Intimate Partner Violence Screening and Intervention in a Primary Care Clinic

Oregon Health & Science University, School of Nursing

Anicka Oyer Meyers, PMHNP-BC

Problem Description

Intimate partner violence (IPV) refers to psychological, sexual, or physical harm that is either threatened or carried out by a partner, spouse, or former partner or spouse regardless of gender or sexual orientation (Williams, Halstead, Salani, & Koermer, 2016; World Health Organization (WHO), 2013). Over one third of women and nearly one third of men in the United States have experienced IPV in some form over the course of their lifetime (Smith et al., 2017). IPV affects all across the spectrums of socioeconomic status, race, age, sexuality, and ethnicity but a disparity exists that disproportionally affects African Americans and Native Americans; African Americans and Native Americans have around 10% higher lifetime prevalence than White Americans (Singh, Peterson, & Singh, 2014). In addition to the potential physical effects of IPV, there are many somatic, mental, and physical health concerns that present in primary care (Hall, Chappell, Parnell, Seed, & Bewley, 2014; McCall-Hosenfeld, Winter, Heeren, & Liebschutz, 2014). Healthcare providers are poised to identify IPV as they may have more contact with and opportunity to assess victims of IPV or their families (Hegarty et al., 2013).

Current surveillance data suggests that only 12-20% of providers are screening for IPV citing a variety of barriers including limited time, lack of preparedness for screening, and a deficit of knowledge about IPV (Valpied & Hegarty, 2015). There is significant support for routine screening for IPV; however, even in the presence of screenings, the report rates of IPV do not match prevalence rates, suggesting that screenings alone are not effective (O'Doherty et al., 2015; Ramachandran, Covarrubias, Watson, & Decker, 2013). Adding interventions following a positive screening have shown some benefit in the literature (Bair-Merritt et al., 2014). Interventions following positive IPV screen vary from referrals and safety planning at the

provider level to implementing on-site advocates on the system level, with various degrees of supporting evidence (Bair-Merritt et al., 2014; Rhodes et al., 2013; Singh et al., 2014).

There is currently not an established response to a patient's disclosure of IPV within the primary care setting of a federally qualified health center (FQHC) located in downtown Portland, Oregon. This is a substantial gap in the services provided at the clinic and does not align with the overall mission of the organization, which is to "provide comprehensive solutions to ending homelessness and achieving self-sufficiency" (Central City Concern, n.d.). Some providers ask about IPV in patient appointments; however, which patients are asked, in what manner are they asked, and how positive screenings are addressed is not standardized among the providers. Additionally, there is no organizational policy related to IPV screening and intervention despite the high-risk population that regularly accesses services through the clinic. This is a missed opportunity to reduce violence as well as increase safety for those who are being subjected to abuse. Standardized screenings, availability of interventions, and policy to support these measures are necessary to address the needs of at-risk patients.

Available Knowledge

IPV screenings

In a Cochrane review of IPV screening studies, screenings were found to increase the number of women who were identified as survivors of IPV but did not demonstrate an effect on health outcomes (O'Doherty et al., 2015). Therefore, screening is not universally recommended for all women accessing health care but rather a subset of women who have signs of abuse or are part of more at-risk groups, such as women with chronic pain, depression, or are pregnant, as these conditions are common among those experiencing IPV (WHO, 2013). However, the United States Preventative Services Task Force (USPSTF) continues to recommend screening all

women of reproductive age, as their research found enough evidence demonstrating that

interventions lower the rates of physical or mental violence and abuse (USPSTF, 2013).

In contrast, a randomized controlled trial conducted by Klevens et al. (2012) found that

there were no differences in quality of life or other measurements, for example emergency room

visits or contact with an IPV agency, among a group of women who screened positive for IPV

and received a resource list, a group of women who received no screening but were given the

resource list, and a group who received neither at a one-year follow-up. There was again no

significant difference between the three groups in a repeat study that measured variance in

knowledge about resources and effects of IPV on physical and mental health (Klevens,

Sadowski, Kee, & Garcia, 2015). The authors contend their findings do not support universal

screenings, however the intervention provided was minimal (Klevens et al., 2015). This research

does suggest that screenings without intensive intervention do not produce significant results,

and bolsters support for screenings in combination with intervention.

Interventions

Systematic reviews conducted by Bair-Merritt et al. (2014) and Rivas et al. (2015) confer

patient benefit from intervention and referral following primary care visits. The evidence is not

conclusive about the effect on emotional abuse, sexual abuse, or overall mental health, although

the level of evidence was mixed and more research is needed (Rivas et al., 2015). Brief

interventions such as those more commonly provided in primary care clinics have mixed

evidence to their effectiveness, although there may be some reduction in abuse and improvement

in mental health at least in the short term (Rivas et al., 2015).

The World Health Organization (WHO) outlines specific responses to IPV survivors in

the areas of mental health support and physical health support, both immediately following an

episode of IPV and in follow-up visits (WHO, 2013). Safety assessment and safety plan accompanied by validating, supportive and nonjudgmental statements are recommended follow-up steps to a positive IPV screening (Singh et al., 2014). Additionally, the most recent USPSTF recommends providers either provide support services to women of reproductive age who screen positive for IPV or refer them to ongoing support, adding further reinforcement for IPV interventions (Nelson, Bougatsos, & Blazina, 2012; USPSTF, 2013).

Screening, Assessment, Intervention, and Documentation, or SAID, is an approach that is supported by the WHO, USPSTF, and the National Consensus Guidelines and can be used in primary care clinics (Singh et al., 2014). When on-site services such as safety plans, danger assessments, and warm hand-offs to community resources are a part of the clinic system, more healthcare providers provide screenings and patient disclosure of IPV also increases (Ramachandran et al., 2013). One benefit to integrating IPV interventions into primary care is that patients return for future visits with their healthcare provider and are not required to come to the clinic for additional appointments (Rhodes et al., 2013).

Futures Without Violence (FWV) is an organization funded by the Department of Health and Human Services that provides resources, training and education, and support for addressing IPV across the United States (Futures Without Violence, 2019). FWV developed a brief educational tool that has been shown to assist women in leaving abusive relationships (Miller et al., 2011). The intervention involves providing universal education about healthy and unhealthy relationships, how relationship affect health, and available resources in under 2 minutes through reviewing and giving out conversation cards on IPV. This process does not require the individual to disclose IPV to the provider; however, it may make the patient more likely to disclose IPV in

the future (Miller et al., 2017). Another FQHC serving a similar population in Portland has successfully implemented a system for giving the conversation cards (O'Connor, 2018).

Within the literature there is a lack of high-level studies specifically on the effects of advocacy interventions such as safety planning, brief counseling and referrals (Rivas et al., 2015). While studies have been conducted and included in systematic reviews, the level of evidence in some studies was low and overall had few comparable outcomes. One stand-out intervention is the conversation card created by FWV (Miller et al., 2011; Miller et al., 2017). It is important to note that research is lacking in IPV screening and interventions for men and gender non-conforming people, as most research on IPV is geared toward women (WHO, 2013).

Rationale

Two years ago, a pilot project on IPV screenings was implemented with one primary care team at the FQHC that is the focus of this project. A Doctor of Nursing Practice (DNP) student began her project by leading a healthcare provider training on IPV. Providers then implemented screenings with all female-identified patients over 2 weeks. Fifteen percent of those screened had experienced IPV within the past year, which is a higher rate than other, similar clinics have found (Helldobler, 2016). Anecdotally providers in the clinic reported increased awareness of IPV following this project. Based on the evidence described above and the foundation laid by the previous IPV project, there is a need for further improvement around IPV screening and intervention in the clinic. Additionally, working with leadership within the clinic to gain support and commitment for further work in this area is a key component to acquiring policy change at the clinic level.

Most women would like healthcare providers to directly, compassionately, ask about IPV in patient visits and provide referrals to additional supports, and believe universal screenings are

important for healthcare providers to implement (Alpert, 2015). In-person contact and communication led women experiencing IPV to feel more open to receiving an intervention or advice (Choo et al., 2016).

When on-site services such as safety plans, danger assessments, and warm hand-offs to community resources are a part of the clinic system, more providers provide screenings and patient disclosure of IPV also increases (Ramachandran et al., 2013). Rhodes et al. (2013) found that the number of patients across 4 community health clinics who screened positive for IPV was significantly higher during the period of time when the advocate was on site. Rates of identifying IPV returned to pre-advocate levels in the 6 months following, demonstrating the necessity of a designated advocate integrated into the clinic for improved outcomes (Rhodes et al., 2013).

Specific Aims

IPV can have fatal and damaging consequences for all those involved. The purpose of this project is to empower providers to screen for IPV within primary care appointments through education and training on a brief universal screening tool. The purpose is also to improve awareness of IPV and referrals for low-income and homeless patients experiencing IPV. The goal is to provide sensitive, informed screenings using the FWV conversation cards during primary care visits and follow-up IPV disclosures with an accessible, drop-in advocate session on-site while limiting the impact on limited provider time. These measures have the potential to benefit patients, their families, and their communities who may not have access to any other IPV supports. This project also fulfills the organizational mission of Central City Concern and could lead to a cultural shift within the clinic as it incorporates IPV screenings into provider practice.

Methods

Context

Old Town Clinic (OTC) is a FQHC and Patient-Centered Medical Home located in downtown Portland. OTC is part of the larger non-profit organization of Central City Concern (CCC). OTC has around 120 staff of the over 800 employees of CCC serving around 5,000 patients 18 and older, around 90% of which are insured primarily through Medicare and Medicaid. A significant portion of the patient population have experienced trauma, and are homeless or unstably housed. OTC also serves a large number of patients who are in active addiction, early recovery, or recovery. The services provided at OTC include primary care, behavioral health, pharmacy, acupuncture, occupational therapy, wellness groups, urgent care, and wound care. OTC refers patients to culturally specific services in addition to supplement care at OTC.

The clinic has an all-staff meeting once per month, each team meets once per month, and professional groups meet once per month and in some cases, more often. The care teams are close-knit; there is an emphasis on team collaboration and bonding, including clinic sponsored events and trainings. Health outcome benchmarks and incentives are regularly disseminated through email. There is an active Quality Improvement (QI) team that is consistently working to expand clinic practices and enhance patient care. Several systemic interventions have been rolled out within the past few years and have been accepted into clinical practice, including a designated person responsible for responding to patients expressing suicide.

Interventions

The QI project proposal was pitched to the clinic leadership team to gain approval and feedback. The leadership team's assessment was that no providers are assessing for IPV outside

of well-woman exams, and did not think an assessment of baseline IPV screenings an effective use of time. Following leadership approval and prior to implementing the intervention, a healthcare provider training was offered for all prescribers and clinicians. The team working together to develop, implement, and carry out the subsequent interventions was a DNP student, PMHNP-BC, and QMHP with significant domestic violence experience. This group worked with providers to empower them to provide IPV screenings and referrals from January-March 2019, including placing FWV conversation cards in all exam rooms. One month into the intervention period, clinic leadership requested an additional IPV training for all medical assistants (MAs), social workers, front desk staff, and nurses. MAs began rooming patients alone for the first 5 minutes to allow time for the IPV intervention. Providers gave out conversation cards and referrals to the advocate session to patients who screened positive for IPV. Following the intervention period, providers were emailed an anonymous survey seeking feedback to assess barriers, areas of growth, and level of comfort with providing the screenings to patients.

The DNP student and QMHP held weekly drop-in advocate sessions on Tuesday mornings from 9:30-11am in a private room within the clinic. The sessions were intended to create safety plans, discuss healthy and unhealthy relationship patterns, and navigate IPV resources in the community. Patients were asked to provide feedback on the helpfulness of the sessions and offer suggestions regarding other support they may find useful. Patient information was not recorded. The project team tracked how many patients accessed the advocacy sessions and themes within the feedback response. These sessions were continuously adapted based on patient and provider feedback.

Study of the Interventions

The proposed methodology for this QI project uses the tenants of the Model for Improvement, including plan-do-study-act (PDSA) cycles, used by the Institute for Healthcare Improvement (Institute for Healthcare Improvement, 2018). Using the aims established above, interventions related to the desired change and measures for determining an effect of the intervention were examined, per the Model for Improvement model. These interventions are described above. PDSA cycles were conducted using the knowledge gained from the previous cycle.

Measures

One outcome measure is how often FWV cards needed to be replaced in exam rooms following the IPV training. Another outcome measure is the number of attendees for the advocate sessions. A process measure was patient feedback for what was helpful from the group and what additional supports they would find useful. A balance measure at the conclusion of the project was evaluated via provider surveys to determine provider's level of comfort with the screening/referral process and where they see gaps in care. The results of the themes from the provider surveys and patient feedback assessed the areas of growth and ensured the project is adapting to the needs of the clinic, the patients, the providers, and the systems they operate within to provide the most effective intervention.

Analysis

The number of FWV conversation cards used in the period of time was estimated based on how many were replaced in exam rooms, checked on a weekly basis. A Chi-squared test was not used as previously planned to see if there is a relationship between positive screenings and follow-up on the referrals to an advocate, as there was no way to track positive screenings.

Provider survey responses were collated and tables were used to represent the data. Finally, confounding factors were assessed throughout to assess validity of the results and identify ongoing barriers to implementation.

Ethical considerations

Ensuring confidentiality and safety while engaging with providers and advocates is essential. Survivors of IPV who are in violent relationships may have fear around talking about IPV or taking any IPV-related resources with them in case an abuser finds it. The clinic has IPV hotline cards that are disguised as salon cards to give out if patients prefer, and the advocate sessions were held in a secluded area of the clinic to mitigate access by an abuser. Additionally, advocates must be well trained in areas of domestic violence and sensitivity toward the complex issues surrounding IPV.

There is a general sense of limited time in provider visits to address all of the complex issues presented by patients. Adding IPV questions to patient visits may be overwhelming for providers or not be seen as the top priority. Furthermore, as mandated reporters, if they discover serious harm as defined by adult protective services (APS) to someone enrolled in a community mental health program, they are required to file a report with APS. This information should be disclosed to patients prior to questions about IPV, which may in itself be a barrier to positive screenings. If a provider feels there is a more pressing need and use of their time with a patient, their clinical judgment should out-rule the efforts of the project so as to not compromise the health and safety of the patients. At the same time, patients who screen positive for IPV must be given all opportunities to access resources and receive assistance due to the serious physical, mental, and somatic health concerns related to IPV. The advocates were an available resource for providers to consult outside of the advocacy sessions.
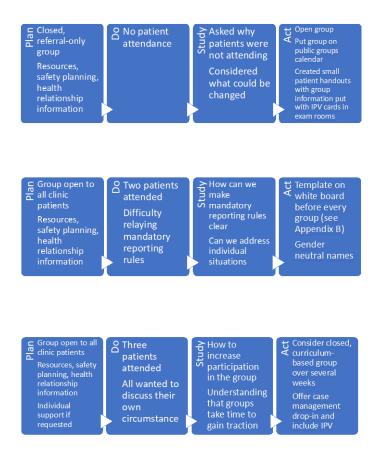
Results

Project Evolution

An initial assessment of clinic practices, policies, and provider responses to a questionnaire regarding IPV screening was planned for to obtain a baseline representation of IPV practices in the clinic. However, the leadership team determined this assessment could be a QI project in itself and they could say the number of IPV screenings and interventions was nearly zero. Additionally, a quicktext option for providers to include in chart notes when using the intervention was not implemented due to time constraints.

Feedback from the provider training was that the policies of the clinic did not support an IPV intervention, as there was not a practice of seeing patients alone. Therefore, a policy of seeing all patients alone for the first 5 minutes of their appointment was established. The MAs, nurses, and front desk staff requested an IPV training for their departments as well following this change, as they were interested in learning more about the IPV intervention and how to put the new policy into effect. Additional feedback from this training helped establish new practices for when patients approach front desk staff with visible signs of abuse or requesting support, as there was not a policy in place for how to respond in these instances. Signage was put up in waiting rooms and exam rooms to support the MAs in establishing the new policy, using the signs as support if patients protested this change.

Following the provider IPV training, the conversation cards were evenly distributed among the 5 teams. Initially cards were placed in team rooms for providers to use as needed. It was clear that providers were not using the cards very often if at all with this arrangement, and leadership approved funding for card holders to be placed in each exam room. Cards were then available in all exam rooms; cards were in English, Spanish, and one form was directed toward

LGBTQ+ communities. Cards were replaced weekly, with some exam rooms needing more

frequent replacement than others. Additionally, small stickers with the phone number of Call to

Safety and the Multnomah Co. crisis line were placed on the back of each card.

The advocate session went through multiple adaptations based on feedback, experience,

and low attendance. The PDSA cycles are displayed below.

Plan	Do	Study	Act
Closed, referral-only group. Resources, safety planning, health relationship information	No patient attendance	Asked why patients were not attending. Considered what could be changed	Open group. Put group on public groups calendar. Created small patient handouts with group information put with IPV cards in exam rooms
Group open to all clinic patients. Resources, safety planning, health relationship information	Two patients attended. Difficulty relaying mandatory reporting rules	How can we make mandatory reporting rules clear. Can we address individual situations	Template on white board before every group (see Appendix B). Gender neutral names
Group open to all clinic patients. Resources, safety planning, health relationship information. Individual support if requested	Three patients attended. All wanted to discuss their own circumstance	How to increase participation in the group. Understanding that groups take time to gain traction	Consider closed, curriculum-based group over several weeks. Offer case management drop-in and include IPV

Outcome Measures

Five patients attended the advocate group within the 3-month period; the first 2 patients

attended the advocate group following the change to an open group. Both participants of the first

group saw the session on the group calendar. Providers told group organizers they were giving

referrals throughout the referral time-period. However, there was no method of tracking referrals,

as stated above. Two orders of 900 cards were made from FWV and an estimated 20-30 cards

were replaced each week after implementing the change to place cards in all 18 exam rooms. In total, around 2,500 cards were in exam rooms, making use of additional cards remaining from the previous QI project.

Process Measures

All attendees of the advocate group found the sessions helpful and supportive. Feedback given was that individualized support was more beneficial than general information about relationship safety, for example reviewing whether a situation qualified for a restraining or stalking order. Feedback that the mandatory reporting regulations made the session difficult was also consistent across all attendees. Participants found the idea of using third person confusing and stated they would find it more helpful if they could discuss their individual circumstance.

Eight out of 16 providers completed the feedback survey; specific results can be found in Appendix B. About half have been using the IPV conversation cards and of those that responded, most stated they found the cards being in exam rooms helpful. All but 1 participant wanted the IPV cards to remain in exam rooms. The primary barriers to using the conversation cards was limited time and focus on other issues during the visit. Finally, the overwhelming theme in response to a request for clinic change suggestions was warm-handoffs to advocates and resources. These responses align with previous research on provider barriers and effective strategies for IPV screening and intervention.

Unintended Consequences

An unexpected benefit of the project involved bringing the policy of seeing patients alone for the first 5 minutes of a visit to fruition. This was a policy had been previously enacted but had fallen off the radar within the clinic culture. Providers voiced a desire to have MAs room patients alone as a result of the IPV training, and clinic leadership quickly responded with a

training for MAs, nurses, social work, and front desk staff in preparation for this change. Signage was developed to support MAs as they began to have conversations with patients about this policy change. Team managers were established as supports for MAs through the transition, and an attention to partner response to this request was recognized as a way to assess danger or risk in the relationship. MAs could let providers know if they had difficulty separating the partner from the patient in order to prioritize IPV conversations in the visit.

Discussion

Summary

This QI project demonstrated areas of growth within the clinic structure, policy, and practices related to IPV screening and intervention. Prior to this project, IPV was not routinely assessed or addressed in primary care visits. There was appreciation for the training on IPV and new intervention through the IPV conversation cards created by Futures Without Violence from providers. The providers found the conversation card intervention strategy to be helpful and placement of the cards in exam rooms handy for patient visits. Providers also requested, per recommendations in the IPV training, to see patients alone for the first 5 minutes. MAs, front desk staff, and nurses were subsequently trained on IPV and given the opportunity to practice having conversations with patients about the new policy. Signs were created and placed around the clinic to let patients know about the new policy.

The advocate group, while having support from clinic providers and staff, had little attendance within the 3-month period. The patients who did attend found the session helpful in addressing their specific situations. One barrier to the advocate sessions was the requirement of mandatory reporting. Patients attended the group to get support for their specific situations, and found it difficult to explain what was going on without disclosing a reportable situation.

Interpretation

  The IPV training and conversation card intervention had the effect of bringing more attention to issues of IPV within the clinic population. The clinic responded to the increased awareness of IPV by training clinic staff on how to respond and implementing a policy for providers to see patients alone for the first 5 minutes of their visit. However, this policy change required the support of the MAs and panel managers to successfully implement the change, potentially taking time from other areas of work.

  The literature indicates that providers are more likely to ask about IPV when they have an intervention to offer (Ramachandran et al., 2013). The results of this QI project support this concept; providers went from rare IPV screenings to utilizing IPV conversation cards and wanting the cards to continue to be available going forward. Furthermore, nearly all providers requested within-clinic advocates and warm-handoffs for patients who disclose IPV. An on-site advocate has been shown to increase the number of positive screenings for IPV (Rhodes et al., 2013). There were no reports of negative impacts of providing the conversation cards to patients.

  Additional exploration is needed to address the barriers to participation in the advocate group. While providers stated they were referring patients to the group, few attended. One barrier may have been the timing of the group from 9:30-11 am on Tuesday mornings. The time was chosen based on the availability of limited space within the clinic. Patients may not feel the urgency of discussing IPV resources after leaving the clinic, which is why having an advocate available for immediate support would be more beneficial (Ramachandran et al., 2013). Another barrier may have been the nature of the group, as many groups in the clinic are closed, curriculum-based groups and patients may not have understood the concept of a drop-in resource session. Furthermore, the QMHP continuing the group beyond the QI project came up against

productivity measures that were not being met by the low participant numbers. She needed to alter her schedule to ensure she was meeting her productivity standards. It was difficult to obtain patient's insight into additional improvements, as too few patients attended the group.

Limitations

This QI project had the benefit of leadership support, investment from providers, and availability of a project team to coordinate the advocate sessions. These factors were essential to the implementation of the project. The complexity of adding a quicktext to the electronic health record (EHR) limited the ability to track interventions and referrals. The structure of the EHR was such that a universal quicktext would have taken several weeks to months to incorporate. As a result, an analysis of the relationship between referrals to the advocate sessions and patient attendance could not be conducted. Additionally, there were so few participants in the advocate sessions and half of the providers did not complete the survey.

Conclusions

This QI project highlighted an important area of healthcare that was not being adequately addressed in the clinic. The clinic took steps toward increasing awareness, establishing safety policies, and placing IPV cards in all exam rooms. The IPV cards will be available ongoing in exam rooms, and leadership continues to support the policy regarding seeing patients alone. There was significant momentum behind the advocate group, and possible changes to the format, timing, and structure are being explored by the QMHP continuing the group. However, the clinic is not able to financially support a staff member who could be trained in IPV advocacy and be available for warm-handoffs in the clinic, leaving a potential gap in care. A beneficial next step would to be establish a relationship with local IPV advocates who could provide support in the

clinic and have the advantage of not being mandatory reporters. Overall, the project could be

bolstered by more data, and process and outcome measures.

References

Alpert, E. J. (2015). Intimate partner violence: The clinician's guide to identification,

    assessment, intervention, and prevention. Retrieved from

    http://www.massmed.org/partnerviolence/

Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., ... &

    Cronholm, P. (2014). Primary care–based interventions for intimate partner violence: A

    systematic review. *American Journal of Preventive Medicine*, *46*(2), 188-194.

Central City Concern. (n.d.). Central City Concern. Retrieved from

    http://www.centralcityconcern.org/

Choo, E. K., Tapé, C., Glerum, K. M., Mello, M. J., Zlotnick, C., & Guthrie, K. M. (2016).

    "That's where the arguments come in": A qualitative analysis of booster sessions

    following a brief intervention for drug use and intimate partner violence in the emergency

    department. *Substance Abuse: Research and Treatment, 10*, 77-87.

Futures Without Violence (2019). National health resource center on domestic violence.

    Retrieved from https://www.futureswithoutviolence.org/health/national-health-

    resourcecenter-on-domestic-violence/.

Hall, M., Chappell, L. C., Parnell, B. L., Seed, P. T., & Bewley, S. (2014). Associations between

    intimate partner violence and termination of pregnancy: A systematic review and meta-

    analysis. *PLoS Eedicine*, *11*(1), e1001581.

Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., ... & Gunn, J. (2013).

    Screening and counselling in the primary care setting for women who have experienced

    intimate partner violence (WEAVE): A cluster randomised controlled trial. *The

    Lancet*, *382*, 249-258.

Helldobler, C. (2016). Intimate partner violence screenings: A quality improvement project to

enhance trauma informed services at an integrated primary care clinic" *Scholar Archive*,

3802. Retrieved from https://digitalcommons.ohsu.edu/etd/3802

Institute for Healthcare Improvement. (2018). How to improve. Retrieved from

http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012).

Effect of screening for partner violence on women's quality of life: A randomized

controlled trial. *Journal of American Medical Association, 308*(7), 681-689.

Klevens, J., Sadowski, L. S., Kee, R., & Garcia, D. (2015). Does screening or providing

information on resources for intimate partner violence increase women's knowledge?

Findings from a randomized controlled trial. *Journal of Women's Health, Issues & Care,
4*(2).

McCall-Hosenfeld, J. S., Winter, M., Heeren, T., & Liebschutz, J. M. (2014). The association of

interpersonal trauma with somatic symptom severity in a primary care population with

chronic pain: Exploring the role of gender and the mental health sequelae of

trauma. *Journal of Psychosomatic Research*, *77*(3), 196-204.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., …

Silverman, J. G. (2011). A family planning clinic partner violence intervention to reduce

risk associated with reproductive coercion. *Contraception*, *83*(3), 274–280.

https://doi.org/10.1016/j.contraception.2010.07.013

Miller, E., McCauley, H. L., Decker, M. R., Levenson, R., Zelazny, S., Jones, K. A., …

Silverman, J. G. (2017). Implementation of a family planning clinic-based partner violence

and reproductive coercion intervention: Provider and patient perspectives. *Perspectives on Sexual and Reproductive Health*, *49*(2), 85–93. https://doi.org/10.1363/psrh.12021

Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence and elderly and vulnerable adults for abuse: Systemic review to update 2004 U.S. Preventive Services Task Force Recommendation. Retrieved from file:///Users/anickameyers/Downloads/ipvelderes%20(1).pdf

O'Connor, T. "Implementing a Universal Education Approach to Intimate Partner Violence in a Patient Centered Medical Home" (2018). *OHSU Digital Collections*. https://doi.org/10.6083/DNUZQG

O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings (review). *The Cochrane Library*.

Ramachandran, D. V., Covarrubias, L., Watson, C., & Decker, M. R. (2013). How you screen is as important as whether you screen: a qualitative analysis of violence screening practices in reproductive health clinics. *Journal of Community Health*, *38*(5), 856-863.

Rhodes, K. V., Grisso, J. A., Rodgers, M., Gohel, M., Witherspoon, M., Davis, M., ... & Crits-Christoph, P. (2013). The anatomy of a community health center system-level intervention for intimate partner violence. *Journal of Urban Health*, *91*(1), 107-121.

Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., ... & Feder, G. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *The Cochrane Library.*

Singh, V., Petersen, K., & Singh, S. R. (2014). Intimate partner violence victimization: Identification and response in primary care. *Primary Care: Clinics in Office Practice*, *41*(2), 261-281.

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 state report. Retrieved from https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

Valpied, J., & Hegarty, K. (2015). Intimate partner abuse: identifying, caring for and helping women in healthcare settings. *Women's Health*, *11*(1), 51-63.

Williams, J. R., Halstead, V., Salani, D., & Koermer, N. (2016). Intimate partner violence screening and response: Policies and procedures across health care facilities. *Women's Health Issues*, *26*(4), 377-383.

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf?sequence=1

Appendix A: Mandatory reporting template

We are mandated reporters, which means we are required to make a call to adult protective services if we hear you are being hurt by/are hurting someone else. To protect you, please use the names Jesse, Cory, Chris, Jordan, Skylar, Taylor, Avery, Phoenix, or Delta.

Appendix B: Provider survey results

Q1. Have you been handing out the IPV cards from exam rooms?		
Answer choices	*Responses*	
Yes	50%	4
No	37.5%	3
No, but I have noticed patients taking them on their own	0	0
I'm not sure what cards you're referring to	12.5%	1
I'm still not sure how to use the cards	0	0
Other	0	0

Q2. Has it been helpful to have the IPV cards in exam rooms? If so, how?
Short-answer responses (5, 3 skipped)
Yes, good to have them there, and pts can look at them when in room prior to provider getting there, too.
Yes. Easily ready to use and a visual reminder.
Yes, it's nice having them close by.
I don't know.
Yes! Keeps it on my radar, and has prompted some patients to initiate the conversation.

Q3. Do you want the IPV cards to continue being available in exam rooms?		
Answer choices	*Responses*	
Yes	87.5%	7
No	0	0
I would rather cards be available elsewhere	12.5%	1
I have no preference	0	0
Other: MA stations, waiting room	12.5	1

Q4. What are the barriers to using the IPV cards in patient visits?		
Answer choices	*Responses*	
Not enough time	37.5%	3
Not sure when to use them	0	0

Not clear how to use them	0	0
Focused on other issues	62.5%	5
Concerned a patient will disclose IPV and I won't be able to support them in the moment	12.5%	1

Other:
  1. Not in workflow, not clear need; already addressing IPV
  2. Didn't know they existed.
  3. This hasn't come up in any visits.
	37.5%	3

Q5. What other changes would you like to see around the clinic related to IPV?
Short-answer responses (6, 2 skipped)
Advocate on site to meet with patients one-on-one.
More streamlined protocol for response and how to connect patient to resources.
Would like for the group to continue. It will take some time to make cultural and practice changes and I am sure the group (culture, practices around IPV) will gain more traction with time.
Warm-handoffs for someone experiencing IPV to talk with a knowledgeable individual about resources and planning. Lunch time IPV trainings for providers.
Nothing at this time.
A better mechanism for warm handoff/connection to resources.