps and project modifications.

This project also illuminates the limitations of EHR templates. While note templates can standardize documentation and increase completeness, they do not necessarily improve the overall accuracy of clinical documentation (Avendano et al., 2014). Embedding the 5Ps screening tool into the NOB note template likely contributed to improved screening rates during this project, but inconsistencies in documentation and missing documentation were still observed. As this project relied on provider use of a specific EHR template, the results are limited by the accuracy and completeness of the data that was documented in the EHR.

Overall, this project and recommendations for future iterations are intended to be tailored to the specific practice environment where the project took place and are not necessarily applicable to other locations. This project's small sample size limits the generalizability of the results to larger populations. Moreover, factors unique to this clinic such as demographics, cultural norms or access to care may have influenced the results and may not reflect the experiences of patients or providers in different settings. This clinic also had a history of participating in QI projects, and providers involved in developing the project idea were also responsible for implementing the intervention.

Next Steps

The findings from this project highlight the importance of a standardized, confidential process for IPV screening and education during the prenatal period. After the project concluded, results were shared with the practice. Providers at the clinic voted to sustain the intervention and continue confidential screening for IPV using the 5Ps screening at the NOB visit.

Despite a statistically significant increase in IPV screening and meeting the goals for the project, this project did not achieve the professional recommendation goal of universal screening. Future projects could continue to explore barriers to universal screening, as well as barriers to rooming patients alone and providing universal education. Qualitative data regarding stakeholder experiences with this project implementation may illuminate additional avenues for improving clinic workflows and decreasing provider and staff burden.

It is important to note that this project focused on IPV screening at the NOB visit. It did not attempt to standardize screening throughout pregnancy or across the reproductive lifespan. Future QI projects could focus on supporting the practice to align with ACOG recommendations to implement universal IPV screening at additional time points, including once per trimester and at a postpartum visit. People may not disclose IPV the first time they are asked, so screening all patients at various times is essential (ACOG, 2022).

Conclusion

This QI project successfully enhanced the IPV screening process at the clinic, resulting in a statistically significant increase in screening documentation and the integration of a standardized approach to confidential IPV screening and education. Despite not meeting the target of universal screening at the NOB visit, the project demonstrated a marked improvement, with 86.2% of patient charts documenting IPV screening compared to a baseline rate of 13.8%. The development of new clinic workflows and the integration of the 5Ps screening tool into the NOB note template were crucial for making confidential IPV screening attainable for staff and providers.

While the project faced several limitations that impacted its overall success, the clinic has expressed a commitment to sustaining the intervention. Future projects may focus on expanding the screening process across additional time points during pregnancy to align with professional recommendations. Further qualitative research and a more comprehensive evaluation of clinic workflows and staff experiences could provide valuable insights for improving the implementation of IPV screening and education in prenatal care settings, ultimately supporting better maternal and neonatal outcomes.

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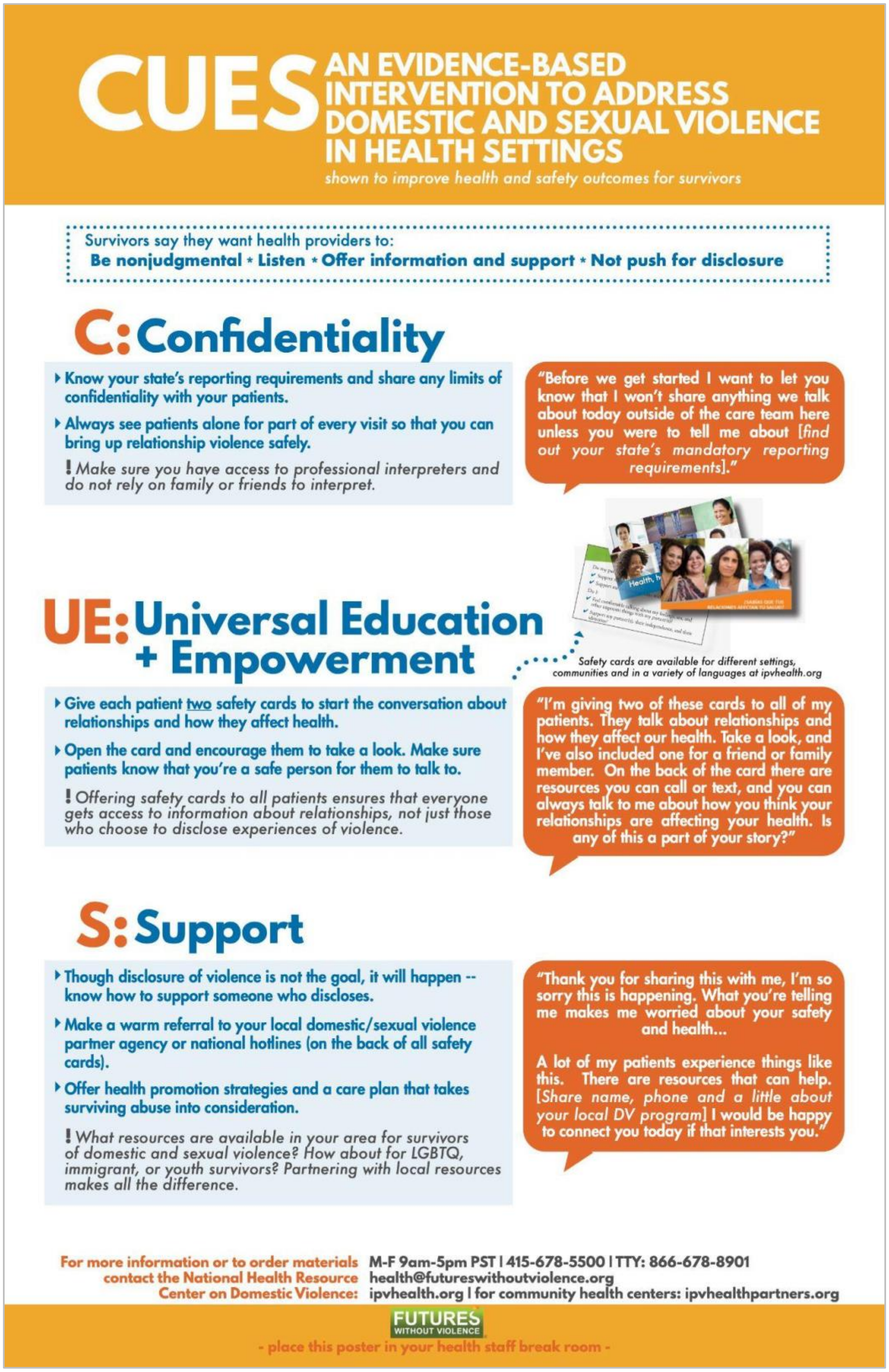
Appendix A: CUES Intervention Framework



CUES AN EVIDENCE-BASED INTERVENTION TO ADDRESS DOMESTIC AND SEXUAL VIOLENCE IN HEALTH SETTINGS

shown to improve health and safety outcomes for survivors

Survivors say they want health providers to:
Be nonjudgmental * Listen * Offer information and support * Not push for disclosure

C: Confidentiality

- Know your state's reporting requirements and share any limits of confidentiality with your patients.
- Always see patients alone for part of every visit so that you can bring up relationship violence safely.

! *Make sure you have access to professional interpreters and do not rely on family or friends to interpret.*

"Before we get started I want to let you know that I won't share anything we talk about today outside of the care team here unless you were to tell me about [*find out your state's mandatory reporting requirements*]."

UE: Universal Education + Empowerment

Safety cards are available for different settings, communities and in a variety of languages at ipvhealth.org

- Give each patient two safety cards to start the conversation about relationships and how they affect health.
- Open the card and encourage them to take a look. Make sure patients know that you're a safe person for them to talk to.

! *Offering safety cards to all patients ensures that everyone gets access to information about relationships, not just those who choose to disclose experiences of violence.*

"I'm giving two of these cards to all of my patients. They talk about relationships and how they affect our health. Take a look, and I've also included one for a friend or family member. On the back of the card there are resources you can call or text, and you can always talk to me about how you think your relationships are affecting your health. Is any of this a part of your story?"

S: Support

- Though disclosure of violence is not the goal, it will happen -- know how to support someone who discloses.
- Make a warm referral to your local domestic/sexual violence partner agency or national hotlines (on the back of all safety cards).
- Offer health promotion strategies and a care plan that takes surviving abuse into consideration.

! *What resources are available in your area for survivors of domestic and sexual violence? How about for LGBTQ, immigrant, or youth survivors? Partnering with local resources makes all the difference.*

"Thank you for sharing this with me, I'm so sorry this is happening. What you're telling me makes me worried about your safety and health...

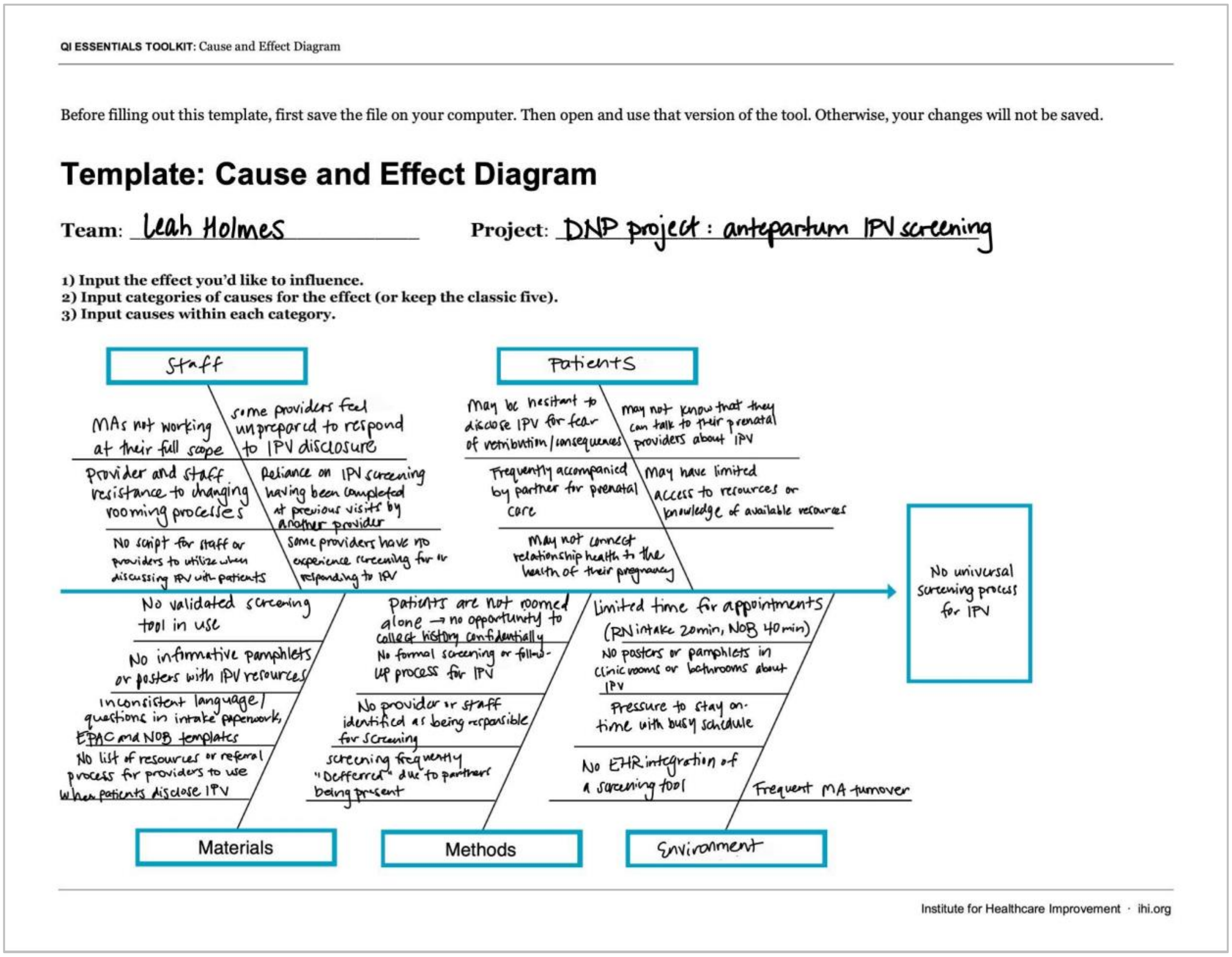
A lot of my patients experience things like this. There are resources that can help. [*Share name, phone and a little about your local DV program*] I would be happy to connect you today if that interests you."

For more information or to order materials contact the National Health Resource Center on Domestic Violence:
M-F 9am-5pm PST I 415-678-5500 I TTY: 866-678-8901
health@futureswithoutviolence.org
ipvhealth.org I for community health centers: ipvhealthpartners.org

FUTURES WITHOUT VIOLENCE

- place this poster in your health staff break room -

Appendix B: Cause & Effect Diagram



QI ESSENTIALS TOOLKIT: Cause and Effect Diagram

Before filling out this template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: Cause and Effect Diagram

Team: Leah Holmes

Project: DNP project : antepartum IPV screening

1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.

Staff
- MAs not working at their full scope
- some providers feel unprepared to respond to IPV disclosure
- Provider and staff resistance to changing rooming processes
- Reliance on IPV screening having been completed at previous visits by another provider
- No script for staff or providers to utilize when discussing IPV with patients
- Some providers have no experience screening for or responding to IPV

Patients
- May be hesitant to disclose IPV for fear of retribution/consequences
- may not know that they can talk to their prenatal providers about IPV
- Frequently accompanied by partner for prenatal care
- May have limited access to resources or knowledge of available resources
- May not connect relationship health to the health of their pregnancy

Materials
- No validated screening tool in use
- No informative pamphlets or posters with IPV resources
- inconsistent language/questions in intake paperwork, EPAC and NOB templates
- No list of resources or referral process for providers to use when patients disclose IPV

Methods
- patients are not roomed alone → no opportunity to collect history confidentially
- No formal screening or follow-up process for IPV
- No provider or staff identified as being responsible for screening
- screening frequently "Defferred" due to partners being present

Environment
- limited time for appointments (RN intake 20min, NOB 40min)
- No posters or pamphlets in clinic rooms or bathrooms about IPV
- Pressure to stay on-time with busy schedule
- No EHR integration of a screening tool
- Frequent MA turnover

No universal screening process for IPV

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Appendix C: Current IPV Screening Attempts

OB Intake Paperwork:

Has there been a history of violence, trauma, or physical, sexual, or emotional abuse in your family, or in your relationship (past or present)? ☐ No ☐ Yes ____________________________
¿Ha habido historia de violencia, trauma, o abuso físico, sexual o emocional en su familia o en su relación (anterior o actual)? ☐ No ☐ Sí ______________________________

OB Intake Visit with RN – Documented in Social Documentation section of History tab:

IPV –
Do you feel safe in your current relationship? yes / no
Has your current partner ever threatened you or made you feel afraid? yes / no
Has your current partner ever hit, choked, or physically hurt you? yes / no

NOB Note Template:

Sexual/Physical Abuse:

- negative - previously screened in OB phone intake
- unable to perform - partner present
- ***
- Do you feel safe in your current relationship {yes / no***}
- Has your current partner ever threatened you or made you feel afraid? {yes*** / no}
- Has your current partner ever hit, choked, or physically hurt you? {yes*** / no}

Trauma screening: "*Traumatic events are very common and can have direct effects on physical and mental health. For these reasons, I've begun asking all of my patients about any prior difficult experiences they've had and whether or not you feel comfortable sharing*."

- None
- ***

Appendix D: 5Ps Screening Tool in NOB Note Template

In Social History section of note template:

5 P's Screening for Substance Use & Intimate Partner Violence

We know pregnancy is an important time for you. We want to address anything that can be harmful to you or your baby and help make your pregnancy as healthy as possible. We've started asking all of our patients about some things that can have a big impact on our health.
Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me about abuse or neglect involving children, elderly or people with disabilities.

Parents: Did any of your parents have a problem with alcohol or other drug use? {YES***/NO}
Peers: Do any of your friends have a problem with alcohol or other drug use? {YES***/NO}
Partner: Does your partner have a problem with alcohol or other drug use? {YES***/NO}
Past: In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? {YES***/NO}
Present: In the past month, have you drunk any alcohol or used other drugs including cannabis? {YES***/NO}
 How many days per month do you drink? ***
 How many drinks on any given day? ***
 How often did you have 4 or more drinks per day in the last month? ***
Smoking: Have you smoked any cigarettes or vaped any nicotine in the past three months? {YES***/NO}
Violence: Are you currently or have you ever been in a relationship where you were physically hurt, threatened, controlled, emotionally abused or made to feel unsafe? {YES***/NO}

Responding to positive screen for **Violence**: {*Links to provider script and resources – SEE NEXT PAGE*}
Responding to a positive screen for **Parents, Peers, Partner**: {*Links to provider script*}
Responding to a positive screen for **Past, Present, Smoking**: {*Links to SBIRT, provider script and resources*}

Provider script & resources for positive IPV screen:

Delete below before signing visit

Responding to IPV Disclosure	
Validate patient's experience:	*Thank you for answering my questions and sharing your experience.* *I'm so sorry this is happening. / This is not your fault. / I'm worried about your safety.* *I'm here to listen without judgment and support you however I can.*
Patient leads next steps:	*Relationships can have a big impact on your health and your baby's. Is it okay if we talk more about your experience?* • **Current IPV:** *What are your goals for your relationship in this pregnancy? How can we help you achieve these goals?* • **History of IPV:** *Is there anything from your past relationship experiences that you want us to know, or that would inform how we care for you in this pregnancy?*
Provide referral to resources:	*I have additional resources that patients often find helpful. Would you like to talk more about them?* **Share resources** verbally or in AVS, if patient agrees this is safe to do so (**.IPVRESOURCES**). **Provide referrals** to support as needed.
Assess and plan for safety:	**Assess for safety in clinic** – Is the perpetrator with the patient? **Assess for safety at home** – Threats of homicide, weapons involved, history of strangulation or stalking, safety of children? *Do you have immediate safety concerns today? We can connect you to support you need today, or help you create a safety plan.* *A safety plan is a set of actions that can help lower your risk of being hurt by your partner.* **Create a safety plan:** https://www.thehotline.org/plan-for-safety/create-your-personal-safety-plan
Hide note from patient:	*The note I write from our visit is automatically shared with you through the patient portal, MyChart. If others have access to your MyChart and someone else seeing this note would cause you harm, I can hide the note from your MyChart so it won't be visible. Would you like me to hide this note or any future notes in which we discuss your relationship safety?* If yes, deselect the "Share with Patient" button to block the note from the patient's MyChart.
Making a report:	*Remember at the start of this visit when we talked about situations where we would have to get others involved? This is one of those times. I know it took a great deal of courage to share this with me, and we need to make sure that you are safe. I will need to report what happened to you. I really would like your help making sure that I understand all of the things you need to make this as safe and supportive as possible for you.*
Follow-up:	*Thank you for talking with me today. Can we plan to follow up at your next visit?* *You can also reach me in these ways: [discuss contact methods]*

In Assessment & Plan section of note template:

Screening for IPV and substance use:
Was patient seen confidentially? {YES/NO***}
Universal IPV education provided (safety cards given to patient)? {YES/NO***}

Did the patient screen positive for **Violence**? {NO/YES}
  If YES:
    Follow-up:
    Resources provided ***
    Referrals provided ***
    Safety planning discussed ***
    Discuss at next visit ***

Did the patient screen positive for **Parents, Peers, Partner**? {NO/YES}
  If YES: Prompts provider to document follow-up

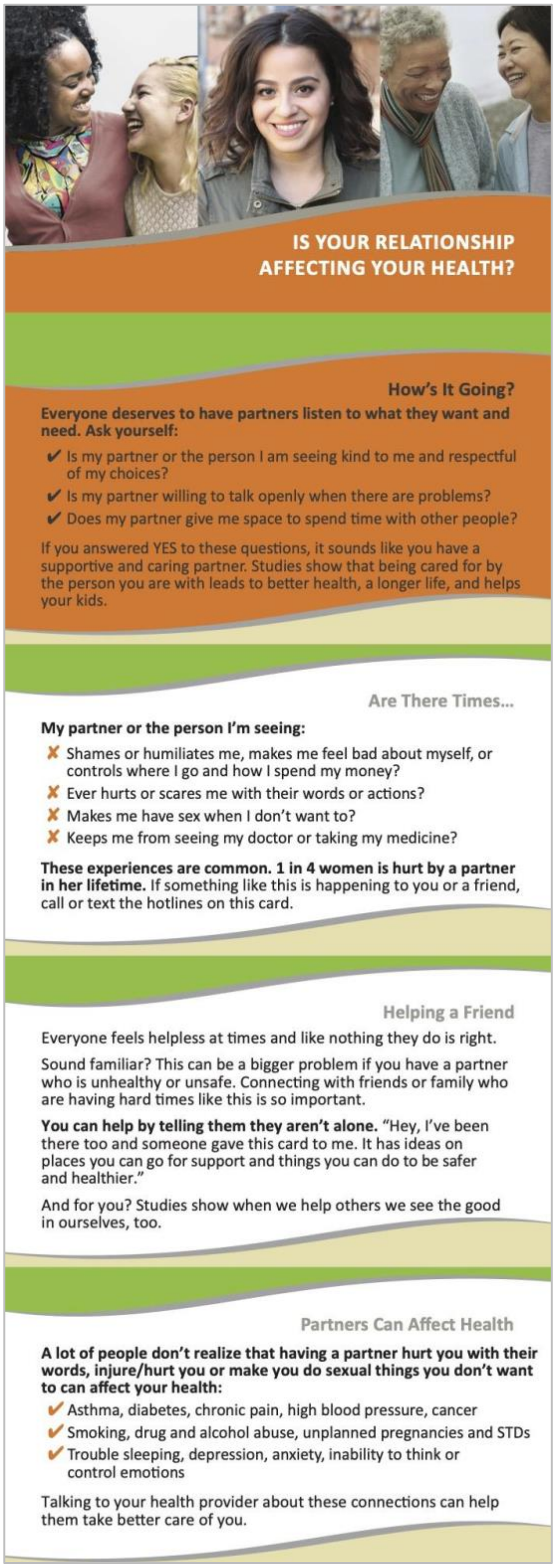
Did the patient screen positive for **Past, Present, Smoking**? {NO/YES}
  If YES: Prompts provider to document follow-up

Appendix E: Front Desk Script

“For this appointment the MA will take you back to the room alone for the start of the visit and your support person can join you for the second part of the visit.”

- ***Why do I have to be alone?*** *This is our clinic policy for everyone coming to the first prenatal visit with a provider.*
- ***When can my support person join me?*** *As soon as the provider is done with the first part of the visit, your support person will be brought back to join you. They will be able to be there to listen to the baby’s heartbeat.*
- ***What if I have more questions?*** *Your provider will be happy to answer any questions you have about this clinic policy.*

Appendix F: Safety Cards from Futures Without Violence



IS YOUR RELATIONSHIP AFFECTING YOUR HEALTH?

How's It Going?

Everyone deserves to have partners listen to what they want and need. Ask yourself:

- ✔ Is my partner or the person I am seeing kind to me and respectful of my choices?
- ✔ Is my partner willing to talk openly when there are problems?
- ✔ Does my partner give me space to spend time with other people?

If you answered YES to these questions, it sounds like you have a supportive and caring partner. Studies show that being cared for by the person you are with leads to better health, a longer life, and helps your kids.

Are There Times...

My partner or the person I'm seeing:

- ✘ Shames or humiliates me, makes me feel bad about myself, or controls where I go and how I spend my money?
- ✘ Ever hurts or scares me with their words or actions?
- ✘ Makes me have sex when I don't want to?
- ✘ Keeps me from seeing my doctor or taking my medicine?

These experiences are common. 1 in 4 women is hurt by a partner in her lifetime. If something like this is happening to you or a friend, call or text the hotlines on this card.

Helping a Friend

Everyone feels helpless at times and like nothing they do is right.

Sound familiar? This can be a bigger problem if you have a partner who is unhealthy or unsafe. Connecting with friends or family who are having hard times like this is so important.

You can help by telling them they aren't alone. "Hey, I've been there too and someone gave this card to me. It has ideas on places you can go for support and things you can do to be safer and healthier."

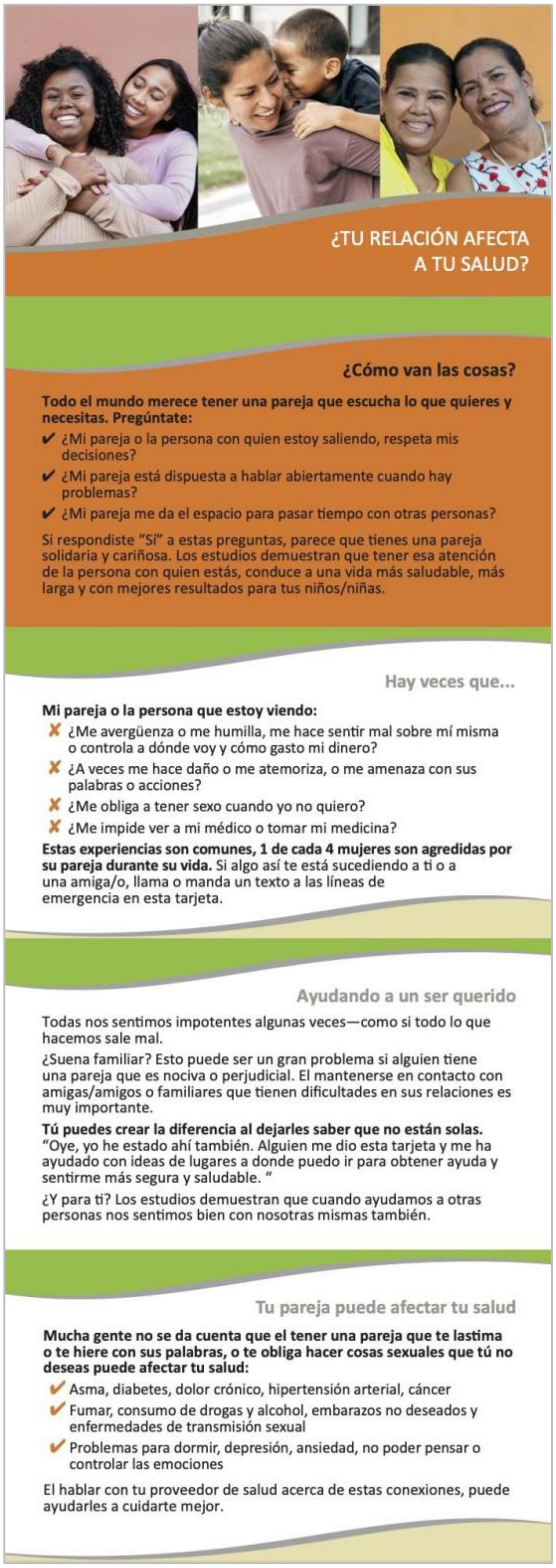
And for you? Studies show when we help others we see the good in ourselves, too.

Partners Can Affect Health

A lot of people don't realize that having a partner hurt you with their words, injure/hurt you or make you do sexual things you don't want to can affect your health:

- ✔ Asthma, diabetes, chronic pain, high blood pressure, cancer
- ✔ Smoking, drug and alcohol abuse, unplanned pregnancies and STDs
- ✔ Trouble sleeping, depression, anxiety, inability to think or control emotions

Talking to your health provider about these connections can help them take better care of you.



¿TU RELACIÓN AFECTA A TU SALUD?

¿Cómo van las cosas?

Todo el mundo merece tener una pareja que escucha lo que quieres y necesitas. Pregúntate:

- ✔ ¿Mi pareja o la persona con quien estoy saliendo, respeta mis decisiones?
- ✔ ¿Mi pareja está dispuesta a hablar abiertamente cuando hay problemas?
- ✔ ¿Mi pareja me da el espacio para pasar tiempo con otras personas?

Si respondiste "Sí" a estas preguntas, parece que tienes una pareja solidaria y cariñosa. Los estudios demuestran que tener esa atención de la persona con quien estás, conduce a una vida más saludable, más larga y con mejores resultados para tus niños/niñas.

Hay veces que...

Mi pareja o la persona que estoy viendo:

- ✘ ¿Me avergüenza o me humilla, me hace sentir mal sobre mí misma o controla a dónde voy y cómo gasto mi dinero?
- ✘ ¿A veces me hace daño o me atemoriza, o me amenaza con sus palabras o acciones?
- ✘ ¿Me obliga a tener sexo cuando yo no quiero?
- ✘ ¿Me impide ver a mi médico o tomar mi medicina?

Estas experiencias son comunes, 1 de cada 4 mujeres son agredidas por su pareja durante su vida. Si algo así te está sucediendo a ti o a una amiga/o, llama o manda un texto a las líneas de emergencia en esta tarjeta.

Ayudando a un ser querido

Todas nos sentimos impotentes algunas veces—como si todo lo que hacemos sale mal.

¿Suena familiar? Esto puede ser un gran problema si alguien tiene una pareja que es nociva o perjudicial. El mantenerse en contacto con amigas/amigos o familiares que tienen dificultades en sus relaciones es muy importante.

Tú puedes crear la diferencia al dejarles saber que no están solas. "Oye, yo he estado ahí también. Alguien me dio esta tarjeta y me ha ayudado con ideas de lugares a donde puedo ir para obtener ayuda y sentirme más segura y saludable. "

¿Y para ti? Los estudios demuestran que cuando ayudamos a otras personas nos sentimos bien con nosotras mismas también.

Tu pareja puede afectar tu salud

Mucha gente no se da cuenta que el tener una pareja que te lastima o te hiere con sus palabras, o te obliga hacer cosas sexuales que tú no deseas puede afectar tu salud:

- ✔ Asma, diabetes, dolor crónico, hipertensión arterial, cáncer
- ✔ Fumar, consumo de drogas y alcohol, embarazos no deseados y enfermedades de transmisión sexual
- ✔ Problemas para dormir, depresión, ansiedad, no poder pensar o controlar las emociones

El hablar con tu proveedor de salud acerca de estas conexiones, puede ayudarles a cuidarte mejor.

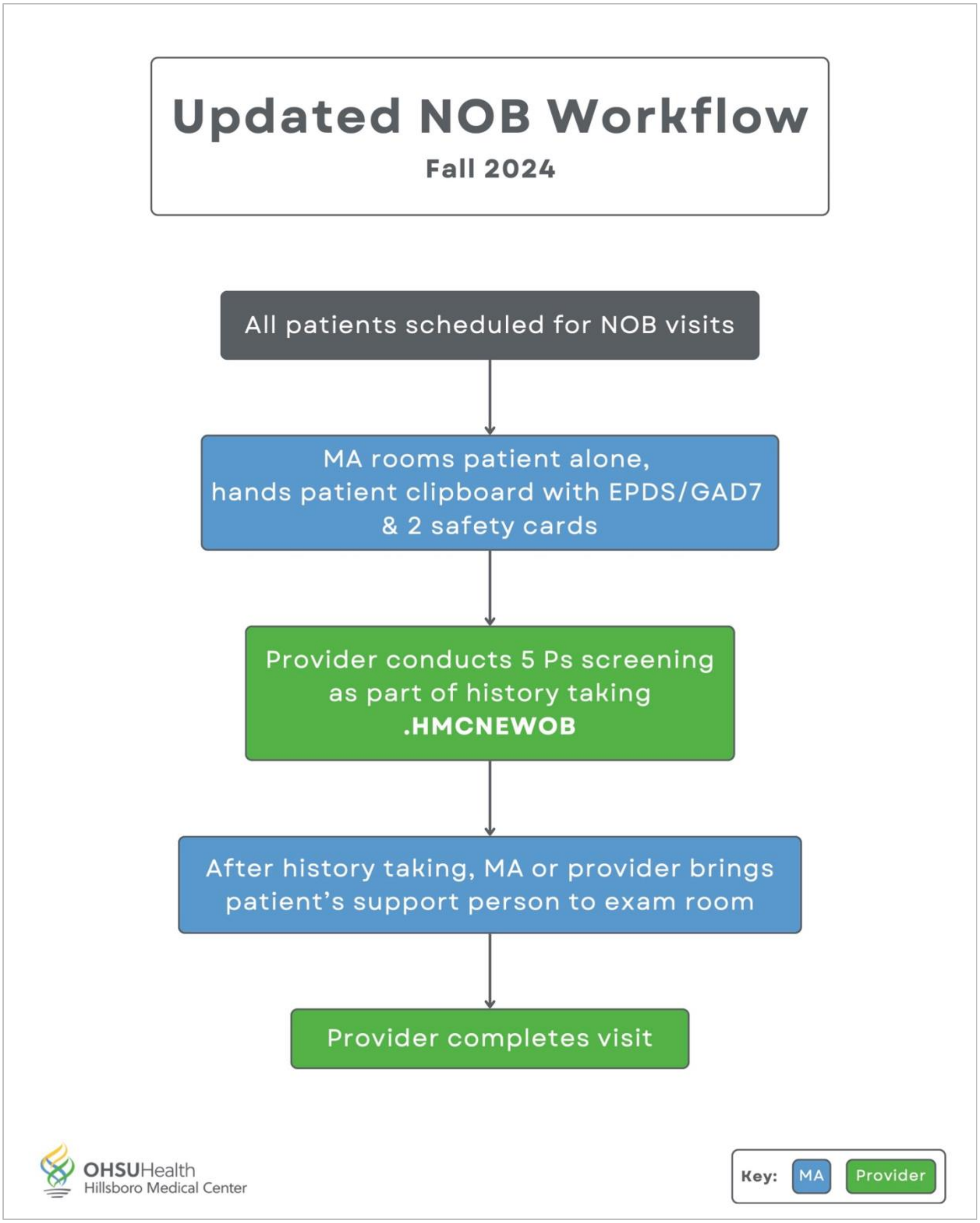
Appendix G: Universal Education Script for MAs

“Here are some forms to complete while you’re waiting for the provider.

One of the things your midwife will talk to you about today is relationship safety. We share these safety cards with all patients, and we have these cards in every exam room and the bathrooms. They have helpful information and a crisis hotline number on them. I encourage everyone to be aware of these cards, you might even want to take one for someone else you know.

All of the providers here have this same conversation with all of our patients. We are all a resource for you if you want to bring this topic up at any time in your care with us.”

Appendix H: Updated NOB Workflow Flowcharts



Updated NOB Workflow

Fall 2024

All patients scheduled for NOB visits

MA rooms patient alone,
hands patient clipboard with EPDS/GAD7
& 2 safety cards

Provider conducts 5 Ps screening
as part of history taking
.HMCNEWOB

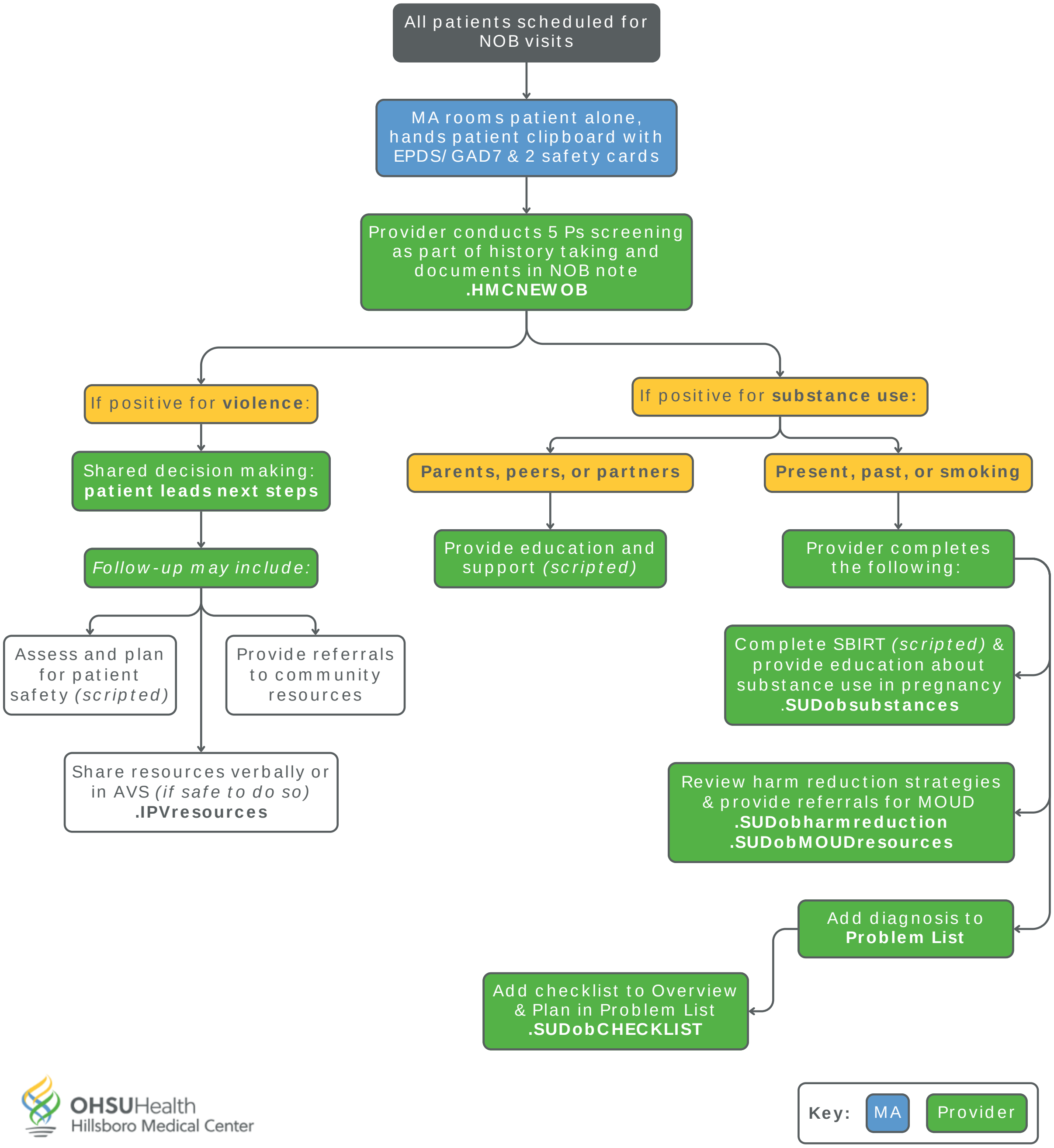
After history taking, MA or provider brings
patient's support person to exam room

Provider completes visit

Updated NOB Workflow

Positive Screen

Fall 2024



All patients scheduled for NOB visits

MA rooms patient alone, hands patient clipboard with EPDS/ GAD7 & 2 safety cards

Provider conducts 5 Ps screening as part of history taking and documents in NOB note **.HMCNEWOB**

If positive for **violence**:

Shared decision making: **patient leads next steps**

Follow-up may include:

- Assess and plan for patient safety *(scripted)*
- Provide referrals to community resources
- Share resources verbally or in AVS *(if safe to do so)* **.IPVresources**

If positive for **substance use:**

Parents, peers, or partners

Provide education and support *(scripted)*

Present, past, or smoking

Provider completes the following:

- Complete SBIRT *(scripted)* & provide education about substance use in pregnancy **.SUDobsubstances**
- Review harm reduction strategies & provide referrals for MOUD **.SUDobharmreduction** **.SUDobMOUDresources**
- Add diagnosis to **Problem List**
- Add checklist to Overview & Plan in Problem List **.SUDobCHECKLIST**

Key: MA Provider

OHSUHealth
Hillsboro Medical Center

Appendix I: Smart Phrase for IPV Resources

Intimate Partner Violence & Sexual Assault Resources

Call to Safety
24/7 crisis and support hotline: **503-235-5333** (local) or **1-888-235-5333**
Can provide referrals to other services, support groups, confidential advocacy, safety planning
Visit https://calltosafety.org
Website has chat/text support option as well
One-click quick button to leave the website if you are worried about someone seeing you on the website

Domestic Violence Resource Center (DVRC) of Washington County
24-hour crisis line: **503-469-8620** (local) or **1-866-469-8600**
Supporting survivors of domestic violence in Washington County and surrounding areas with advocacy emergency shelter, crisis line response, and safety planning
Visit https://www.dvrc-or.org/
One-click quick button to leave the website if you are worried about someone seeing you on the website

Oregon Coalition Against Domestic and Sexual Violence (OCADSV)
List of local resources; can filter by county, language and service
Visit https://www.ocadsv.org/find-help/

Bradley Angle
Emergency shelter, transitional housing, support groups, legal advocacy, economic justice and financial advocacy, services for children and youth, confidential advocacy, safety planning, and referrals to other services
Visit https://bradleyangle.org/
Call 503-232-1528

Rose Haven
Only day shelter and community center specifically serving women, children, and gender-diverse people in Portland
Provide meals, clothing, first aid, mailing addresses, hygiene, restrooms, showers, educational programs and guidance through medical and social services
Visit https://rosehaven.org/guest-calendar/ for daily schedule
Call 503-248-6364

Gateway Center for Domestic Violence Services
Offer legal aid, public assistance, restraining orders, spiritual support, adult/children/youth/teen counseling, child care, and many other resources
Visit https://sites.google.com/multco.us/thegatewaycenter/
Call 503-988-6400 (Monday-Friday, 9am-4pm) for one-on-one support with an experienced advocate to help develop a personal plan and connect to services

~ Servicios en Español ~

Un Nuevo Inicio para Concluir el Abuso (UNICA)
Línea de crisis disponible 24 horas al día: **503-232-4448**
24/7 support line and resources for Spanish-speaking survivors of domestic violence
Provide immediate assistance with advocacy, case management, legal help & medical accompaniment
Also offer housing, mental health and systems navigation/advocacy support

Sexual Assault Resource Center (SARC) Latin@ Services Program
Línea de crisis disponible 24 horas al día: **503-640-5311** (local) or **888-640-5311**
Phone/text/chat support services in Spanish and English
If a Spanish-speaking advocate is not available at the time of a call, a Language Line interpreter will be used
Resources for self-identified Latin@s and/or Spanish-speaking survivors in Washington County
Visit https://sarcoregon.org/latinx-services/
Offered in Spanish: case management advocacy, individual counseling, therapeutic support groups
Other services offered: housing advocacy, community education, outreach events and activities

Appendix J: Demographic Tables

Table 1. Demographic characteristics, baseline vs. intervention

Demographic Characteristics	Baseline (n = 58)	Intervention (n = 65)
Provider Type, n (%)		
CNM	51 (87.9%)	49 (75.4%)
OB	7 (12.1%)	16 (24.6%)
Age, mean (SD)	30 (5.47)	31 (6.43)
Parity, n (%)		
Nulliparous	23 (39.7%)	24 (36.9%)
Multiparous	35 (60.3%)	41 (63.1%)
Race, n (%)		
White	41 (70.7%)	45 (69.2%)
Black/African American	3 (5.2%)	3 (4.6%)
American Indian/Alaska Native	0 (0.0%)	1 (1.5%)
Asian	3 (5.2%)	4 (6.2%)
More than one race	6 (10.3%)	4 (6.2%)
Declined	5 (8.6%)	8 (12.3%)
Ethnicity, n (%)		
Hispanic, Latino/a/x, or Spanish Origin	19 (32.8%)	21 (32.3%)
Not Hispanic, Latino/a/x, or Spanish Origin	36 (62.1%)	33 (50.8%)
Declined	3 (5.2%)	11 (16.9%)
Primary Language, n (%)		
English	53 (91.4%)	53 (81.5%)
Spanish	3 (5.2%)	9 (13.8%)
Farsi	1 (1.7%)	0 (0.0%)
Sinhala	1 (1.7%)	0 (0.0%)
Arabic	0 (0.0%)	1 (1.5%)
Dari	0 (0.0%)	1 (1.5%)
Amharic	0 (0.0%)	1 (1.5%)
Insurance, n (%)		
Medicaid	31 (53.4%)	41 (63.1%)
Private	27 (46.6%)	23 (35.4%)
Uninsured	0 (0.0%)	1 (1.5%)
Self-pay	0 (0.0%)	0 (0.0%)

Table 2. Demographic characteristics, screened vs. not screened

Demographic Characteristics	Screened (n = 56)	Not Screened (n = 9)
Provider Type, n (%)		
CNM	42 (75.0%)	7 (77.8%)
OB	14 (25.0%)	2 (22.2%)
Parity, n (%)		
Nulliparous	22 (39.3%)	2 (22.2%)
Multiparous	34 (60.7%)	7 (77.8%)
Race, n (%)		
White	39 (69.6%)	6 (66.7%)
Black/African American	2 (3.57%)	2 (22.2%)
American Indian/Alaska Native	1 (1.79%)	0 (0.0%)
Asian	4 (7.14%)	0 (0.0%)
More than one race	3 (5.36%)	0 (0.0%)
Declined	7 (12.5%)	1 (11.1%)
Ethnicity, n (%)		
Hispanic, Latino/a/x, or Spanish Origin	18 (32.1%)	3 (33.3%)
Not Hispanic, Latino/a/x, or Spanish Origin	27 (48.2%)	6 (66.7%)
Declined	11 (19.6%)	0 (0.0%)
Primary Language, n (%)		
English	47 (83.9%)	6 (66.7%)
Spanish	7 (12.5%)	2 (22.2%)
Farsi	0 (0.0%)	0 (0.0%)
Sinhala	0 (0.0%)	0 (0.0%)
Arabic	1 (1.79%)	0 (0.0%)
Dari	1 (1.79%)	0 (0.0%)
Amharic	0 (0.0%)	1 (11.1%)
Insurance, n (%)		
Medicaid	33 (58.9%)	8 (88.9%)
Private	22 (39.3%)	1 (11.1%)
Uninsured	1 (1.79%)	0 (0.0%)
Self-pay	0 (0.0%)	0 (0.0%)

Table 3. Demographic characteristics, positive vs. negative screening

Demographic Characteristics*	Positive Screen (n = 8)	Negative Screen (n = 47)
Parity, n (%)		
Nulliparous	2 (25.0%)	20 (42.6%)
Multiparous	6 (75.0%)	27 (57.4%)
Race, n (%)		
White	5 (62.5%)	33 (70.2%)
Black/African American	0 (0.0%)	2 (4.3%)
American Indian/Alaska Native	0 (0.0%)	1 (2.1%)
Asian	0 (0.0%)	4 (8.5%)
More than one race	2 (25.0%)	1 (2.1%)
Declined	1 (12.5%)	6 (12.8%)
Ethnicity, n (%)		
Hispanic, Latino/a/x, or Spanish Origin	2 (25.0%)	16 (34.0%)
Not Hispanic, Latino/a/x, or Spanish Origin	4 (50.0%)	22 (46.8%)
Declined	2 (25.0%)	9 (19.1%)
Primary Language, n (%)		
English	8 (100.0%)	38 (80.9%)
Spanish	0 (0.0%)	7 (14.9%)
Farsi	0 (0.0%)	0 (0.0%)
Sinhala	0 (0.0%)	0 (0.0%)
Arabic	0 (0.0%)	1 (2.1%)
Dari	0 (0.0%)	1 (2.1%)
Amharic	0 (0.0%)	0 (0.0%)
Insurance, n (%)		
Medicaid	6 (75.0%)	26 (55.3%)
Private	2 (25.0%)	20 (42.6%)
Uninsured	0 (0.0%)	1 (2.1%)
Self-pay	0 (0.0%)	0 (0.0%)

**Total n = 55 because one patient declined to answer the 5Ps question about IPV*