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Quality Improvement: Intimate Partner Violence Screen in Nurse Home Visit Program

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Abstract

Purpose: Women are disproportionately impacted from intimate partner violence (IPV). Their children also experience long-term adverse consequences. Effective IPV prevention and intervention efforts are vital. This quality improvement project addressed the lack of an evidence-based IPV training and protocol in a nurse home visit program.

Methods: Stakeholder engagement and an evidence-based practice intervention were implemented. Training effectiveness was examined by the pre-post-training assessments; completed by 17 nurses. To measure the IPV practice change, 196 pre- and 107 post-intervention charts were reviewed.

Results: The training significantly increased nurse knowledge and comfort ($t=5.9$, $p< .001$). Only 22% of those referred due to recent IPV history were screened before the intervention; 65% after the intervention. Multivariate analysis of screening rates was performed; predictors included county, mental health status, education, subprogram, and IPV referral reason. Due to low power, a one-tail test was employed. One county was 14 times less likely to screen than the other county ($p= .023$). 93% of those referred due to IPV history were enrolled in the crisis response subprogram, only offered by the other county. Those referred due to IPV history were three times more likely to be screened ($p=.042$) than those referred for other reasons. There was no significant change observed on IPV disclosure and intervention practice.

Conclusions: The adoption of an evidence-based IPV training and protocol is a key to provide effective IPV interventions. Consistent monitoring and support to remove barriers as well as the strong collaboration are essential to keep this practice change effective and sustainable.

Keywords: intimate partner violence, domestic violence, screening, intervention, quality improvement, home visit

Quality Improvement: Intimate Partner Violence Screen in Nurse Home Visit Program

Introduction

Intimate partner violence (IPV) or domestic violence (DV) is a public health problem. IPV is defined as "physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p.11). Risk factors for IPV victims are being a young age (e.g., adolescents and young adults), living in poverty, having a personal or family history of violence, and experiencing relationship problems (McTavish, McGregor, Wathen, & McMillan, 2016; Niolon et al., 2017).

Women are disproportionately affected by high morbidity and mortality associated with IPV (Niolon et al., 2017; Petrosky et al., 2017). In the United States, 23% of women experience physical IPV and 16% of women experience sexual violence in their lifetimes (Niolon et al., 2017). According to the 2003-2014 National Violent Death Reporting System data, IPV was responsible for 55.3% of female homicide deaths (Petrosky et al., 2017).

Locally, 18,501 Coloradans reported IPV related offenses in 2016, such as simple assault (13,213 victims), aggravated assault (2,295 victims), and sexual violence (558 victims) (Colorado Bureau of Investigations [CBI], 2017). However, these numbers might have been substantially higher as only 56% of nonfatal IPV victimizations in the United States were reported in 2006-2015 (Bureau of Justice Statistics, 2017). In that same year, 42 Coloradans died of IPV related causes (CBI, 2017).

On the other hand, many IPV survivors experience adverse health consequences, such as chronic diseases (e.g, cardiovascular diseases and gastrointestinal disorders), mental health problems, and substance use at high rates (Niolon et al., 2017), which result in high direct medical and mental health care costs (Center for Disease Control and Prevention [CDC], 2017).

Additionally, lost productivity and high criminal justice system costs are other examples of economic burdens of IPV (Niolon et al., 2017). Moreover, since children of IPV victims often witness or are exposed to violence, many suffer from long-term physical, social, and psychological consequences. They are also at risk for becoming IPV victims or perpetrators themselves in the future (McTavish et al., 2016).

Importantly, comprehensive IPV prevention and intervention efforts effectively lead to reductions in morbidity and mortality associated with IPV. These efforts include comprehensive programs for adolescents, family-based programs, early childhood home visitation, and victim-centered services (e.g., hotline, shelter, and crisis intervention) (Niolon et al., 2017). Essentially, healthcare providers hold an essential role in identifying IPV victims, providing brief counseling, addressing safety, and referring patients to appropriate resources (American College of Obstetricians and Gynecologists, 2012; U.S. Preventive Services Task Force, 2013). Yet, healthcare providers face challenges when adopting evidence-based IPV screening and intervention practices. For example, negative provider attitude, a lack of IPV screening and intervention knowledge, and a lack of screening protocol are some of the individual and/or system-level barriers (Alvarez, Fedock, Grace, & Campbell, 2016).

The organizational gap analysis revealed that the nurse home visit program of Colorado's local public health agency lacked an evidence-based IPV screening and intervention practice. The program offers health education, care coordination, and case management services to at-risk mothers and children. Home visit clients are mainly referred directly from the County Department of Human Services and Child Protection Services. In fact, many clients experience IPV, have history of IPV, and/or have several risk factors for becoming IPV victims. Therefore, vulnerable mothers and children, who are served by the home visit program, may face increased

risk for mortality and adverse health consequences associated with IPV due to a lack of effective IPV screening and intervention practice.

In order to address the identified problem, this quality improvement (QI) project implemented two interventions, including the stakeholder engagement and an evidence-based IPV screening and intervention protocol including a comprehensive IPV training. The purpose of the project is that home visit nurses would adopt a new practice of effectively screening clients for IPV, counseling IPV victims about safety and resources, and ensuring the utilization of IPV community resources. Therefore, in the long run, the effective adoption of an evidence-based IPV practice would decrease women's risks for mortality and adverse health consequences associated with IPV. This paper discusses the literature review of evidence-based IPV screening and intervention practices, describes the problem and the practice gaps in the nurse home visit program, and evaluates the QI project. For the purpose of this paper, the terms "IPV" and "DV" will be used interchangeably.

Review of the Literature

The literature search was conducted using six databases, including Web of Science, Nursing Journals@Ovid, CINAHL, PubMed, UpToDate, and National Guideline Clearinghouse, in order to identify articles relating to public health and nursing subjects as well as clinical practice guidelines. The Medical Subject Headings (MeSH) terms used for this literature search included *domestic violence* or *intimate partner violence* as well as *screening* or *screening tool*. Inclusion criteria for searching articles were identification of IPV, female population, healthcare setting, English language, and nursing journals. Additionally, in order to select the most current evidence on the topic, those studies that were published within the last five years (2013-2017) were only included. Exclusion criteria were elder abuse and main study locations outside the

U.S., Western Europe, Canada, or Australia, considering possible cultural differences in perceptions about IPV. Initially, 23 articles were found. To further limit the search results, additional consideration of academic journals, antenatal period, and home visiting setting were considered, eliminating 12 studies. Finally, 11 studies were reviewed and synthesized, referencing the "Levels of Evidence and Grades of Recommendations" (Shekelle, Woolf, Eccles, & Grimshaw, 1999).

First, three studies were rated with the highest level of evidence ("level I"), including a systematic review and meta-analysis of random control trials (Hussain et al., 2015), a systematic review and meta-analysis of random or quasi-random studies (O'Doherty et al., 2014), and a multi-methods study including random control trials (Sprague et al., 2016). Second, a qualitative meta-synthesis (LoGiudice, 2015) was rated as "level II." Third, three "level III" studies include a systematic review of quantitative and qualitative studies (Alvarez et al., 2016), a non-experimental descriptive study/quality improvement (Day et al., 2015), and a qualitative case study (Jack, Ford-Gilboe, Davidov, MacMillan, & NFP IPV Research Team, 2016). Finally, the four "level IV" studies include two clinical practice guidelines (Weil, 2016; World Health Organization [WHO], 2013) and two expert opinions (Amar et al., 2013; Miller, McCaw, Humphreys, & Mitchell, 2015).

IPV Screening Intervention Outcomes

Screening for IPV leads to an increase in identification across multiple settings. For example, O'Doherty et al. (2014) found that the IPV screening significantly increased the identification of IPV, especially in antenatal settings. In a recent review by Sprague et al. (2016), 70.6% of studies reported an increase in IPV identifications. Although screening leads to successful identification of IPV, the impact of identification (e.g., referral rate and prevention of

future IPV episodes) is less understood and there is limited evidence that identification of screening results in an increased quality of life (O'Doherty et al., 2014; Sprague et al., 2016).

Computer-Based IPV Screening

Self-administered computer-based IPV screening method attains higher rates of IPV identification than other methods do. For example, Hussain et al. (2015) found that the odds of IPV disclosure was 39% higher compared to the face-to-face interview method. Furthermore, O'Doherty et al. (2014) and Weil (2016) also emphasized the effectiveness of utilizing computer-based screening and self-administration in identification of IPV. However, there is limited evidence on patient satisfaction and preference over a specific screening method (Hussain et al., 2015).

IPV Screening Tools

Utilizing validated IPV screening tools is more effective in identifying IPV. For example, Weil (2016) discussed the sensitivity and specificity of several validated IPV screening tools, such as HITS (Hurt, Insult, Threaten, Scream) and WAST (Woman Abuse Screen Tool). In a review of IPV screening programs by Sprague et al. (2016), 72.5% of the studies used validated IPV questionnaires, such as Partner Violence Screen and WAST. In their IPV screening program, Day et al. (2015) used a four-item IPV screening tool and a 28-item comprehensive questionnaire. Moreover, Alvarez et al. (2016) and LoGiudice (2015) examined the utilization of validated IPV screening tools as a reinforcing factor for IPV screening practice adoption. Although these studies did not recommend a particular IPV screening tool, they emphasized the benefits of utilizing validated screening tools (Alvarez et al., 2016; Day et al., 2015; LoGiudice, 2015; Weil, 2016).

IPV Screening and Interventions Implementation

Recommendations for IPV screening implementation and actual practice among healthcare providers are inconsistent across the multiple settings. For example, Alvarez et al. (2016) and Weil (2016) found that even though routine screening is highly recommended, screening practices vary among providers. Instead, many providers performed selective/indicator-based screening (i.e., screen if injury was present or IPV was suspected) (Alvarez et al., 2016). Furthermore, others including WHO (2013) and Jack et al. (2016) recommend against routine IPV screening and in favor of selective/indicator-based screening. Considering the nature of long-term relationships, Jack et al. (2016) advocated for a tailored IPV screening implementation for nurse home visitation program. Moreover, Miller et al. (2015) discussed the importance of routine inquiry with IPV related educational resources (such as a safety card) that may be more meaningful for patients. Even though recommendations for IPV screening implementation vary, most studies consistently identified the importance of providing comprehensive IPV screening practice and interventions that include counseling, safety identification, referrals, and addressing the health needs of IPV victims (Amar et al., 2013; Jack et al., 2016; Miller et al., 2015; Weil, 2016; WHO, 2013).

Reinforcing Factors and Barriers for IPV Screening Practice

Reinforcing factors for IPV screening practice were identified across multiple settings. For example, with having clear clinic-level protocols and follow-up practice, providers are more likely to ask about IPV (Alvarez et al., 2016; LoGiudice, 2015; Miller et al., 2015). Another key reinforcing factor is having trusting and therapeutic relationships with patients (Alvarez et al., 2016; Jack et al., 2016; LoGiudice, 2015). Furthermore, providing adequate staff training (Alvarez et al., 2016; Amar et al., 2013; Day, 2015; Jack et al., 2016; Miller et al., 2015; WHO,

2013) and ensuring the availability of community referral resources (Amar et al., 2013; LoGiudice, 2015; Miller et al., 2015) are other key reinforcing factors for effectively encouraging the adoption of IPV screening practice.

Moreover, addressing barriers for IPV screening practice is also important when implementing an IPV screening program. Some barriers include time constraints, provider-discomfort and negative beliefs about IPV screening, inadequate and unclear protocol and referral system, language barriers, and presence of a partner (Alvarez et al., 2016; LoGiudice, 2015). Additionally, the responsibilities of mandated reporters, especially involving children should also be carefully addressed (Alvarez et al., 2016; Amar et al., 2013; Jack et al., 2016; WHO, 2013).

In summary, the key components of effective IPV screening and intervention strategies include the utilization of validated IPV screening tools, the consideration for a tailored IPV screening implementation for nurse home visitation program, routine inquiry with IPV related educational resources, and comprehensive IPV screening and intervention services. Although IPV screening increases the identification of IPV, little is known if the identification of IPV increases quality of life of IPV victims. Furthermore, self-administered computer-based IPV screening is more effective in identifying IPV, however, little is known if patients prefer such method better than others. Additionally, some articles emphasize the importance of routine IPV screening but others recommend against and value the benefit of selective or tailored IPV screening practice. The literature review also points out the importance of considering reinforcing factors and addressing barriers for IPV screening practice, such as adequate provider education, existence of clear protocols and referral system, and provider's comfort level and belief about IPV screening. Although the evidence supports the benefit of effective IPV

screening and intervention practice, home visit nurses would benefit from more comprehensive provider IPV training opportunities to address perceived and actual barriers to a practice transformation (Bianchi, Cesario, & McFarlane, 2016).

Evidence Based Practice Model

The Knowledge to Action (K2A) framework facilitates the implementation of evidence-based interventions into practice through several steps, such as 1) “knowledge creation” (knowledge inquiry, synthesis of knowledge and creation of knowledge tools) and 2) “action cycle,” including evaluating outcomes and ensuring the sustainability of change. The “action cycle,” which is based on theories of planned action, intentionally brings practice transformation in health care systems and settings. It is important to engage various stakeholders throughout the process (Straus, Tetroe, & Graham, 2009).

Methods

This QI project implemented an evidence-based IPV screening and intervention protocol between September 2018 and February 2019. Guided by the K2A framework (Straus et al., 2009), the project completed the “stakeholder engagement” and the “IPV training and protocol implementation” activities. This QI project intended to address a lack of formal IPV screening and intervention protocol and a need for a comprehensive IPV training opportunity in the nurse home visit program, by incorporating some key components of evidence-based IPV screening and intervention strategies found in the literature review.

First, a validated screening tool (WAST) was selected to be used as it approaches IPV with comprehensive perspectives including physical, emotional, and sexual violence (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Additionally, WAST-short questionnaire (using the first two questions of WAST) assesses tension in relationship and how a couple handles

disagreements (Basile, Hertz, & Back, 2007), with scores ranging from zero to two per question. For the total score of one or above, answering the remainder of WAST questions is advised (Brown, Lent, Schmidt, & Sas, 2000).

Although the interpretation of WAST scores was originally defined as based on provider's clinical judgment (Brown et al., 2000), others defined a score of 13 or higher (scores ranging from one to three per question) as a "positive" IPV screen result (Sprague et al., 2012; Yut-Lin & Othman, 2008). In addition to the use of WAST-short and WAST, key concepts of IPV screening and intervention practice were incorporated, such as routine inquiry with IPV related educational resources (a safety card) (Miller et al., 2015) and used the standardized comprehensive IPV screening and intervention policy and procedure (Bianchi et al., 2016).

Second, the IV training curriculum for home visitors by Futures Without Violence (*Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Trauma Informed Domestic Violence Programming and Practice)* was used to provide a comprehensive provider IPV training (Chamberlain & Levenson, 2015). The training curriculum contains three modules, such as 1) the Module One (*What About Me?: Moving Toward a Trauma-Informed Understanding of How Our Work Can Affect Us*), 2) the Module Two (*Domestic Violence, Perinatal Health, and Reproductive Coercion: Definitions and Dynamics*), and 3) the Module Three (*Assessment and Safety Planning for Domestic Violence in Home Visitation*). Originally, the curriculum was funded by Administration for Children and Families of U.S. Department of Health and Human Services, to support maternal and child home visitation programs in addressing IPV issues (Chamberlain & Levenson, 2015).

Goal and Objectives

The long-term goal of this QI project was that at-risk mothers, who experience IPV, would receive effective IPV screening and intervention services and utilize community IPV resources to decrease their risks for adverse health consequences related to IPV. The Table 1 below describes the goal, objectives, and timeline of this project.

Table 1

IPV Screening and Intervention QI Project Goal, Objectives and Timeline

Goal	Objective	Timeline
Improve IPV screening and intervention practice	1. Identify stakeholders and meet to develop a new IPV screening and intervention protocol	September 2018 to October 2018
	2. Provide a comprehensive provider IPV training for home visit nurses	November 5, 2018
	3. Implement a new IPV screening and intervention protocol	November 15, 2018
	4. Evaluate whether home visit nurses adopted the new IPV screening and intervention practice, as evidenced by: • 50% increase in identification of IPV • 90% of IPV victims actively referred to community resources • 50% increase in confirmed resource utilization by IPV victims who were actively referred to IPV resources	September 2018 to February 2019

Project Site and Population

The project site was a nurse home visit program of a large urban local public health agency in Colorado. The program works closely with County Department of Human Services (DHS) and Child Protection Services (CPS) and receives referrals from them. The Table 2 below lists the eligibility and the description of each subprogram.

Table 2

Nurse Home Visit Subprograms Descriptions

Subprogram	Eligibility	Description and Service Period
Program A	TANF (Temporary Assistance for Needy Families/federal-state cash assistance program) eligible mothers and children	Long-term case management during prenatal period through children turning 12 months old
Program B	Embedded into the Department of Human Services (DHS) team	Crisis response and safety assessment. Up to three visits during a 60 day period
Program C	Families under active investigation by DHS	Case management for four to seven months period
Program D	Referred by the Child Protection Services (CPS) when families did not warrant an investigation but require additional support	Short-term case management for up to four visits over a two months period from opening a case

Furthermore, the project population included the key stakeholders (the nurse leaders of the home visit program and additional community IPV prevention experts) and home visit nurses. Additionally, in order to evaluate the intervention outcomes, client charts from pre- and post-intervention groups were reviewed.

Interventions

This QI project consisted of two activities, including 1) stakeholder engagement and 2) an evidence-based IPV training and protocol implementation. The stakeholder engagement activity was initiated in September 2018. Additionally, the evidence-based comprehensive provider IPV training and protocol implementation activity was carried out between November 2018 and February 2019.

Stakeholder engagement. Guided by the K2A framework (Straus et al., 2009), as a part of "action cycle" step, the home visit program nurse leaders as well as community IPV experts were recruited to participate in this process. On October 1, 2018, the 90-minutes stakeholder meeting was conducted to review the draft evidence-based IPV screening and intervention protocol. The stakeholders actively engaged in the discussion and provided with various

feedback and suggestions to be included in the final protocol (See Appendix B for the IPV screening and intervention protocol).

Evidence-based IPV training and protocol implementation. The next step of "action cycle" step under the K2A framework was the implementation of a new practice (Straus et al., 2009). During the stakeholder engagement process in September 2018, the home visit program nurse leaders and three IPV community experts (a local DV shelter representative, a social worker, and a local IPV advocacy agency/shelter outreach worker) were recruited to be a part of the IPV training team as co-trainers.

First, as soon as the time, location, and the detailed-agenda of the training event was finalized, the home visit program nurse leaders sent out the calendar invite with the training agenda, encouraging the home visit nurses to participate. Second, co-trainers reviewed the Futures Without Violence training curriculum and coordinated the training plan in October 2018. The training included the hands-on exercises for nurses to practice the new IPV screening and intervention protocol. Moreover, the home visit program nurse manager secured the funding for food (snacks and lunch) and handled the logistics. Additional preparation for the training involved ordering of the Futures Without Violence safety cards and printing out training materials and handouts. Finally, the IPV training was conducted on November 5, 2018.

Data Collection and Analysis

Guided by the K2A framework (Straus et al., 2009), as an important component of "action cycle" step, the outcome evaluation of the new protocol implementation was conducted to assess a "sustainable practice of knowledge translation." The evaluation also assessed the effectiveness of comprehensive IPV staff training.

IPV training effectiveness. To examine the effectiveness of IPV training, knowledge and abilities regarding IPV screening and intervention practice was assessed on prior to and after the training. First, the 19-questions pre-training assessment was administered prior to the IPV training (See Appendix C for Futures Without Violence pre-training assessment for home visitors). So that pre- and post-training assessment data could be matched for evaluation, each participant was asked to create a unique ID that would be used for both pre- and post-training assessments. For example, a unique ID consisted of the following: 1) birthday "day of the month" and 2) first three letters of mother's FIRST name (e.g. If birthday is December 1st and mother's first name was Catherine, ID would be "01cat" – use lower case letters).

In detail, the first ten questions measured provider knowledge and abilities on performing trauma-informed IPV screening and intervention practice. The additional nine questions assessed their readiness to perform IPV screening and identify gaps in their current IPV screening and intervention practice, learning needs, and a plan for the application of the new knowledge.

Second, at the end of training, the attendees completed the post-training assessment, noting the same unique ID from the pre-training assessment (See Appendix D for Futures Without Violence post-training assessment for home visitors). The post-training assessment consisted of 20 questions, including the same ten questions that measured self-assessment on provider knowledge and abilities on performing trauma-informed IPV screening and intervention practice. Additional six questions measured provider comfort level and behaviors related to trauma-informed IPV screening and intervention practice. Furthermore, the post-training assessment also included four open-ended training evaluation questions. Finally, additional four close-ended training evaluation questions were asked to assess the level of satisfaction among the training attendees (See Appendix E for the training satisfaction questions).

Prior to examining change in provider knowledge and comfort in IPV screening, basic descriptive statistics was used to describe self-assessment on their readiness to perform IPV screening and identify gaps in their current IPV screening and intervention practice, learning needs, and a plan for the application of the new knowledge. Furthermore, the matched paired t-tests was performed, comparing the likert scale scores of pre- and post-training assessment. Furthermore, basic descriptive statistics was used to describe self-assessment on provider comfort level and behaviors related to trauma-informed IPV screening and intervention practice following the training. Additionally, basic descriptive statistics was also used to list frequent responses for each open-ended evaluation question as well as to describe the frequencies of close-ended satisfaction question responses.

Intervention outcomes. To collect outcome evaluation data, multiple chart reviews were performed to abstract chart data from both prior to and following the implementation of the new IPV screening and intervention protocol (See Appendix F for the chart audit tool). The charts were selected using a convenience data sampling method. The constructs measured by the chart audit tool included 1) change in IPV screening practice, 2) change in IPV intervention practice (did nurses appropriately respond to screening results), and 3) change in resource utilization by IPV victims (did IPV victims utilize community IPV resources).

First, the home visit program manager reviewed their case status tracking spreadsheet to identify the client chart numbers for the chart review. Second, three chart abstractors reviewed and recorded the data from client charts that were opened from November 1, 2017 to January 31, 2018 (during the same time period three months of previous year of the protocol implementation) and that were opened from November 15, 2018 to February 14, 2019 (during the following three months of the initiation of the new IPV practice). To evaluate the reliability of data, at the

beginning of chart review process, all chart abstractors reviewed five same charts and compared the chart audit results for consistency in data collection. A descriptive statistics method, independent t-tests was performed to measure practice change in IPV screening practice, IPV intervention practice, and clients utilizing IPV community resources. Additionally, some client characteristics were also collected and described using a descriptive statistics method.

Change in IPV screening practice. First, to measure change in IPV screening practice (mean percentage of clients screened), the percentage of time home visit clients were screened for IPV at least once during the pre-intervention and the post-intervention were compared. Second, in order to measure change in IPV disclosure, the percentage of IPV disclosure (number of IPV positive clients over number of clients who are screened for IPV) during pre-intervention and the post-intervention were compared.

IPV intervention practice. To measure change in IPV intervention practice (mean percentages of danger assessment completion, safety planning completion, and referrals made), the following indicators were compared between the pre-intervention and the post-intervention. First, the percentage of danger assessment completion (number of IPV positive clients with danger assessment completed over number of IPV positive clients) was compared. Second, the percentage of safety planning completion (number of IPV positive clients with safety planning completed over number of IPV positive clients) was compared. Finally, the percentage of active referrals made to IPV community resources (number of IPV positive clients with active referrals made over number of IPV positive clients) was compared.

Resources utilization by IPV victims. To measure resource utilization by IPV victims who were actively referred to IPV resources, the percentage of resource uptake by IPV victims who were actively referred to IPV community resources (number of IPV positive clients with

resource utilization recorded over number of IPV victims who were actively referred to resources) during the pre-intervention and the post-intervention were compared.

Ethical Considerations/Protection of Human Subjects

This project was determined by University of Massachusetts Amherst's Institute Review Board (IRB) as a "Not Human Subjects Research" and did not require IRB approval (IRB Determination Number 18-135). This QI project's intent was to implement an evidence-based IPV screening and intervention protocol to improve client services provided by the home visit nurses. Throughout the QI project planning and implementation, the purpose of the QI project and the detailed project design were communicated to the project site, home visit nurses, and stakeholder group.

During the implementation phase, the DNP student and the home visit nurses followed the standards of care for IPV screening and intervention practice at the site. All clients served by the nurse home visit program were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), protecting the privacy of clients' health information (Office for Civil Rights, Department of Health and Human Services, 2013). The risk to clients, who received services with the new IPV screening and intervention practice was no different from the risks of clients receiving standard care (previous IPV screening and intervention practice).

The training and intervention assessment data, which was collected as part of evaluation the impact of this project, were aggregated and did not include any potential personal identifiers. First, the individual unique IDs used for training assessment data did not contain personal identifiers (e.g., birthday "day of the month" and first three letters of mother's first name). Second, client confidentiality was assured by coding the client chart numbers with randomly

assigned identification numbers. The list of client chart numbers and associated unique identification numbers were kept secured and password-protected in an electronic file on the project site's network drive, which was only accessible to the project coordinators.

Results

Stakeholder Engagement

A total of nine people participated in the 90-minute face-to-face stakeholder meeting on October 1, 2018. Table 3 below presents a summary of stakeholder group discussions on the IPV screening and intervention protocol and describes the feedback on the new IPV screening and intervention protocol and its training plan, provided by the stakeholder group. The feedback included 1) need for additional training opportunities, 2) the need for frequent IPV screening in an organic way, 3) coordinating with County DHS caseworkers for securing a private space for IPV screening, 4) assessing immediate past and future relationships for IPV risks, 5) asking IPV screening questions to a woman who was IPV perpetrator herself, 6) exploring ways to assess women of IPV risks when IPV screening questions cannot be asked directly, 7) making warm referrals even when danger assessment result is not "immediate danger," and 8) strengthening the active referral follow-up system.

Table 3

Summary of Stakeholders Discussions on the IPV Screening and Intervention Protocol

Draft Protocol	Stakeholders Comments	Final Protocol
Training content	Add "any relevant webinars hosted by Violence Free Colorado and National Coalition Against Domestic Violence" to training protocol.	Relevant webinars hosted by Violence Free Colorado & National Coalition Against Domestic Violence were added to training.
IPV screen at the initial or second visit, once per trimester, and at the postpartum visit	Frequent IPV screening and asking about IPV as a part of every home visit encounter. Screen at the initial visit and	Screen at the initial visit (if appropriate) and every 4th visit at a minimum. Consider asking informal IPV

	every 4th visit at a minimum.	screening questions at every visit (if appropriate) – *e.g., "Is anything changed in your relationship since we met last time?"*
Provide sufficient time to educate (and screen) women in a private secure area free of any family members, children, spouse, or partner.	For Program B, during a joint visit with a County DHS caseworker, ask if a caseworker can arrange private time with women for nurses to screen for IPV.	[Program B] Work with caseworkers if they can arrange private time with women for IPV education and screening.
IPV Identification	Even if a woman is not currently in a relationship at a time of screening, educate and screen for IPV exposure in regards to most recent/prior relationship experience and/or possible immediate future relationships. Many women often experience off and on "relationship" with previous partners.	If the woman says she is not currently in a relationship, ask about most recent/prior relationship experience and/or possible immediate future relationships in regards to her risk for IPV exposure.
IPV Identification	Discussed if appropriate to screen women for IPV even if the woman is the IPV perpetrator herself. Some clients are referred to the program because of reported IPV cases.	Even if the woman is the IPV perpetrator, still conduct the IPV screening.
IPV Identification	Discussed ways to assess IPV risk when nurses cannot ensure "private" and "safe" area free of any family members, children, spouse, or partner, while ensuring the safety of women.	Do not ask IPV screening questions if asking her in a "private" and "safe" area is not possible. Discuss with supervisors for other ways to ask the woman about IPV experience. Always assure safety of a woman when screening.
IPV Assessment	Discussed best ways to refer women to IPV resources even if danger assessment results may not be immediate danger.	May contact local or National Crisis Line if the woman is not in immediate danger but would benefit from a follow-up from a local IPV advocate. Obtain verbal permission and assure the woman's safety before making a referral call. Document in client chart.
IPV Referral Follow-up	Discussed best ways to follow up on active referrals, ensuring	For active referrals, obtain a release of information (ROI) for

	the safety of woman.	coordination of care and follow-up. Follow up with a referred agency to verify whether the woman accessed services if a ROI is obtained. If ROI is not obtained at the time of referral, follow up with the woman directly. Complete a follow-up within 5 business days and document in client chart. Assure the safety of woman when contacting her. Document in client chart.

Additionally, the stakeholder group suggested the use of an online-based screening or a phone screening (especially when a private and safe space is not assured at the time of screening) and offering more training for nurses to practice asking IPV screening questions in an organic way. One stakeholder emphasized the importance of screening fathers and same sex couples. After the stakeholder meeting, the revised IPV screening and intervention protocol was shared via email with the stakeholder group to seek additional feedback and requested a final review prior to the new IPV protocol implementation training.

IPV Training Effectiveness

A total of 17 nurses attended the IPV training (89% attendance). The community IPV experts and the home visit program nurse leaders effectively contributed to providing the IPV training. They attentively responded to the attendees' questions, were able to elaborate on the topics, and effectively explained the application of trauma-informed IPV practice.

During the new IPV screening and intervention protocol practice time, nurses also provided feedback. The protocol revisions were reflected of some of this feedback, including:

1. Adding a sentence of "further educate the woman about the impact of IPV and other relevant information (e.g., the impact of IPV on children, Power and Control Wheel, etc.)"
2. Documenting as "IPV SUSPECT" when a nurse suspects the woman may be experiencing IPV or child witnessing IPV even when a disclosure is not made or when the total score of WAST is less than 12.
3. Even when considered as "IPV SUSPECT," a nurse should go over the safety-planning tool and conduct the danger assessment.
4. Adding the Colorado StandUp as a perpetrator resource.
5. Need for the Spanish version of WAST screening form as the home visit program serves some monolingual Spanish-speaking mothers.

Their feedback was essential to the protocol revisions. The new IPV screening and intervention protocol was implemented on November 15, 2018. One week after the implementation of the new protocol, the home visit program manager met with nurses to review the screening process and answer any questions may have come up.

The IPV training effectiveness was assessed comparing the level of knowledge and abilities regarding IPV screening and intervention practice on prior to and after the training, using the pre- and post-training assessment tools. First, the Table 4 shows the summary of the pre-training self-assessment questions. They asked the nurses' self-assessment on their readiness to perform IPV screening and identified gaps in their current IPV screening and intervention practice, learning needs, and plans for the application of the new knowledge.

Table 4

Summary of Pre-training Self-assessment Questions

Response	% Total (N=17)
Pre-training IPV screening and intervention practice:	
• Had training on domestic and sexual violence before	65%
• Clients have disclosed to them that they are victims of domestic and/or sexual violence in the past six months	59%
• More than half of their clients revealed that they were the IPV victims	18%
Own IPV screening barriers:	
• The partner is present for the visit	77%
• Not enough time	35%
• Not sure how to ask questions without seeming too intrusive	35%
• Not sure what to say if clients disclose an abusive/violent relationship	24%
• Not knowing where to refer clients to	24%
Strength of the program:	
• Having supports for staff exposed to violence	88%
• Materials on domestic and sexual violence that are specifically targeted to teen parents	88%
• Partnership with a local domestic violence agency	65%
Own learning needs	
• Learning more about the effects and impacts on children who witness/experience IPV	
• Learning what to do when no IPV disclosure but IPV was suspected	

A majority of nurses had training on domestic and sexual violence and recently experienced their clients disclosing IPV to them. Some of their IPV screening barriers identified were the presence of partner, time limitation, provider discomfort in screening and responding to IPV disclosure.

Second, the post-training assessment form asked the nurses' comfort level and behaviors related to trauma-informed IPV screening and intervention practice after the training were measured. Almost all nurses indicated that they feel comfortable with trauma-informed IPV practice including effective local resources utilization, self-care, and universal education about IPV and childhood exposure to violence (See Table 5).

Table 5

Summary of Post-training Self-assessment Questions

Response	% "agreed or strongly agreed" response (N=17)
Comfort level and behaviors related to trauma-informed IPV screening and intervention practice after the training:	
• Understood the value of making connections to local DV programs and hotlines	100%
• Understood how mindful movements can be strategy for own self-regulation and clients	82%
• Would consider calling DV hotline or referring client to it if they need help	100%
• Would provide information about DV/sexual violence/childhood exposure to violence to all of home visitation clients.	100%
The application of the new knowledge:	
• Will integrate universal education, using the safety card approach in the safety card, approach, into DV screening with the clients.	94%
• Will discuss reproductive coercion with clients	82%
• Continually checking themselves about the way they introduce materials and screening tools connected to DV	71%

Furthermore, after the training, a majority of nurses indicated that they were more likely to adopt new knowledge into their practice, such as the use of safety card and education about reproductive coercion. Moreover, 71% of nurses responded that they would continuously strive to improve their IPV screening practice. In addition, nurses also expressed that the additional supports needed for a practice change as educational materials for childhood exposure to violence (CEV) available, having more supervision and team reflection time, more opportunities for continuing education about IPV, more feedback on their IPV practice, and having a standardized/updated IPV protocol.

Third, a paired-samples t-test was conducted to measure the mean of differences between the post- and pre-total score of likert-scale questionnaires (the ten questions that measured self-

assessment on provider knowledge, comfort-level, and behavioral application on performing trauma-informed IPV screening and intervention practice) (See Table 6).

Table 6

Result of Paired t-test and Descriptive Statistics for Pre- and Post-training Assessment

	Pre-training assessment		Post-training assessment			95% CI for Mean Difference		*p*			
	M	SD	M	SD	N			(2-tailed)	r	t	df
Total score	34.2	6.2	42.8	2.8	17	5.4	11.6	< .001	.279	5.85	16

The findings indicated that there was a significant difference in the mean total scores of the post-training assessment (*M*=42.8) and the mean total scores of the pre-training assessment (*M*=34.2), p < .001. Additionally, as shown on the Table 7, a Wilcoxon signed rank test was also conducted because of the violation of normality. The result also indicated that the median total ranks of post-training assessment (*Mdn*=42) were statistically significantly higher than the median ranks of pre-training assessment (*Mdn*=36), p < .001

Table 7

Result of Wilcoxon Signed Rank Test and Descriptive Statistics for Pre- and Post-training Assessment

	Pre-training assessment			Post-training assessment				*p*	
	Mdn	Min	Max	Mdn	Min	Max	n	(2-tailed)	Z
Total rank	36	22	42	42	40	50	17	< .001	-3.628

Fourth, fifteen nurses answered the anonymous electronic training satisfaction survey. The results from the training satisfaction questions indicated that the length of training (87%), the quality of the information presented (93%), the quality of the training materials (100%), and the organization of the training (93%) were good, very good, or excellent. Additionally, everyone (100%) rated the overall quality of the training as good, very good, or excellent and rated the training met their needs or expectations as satisfactory or excellent. Eleven nurses (83%) said the training content was very or extremely helpful and trainers were very or

extremely effective. Finally, additional positive feedback/strengths of the training include "having community partners as trainers/resources," "having information about community resources and a standardized screening tool," "having to do role-play/practice during the training," "learning about the secondary trauma information," and "the safety card training." Two challenges were identified during the training event. First, there were some technical difficulties with playing two online video clips from the Futures Without Violence's DropBox (the video clips kept buffering because of wireless network band limitation at the training site). Second, since the training time had to be shortened due to limited time availability of nurses, the presenters tended to rush through the contents and training materials at times.

Intervention Outcomes

First, as the pre-intervention data, a total of 211 client charts, which were about 70% of total opened charts from November 1, 2017 to January 31, 2018, were reviewed and recorded as pre-intervention data. Due to the main caregivers being men (father of child [12] and grandfather [three]), 15 pre-intervention chart data were excluded from the data analysis. A total of 196 pre-intervention chart data was used for data analysis.

Second, a total of 114 client charts, which were about 77% of total opened charts from November 15, 2018 to February 14, 2019, were reviewed and recorded as post-intervention data. Six post-intervention chart data were excluded from the data analysis due to the main caregivers being men. The Program D was discontinued soon after the IPV protocol implementation due to the funding change and no charts from this program were reviewed for post-intervention data. A total of 107 post-intervention chart data was used for data analysis.

Client characteristics. The client characteristics from the pre- and post-intervention chart audits illustrate that the majority of charts were from the Program B, which provide crisis response and safety assessment of urgent CPS cases and only offered by the County B. The referrals reasons to the nurse home visit program were CPS involvement, drug/alcohol or substance use, and recent IPV history, in the highest order. Additionally, “other” cases were referred due to child neglect, physical abuse, sexual abuse, and growth delay (See Table 8).

Table 8

Client Characteristics from the Pre- and Post-Intervention Chart Audits

Characteristic	Pre-Intervention (n=196)		Post-Intervention (n=107)	
	N	%	N	%
County				
County A	28	14%	15	14%
County B	168	86%	92	86%
Subprogram				
Program A	26	13%	13	12%
Program B*	146	75%	82	77%
Program C	21	11%	12	11%
Program D	3	2%	0**	0%
Referral Reasons (multiple selections)				
Drug/alcohol or substance use	79	40%	42	39%
History of child protection service	161	82%	81	76%
IPV	41	21%	26	24%
Medical neglect	18	9%	14	13%
Intellectual/developmental disability	9	5%	10	9%
Mental health concerns	2	1%	1	1%
Discipline concerns	7	4%	3	3%
Resources/financial concerns	28	14%	10	9%
Educational neglect	0	0%	1	1%
Other	8	4%	24	22%
Caregiver Mental Health Status				
Current diagnosis/in care	48	25%	31	29%
Current diagnosis/not in care	29	15%	6	6%
Past diagnosis	11	6%	4	4%
No diagnosis	86	44%	52	49%
Unknown	22	11%	14	13%
Caregiver Education				
Did not complete high school	38	19%	12	11%
High school or GED	38	19%	25	23%

Some college	19	10%	26	24%
Vocational training	5	3%	9	8%
College	9	5%	8	8%
Graduate	1	1%	1	1%
Unknown	86	44%	25	23%
Living Situation				
Homeless	6	3%	1	1%
Unstable/housed	11	6%	6	6%
Stable/housed	164	84%	98	92%
Unknown	15	8%	2	2%
Caregiver Insurance Status				
Medicaid	130	66%	77	72%
Private insurance	25	13%	9	8%
Uninsured	10	5%	6	6%
Unknown	31	16%	15	14%

Note. *Program B was only offered by the County B; **Program D was discontinued right after the protocol implementation and no post-intervention chart reviews.

Furthermore, the summary of caregiver characteristics illustrates mental health diagnosis and treatment status, education levels, living and housing situation, an insurance status. There were many charts where caregivers' mental health status, education, living situation, and insurance status were not documented or marked as unknown by the nurses.

Change in IPV screening practice. Chi-square test was performed to determine whether the IPV screening rates differ by pre- or post-intervention (see Table 10).

Table 10

Result of Chi-Square Test and Descriptive Statistics for IPV Screen Rates

	IPV screen done at least once	
	Yes	No
Pre-Intervention	78 (39.8%)	118 (60.2%)
Post-Intervention	54 (50.5%)	53 (49.5%)

Note. χ^2 =3.2, df=1, p = 0.073. Numbers in parentheses indicate column percentages.

The mean percentage of IPV screening done at least once from the pre-intervention charts was 39.8% compared to the post-intervention charts of 50.5% (27% increase). The chi-square test result showed no significant difference in IPV screening rates between pre- and post-intervention data, at the .05 significance level.

Additionally, the screen rates of three subprograms were Program A (42.3% and 53.8%), Program B (39.0% and 47.6%), and Program C (38.1% and 66.7%) comparing pre- and post-intervention data. On the other hand, when looking at a referral reason to a home visit program, prior to the intervention, only 22% of those referred for a home visit due to recent IPV history were screened. After the intervention, the screening rate increased to 65% (195% increase).

Furthermore, multivariate analysis of post-intervention IPV screening rates for all women referred, was performed. The predictors included county (county A), mental health status (current mental health diagnosis), education (did not complete high school), subprogram (program B), and referral reason (referred for recent history of IPV) (see Table 11).

Table 11

Summary of Logistic Regression Analysis for Variables Predicting IPV Screening Rate

Predictor	β	*SE* β	Wald's χ^2	*df*	*p* (one-tail test)	Odds Ratio
Recent IPV history as a referral reason to the home visit program	1.108	.638	3.018	1	.041	3.029
County A	-2.644	1.325	3.981	1	.023	.071
Mental health status (current diagnosis)	.850	.531	2.564	1	.055	2.339
Education (did not complete high school)	-.109	.526	.043	1	.418	.897
Program B	1.506	1.178	1.636	1	.101	4.511

Note. χ^2 (5, N=74) = 11.6, Nagelkerke R^2 = 0.19, p = .041.

Due to low power, a one-tail test was employed. The results of the logistic regression indicated that there was significant association if recent IPV history as a referral reason to the home visit program, clients were three times more likely to be screened for IPV (p = 0.041). Additionally, if enrolled in County A, 14 times less likely to be screened for IPV (p = 0.023) than County B. 93% of those referred due to recent IPV history were enrolled in the crisis response subprogram, which was only offered by County B.

Moreover, the chi-square test of determining whether the IPV positive/disclosure rates differ by pre- or post-intervention. Since the new IPV screening and intervention protocol included the documentation of "IPV suspect" when a nurse suspects IPV when a disclosure is not made or when the total score of WAST is less than 12, the IPV suspect cases were included as IPV positive/disclosure numbers in this data analysis (see Table 12).

Table 12

Result of Chi-Square Test and Descriptive Statistics for IPV Positive/Disclosure Rate

	IPV screen result	
	Positive or Suspect	Negative
Pre-Intervention	11 (14.1%)	67 (85.9%)
Post-Intervention	10 (18.9%)	43 (81.1%)

Note. χ^2 =.532, df=1, p= .466. Numbers in parentheses indicate column percentages.

The mean percentage of IPV positive or suspect result from the pre-intervention chart review data was 14.1% compared to the prost-intervention chart review data of 18.9% (34% increase). The results show no statistically significant difference in IPV disclosure (positive or suspect IPV screen results) between pre- or post-intervention data, at the .05 significance level.

Change in IPV intervention practice. First, a chi-square test was performed to determine whether the danger assessment (DA) completion rates differ by pre- or post-intervention. In this data analysis, the IPV suspect cases were included as IPV positive/disclosure cases as the new protocol directs nurses to go over the safety-planning tool and conduct the danger assessment for IPV suspect clients. The mean percentage of DA completion from the pre-intervention charts was 36.4% compared to the prost-intervention charts of 36.4%. The result showed no statistically significant difference in DA completion rates between pre- and post-intervention charts, χ^2 (1, N=22) = 0.000, p = 1.00.

Second, a chi-square test was also performed to determine whether the safety planning completion rates differ by pre- or post-intervention. The mean percentage of safety planning completion from the pre-intervention charts was 39.8% compared to the prost-intervention charts of 33.3%. The result showed no statistically significant difference in safety planning completion rates between pre- and post-intervention charts, χ^2 (1, N=23) = 0.023, p = 0.879.

Resources utilization by IPV victims. First, a chi-square test was also performed to determine whether the IPV resource referral rates differ by pre- or post-intervention. In this analysis, the IPV suspect cases were included as IPV positive/disclosure cases. Since the number of active referrals was minimum (there was only one active referral in the pre-intervention chart data), passive referrals were also included in this data analysis. The mean percentage of IPV resource rates (active or passive referrals) from the pre-intervention charts was 63.6% compared to the post-intervention charts of 66.7%. The result showed no statistically significant difference in IPV resource referral rates between pre- and post-intervention charts, χ^2 (1, N=23) = 0.023, p = 0.879. Second, the resource utilization by IPV victims who were actively referred to IPV resources comparing the pre-intervention and post-intervention was not measured due to

insufficient data to run a chi-square test.

Facilitators and Barriers

Facilitators. There were several facilitators in implementing the successful stakeholder engagement activities as well as delivering the successful comprehensive IPV training event. First, the home visit program nurse leaders were very supportive and facilitated the implementation of this QI project. In detail, they effectively communicated the importance of the QI project to community partners (stakeholders) and the home visit nurses. Therefore, it fostered a stronger engagement from the stakeholder group and the home visit nurses. Additionally, after the training, the home visit program nurse leaders continued to monitor and encourage the adoption of the new IPV screening and intervention practice. For example, the program manager frequently checked in with nurse supervisors and nurses about the progress of new IPV practice uptake and offered support if anyone needed a clarification or guidance.

Another facilitator was the fact that many home visit nurses already had strong interests in learning more about how to screen for IPV effectively and respond to a positive IPV disclosure in a client-centered way. As many clients were already experiencing IPV and/or at-risk for becoming IPV victims, home visit nurses were greatly motivated to address this public health issue and to mitigate the negative impacts of IPV.

Barriers. Several barriers were identified during the implementation of the stakeholder engagement activities as well as providing the comprehensive IPV staff training. First, there was a time constraint for the stakeholder engagement and participation in the QI activities due to competing priorities. Second, the training team opted to offer the all-day training (six hours) instead of two half-day training because it was challenging for all nurses to be available at once. The original training curriculum is based on two half-day training and permits the elimination of

some hands-on exercises to reduce training hours. Therefore, some individual and group hands-on exercises had to be eliminated and some talking points had to be rushed to cover. Finally, two additional major program changes happened in 2018, including the implementation of two other evidence-based screening and intervention tools (a pregnancy intention and spacing question and adverse childhood experience questions). Therefore, these program practice changes and the implementation of new screening tools may have been barriers to adopt IPV screening change among nurses.

Discussion

The K2A framework (Straus at el., 2009) guided the every step of this QI project planning (the literature search and review), implementation (the development of new IPV screening an intervention protocol and IPV training), and evaluation (the assessment of the stakeholder engagement, the IPV training effectiveness, and the outcomes from the implementation of new IPV protocol). First, the findings from the pre-and post-training assessment data, which showed significant increase in provider knowledge, comfort-level, and behavioral application on performing trauma-informed IPV screening and intervention practice, confirmed the benefit of providing adequate staff training as a reinforcing factor for improving IPV screening practice (Alvarez et al., 2016; Amar et al., 2013; Day, 2015; Jack et al., 2016; Miller et al., 2015; WHO, 2013). The evidence-based comprehensive IPV practice training by the Futures Without Violence was effective in increasing provider knowledge and comfort-level and encouraging adopting trauma-informed IPV screening and intervention practice.

Throughout the project, as emphasized by the K2A framework, the stakeholders were recruited and encouraged to provide feedback on the new protocol as well being a part of IPV staff training team (Straus at el., 2009). According to the post-training assessment and training

satisfaction survey results, involving the community IPV advocates and community-based IPV resource providers in providing the IPV staff training was also effective in ensuring that nurses felt more confident in providing IPV intervention and connecting victims with community resources (Amar et al., 2013; LoGiudice, 2015; Miller et al., 2015).

Second, although most findings were not statistically significant, the use of evidence-based, comprehensive IPV screening and intervention protocol (Amar et al., 2013; Jack et al., 2016; Miller et al., 2015; Weil, 2016; WHO, 2013) including the utilization of validated IPV screening tools (WAST-short and WAST) effectively increased the IPV screening rates for those mothers who were referred to the home visit program due to recent IPV history (Alvarez et al, 2016; Day et al., 2015; LoGiudice, 2015; Weil, 2016). Most nurses did not screen these mothers prior to the intervention simply because of the referral reason as recent history of IPV (e.g., perpetrator themselves, open IPV cases, or perpetrator in jail, etc.). The IPV practice experts (stakeholders) felt it was still important to screen for IPV for these women to document, educate, and intervene accordingly. Furthermore, the IPV screening barriers among the home visit nurses identified in the pre-training assessment and the chart review were similar to those that were discussed in the literature, such as time constraints, provider-discomfort about IPV screening, not knowing where to refer clients, and presence of a partner (Alvarez et al., 2016; LoGiudice, 2015).

Additionally, although the use of an evidence-based comprehensive IPV screening and intervention protocol was proven to be effective in increasing the identification of IPV (O'Doherty et al, 2014; Sprague et al, 2016), the findings from this QI project did not show a significant change. Although one of objectives of this project was to increase IPV identification by 50%, there was only a 34% increase (including suspect cases). Furthermore, the IPV

intervention practice data did not show any increases, such as the completion of danger assessment and safety planning and referral follow up. Although the project hoped that 90% of clients with IPV disclosure were referred actively to IPV resources, only 67% were actively or passively referred. Unfortunately, the resource utilization of active referrals was not assessed due to only one active referral done. Although the danger assessment and safety planning intervention were indicated due to the IPV disclosure, nurses did not provide such brief IPV interventions. In detail, for some home visit cases, nurses did not complete danger assessment and safety planning because IPV perpetrators were already in the jail or not living together when they were screened for IPV.

Limitation and Future Recommendations

One limitation identified for this QI project was that the IPV screening and intervention protocol was originally proposed to screen only female clients utilizing the WAST-short at first. The protocol specifically delineates that if the WAST-short screening result is positive, nurses would complete the full version of WAST questions. Even though the full version of the WAST has been identified as suitable for screen men, the WAST-short is not suitable to screen men (Arkins, Begley, & Higgins, 2016). Although the pre-intervention chart review findings and the stakeholder feedback revealed that some primary caregivers were fathers or grandparents, it would have been challenging to modify the approved project proposal to screen male clients using the full version of WAST. In future, in order to include screening IPV among men clients, it is recommended that the new IPV screening and intervention protocol should include the use of full version of WAST for male clients.

Additionally, the nurses did not often document active referrals and follow-up with IPV resources as many clients in Program B have ongoing caseworkers. Therefore, any abnormal

findings from the assessment would have been communicated with DHS and CPS caseworkers and caseworkers would follow up with clients directly. In future, in order to measure the impact of IPV screening and intervention practice, it is recommended that the documentation of care coordination efforts with caseworkers may be highly encouraged.

Conclusion

This QI project, guided by the K2A Framework (Straus et al., 2009), addressed a lack of effective IPV prevention strategies for high risk mothers and infants served by the home visit nurses. The provision of the evidence-based comprehensive IPV practice training by the Futures Without Violence was highly effective in increasing provider knowledge and comfort-level in performing trauma-informed IPV screening and intervention practice. The significant improvement in IPV screening rate was observed for those who were referred to the home visit program due to recent IPV history. On the other hand, the implementation of an evidence-based comprehensive IPV screening and intervention protocol did not show statistically significant improvement in IPV disclosure or intervention practice (danger assessment, safety planning, and referral utilization). Nurses continued to experience some barriers to IPV screening such as time constraints and presence of a partner.

Furthermore, the K2A Framework emphasizes the importance of a sustainable practice of knowledge translation and further collaboration with community resources (Straus et al., 2009). Therefore, the first future recommendation for a sustainable IPV practice change include consistently following the new IPV screening and intervention protocol, especially hosting the annual comprehensive IPV staff training, using the Futures Without Violence's training curriculum in collaboration with local IPV advocate and resource staff (Hamberger, Rhodes, & Brown, 2015). The second recommendation is for nurse leaders to conduct chart audit to assess

IPV screening rate, IPV disclosure, and resources utilization every six to 12 months (Hamberger, Rhodes, & Brown, 2015). The third recommendation includes the nurse leaders to continue to champion and brainstorm strategies to address barriers to IPV screening by nurses. Other recommendations identified from the project limitations include expanding the use of WAST with male caregivers and encouraging nurses to document care coordination efforts with caseworkers.

The project dissemination plan includes providing a brief presentation of the findings to the project site team as a lunch and learn webinar in April 2019, submitting a poster abstract to Colorado's annual public health conference in August 2019, and considering submitting an article to be published in journals such as Journal of Public Health Nursing. Although this project was specific to the home visit nurses who work with vulnerable mothers and children, the project design and approach could be applicable to other nursing programs or clinic settings as long as the screening and intervention protocol and the training would be tailored to the local context and needs.

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Appendix A: Woman Abuse Screening Tool (WAST) and WAST-Short

<table>
<tr><td colspan="2">Woman Abuse Screening Tool (WAST) - Short
• Begin with the first 2 questions. If the total score is 1 or above, ask the remaining WAST questions.</td><td rowspan="3">Subtotal
[ ]</td></tr>
<tr><td>1. In general, how would you describe your relationship?</td><td>□ A lot of tension (2)
Some tension (1)
No tension (0)</td></tr>
<tr><td>2. Do you and your partner work out arguments with:</td><td>Great difficulty? (2)
Some difficulty? (1)
No difficulty? (0)</td></tr>
<tr><td colspan="2">The remainder of WAST questions
• Score of 13 or higher of 8-item questions is considered as “positive” IPV screen (Sprague et al., 2012; Yut-Lin & Othman, 2008).
• Interpretation of scores and significance of IPV experience is based on clinical judgment (Brown et al., 2000).</td><td rowspan="7">Subtotal
[ ]</td></tr>
<tr><td>3. Do arguments ever result in you feeling down or bad about yourself?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>4. Do arguments ever result in hitting, kicking or pushing?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>5. Do you ever feel frightened by what your partner says or does?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>6. Has your partner ever abused you physically?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>7. Has your partner ever abused you emotionally?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>8. Has your partner ever abused you sexually?</td><td>Often (3)
Sometimes (2)
Never (1)</td></tr>
<tr><td>IPV screening (circle) Negative Positive
Notes:</td><td colspan="2">Total Score (Question 1-8)
[ ]</td></tr>
</table>

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Appendix B: Intimate Partner Violence Screening and Intervention Protocol

1.	Protocol	All home visit program nurses are responsible for educating women about Intimate Partner Violence (IPV) using a safety card and conducting face-to-face IPV screening using a validated IPV screening tool (WAST-short [Woman Abuse Screen Tool] and WAST) at the *initial and every 4th visit* as appropriate. If a disclosure is made, assessment will be conducted, and a referral will be made to appropriate IPV resources. If IPV is suspected but there is no disclosure, nurse will consult with supervisors and may make a referral to appropriate resources and agencies following the agency policy (e.g., child witnessing violence). All home visit nurses shall complete the relevant IPV screening, assessment, and intervention trainings.
2.	Scope	All NSP nurses
3.	Purpose	The intent of the IPV screening and intervention protocol is to provide home visit nurses with the tools and skills to identify, assess, and refer women (and children) who are experiencing IPV so their health and safety needs would be met.
4.	Definition of Terms	IPV: Intimate Partner Violence WAST: Woman Abuse Screen Tool
5.	Training Content	Annual training: ● Futures Without Violence healthy moms, happy babies: A train the trainers curriculum on trauma informed domestic violence programming and practice ● Danger Assessment overview ● IPV101 and Safety Planning presentation by Family Tree Domestic Violence Outreach Program ● Any relevant webinars hosted by Violence Free Colorado (https://www.violencefreecolorado.org) & National Coalition Against Domestic Violence (https://www.bwjp.org/resource-center/resource-results/national-coalition-against-domestic-violence.html) At least once: ● Webinars and website resources o Futures Without Violence ▪ Gun Violence ▪ Defending Childhood o The Cycle of Violence o Safety Plan – National Domestic Violence Hotline Website
6.	Procedure	**Preparation** 1. Provide sufficient time to educate (and screen) women **in a private**

		<u>secure area</u> free of any family members, children, spouse, or partner. 2. Inform about the mandatory reporting responsibility regarding children witnessing violence. 3. Inform about the possibility of sharing relevant information with County Human Services for care coordination. 4. [Program B] Work with case workers if they can arrange private time with women for IPV education and screening. **Education** 1. Educate women about IPV using a Futures Without Violence safety card. Assure safety and ask if she wants to keep the safety card. Always give two cards (to share with friends etc). 2. Sample scripts include: a. *"I've started giving these cards to all of my clients."Open the card and do a quick review. "It talks about healthy and safe relationships… and how relationships affect your health"* b. *Create a sense of empowerment. "We give this to everyone so they know how to get help for themselves if they were to need it and so they can help a friend or family member…"* **Identification** 1. Address the immediate needs of the client first. Depends on rapport and observation of indicated risks for IPV, IPV screening shall be conducted **<u>at the initial visit, then every 4th visit at a minimum.</u>** 2. Even if the woman is the IPV perpetrator, still conduct the IPV screening. 3. Provide sufficient time to conduct face-to-face IPV screening in a **<u>"private"and "safe"</u>** area free of any family members, children, spouse, or partner. 4. Explain confidentiality and the mandatory reporting responsibility prior to screening. 5. Sample scripts include: a. *"We talked about healthy and safe relationships. Do you have any questions?"* b. *"I'd like to go over some questions just so we can get a better sense of how it is going in your relationship."* 6. If the woman says she is not currently in a relationship, ask about most recent/prior relationship experience and/or possible immediate future relationships in regards to her risk for IPV exposure. 7. Do not ask IPV screening questions if asking her in a "private" and "safe" area is not possible. Discuss with supervisors for other ways to ask the woman about IPV experience. **<u>Always assure safety of a woman when screening.</u>** 8. If WAST-short scores 1 or more, conduct the remainder of WAST.

		9. If the total score of WAST is 13 or more, consider it as **IPV POSITIVE** screen. However, always use clinical judgment for interpretation of results. Document the responses and actions in client chart.
		10. If a disclosure is not made (or when the total score of WAST is less than 12), but the nurse suspects the woman may be experiencing IPV or child witnessing IPV, consider using the safety planning tool and danger assessment, discuss the case with supervisor, follow the agency protocol for appropriate referrals. Document as "**IPV SUSPECT**" and document the responses and actions in client chart.
		11. Consider asking informal IPV screening questions at every visit.
		    a. e.g., "Is anything changed in your relationship since we met last time?"
		
		Assessment
		● When IPV POSITIVE or IPV SUSPECT (when appropriate, use clinical judgment),
		    ○ Conduct a thorough assessment and **document about history of acute IPV events** (e.g., length of time the abuse has occurred, types of abuse experienced, past injuries related to abuse, and treatment/care received related to IPV) as appropriate. Document in client chart.
		    ○ Further educate her about the impact of IPV and other relevant information as appropriate (e.g., the impact of IPV on children, Power and Control Wheel, etc.)
		    ○ Assess her safety needs by conducting the **danger assessment**. Follow danger assessment scoring guide and protocol for follow-up.
		        ■ May contact local or National Crisis Line if the woman is not in immediate danger but would benefit from a follow-up from a local IPV advocate. Obtain verbal permission and assure the woman's safety before making a referral call. Document in client chart.
		    ○ Help the woman develop a **safety plan** using the Family Tree's Safety Planning tool. Document in client chart.
		
		Referral
		1. Discuss with the woman about community support and resources. Allow the woman to decide which agency she prefers and believes will be the most helpful to her at the time.
		2. Consider "active" referral (e.g., facilitating referrals and coordinating care by obtaining releases of information) vs. just giving the information ("passive" referral). Document in client chart.

		○ Safehouses and Crisis Line ○ Legal Help ○ Support Services ○ Rape Assistance ○ Help for an Abusive Partner 3. If she declines active referrals that may be beneficial to her, assure her safety and may provide the woman with written information regarding how to contact the agency when she is ready (passive referrals). 4. For active referrals, obtain a release of information (ROI) for coordination of care and follow-up. 5. Follow up with a referred agency to verify whether the woman accessed services if a ROI is obtained . If ROI is not obtained at the time of referral, follow up with the woman directly. 6. Complete a follow-up within 5 business days and document in client chart. Assure the safety of woman when contacting her. Document in client chart.
7.	References/ Related Documents	Domestic Violence or Intimate Partner Violence Reporting Policy Domestic Violence or Intimate Partner Violence Reporting Procedure Danger Assessment Safety Planning WAST-short and WAST Futures Without Violence Safety Card ● "Healthy Moms, Happy Babies" ● "Did you know your relationship affects your health?" Power and Control Wheel http://www.ncdsv.org/images/PowerControlwheelNOSHADING.pdf Bianchi, A.L., Cesario, S.K., & McFarlane, J. (2016). Interrupting intimate partner violence during pregnancy with an effective screening and assessment program. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 45,* 579-591

Appendix C: Pre-Training Assessment For Home Visitors

Unique ID: ___________

Use 1) birthday's "day of the month" and 2) first three letters of mother's FIRST name. (e.g. If one's birthday was December 1st and mother's first name was Catherine, code would be "01cat" – use lower case letters).

Please circle one answer for each of the following questions:

1. I am familiar with how working with clients who are experiencing domestic or sexual violence and/or other trauma can affect me and my co-workers.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
2. I know several self-care strategies that can help to prevent the effects of vicarious trauma when working with families experiencing domestic and/or sexual violence.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
3. I am familiar with how trauma-informed programming can reduce staff barriers to screening for domestic violence.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
4. I know what local & national resources are available to assist my clients if they have experienced domestic violence.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
5. I have the skills to help a client who is experiencing domestic violence – I know what to say and do.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
6. I have the skills to educate clients about reproductive coercion and birth control sabotage.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
7. I am familiar with the evidence-based safety card approach to educate clients about domestic violence and healthy relationships	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
8. I am comfortable talking with my clients about healthy and unhealthy relationships.	A. Strongly Disagree B. Disagree

<table>
<tr><td></td><td>C. Neutral
D. Agree
E. Strongly Agree</td></tr>
<tr><td>9. I have the knowledge to talk with my clients about birth control that is not dependent on a partner (i.e., emergency contraception, IUD).</td><td>A. Strongly Disagree
B. Disagree
C. Neutral
D. Agree
E. Strongly Agree</td></tr>
<tr><td>10. I am confident in my ability to help a client with safety planning when domestic violence is disclosed.</td><td>A. Strongly Disagree
B. Disagree
C. Neutral
D. Agree
E. Strongly Agree</td></tr>
<tr><td colspan="2">11. The following are frequently identified barriers for IPV screening. Please circle at least one action item (barrier) that you intend to do differently (address your own screening barriers) following the training today (circle as many as apply):
A. Not enough time
b. It's not my job/ or in my job description
C. Asking doesn't help
D. The partner is present for the visit
E. Worried about upsetting the client
F. Not sure what to say if they disclose an abusive/violent relationship
G. Afraid about what would happen if they told me
H. Not sure how to ask questions without seeming too intrusive
I. Not knowing where to refer them to
J. Worried about mandated reporting to child welfare or child protective services
K. Have already screened them at past visit
L. Does not apply to my client population
M. Other ____</td></tr>
<tr><td>12. Have you ever had training on domestic and sexual violence?</td><td>A. Yes
B. No</td></tr>
<tr><td>13. In the past 6 months, how many of your own clients have disclosed to you that they are victims of domestic and/or sexual violence?</td><td>A. 75% or higher
B. 50% to 74%
C. 25% to 49%
D. 10% to 24%
E. None</td></tr>
<tr><td>14. As part of your home visits, are there specific protocols about what to do when a client discloses domestic and/or sexual violence?</td><td>A. Yes
B. No
C. Not applicable
D. Don't know</td></tr>
<tr><td colspan="2">15. Does your home visitation program have (circle all that apply)?
A. Reflective supervision
B. Regular debriefing/case conferences about difficult cases
C. Supports for staff exposed to violence
D. Partnership with a local domestic violence agency
E. Brochures, cards or information about domestic and sexual violence</td></tr>
</table>

<table>
<tr><td colspan="2">F. Prompts inserted into intake forms to assess for domestic and sexual violence
G. In-service trainings for all staff on domestic and sexual violence
H. Materials on domestic and sexual violence that are specifically targeted to teen parents
I. Other (please be as specific as you can): ___________________________________</td></tr>
<tr><td>16. Are educational materials available on domestic and sexual violence in the languages most commonly spoken in your clinic setting?</td><td>A. Yes
B. No
C. Not sure</td></tr>
<tr><td>17. Are the materials available on domestic and sexual violence inclusive of diverse relationships including sexual minorities, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) clients?</td><td>A. Yes
B. No
C. Not sure</td></tr>
<tr><td colspan="2">18. What support do you need to incorporate discussion of domestic and sexual violence in all your home visits? (circle all that apply)
A. Workshops and training sessions
B. Protocols that include specific questions to ask
C. List of violence-related resources and who to call with questions
D. Case consultation
E. On-line training
F. Other (Please specify)
____
____
____</td></tr>
<tr><td colspan="2">19. Please describe one thing that you want to be addressed in the training today that would really help you to work with clients experiencing domestic violence/sexual assault (be as specific as you can):</td></tr>
<tr><td colspan="2">Additional Comments:</td></tr>
</table>

Source: Chamberlain, L., & Levenson, R. (2015). *Healthy moms, happy babies: A train the trainers curriculum on trauma informed domestic violence programming and practice (2nd ed.).* Futures Without Violence.

Appendix D. Post-Training Assessment For Home Visitors

Unique ID: ___________
Use 1) birthday's "day of the month" and 2) first three letters of mother's FIRST name. (e.g. If one's birthday was December 1st and mother's first name was Catherine, code would be "01cat" – use lower case letters).

Please circle one answer for each of the following questions:

1. I am familiar with how working with clients who are experiencing domestic or sexual violence and/or other trauma can affect me and my co-workers.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
2. I know several self-care strategies that can help to prevent the effects of vicarious trauma when working with families experiencing domestic and/or sexual violence.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
3. I know what local & national resources are available to assist my clients if they have experienced domestic *and/or sexual violence.*	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
4. I am familiar with how trauma-informed programming can reduce staff barriers to screening for domestic violence with clients.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
5. I have *better* skills to help a client who is experiencing domestic violence *(DV) with my clients than I did at the beginning of today's training.*	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
6. I have the skills to *provide universal education* for reproductive coercion and birth control sabotage *with my clients.*	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
7. I am familiar with the evidence-based safety card approach to educate clients about domestic violence and healthy relationships	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
8. I am comfortable talking with my clients about healthy and unhealthy relationships.	A. Strongly Disagree B. Disagree

	C. Neutral D. Agree E. Strongly Agree
9. I have the knowledge to talk with my clients about birth control that is not dependent on a partner *(i.e., emergency contraception)*.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
10. I am confident in my ability to help a client with safety planning when domestic violence is disclosed.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
11. I understand the value of making connections to local DV programs and hotlines.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
12. I understand how mindful movement can be strategy for my own self-regulation and my clients.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
Following the training today, I am more likely to:	
13. Integrate universal education, using the safety card approach, into domestic violence (DV) screening with my clients.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
14. Consider calling the domestic violence hotline or referring my client to it if they needed help.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
15. Provide information about DV/SV/*CEV* to all my home visitation clients.	A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
16. Please circle at least one action item that you intend to do differently following the training today (circle as many as apply): A. Make safety cards related to DV/SV available to all home visitation clients. B. Discuss reproductive coercion with my clients. C. Continually check myself about the way I introduce materials and screening tools connected to DV (how the tools or questions are framed matter) D. Work with our home visitation program to insert a prompt into our intake and	

follow up forms to include assessment for domestic and sexual violence (DV/SV) E. Offer an in-service training for all home visitation staff on trauma informed DV F. Set up a home visitation protocol for assessing for DV/SV/CEV with home visits G. Other (please be as specific as you can):	
16. Are educational materials available on domestic and sexual violence in the languages most commonly spoken in your clinic setting?	A. Yes B. No C. Not sure
17. What support do you need to incorporate discussion of domestic and sexual violence (DV/SV) and childhood exposure to violence (CEV) in all your home visitation encounters?	
18. What was the most useful/valuable part of this training for you?	
19. What was the least useful/valuable part of this training for you?	
20. What is one thing you would change to improve this training?	
Additional Comments:	

Source and Adopted from: Chamberlain, L., & Levenson, R. (2015). *Healthy moms, happy babies: A train the trainers curriculum on trauma informed domestic violence programming and practice (2nd ed.).* Futures Without Violence.

Appendix E: Training Satisfaction Questions

1. How do you rate the following?

	Poor	Fair	Good	Very Good	Excellent
Length of the training					
Quality of the information presented					
Quality of the training materials					
Organization of the training					
Overall quality of the training					

2. How would you rate today's training for meeting your needs or expectations?
   - Excellent
   - Satisfactory
   - Unsatisfactory
   - Poor

3. How helpful was the content presented today?
   - Not at all helpful
   - Not so helpful
   - Somewhat helpful
   - Very helpful
   - Extremely helpful

4. How effective were the trainers today?
   - Not at all effective
   - Not so effective
   - Somewhat effective
   - Very effective
   - Extremely effective

Appendix F. Chart Audit Tool

Record Tracking ID		
Indicator	Data Field	Data (Circle)
Client Characters	County	A B
	Enrolled subprogram	Program A Program B Program C Program D
	Referral reasons for NSP services	Drug/Alcohol or substance use History of Child Protection Service Case IPV Medical Neglect Intellectual/Developmental Disability Mental Health Concerns Discipline Concerns Resources/Financial Concerns Educational Neglect Other ______________________________ Not specified
	Living Situation	Homeless Unstable/housed Stable/housed Unknown
	Monthly Income	$
	Insurance Status	Medicaid Private Insurance Uninsured Unknown
	Mother Education Level	Did not complete High School High School Diploma or GED Some college credit, no degree Trade/technical/vocational training College degree Graduate degree
	Mental Health Status	Current Diagnosis/In care Current Diagnosis/Not in care Past Diagnosis No Diagnosis
IPV Screening	IPV screen done at least once	Yes No
IPV Disclosure	IPV Screening Result	Positive Negative
Danger Assessment Completion (IPV	Danger Assessment done	Yes No

screen positive clients only)		
Danger Assessment Level of Danger	Level of Danger	Variable Danger Increased Danger Severe Danger Extreme Danger
Danger Assessment Action	Interventions Responding to Danger Assessment Findings	Safety Planning Contact appropriate authorities Social Worker Referral to external services
Safety Planning Completion (IPV screen positive clients only)	Safety Planning done	Yes No
Referrals (IPV screen positive clients only)	Referral made for IPV resources	Active Referral Passive Referral Where_______________________________
Resource Utilization (Actively referred clients only)	Resource uptake by client- whether she accessed services	Yes No Unknown (unable to find out) Not Applicable