

Implementing Universal IPV Education Within a FQHC Women's Health Center: A Quality  
Improvement Project

DNP Project Proposal

Isabella Pribyl Dodds, BSN, MN

Oregon Health and Science University

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### **Problem Description**

Intimate partner violence (IPV) is a concern that providers share with their patients; however, many feel inadequately prepared to screen for and respond to IPV disclosures. The World Health Organization defines IPV as “any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship” (World Health Organization, 2012). The WHO further elaborates what constitutes IPV as acts of physical violence, sexual violence, psychological violence and controlling behaviors (World Health Organization, 2012). The Center for Disease Control echoes a similar definition while adding stalking to the list of categories that constitute IPV (Center for Disease Control, 2019).

Intimate Partner Violence in the United States is a common problem with 1 in 4 to 1 in 3 cis-women and 1 in 10 cis-men experiencing some form of IPV in their lifetime (CDC, 2019). The prevalence for physical violence, stalking and rape is greater for Black, Native American, Alaskan Native, and transgender/gender non-conforming populations (Singh, Peterson, & Singh, 2014). Furthermore, IPV is often associated with health complications such as depression, chronic disease, low birth weight babies, anemia, fractures, substance use, suicide, unintended pregnancies, chronic pain and many more long term consequences (American College of Obstetricians and Gynecologists, 2012,) (Singh, Peterson, & Singh, 2014).

The acute and chronic impacts of IPV place large financial and logistical burdens on the health care system. After exposure to IPV, survivors have an approximately two-fold increase in healthcare use compared to people without exposure (Singh, Paterson & Singh, 2014). In the United States, the cost of health care during the first year after an incident of IPV is estimated to be somewhere between 2.3 and 7 billion dollars (Singh, Paterson, & Singh, 2014). The annual

healthcare cost for women who have experienced physical IPV is 42% greater than those who have not (Lee et. al, 2019).

The sum of this evidence points to the need for healthcare providers to routinely address IPV during their clinical work. Clinicians are often the touch point for IPV disclosure and in a prime position to be able to connect patients with long term resources (Kalra, Tanna, & Gracia-Moreno, 2017). However, many barriers to addressing IPV exist including lack of training, time constraints, and not knowing how to respond when someone disclosed IPV (Lee et. al, 2019). Additionally, qualitative literature demonstrates that patients want their providers to ask about IPV and provide them with options (Dienemann, Glass, & Hyman, 2005). There is a window of opportunity to reduce the harmful effects of IPV that begins with healthcare providers direct interaction with patients, the provision of resources and universal IPV education.

### **Summary of What is Known About the Problem: What is the Role of Healthcare Providers?**

Survivors of IPV have stated that healthcare providers screening for IPV alone is therapeutic as it communicates that they care about the person's safety; however, they also express that screening without provider response can be harmful (Decker et. al, 2017). Most medical governing organizations support some form of screening for IPV specifically for cis-gendered women. This is most likely due to the disproportionate amount of violence that cis-gendered women face compared to their cis-male counterparts, however, it neglects to address the high prevalence of IPV that transgender and gender non-conforming patients face (Singh, Paterson, & Singh, 2014). While the timing of screening differs, all major healthcare governing bodies acknowledge the importance of IPV screening by healthcare providers. The WHO

recommends targeted screening, the United States Preventative Services Task Force recommends screening all women between 14 and 46, and the American College of Obstetrics and Gynecology recommends universal screening with additional screening in pregnancy at the first prenatal appointment, once per trimester and in the postpartum period (Singh, Paterson, & Singh, 2014). Qualitative research demonstrates that the vast majority of women support universal IPV screening (Dienemann, Glass & Hyman, 2005). Additionally, screening and brief counseling is part of the required free preventative services in the Affordable Care Act (Miller, McCaw, Humphreys, & Mitchell, 2015).

While screening is largely accepted as important, multiple studies have demonstrated low percentages for provider screening that range from 1.5% to 12% in primary care settings (Lee et. al, 2019). This is largely due to logistical and perceived provider barriers. Provider discomfort and fear of inadvertently being offensive is a significant barrier to screening for IPV (Sutherland, Fontenot, & Fantasia, 2014). Many providers state that a lack of education about screening for and responding to IPV led them away from screening (Sutherland, Fontenot, & Fantasia, 2014). Having no standardized response to positive IPV disclosures often prevented providers from screening for IPV (Lee et. al, 2019). All of this demonstrates that healthcare providers need additional training, tools, and systematic structures to address IPV.

While screening for IPV is an important component in addressing this health crisis, clinic-based screening efforts alone have yielded mixed results for improving outcomes associated with IPV (Decker et. al, 2017). Provider response often focuses on encouraging the patient to leave the relationship which may be unrealistic, potentially harmful, and can lead to more physical injuries (McKibbin, & Gill-Hopple, 2018). Advocating for leaving as the only option puts patients in danger. The first six months after leaving a situation involving IPV

presents the greatest risk for severe assault and homicide (McKibbin, & Gill-Hopple, 2018). This is especially true when providers advocate for patients to leave without proper resource referral and safety planning (Kalra, Di Tanna, Garcia-Moreno, 2017). When providers have not been taught how to respond to patients experiencing or disclosing IPV, ill-informed advice can have dire and dangerous consequences.

### **Population Specific Background Information**

This quality improvement project took place in Southern Oregon at a clinic that serves a large percentage of Latinx patients. Additionally, this community is currently facing two natural disasters: the Covid-19 pandemic, and the devastating Alameada and West Obenchain fires that destroyed significant portions of the local towns and the surrounding areas.

According to recent literature, cisgender Latina women in the United States do not experience increased rates of IPV; however, when this community experiences IPV, access to formal services is often limited due to legal and language barriers which results in more severe consequences of IPV such as increased rates of homicide (Alvarez, & Fedock, 2018). Having care providers who speak Spanish, are aware of laws regarding immigration and resources, and are aware of resources specific to this community is a crucial piece to responding effectively to IPV disclosures within the Latinx community (Alvarez, & Fedock, 2018). Overall, there is a general dearth of research on how to provide culturally humble, and linguistically appropriate care to this population and other marginalized communities and specific calls for additional formal research have been made (Alvarez, & Fedock, 2018). Given the specifically high percentage of patients who fall within the category of Latinx at the project site, implementation of the intervention necessitated strong community partnerships with Latinx resources.

Additionally, all materials were duplicated in Spanish with referrals to Spanish resources with Spanish speaking personnel.

The Covid-19 Pandemic has created an increased need for a robust clinical IPV strategy. Previous studies suggest that IPV increases during times of emergencies, such as the Covid-19 pandemic (Moreira, & da Costa, 2020). According to the Secretary General of the United Nations, on a global scale there has been a “horrible surge” of IPV cases as stay-at-home orders are placed, kids are no longer in school, physical and social isolation has increased, employment has become scarce, and underlying and overt stressors have heightened (Zero, 2020). As time at home has increased, so has increased exposure to IPV and there is a greater risk of more severe health related consequences of IPV (Zero, 2020). Times of greater stress often leads to increased incidence of IPV (Moreira, & de Costa, 2020). Social distancing puts victims at increased risk as isolation and control are critical tactics used by perpetrators of IPV (Moreira, & de Costa, 2020). This isolation has the potential to have even greater effects on communities where isolation itself plays a key role in consequences of IPV. This is particularly the case for undocumented immigrants who are already at increased risk for more severe consequences of IPV. Anti-immigrant rhetoric that has increased on a national level has created an additional barrier for immigrant communities accessing care (Zero, 2020). Communities with increased vulnerabilities such as physical and social isolation, fear of law enforcement, language barriers, legal status and a lack of linguistically and culturally relevant resources face greater consequences when IPV occurs (Zero, 2020).

To compound difficulties facing many in this community the Alameda fire destroyed somewhere close to 3,000 structures in two small, predominantly latinx and immigrant communities (Wilson & Trinca, 2020). After the 2004 Tsunami in India, IPV incidence increased

48% in the next ten years, highlighting the lasting destabilizing effects of a natural disaster on pieces of life that contribute to IPV (Rao, 2020). Additionally, studies indicate that disaster response efforts seldom mitigate the increase in IPV unless they address previously standing inequities (Rao, 2020).

Other studies have found that natural disasters can offer an immediate protective factor against IPV as a community rallies together, but that often there is a dramatic rise in IPV as time goes on and community aid dwindles (Bell, & Folkerth, 2016). While the difference between the outcome of a natural disaster on IPV incidence is undoubtedly multifactorial, these studies cite loss of social networks and cultural integration and poverty/low socioeconomic status as aggravating factors (Bell, & Folkerth, 2016).

This project was planned prior to the devastating Southern Oregon fires of 2020 but quickly became more essential in the aftermath. The vast loss of small tight knit communities and personal properties often in low socioeconomic living communities without insurance policies, the disruption of multigenerational homes coupled with the social isolation, economic instability, and undercurrent of stress already in place from the Covid-19 pandemic, has the potential to dramatically increase the incidence of IPV in this community.

## **Rationale**

### **Universal IPV Education**

This project focuses on the concept of universal IPV education and resource distribution to all patients regardless of disclosure. The current body of literature that has examined the effects of universal education to address IPV within various healthcare settings reports useful findings that indicate this approach has a positive effect on both patients and providers. A 2016

study assessed 4009 cis-females from the ages of 16-29 that received universal IPV education. This study found that universal education did not significantly reduce reproductive coercion or partner violence, but it did increase patient knowledge of resources and increased patient self-efficacy to enact harm reduction strategies (Miller et. al, 2016). There was also evidence of increased use of IPV resources (Miller et. al, 2016). A similar but smaller quasi-experimental study conducted a year later with patients who received universal education and were provided a standardized safety card on IPV demonstrated that patients found this intervention helpful regardless of IPV history (Decker et. al, 2017). Additionally, patients reported that this intervention increased their perception that their providers cared for their health and safety and reported increased confidence in their provider's ability to respond to IPV disclosures and provide follow-up (Decker et. al, 2017). The results from both these studies emphasize the point that aside from the dichotomy of positive and negative IPV disclosures, there are patients who chose not to disclose but would benefit from education and resources, whether for themselves or someone they know (Miller, McCaw, Humphreys, & Mitchell, 2015). Providing universal education informs patients that even if they chose not to disclose at a particular appointment, they can disclose at another date and be met with a knowledgeable and supportive provider. Finally, providers and patients alike reported positive responses to a universal education response. For example, providers stated that the intervention increased their confidence discussing IPV and reproductive coercion and additionally stated that encouraging patients to share the information with their friends/community helped facilitate the conversation (Miller et. al, 2017). Patients reported that this approach provided them with important information while helping them feel supported, less isolated and empowered to help other people in their lives (Miller et. al, 2017).



Research supports the CUES intervention from Futures without Violence as a standardized way for clinics to implement a universal education approach (Futures Without Violence, 2018). The CUES Intervention is a mnemonic that consists of **C**onfidentially seeing all patients while disclosing limitations of **C**onfidentiality, providing **U**niversal **E**ducation and **E**mpowerment through the provision of a standardized safety card and a universal discussion about healthy and unhealthy relationships and the health effects of IPV (See Appendix B). Finally **S**upport in the form of mental health referrals and warm-referrals to local IPV resources (Futures Without Violence, 2018).

### **Philosophical Underpinnings**

The philosophical underpinnings that support the implementation of the DNP project are universal trauma informed care coupled with shared decision making. In this intervention, the provider's responsibility was to have this discussion with all patients, assuming that it is impossible to determine who might need the information themselves or who might not feel safe disclosing IPV in order to access resources. The prevalence of trauma, specifically physical, verbal and sexual abuse is much greater than demonstrated by patients who elect to disclose this information to their healthcare providers (Reeves, 2015). Additionally, a trauma-informed approach to address IPV has the potential to meet the unique health needs of those experiencing IPV by emphasizing a patient directed response, first and foremost by providing information and resources without necessitating disclosure. This principle is based on the concept of shared decision making in which an intentional method is used by clinicians to help patients become "well-informed, help them develop their personal preferences for available options, and provide professional guidance when appropriate" without dominating the decision making process (Elwyn, Dehlendorf, Epstein, Marrin, White, & Frosch, 2014). By providing education,

resources and creating a patient led environment for provider response and support regardless of patient disclosure, the clinician applied both theories of trauma informed care and shared decision making by handing autonomy, control, and power back to the patient without necessitating any reciprocity of shared information.

### **Specific Aims**

This project has two aims:

- **Global Aim:** To decrease health consequences of IPV by providing universal IPV education and resources regardless of disclosure status.
- **Specific Aim:** Between January 1 and April 1 of 2021, there will be documentation of universal IPV education delivered to patient's confidentially in the medical record of eighty-percent of well-woman and initial prenatal appointments at the outpatient clinical site.

### **Context**

This project took place with the midwives at a Federally Qualified Health Center (FQHC) clinic in Southern Oregon whose mission is to serve all people in the area with an emphasis on patients who have barriers to accessing care. The larger organization offers comprehensive care including primary care and dental care. The midwifery group provides women's health care that encompasses puberty to menopause.

The patients and population of this project included all prenatal patients and all patients seeking care for well-woman exams. The midwifery staff has decided to exclude problem oriented gynecology appointments due to the short time frame that they are allotted for those visits as well as simplifying the first run through this intervention. In addition, parts of the

project involved staff education including front desk, medical assistants, mental health practitioners, midwives, and nursing staff. Seventy-seven percent of patients at this clinic qualify as low income and receive discounted health-care services, fifty-four percent are on OHP, twenty-three percent are uninsured, seven percent have Medicare, and sixteen percent have private insurance. This clinic serves a large percentage of the Latinx community, twenty-nine percent of their total patient population.

### **Intervention**

The evidence-based CUES intervention established through IPVhealth.org and Futures Without Violence was implemented. This intervention contains 4 steps to creating a clinic wide response to IPV. The first step is Confidentiality. Confidentiality includes ensuring that each patient is seen alone for at least part of the visit and that providers disclose their legal limits on confidentiality before beginning any discussion about IPV (Futures Without Violence, 2018). Ensuring that patients are seen alone is a key component to effective universal education and effective IPV screening. While the clinic had been seeing all patients alone for the past several months due to Covid-19, they recently started allowing support people back into exam rooms for well-woman and prenatal care visits. Additionally, the clinic had never had a workflow to see patients confidentially before this quality improvement project. The clinic currently uses the 5 P's screening tool to screen for drug and alcohol abuse as well as IPV at all initial prenatal visits. The 5 P's screen is still handed to each patient on a clip board with a dry erase marker to be filled out without a confidential space to do so (Enhanced 5 P's Behavioral Risk Screening Tool, n.d).

Implementing a confidential workflow started with adding a line to the paperwork that was sent out before all wellwoman care visits and initial prenatal visits that stated "at the

beginning of your appointment, the medical team will bring you back to the exam room to fill out confidential paperwork. Afterwards, we will welcome your support person back for the rest of your visit". When the patient arrived, they were checked in by the front desk staff who gently reminded them that they would be brought back alone initially and then their support person would be welcomed back with them. The front desk staff then handed them the IPV resources and 5 P's screening tool and directed them to their room. The front desk staff stated "Please fill out this screening tool. We include this safety card at all wellwoman (or initial prenatal) appointments because relationship violence is so common. Take a moment to look it over, your midwife will talk more about it with you. If you want to take it home, you are welcome to, otherwise just leave it clipped to your clipboard". After allowing a few minutes for the patient to fill out the form and read through the card, the midwife came in and had the brief universal education conversation with the patient. After this conversation took place, the midwife either continued the visit confidentially if a disclosure happened or if the patient expresses an immediate need for referral or safety, or the MA brought the patient's support person back into the room for the rest of the visit.

The second part of the CUES intervention is Universal Education and Empowerment (Futures Without Violence, 2018). IPVhealth.org has free safety cards available for healthcare centers to order that are used to talk with patients about the difference between healthy and unhealthy relationships as well as the health effects of IPV (See appendix A) (Futures Without Violence, 2018). They encourage dispensing more than 1 card so that patients can share the information with family and friends. Along with clipping them to the clipboards with the 5 P's screen, these safety cards were strategically placed in all exam rooms as well as in all bathrooms so that patients could privately choose whether or not to take one home. Additionally, all

providers were given a universal script to use as a baseline on standardizing a universal education approach to IPV (see appendix B).

The final step in the CUES intervention is Support. While Future Without Violence and IPVhealth.org emphasize that disclosure is not and should not be the goal of a universal education approach to IPV, disclosure will inevitably happen, and a helpful response is required (Futures Without Violence, 2018). The clinic's response consisted of using shared decision making to determine what support each patient would like. This response ranged from a safe space to confidentially talk about their experience to referral for immediate protection and housing. All referrals went through Community Works which is Southern Oregon's local IPV resource. Community Works had expressed enthusiastic support for this partnership and had requested that ideally referrals are made by the patient calling the crisis line from a secure phone. This secure phone was designated in a confidential area within the clinic. If a patient did not feel comfortable calling for themselves, clinic staff would be available to do so. From there, Community Works connected the patient with an advocate who conducted a safety assessment, discussed patient needs and resources, and then made provisions for connection with these resources. Community Works had access to Spanish speaking bilingual advocates who could provide culturally relevant and linguistically appropriate aid to the Latinx community and they were currently working on hiring another bilingual advocate. Additionally, Community Works was able to provide long term shelter with private rooms, 24/7 staffing and a trauma-informed approach to care, transitional housing for homeless youth, financial resources, staff who are specifically trained to work with law enforcement as advocates for IPV survivors, advocates who are stationed in the court house, the local hospitals and within social services sectors. Community Works also provided a 24/7 crisis line. After the patient and provider determined

what support was wanted and the referral process was complete, the provider documented the disclosure, the type of desired support, the referral process made, and any follow-up needs.

Additionally, it must be noted that given the high prevalence of IPV in the United States, those experiencing IPV or survivors of IPV will not only be patients but also employees who will need support. Futures Without Violence detailed a comprehensive support plan for employees currently experiencing IPV which was adapted to fit this specific clinic needs. Employees were encouraged to reach out for support including resource referral, self-care strategies, and HR support. The reality that staff are or have likely experienced IPV was discussed at all meetings, trainings, and information sessions. The goal of these discussions is to reduce the shame, isolation, and secrecy of IPV as well as providing resources, information and support to staff.

### **Implementation and Study of the Intervention**

The study of this intervention follows the Plan-Do-Study-Act cycle.

**Plan:** A new process to address and respond to IPV was addressed as a quality improvement need by the midwives at the clinic. It was decided that the clinic would use Universal IPV Education. Before starting the first implementation cycle, two provider trainings occurred. The first training was provided by this DNP student writer as an introduction to IPV within a clinical setting, the universal education approach, the research behind this approach and the project specifics. In the second part of the training, the local IPV resource, Community Works, provided a more detailed and comprehensive training on how clinics can best support and refer patients for IPV services. Both these trainings took place in person with social distancing at bimonthly CNM staff meetings. Community Works has a well-established partnership with healthcare settings in the community and had funding to provide this training for free. From there, providers were

given the Universal Education script (see appendix B) as a template for having these conversations. Feedback was solicited and incorporated into the steps moving forward. Safety cards and clinic posters were provided from Futures Without Violence (See Appendix A and E). Posters were hung in restrooms and safety cards were made available in all exam rooms as well as all restrooms. A dot phrase was incorporated into the standardized electronic health record templates all the midwives use for both the well-woman and initial prenatal notes and the midwives were instructed on its use (see Appendix D).

The clinic was previously recommending that any well-woman visit that did not require an exam was done via telehealth. Futures without violence had a webinar giving specifics about how to deliver universal education via telehealth. Important content from that webinar was disseminated to the midwives during the first in person training and in written format but was not used as they stopped seeing patients via telehealth by the time the PDSA cycles began (see Appendix E).

**Do:** The first PDSA cycle took place in January of 2021, the second PDSA cycle took place in February of 2021, and the third PDSA cycle took place in March 2021. Each cycle ran three weeks with the fourth week in the month being reserved for evaluation, feedback and adjustments before the next PDSA cycle.

**Study:** Results of each PDSA cycle were gathered during week 4 of each month after a chart review of all the well-woman and initial prenatal exams that took place during those three weeks was done to determine what percentage of these visits included both confidentiality and universal IPV education. The results were shared with clinic staff and providers. Feedback on success and

improvement possibilities was gathered through a phone call with the project champion, Stephanie Estes, CNM.

**Act:** Feedback was assessed, and a new plan was made for the next cycle that addressed improvement possibilities. Areas that required process feedback and improvement were the sample universal education script, time restrictions specifically related to the confidentiality workflow, provider education and electronic health record dot phrase difficulties. After this process occurred, another PDSA cycle was run.

### **Evaluation of Intervention Success**

**Assumption made:** This quality improvement project was based on the assumption that the implementation of a universal education approach would improve access to resources and harm reduction for victims of IPV. This assumption was based on the randomized control studies and evidence listed in sections above. Because, this assumption exists and is supported by high quality evidence, evaluation of the intervention was based on whether or not universal IPV education occurred.

### **Measures**

During week 4 of each PDSA cycle a chart review took place of all initial prenatal appointments and well-woman care appointments. Data collection was done by looking at each provider's schedule for the three weeks of the PDSA cycle and documenting whether or not a patient was seen confidentially and whether or not universal IPV education was provided. A percentage was calculated by dividing the total number of well-woman and initial prenatal appointments where patients were seen confidentially and universal IPV education was provided by the total number of well-woman and initial prenatal appointments. No patient identifies were



collected or recorded during this process. Trends between PDSA cycles were documented and assessed based on changes implemented between PDSA cycles.

This measure has high reliability as it is a single reference point legally documented in patient charts and is easily reproduced if this project were to be replicated at a separate site. This measure has potentially less validity as provider perception of whether or not they delivered universal IPV education is somewhat subjective. This subjectivity was accounted for by providing a sample script (see appendix B) and by providing standardized IPV education material (see appendix A and C) (Futures Without Violence, 2018). Additionally, after each PDSA cycle, providers were asked how documentation of universal IPV education went and if there were any barriers to accurately documenting the intervention that might be interfering with the reliability and validity of the data set. These concerns were communicated through the project champion Stephanie Estes. These issues were then addressed before the next PDSA cycle.

### **Analysis**

Analysis was based on if there is an improvement in percentage of patients who receive universal IPV education. No baseline data will be collected as this intervention is not currently in place at this clinic. During the evaluation week at the end of each PDSA cycle, feedback on what went well and what needs improvement from providers and clinic staff was used to draw inferences from the data as well as help determine why the rate of universal education either improved, remained the same, or declined.

### **Ethical Considerations**

The implementation of this project did not pose any ethical concerns for the patients who seek care at the clinic. The universal IPV education and CUES intervention from Futures Without Violence did not replace any current IPV screening or response system within the clinic and therefore did not remove any vetted service from any patients. Additionally, all patients, regardless of disclosure, received information on IPV including a crisis number ensuring that more patients had access to IPV resources. Furthermore, a universal IPV education approach removes barriers such as fear of legal, social or personal repercussions that might result from seeking IPV information or personal disclosure. Additionally, all materials were available in English and Spanish removing language barriers for a significant portion of patients. For patients who did not speak English or Spanish, all universal IPV education was conducted by someone who speaks the language or with the use of a certified medical interpreter. No information using patient identifiers was gathered and all appointment data was recorded using a number system, such as well-woman appointment 1 (PDSA cycle 1). There are no conflicts of interest and no formal ethics review was done.

### **Implementation of Project**

Each PDSA cycle had new challenges and adjustments that were addressed in real time to establish a successful implementation of this project.

In PDSA Cycle 1 the main issues were staff not being aware the project was starting and what their roles were, Community Works materials not being translated into Spanish yet, and clinic workflow changes. Initially, the PDSA cycle 1 start date was pushed back because Community Works had not translated and printed their materials in Spanish. Having both English and Spanish versions of the local safety resources was a key component to reaching the population of this clinic. When it became obvious that these resources would not be available for

months, information in Spanish was pulled off Community Works website and made into business cards to be distributed to all patients. This adjustment is currently still in place until Community Works has their materials ready.

Additionally, some of the midwifery staff and clinic staff was not prepared/aware that the project was starting during PDSA cycle 1 despite the staff meetings and packets detailing roles and start dates that were passed out. To remedy this, this doctoral student spent time each day physically present in the clinic to address questions, describe the project, redistribute packets, answer questions and offer motivation for implementation.

Finally, after observing the clinic workflow, it became obvious that the front desk staff were the people interfacing with patients about the safety cards. The decision was made to remove the MA's from the workflow except to notify the provider when a patient was ready to be seen or to bring a partner back to the exam room. Instead the front desk staff were trained on handing out the safety cards and directing patients back to their rooms.

In PDSA Cycle 2, the main concern addressed was partner wait time while the IPV education was being conducted. There was a patient who complained at another branch of the project organization that her partner had to wait for a long time to before being brought into the visit. This complaint was sent to clinic staff at the project site who were concerned about whether or not this intervention was possible if patients were complaining. A few alternatives were discussed including putting the IPV education at the second prenatal instead of the first, having the MA's deliver the provider script and IPV education, delivering the IPV education at the end of the prenatal visit and asking the partner to leave, or delivering IPV education to both the patient and their support person. Eventually, it was decided that the workflow would remain the same but that the clinic staff would remind patients of their appointment would emphasize

that patients would be seen alone initially. After this alteration, there were no additional complaints.

In PDSA Cycle 3, the main concern was that there was a drop off in specific providers' consistency of delivering and documenting the IPV education. When explored, it was discovered that because of the changes in Covid-19 policies after the vaccination roll out happened, some midwives had switched back to their pre-covid dot phrases, which did not include the IPV education dot phrases. These providers were relying on these dot phrases as both a reminder to do the IPV education and to document it. After discovering this, providers were reminded to add the IPV dot phrases back into their templates.

### **Outcomes**

Overall, the project was successful and the measurable outcomes improved with each PDSA cycle. The final feedback was that the clinic intends to keep the intervention in place indefinitely. The percentage of well-woman care visits that included complete, confidential IPV education increased from thirty-three percent in PDSA cycle 1 to sixty-eight percent in PDSA cycle 2, to seventy-three percent in PDSA cycle 3. This final percentage was seven percentage points short of the project's aim, however, the clinic is on track to eventually meet this goal as they progress forward. The percentage of initial prenatal visits that included complete, confidential IPV education increased from forty-one percent in PDSA Cycle 1 to fifty-seven percent in PDSA Cycle 2, to eighty-eight percent in PDSA Cycle 3 exceeding the project aim for initial prenatal visits. The final average of both initial prenatal visits and well-woman care visits was 80.5% which is just above the project aim of 80%. The percentages of visits where patients were seen alone but no IPV education was conducted was also tracked.

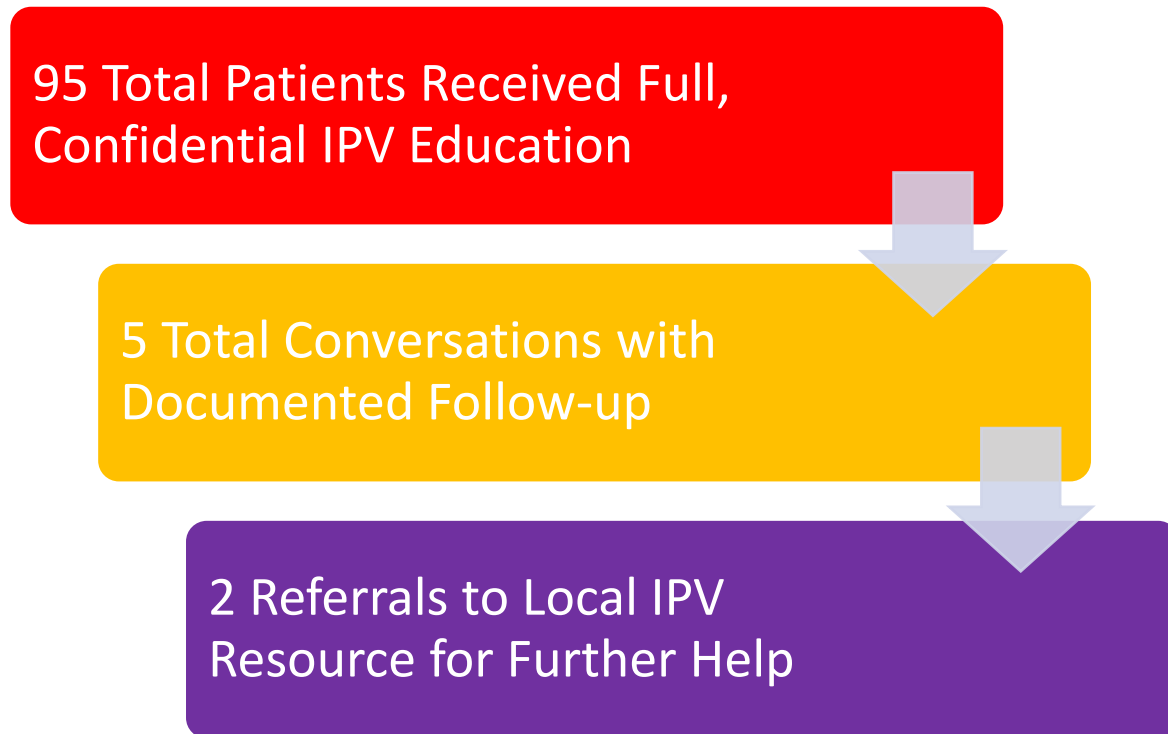


Figure 1: This figure illustrates the total number of patients who received full IPV education and the number of patients who received additional, documented, aid because of that education.

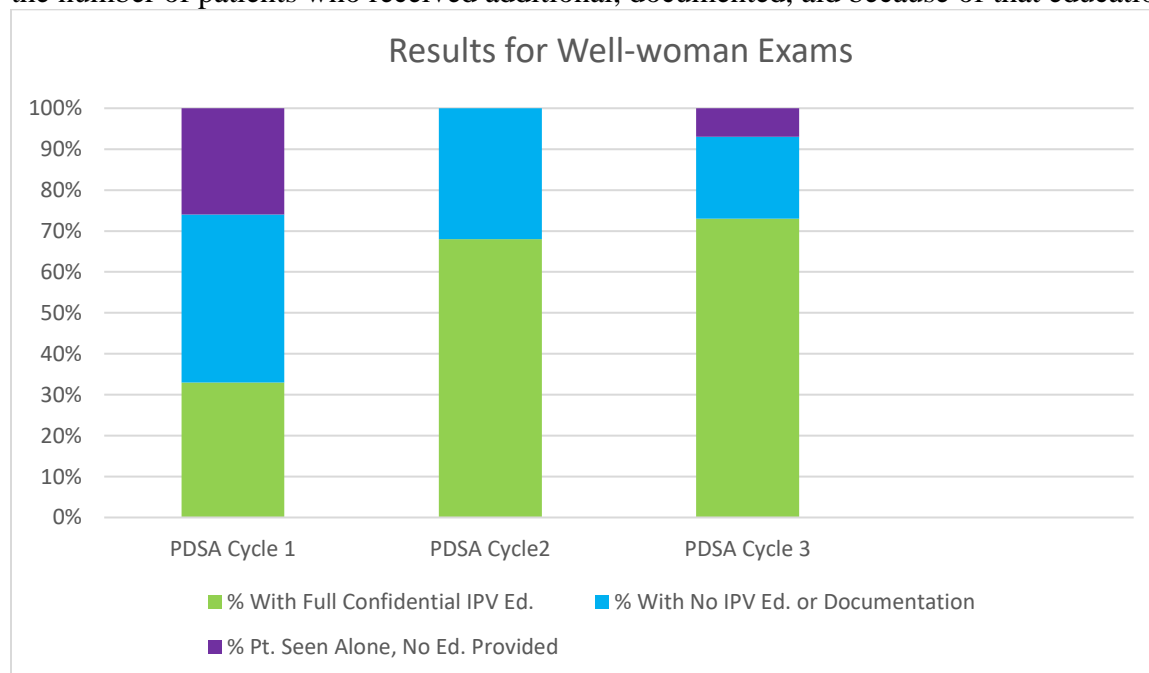


Figure 2: This figure illustrates the percentage change of patients there for well-woman exams who received full IPV education, patients who were seen alone but received no IPV education, and the percentage of patients who had no documentation in their chart about being seen alone or receiving any IPV education across the three PDSA cycles.

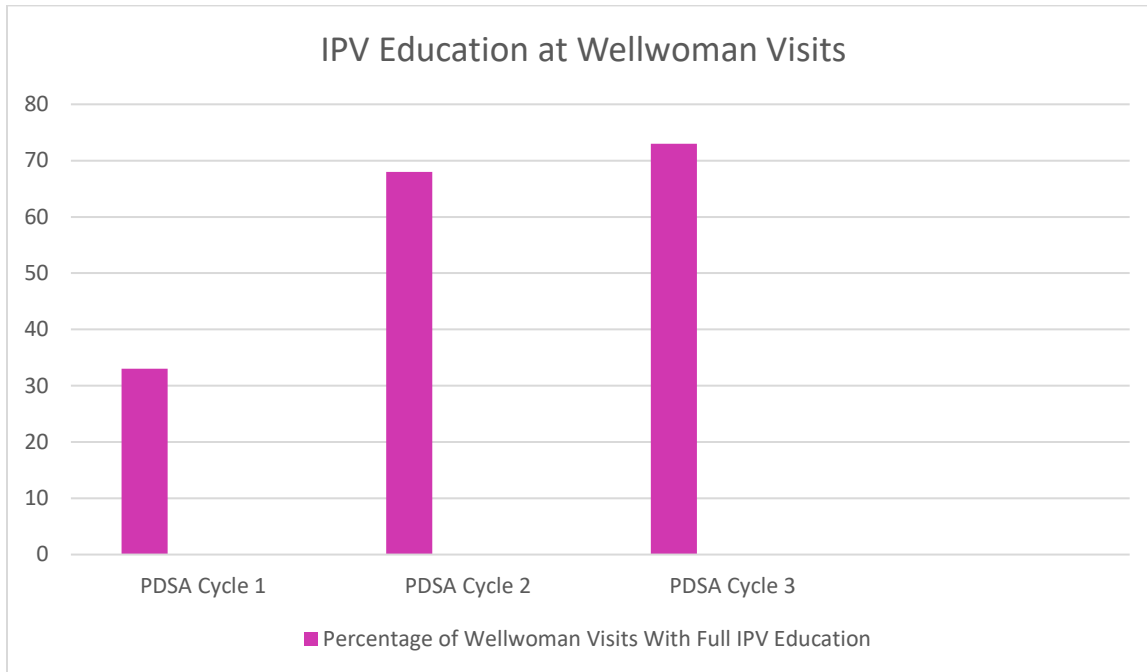


Figure 3: This figure shows the percentage of people seen for well-woman exams who received full, confidential IPV education across the three PDSA cycles.

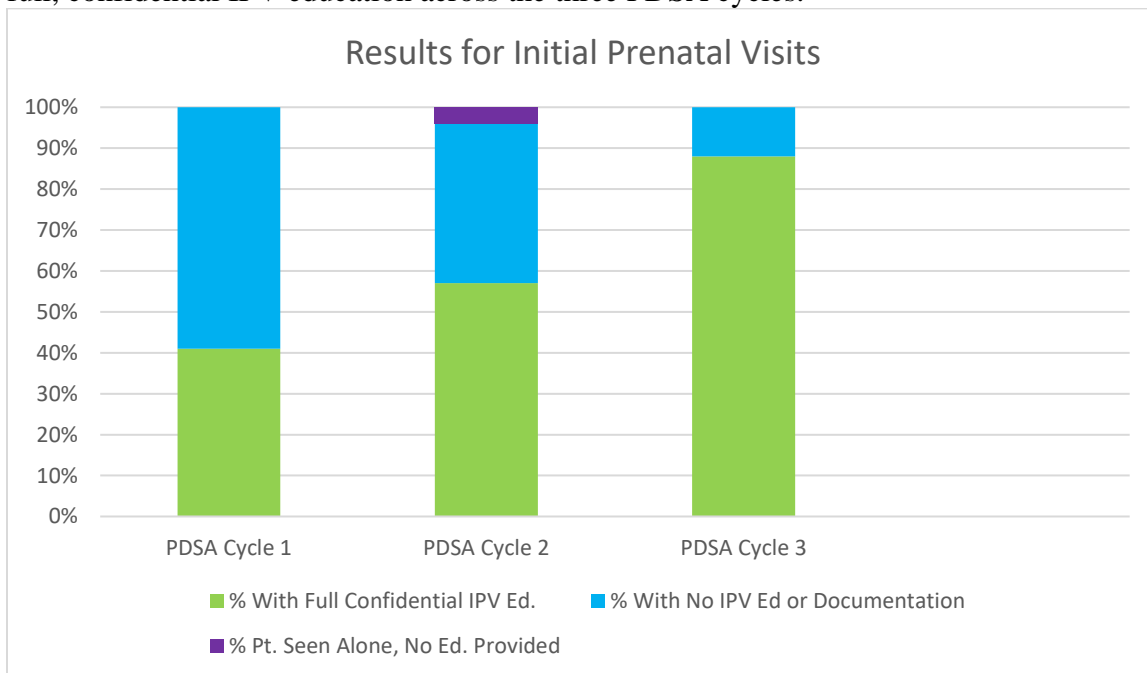


Figure 4: This figure illustrates the percentage change of patients seen for initial prenatal visits who received full IPV education, patients who were seen alone but received no IPV education, and the percentage of patients who had no documentation in their chart about being seen alone or receiving any IPV education across the three PDSA cycles.

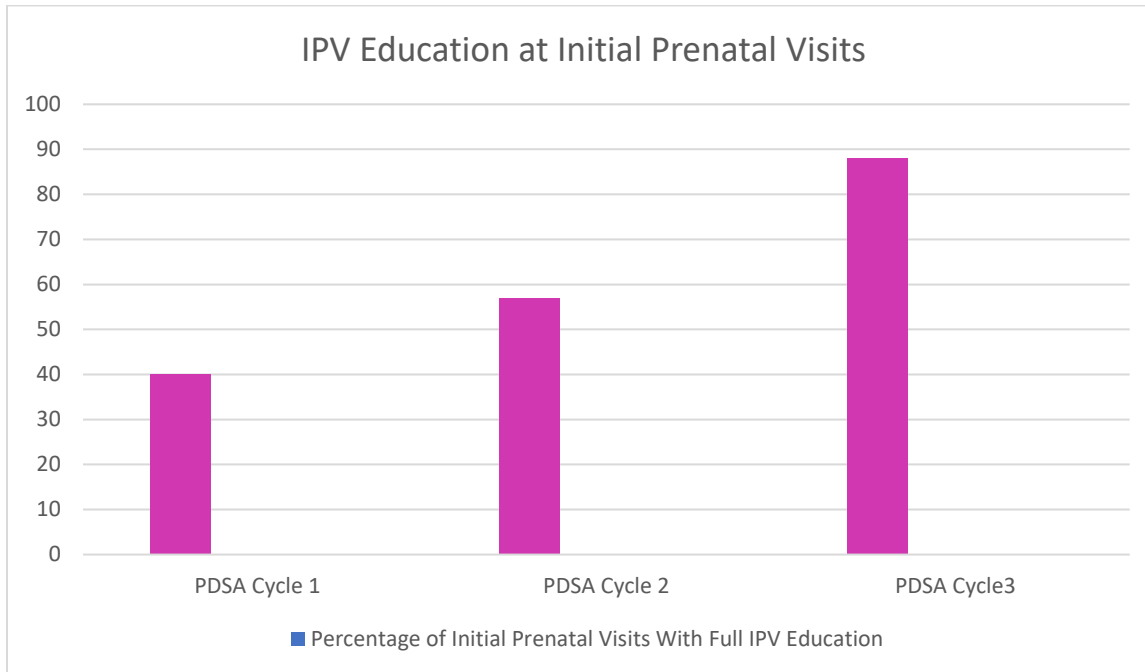


Figure 5: This figure shows the percentage of people seen for initial prenatal visits who received full, confidential IPV education across the three PDSA cycles.

**Differences Between Expected and Achieved Results:**

Overall, the results of the last PDSA Cycle met the project aim. The average of both initial prenatal visits and well-woman care visits was 80.5% which is just above the project aim of 80%. It is expected that this percentage would increase if data tracking continued as in PDSA Cycle 3. One provider’s personal percentage dropped significantly, and when asked why, she responded that she had switched back to her pre-covid note templates that did not include the IPV dot phrase which she used as her reminder to complete the IPV education. She subsequently added the dot phrase into her new notes. The project was successfully implemented in a way that not only meets the project aim but will likely exceed it in the future.

**Comparison of Results to Literature:**

The bulk of the literature measures success based on whether patients respond positively to the intervention and provider comfort addressing IPV. This project did not measure those outcomes; however, through informal conversations with providers and clinic staff, feedback was obtained. Providers reported an overall positive response from patients. A few stand-out comments and stories consisted of one patient describing how her daughter was killed via IPV a year ago and how having an intervention like this might have saved her. She was very happy that it was being implemented. Another patient told the midwife that she had escaped IPV in her past relationship and how this intervention would have saved her a lot of difficulty. The clinic staff reported subjectively higher patient annoyance by the intervention; however, their interaction was before patients had received the IPV education and this sentiment was not typically brought up after patients had a private IPV conversation with their provider.

Additionally, the bulk of the literature describes how this intervention benefits providers and how providers express increased confidence responding and discussing IPV with their patients. The midwives echoed these sentiments, expressing increased confidence after receiving the training from Community Works and becoming familiar with the IPV script. Additionally, they expressed a new understanding for community resources and how to refer patients to them.

This project does not look at data on whether patients came back at later visits and disclosed IPV or accessed resources/referrals. Tracking this would have been another way to measure the success of the intervention and compare it to the data demonstrated in the literature.

### **Practice Related Implications and Next Steps**

While the PDSA cycles are complete, there are a few next steps that must be solidified before the project is set to be a long-term sustainable intervention.



The first step is for a staff member to be assigned and connected with Community Works and Futures Without Violence so that all material orders can be independently accomplished. Ideally this person is also a project champion so that there continues to be motivation for success from someone physically present in the clinical setting. Second, the dot phrase must be incorporated into all post-covid note templates so that if providers start using those templates again, the dot phrases are available as documentation and reminder to carry out the education. Third, the clinic needs to connect with the auditor (who has not been hired yet) for the Reproductive Health Program to ensure that this intervention and the way it is charted fulfills all Reproductive Health Program requirements. All project outcomes and recommendations moving forward have been discussed with the current project champion who plans to bring the results and recommendations moving forward to the other providers and clinic personnel. She has stated that the clinic plans to keep Universal IPV Education indefinitely.

**Conclusion:**

Overall, this project met its aim, and has been established as a long-term practice that will stay in place at the clinic for the indefinite future. Continued success depends on the next person to serve as the IPV education champion who further facilitates community resource connections and troubleshoots logistical difficulties. Full Universal IPV Education was delivered to 95 patients over the course of the three project cycles. If this project stays in place, there will be a much larger reach in a community that has multiple risk factors for increasing rates and consequences of IPV. This project is replicable in any midwifery/OBGYN practice setting and has the potential to make lasting differences in the lives of many communities.



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**Appendix A: Provider Sample Script- approximately 1 minute in length-**

Thank you so much for taking the time to answer all our questions on your intake forms. I see that you have marked \*\*\*insert answer to IPV screening questions\*\*\*. I have this conversation with all my patients regardless of how they answer that question. In the United States, intimate partner violence is really common. We estimate that somewhere between 1 in 3 and 1 in 4 women will experience it in their lifetime. I know that for many of my patients who are experiencing IPV, or have in the past, disclosing that information to me on an intake form, or at all, is really uncomfortable and might not even feel safe. I just want to let you know that I am someone you can talk to about intimate partner violence and I can work with you to find ways to increase your safety or health as well as connecting you with resources. 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 midwives 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 anytime in your care with us.

**Appendix B: Safety card from Futures Without Violence –**

**Are you in a HEALTHY relationship?**

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

- ✓ Is my partner or the person I am dating kind to me and respectful of my choices?
- ✓ Does my partner support my using birth control that's best for me?
- ✓ Does my partner support my decisions about if or when I want to have children?

If you answered YES to these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, a longer life, and helps your children.

**Are you in an UNHEALTHY relationship?**

**1 in 4 women are hurt by a partner in their lifetime. Ask yourself:**

- ✗ Does my partner shame or humiliate me?
- ✗ Does my relationship make me feel worse about myself?
- ✗ Does my partner ever hurt, scare or threaten me with their words or actions?
- ✗ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✗ Does my partner make me have sex when I don't want to?

If you answered YES to any of these questions, *your health and safety may be in danger*. For help, talk with your health care provider, and 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 happen in relationships—especially ones that are unhealthy or unsafe. Connecting with friends or family who struggle in their relationships is so important.

You can make a difference by telling them they aren't alone. "Hey, I've been there too and someone gave this card to me. It has ideas about 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.

**Who controls pregnancy decisions?**

**Ask yourself. Has my partner ever:**

- ✓ Tried to pressure me to get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

**If I've ever been pregnant:**

- ✓ Has my partner threatened to hurt me if I didn't do what they wanted with the pregnancy (in either direction – continuing with the pregnancy or abortion)?

If you answered **YES** to any of these questions, *you are not alone* and you deserve to make your own decisions without being afraid.



**Taking Control**

**A partner may see pregnancy as a way to keep you in their life and stay connected to you through a child – even if that is not what you want. Your health care provider can offer birth control that your partner won't know about.**

- ✓ The copper IUD is a small, safe, hormone-free device placed into the uterus to prevent pregnancy for up to 12 years. The IUD has strings that can be cut off so your partner can't feel them and you will still get a regular period.
- ✓ Emergency contraception (EC – some call it the morning after pill) is taken up to five days after unprotected sex to prevent pregnancy. The sooner you take it, the better it works. Hide EC by taking it out of its packaging and putting it in an envelope or empty pill bottle so your partner won't know what it's for. To find a provider near you: [www.bedsider.org](http://www.bedsider.org)

**Getting Help**

- ✓ If your partner or the person you are seeing checks your cell phone or texts, talk to your health care provider about using their phone to call the hotlines on this card – so your partner can't see it on your call log.
- ✓ The folks on the hotline can help you with a plan to be safer. You can find out more online: [www.joinonlove.org/my\\_plan\\_app](http://www.joinonlove.org/my_plan_app)

**If you have an STD and are afraid your partner will hurt you if you tell them:**

- ✓ Request partner notification from the public health department anonymously, without using your name.
- ✓ Use online partner notification services without using your name at [www.inspot.org](http://www.inspot.org). For other STDs: [www.sotheycanknow.org](http://www.sotheycanknow.org)

Funded by the U.S. Department of Health and Human Services, Administration on Children, Youth and Families (Grant #90EY0414)

Everyone deserves a healthy and respectful relationship. We know that doesn't always happen. If you are being hurt by your partner, it is NOT your fault.



Funded by the U.S. Department of Health and Human Services, Administration on Children, Youth and Families (Grant #90EV0414)

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www.acog.org

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Everyone deserves a healthy and respectful relationship. We know that doesn't always happen. If you are being hurt by your partner, it is NOT your fault.

The National Domestic Violence Hotline has staff who are trained to help people in unsafe relationships. They answer the phone 24/7, can help you plan for safety and provide support – and everything you tell them is private and confidential.

The Hotline  
1-800-799-SAFE (1-800-799-7233)  
TTY 1-800-787-3224 [www.thehotline.org](http://www.thehotline.org)  
Develop a safety plan using this app:  
[http://www.joinonelove.org/my\\_plan\\_app](http://www.joinonelove.org/my_plan_app)



**DID YOU KNOW YOUR RELATIONSHIP AFFECTS YOUR HEALTH?**

**¿Estás en una relación SALUDABLE?**

Toda persona merece tener una pareja que escuche lo que quiere y necesita. Pregúntate:

- ✓ ¿Mi pareja o la persona que estoy viendo es amable y respeta mis decisiones?
- ✓ ¿Mi pareja apoya el control de natalidad que es mejor para mí?
- ✓ ¿Mi pareja apoya mi decisión acerca de si quiero o cuándo quiero tener hijos/hijas?

Si contestaste "Sí" a cualquiera de estas preguntas, es probable que estés en una relación saludable. Los estudios demuestran que estas clases de relaciones conducen a una vida más saludable, más larga y con mejores resultados para sus niños/niñas.

¿Estás en una relación MÁLA?

**1 de cada 4 mujeres son agredidas por su pareja durante su vida. Pregúntate:**

- ✗ ¿Mi pareja me avergüenza o me humilla?
- ✗ ¿Mi relación me hace sentir MAL sobre mi misma?
- ✗ ¿Mi pareja a veces me hace daño, me atemoriza o me amenaza con sus palabras o acciones?
- ✗ ¿Mi pareja interfiere con mi control de natalidad o trata de hacerme quedar embarazada cuando no lo quiero estar?
- ✗ ¿Me obliga mi pareja a tener sexo cuando yo no lo quiero?

Si contestaste "Sí" a cualquiera de estas preguntas, *tu salud y seguridad pueden estar en peligro*. Para obtener ayuda, habla con tu proveedor de atención médica, llama a las líneas de ayuda en esta tarjeta.

---

Cómo ayudar a una amiga

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

¿Suenan familiares? Esto puede suceder en las relaciones, sobre todo las que son malas o perjudiciales. El mantenerse en conexión 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, también nos sentimos bien con nosotras mismas.

---

¿Quién controla las decisiones sobre los embarazos?


Pregúntate: Alguna vez mi pareja:

- ✓ ¿Me ha tratado de presionar a quedar embarazada?
- ✓ ¿Me ha hecho daño o me ha amenazado por no querer quedar embarazada?

Si alguna vez has estado embarazada:

- ✓ ¿Mi pareja me ha amenazado con hacerme daño si no hago lo que mi pareja desea con el embarazo (en cualquier dirección – continuar con el embarazo o tener un aborto)?

Si contestaste "Sí" a cualquiera de estas preguntas, *no estás sola* y mereces poder tomar tus propias decisiones sin tener miedo.



Tomando Control

Una pareja puede ver el embarazo como una manera de mantenerse en su vida y mantenerse en contacto contigo a través de tener una hija/hijo – incluso aunque tú no lo quieras. El médico te puede ofrecer control de natalidad sin que lo sepa tu pareja.

- ✓ El DIU es un dispositivo intrauterino pequeño, seguro, libre de hormonas, que se coloca en el útero para prevenir el embarazo hasta por 12 años. El DIU tiene cordones que se pueden cortar para que tu pareja no los sienta y tú todavía podrás tener un periodo regular.
- ✓ La anticoncepción de emergencia (AE – algunos la llaman la píldora del día siguiente) se puede tomar hasta cinco días después del acto sexual para prevenir el embarazo. Cuanto antes se tome, mejor funciona. Para ocultar el AE sácalo del paquete y pon la pastilla en un sobre o botella vacía y tu pareja no sabrá lo que es. Para encontrar un proveedor cercano: [www.bedsider.org/es](http://www.bedsider.org/es)

Buscar Ayuda

- ✓ Si tu pareja o la persona que estás viendo vigila tu teléfono celular o textos, habla con tu proveedor de salud para usar otro teléfono para llamar a las líneas de emergencia que están en esta tarjeta—para que tu pareja no lo vea en las llamadas que has marcado.
- ✓ La gente en la línea de ayuda listada en esta tarjeta te puede ayudar con un plan para sentirte más segura.

**Si tienes una enfermedad de transmisión sexual (ETS) y temes que tu pareja te hará daño si se lo dices:**

- ✓ Podrías solicitar una notificación anónima a tu pareja al departamento de salud pública, sin utilizar tu nombre.
- ✓ Podrías usar un servicio de notificación en línea sin usar tu nombre en [www.inspot.org](http://www.inspot.org). Para otras ETS: [www.sotheycanknow.org](http://www.sotheycanknow.org) en inglés.

Financiado en parte por el Departamento de Salud y Servicios Humanos y la Administración para Niños, Jóvenes y Familias (concesión #950EV0414).

Toda persona merece una relación saludable y respetuosa. Sabemos que eso no siempre ocurre. Si estás siendo agredida por tu pareja, NO es tu culpa.

Línea Nacional contra la Violencia Doméstica (National Domestic Violence Hotline). Contestan el teléfono las 24 horas, pueden ayudar a crear un plan de seguridad y proporcionar apoyo – y todo lo que les digas es privado y confidencial.

Línea de Ayuda  
**1-800-799-SAFE (1-800-799-7233)**  
**TTY 1-800-787-3224** <http://espanol.thehotline.org>

Consejos para planear tu seguridad  
<http://espanol.thehotline.org/solicite-ayuda/el-camino-hacia-la-seguridad>

Para encontrar un centro de salud:  
<https://findahealthcenter.hrsa.gov>

Información sobre leyes y recursos nacionales:  
<http://www.womenslaw.org>

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**Appendix C: Posters for Bathroom**

**Did You Know Your Relationship Affects Your Health?**

Women thrive in healthy relationships—ones that are respectful, caring and supportive.

**Healthy Relationships?**

Are those where a boyfriend or husband doesn't call you names, control you or hurt you.

We know a lot of women have friends, colleagues, or family who may be in unhealthy relationships.

This little card has information that can help them. It talks about what women deserve in relationships.

This includes information on the IUD and emergency contraception (EC), birth control that she can control, that he doesn't have to know about if he is trying to get her pregnant when she doesn't want to be.

It can feel powerful to help a friend feel not so alone.

**We are all part of making a difference in the lives of women.**

Nobody deserves to be hurt or ashamed by the person they love. Health care providers can help and these confidential hotline numbers support women through listening and safety planning 24/7.

National Domestic Violence Hotline  
1-800-799-SAFE (1-800-799-7233)  
TTY 1-800-787-5224

Teen Dating Abuse Hotline  
1-866-351-9474

The American College of Obstetricians and Gynecologists  
Member of the American Medical Association

**FUTURES WITHOUT VIOLENCE**

Division of Family Violence Prevention and Services

# ¿SABÍA USTED QUE SU RELACIÓN AFECTA SU SALUD?

## ¿Está usted en una relación SANA?

### Pregúntese lo siguiente:

- ¿Me obliga mi pareja a tener sexo, aún cuando no quiero?
- ¿Se entremete mi pareja con mis anticonceptivos o se niega a usar condones?
- ¿Alguna vez ha intentado mi pareja embarazarme cuando yo no quería?

### Si usted contestó sí a alguna de estas preguntas, no está sola.

- ✓ Tantas como 1 en 3 mujeres han experimentado sexo forzado u obligado y/o abuso
- ✓ Muchas han experimentado sabotaje anticonceptivo
- ✓ Aquéllas que han sido lastimadas tienen el triple de probabilidades de contraer una enfermedad de transmisión sexual (STD) en comparación con mujeres que nunca han sido lastimadas

**Si su pareja está entremetiéndose con sus anticonceptivos o no está usando condones, hable con su proveedor de atención médica acerca de la píldora del día después para ayudar a prevenir un embarazo no deseado.**

**Family Violence  
Prevention Fund**

[www.endabuse.org](http://www.endabuse.org)

**Si usted o alguien que usted conoce tiene miedo o necesita ayuda, llame a:**

La Línea Nacional de Emergencia sobre Violencia Doméstica  
1-800 799-7233 TTY 1-800 595-4889

La Línea de Emergencia sobre Violencia Doméstica  
entre Adolescentes 1-866 331-9474



**Appendix D: Dot Phrase for charting- Providers will be encouraged to elaborate on conversation if patient discloses, requests resources or conversation needs follow-up.**

Was patient seen confidentially: YES/NO\*\*\*

Universal IPV education provided: YES/NO\*\*\*

Follow-up Needed: YES/NO\*\*\*

Resources referred: YES/NO\*\*\*

## Appendix E: Guidelines for Universal IPV Education via Telehealth from Futures Without Violence

### Telehealth, COVID-19, Intimate Partner Violence, and Human Trafficking: Increasing Safety for People Surviving Abuse

*A Guide for Community Health Centers and Partnering Domestic Violence Advocacy Programs*

The COVID-19 public health crisis and subsequent social distancing measures are increasing risk for survivors of intimate partner violence (IPV) and human trafficking (HT) and their children, reducing families' financial security, making it harder to stay connected to support networks, and is a source of stress. This increased stress and increased proximity to the person causing harm may intensify abuse. As many health centers now shift to telehealth, providing virtual support to patients, including those who may be experiencing abuse or exploitation, can be lifesaving. Health centers and local domestic violence advocacy programs can establish, or build upon their partnerships to support survivors of IPV/HT and promote their health and safety. (See page 3 "Building Sustainable and Fruitful Partnerships between Community Health Centers and Domestic Violence Advocacy Organizations" for additional information and guidance).

#### Before the visit:

- Prepare a "script" integrating information into the visit about IPV/HT and available survivor support resources for people to share with their family and friends.
- Understand that telehealth visits may not be a safe time for discussing IPV/HT—others may be in the room or listening in.
- Connect with local domestic violence advocacy agencies and hotlines to understand what services they offer.
- Identify other ways to share info with patients: add in patient portals, staff resource lists, e-newsletters, and by U.S. mail (ask patient if it is safe to do so).



#### During the visit:

Offer normalizing information about relationships, health, and stress during the COVID-19 public health crisis. One method for this is the "CUES" intervention for IPV/HT, which can be used within telehealth visits:

**C:** Prioritizing **Confidentiality** by ensuring it is safe for the patient to speak over the phone/video and letting them know that their health information will be kept safe (disclosing any reporting requirements).

*"Your medical information is confidential, that doesn't change because were not in a clinic setting. I will not share anything we talk about here outside of with the care team [or if you tell me refer to your state law]. Are you somewhere where you can speak freely?"*

**UE:** Offering **Universal Education** to all patients about how stress can affect relationships and relationships can affect health, and that there are supportive resources available.

*"Before we get started, I want to say that I know COVID-19 has made things harder for everyone. Because people are stressed, we're sharing ideas about helping yourself and people you care about. For example, we may experience more stress now in our relationships including increased fighting or harm, and that can affect our health. There is free, confidential help available if you know someone who is being hurt in their relationship. Would it be okay if I sent some resources for you to share? I will also send information on support around parenting, access to food and stress. How are things going right now for you?"*

Providers can also offer **Universal Education** to patients normalizing financial struggles to pay for necessary things like food and shelter, and where to go for support if they need it.

*"Many people are also feeling pressure around money and paying rent or bills—sometimes others take advantage of people for work and also for sex—so we're sharing information about resources that are available if you find yourself in a situation like this. Can I give you unemployment resources, housing and food support, and other things to share if you know someone who needs it?"*

**E:** Providers can also encourage patients to share these resources with friends and family. Research has shown that being able to support others is a form of **Empowerment**, and can also be healing.

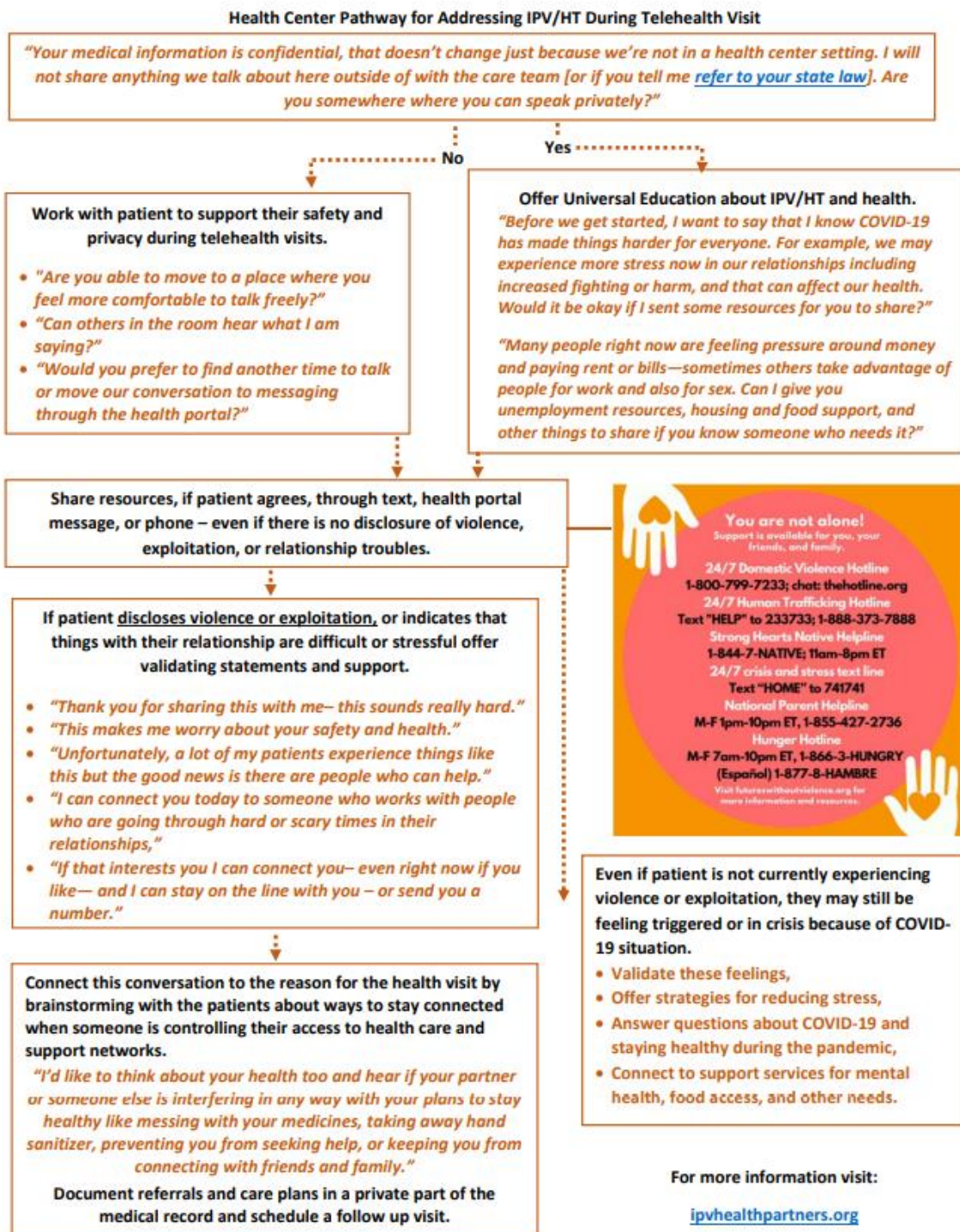
*"You can also share these resources with friends or family if you think it may help them, too."*

**S:** Providing **Support** if patients disclose experiences of IPV/HT or other needs, offer validating messages, information to support health, a warm referral to a domestic violence advocacy program, and a crisis text line.

*"Thank you for sharing this with me. I am so sorry this is happening. What you are telling me makes me worry about your safety and health. A lot of my patients experience things like this and there are people who can help. I can connect you today if that interests you – even right now if you like—and I can stay on the line with you - whatever you like."*

You may also be able to brainstorm with patients who are experiencing violence or exploitation about ways to stay connected when someone is controlling their access to health care and support networks.

*"I'd like to think about your health too and hear if your partner or someone else is interfering in any way with your plans to stay healthy like messing with your medicines, taking away hand sanitizer, preventing you from seeking help, or keeping you from connecting with friends and family."*



For more information visit:

[ipvhealthpartners.org](http://ipvhealthpartners.org)

[futureswithoutviolence.org/protecting-your-health/](http://futureswithoutviolence.org/protecting-your-health/)