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Implementing Intimate Partner Violence Screening in the Primary Care Setting

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Implementing Intimate Partner Violence Screening into the Primary Care Setting

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Table of Contents

Abstract	3
Implementing Intimate Partner Violence Screening into the Primary Care Setting	4
Background	4
Problem Statement	5
Organizational “Gap” Analysis of Project Site	5
Review of the Literature	6
Evidence Based Practice: Verification of Chosen Option	12
Theoretical Framework	12
Goals, Objectives, and Expected Outcomes	13
Methods	14
Project Site and Population	14
Instruments	15
Data Collection Procedures	16
Data Analysis	17
Ethical Considerations/Protection of Human Subjects	17
Results	18
Discussion	23
Conclusion	26
References	28
Appendix A Gap Analysis	32
Appendix B Theoretical Framework	33
Appendix C Measurement Instrument	34
Appendix D Cost Benefit Analysis	36
Appendix E Timeframe Table	37
Appendix F Institutional Review Board Approval	38

Abstract

Background. Intimate partner violence is a highly prevalent problem in the United States and leads to serious negative physical and psychological health outcomes, including death. There are screening tools that can detect IPV, yet screening rates in healthcare settings remain low, due to a variety of barriers, including lack of time, confidence, screening policies, and resources.

Purpose. The purpose of this DNP project was to increase IPV screening rates within a primary care clinic. **Methods.** To accomplish the purpose of the project, an education intervention on IPV and available resources was provided to clinicians and staff. This was followed by administration of the Extended-Hurt, Insult, Threaten, Scream (E-HITS) screening tool to women ages 18-55 who presented for an annual physical exam over a 6-week period. Outcomes included documented screening rates, as well as feedback from clinicians and staff on barriers.

Results. 55 eligible women were seen in the primary care clinic and 44 women completed the E-HITS screening, for an 80% screening rate. Three clinicians (n=3, 50%) and four nursing staff members (n=4, 66.67%) responded to the survey and 100% of participants somewhat or strongly agreed that the screening was efficient. 100% of clinicians felt very or extremely confident in responding to IPV. Almost all (n=3, 75%) nursing staff members denied barriers to screening.

Conclusion. IPV is a highly prevalent and can lead to dangerous health outcomes. Primary care clinicians and nursing staff are in a unique position to screen and provide interventions and resources for patients experiencing IPV. Screening can be efficient in the primary care setting, and policies should be in place to help support clinicians and nursing staff members to consistently screen eligible patients.

Keywords: Intimate partner violence, IPV, screening, primary care

Implementing Intimate Partner Violence Screening into the Primary Care Setting

Intimate partner violence (IPV) is defined as sexual, physical, and/or psychological abuse by an intimate partner that 36% of women in the United States experience during their lifetime (United States Preventative Services Task Force [USPSTF], 2018). This highly prevalent problem leads to negative health outcomes and has been found to be accurately detected by screening tools. However, the rates of screening among primary care clinicians remains low.

Background

IPV affects all genders, ages, races, ethnicities, and socioeconomic statuses, however, there are certain factors that place people at increased risk of experiencing IPV (Weil, 2020b). Risk factors for IPV include prior history of IPV, female gender, age under 24, unemployment or low educational background, witnessing IPV as a child, and African American and Alaskan Native race (Weil, 2020b). Relationship factors also can put someone at risk for IPV, including high levels of jealousy or controlling behavior from a male partner (Weil, 2020b). Community factors that increase IPV risk include isolation during the Covid-19 pandemic, gender norms that reinforce notions that women should be submissive to men, and lack of community punishment against those who perpetrate IPV (Weil, 2020b).

Women who experience IPV are at higher risk of poor physical and mental health outcomes. Some negative physical health outcomes that have been associated with IPV include musculoskeletal pain, headaches, gynecologic disorders and genitourinary infections such as sexually transmitted infections or urinary tract infections (Weil, 2020b). Negative mental health outcomes that can result from IPV include post-traumatic stress disorder, eating disorders, sleep disorders, psychosocial challenges, and suicide attempts (Weil, 2020b). IPV can also result in

suicide or homicide (Weil, 2020b). 14% of homicides in 2007 were attributed to IPV (Weil, 2020b).

Healthcare providers are in a unique position to screen for IPV and have been recommended to do so by a variety of professional organizations, including the USPSTF, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics (USPSTF, 2018). There have been screening tools identified that accurately detect IPV in women of a reproductive age (USPSTF, 2018). Although it is known that individuals of all genders and ages experience IPV, there have not been screening tools identified that can accurately detect IPV in groups other than women of a reproductive age, so it has not been recommended to screen these groups (USPSTF, 2018).

Problem Statement

The risk of IPV among women of a reproductive age is indicated by high rates (1 in 3 women in the United States) of psychological, physical, and sexual abuse that can result in a range of negative health outcomes and is in part a result of lack of screening and identification of IPV in healthcare settings where opportunity for intervention exists.

Organizational “Gap” Analysis of Project Site

Gap analyses are important tools to help bridge the gap between evidence and clinical practice, which can help improve safety and quality outcomes in healthcare (Davis-Ajami et al., 2014). Using practice guidelines as the best evidence and comparing that with what is typically being done in a practice setting sets the foundation for the gap analysis (Davis-Ajami et al., 2014) and therefore for the entire capstone project for the DNP student. This gap analysis will present the best practice for IPV screening and compare that with the current practice in an identified primary care setting.

The PRECEDE/PROCEED model was used to conduct the gap analysis. This model ensures engagement with the community where the project is taking place (The University of Kansas [KU], 2008) and leads to an interactive approach, which creates a more sustainable and useful project for the stakeholders. The clinical site for this project was a family practice in Vermont.

Phase 1 of the model was established by discussing needs for improvement in the practice with the office manager. This DNP student relayed the screening recommendations for IPV, and the office manager expressed interest in adopting the practice, and therefore improved IPV screening was identified as a need of the clinic.

Intimate partner violence is only one of two social determinants of health that the USPSTF has published a recommendation in support of screening for it (Krist et al., 2019). In order to improve the socioeconomic health of a population, it is important to screen for social issues such as IPV that negatively impact health outcomes, which established my “epidemiological diagnosis”, or phase 2 of the PRECEDE/PROCEED model (KU, 2018).

There is evidence that screening and early intervention for IPV can help improve the negative health consequences of IPV, which is the foundation for phase 3, “behavioral and environmental diagnosis”, since this evidence-based practice can help reduce the negative health outcomes that victims of IPV face (KU, 2018; USPSTF, 2018). See Appendix A for the detailed gap analysis.

Review of the Literature

The databases PubMed and CINHALL were searched using the MeSH terms “intimate partner violence” OR “IPV” and “primary health care” and “screening”. Filters were applied to limit the results to the last 5 years and written in English. This left 125 publications in PubMed.

The same filters were applied in CINHALL, with the addition of including only results that were peer-reviewed, and published in academic journals, which resulted in 112 results.

All identified sources were reviewed and considered for inclusion if they were an original research study that took place in the United States, or a systematic review, and pertained to screening for IPV (tools, rates, barriers, and/or facilitators). Studies were excluded if they included only pregnant women, or only men, since these are specific populations that are not easily generalizable. Other issues of IPV, such as negative health outcomes, healthcare utilization, IPV perpetration, or prevalence of IPV were also excluded since the problem is focused on improving screening and intervention. Duplicates were removed from the search and the final study count was 13. Each selected study was reviewed, and information was extracted regarding the participants, study purpose, research design, findings, and limitations.

Participants, Purposes, and Designs

Of the 13 studies reviewed, participants in seven studies were from a healthcare facility, including three studies focused on healthcare providers such as physicians, physician assistants, nurses, and nurse practitioners (Bender, 2016; Meredith et al., 2017; Tavrow et al., 2017). Three studies included healthcare providers as well as office managers, or other clinic personnel (Alvarez et al., 2018; Iverson et al., 2019; Williams et al., 2016). The final study was a mixed methods design including healthcare providers and clinic personnel, as well as chart reviews (Clark et al., 2020).

There were several different types of study designs used. Five studies were cross-sectional, three studies were qualitative, two studies were retrospective chart reviews, two studies were systematic reviews, and one study used a mixed method design. All of these studies had the aim of determining current screening practices, with additional information also being

sought out, such as if provider demographics (Tavrow et al., 2017) or beliefs and self-efficacy predicted screening rates (Meredith et al., 2017), the comprehensiveness of screening programs (Williams et al., 2016), how providers respond to IPV disclosure and their views on the use of an online safety app (Alvarez et al., 2018), barriers and opportunities for screening (Iverson et al., 2019), and the use of the Consolidated Framework for Implementation Research to identify barriers and opportunities for screening (Bender, 2016; Clark et al., 2020).

Two studies included patients as participants, with one of those studies evaluating the benefit and safety of women's participation in an 18-month IPV screening and intervention program (Hamberger et al., 2020) and the other being a correlational study to determine accuracy of IPV screening and demographics of women who have experienced IPV (Latta et al., 2016). One of the retrospective chart reviews was intended to determine if secondary screening was taking place for patients who previously screened positive (Iverson et al., 2018), and the other aimed to determine current screening rates and compare screening rates among physicians and medical assistants (Sharpless et al., 2018). One of the systematic reviews focused on studies on screening among healthcare providers (Alvarez et al., 2017) and the other reviewed available IPV screening tools (Arkins et al., 2016).

Screening Rates and Types

Variable IPV screening rates were noted from the literature. Two studies found similar screening rates; one found that 59.5% of providers had screened patients for IPV once or more over the last year (Meredith et al., 2017), and another found that 49% performed routine screening (Bender, 2016). In contrast, the researchers in one study found that all participants reported some type of IPV screening (Alvarez et al., 2018). However, this study used only 17 healthcare providers and did not use standardized or consistent screening (Alvarez et al., 2018).

One study found that only 35% of patients had been screened over the last five months (Clark et al., 2020), and this came from a chart review which provides a more objective finding.

Researchers in another study reported only 14% of participants “always” screened (Tavrow et al., 2017). One group of researchers found that the screening rate varied from 0-77% among clinics in the same network with the same policies (Sharpless et al., 2018). Findings from one systematic review supports these variable rates, as they reported a routine screening rate of 2-50%, however rates of selective screening (such as when a patient presents with an injury) were higher at 45-85% (Alvarez et al., 2017).

In one study in which office managers made up the majority of the participants, 78.1% reported policies and procedures for IPV screening and response exist, and 75.5% of those participants reported routine screening over the last 6 months (Williams et al., 2016). In contrast, another study reported that 69% of participants reported no screening protocol in place or no knowledge of one in place at their facility (Clark et al., 2020). It is important to note that in the Williams et al (2016) study, the majority of participants were office managers, compared with the Clark et al (2020) study, in which physicians and nurses were the participants and a lower rate of knowledge of screening protocols was reported.

Some researchers found that the type of screener influenced the screening rate. For example, studies found that nurses or medical assistants had higher rates of screening compared with physicians (Alvarez et al., 2017; Sharpless et al., 2018). Interestingly, one study reported that osteopathic physicians were more likely than physicians, nurses, or nurse practitioners to screen for IPV (Bender, 2016). One group of researchers found no difference in screening rates based on provider type, but they did find that females were more likely than men to screen

(Tavrow et al., 2017). Contrary to this finding, two studies found male providers to be more likely than female providers to screen (Bender, 2016; Sharpless et al., 2018).

Screening Tools

In regard to screening tools, the systematic review of screening tools identified three tools that had been referenced against a standard and had strong psychometric properties (Arkins et al., 2016). The Women Abuse Screen Tool (WAST) was the most validated tool and had strong specificity, but there was a range in its sensitivity (Arkins et al., 2016). The Humiliation, Afraid, Rape, Kick (HARK) tool had the strongest properties, but had been the least tested (Arkins et al., 2016). The Abuse Assessment Screen (AAS) had strong specificity, but weak sensitivity (Arkins et al., 2016).

Self-report of IPV was higher (47% of participants) than positive IPV screens from the Hurt, Insulted, Threatened, or Screamed at (HITS) questionnaire (33%), and the authors attributed this to the narrow definition of IPV that the HITS questionnaire refers to (Latta et al., 2016). However, a higher score overall on the Extended-HITS (E-HITS) questionnaire was found to infer more severe IPV experiences (Iverson et al., 2018).

One systematic review of healthcare providers reported that indirect screening was more likely to occur than the use of a standardized tool (Alvarez et al., 2017). In another study, only 6.5% of participants who had an identified screening protocol were able to identify a screening tool used (Williams et al., 2016). In regard to secondary screening following a positive screen, only three of 11 medical centers had secondary screening and only 56.4% of women who initially screened positive received a secondary screening at these sites (Iverson et al., 2018).

Factors Associated with Screening

There seems to be a relationship between a provider's confidence, knowledge, or self-efficacy in screening and responding to IPV, and their likelihood of screening. Higher levels of confidence and self-efficacy were associated with higher levels of screening (Alvarez et al., 2017; Meredith et al., 2017; Tavrow et al., 2017), and in the study with high screening rates, most providers also felt "fairly well prepared" to screen for IPV (Alvarez et al., 2018). Similarly, the more training a provider had in IPV, the more likely they were to screen for IPV (Alvarez et al., 2018; Bender et al., 2016; Iverson et al., 2019), and this was recognized as a facilitator for implementing IPV into practice in one study (Alvarez et al., 2017).

Barriers to Screening

Six studies addressed barriers to implementing IPV screening and adequate response, and they all included lack of referral options or patient resources as a barrier to screening (Alvarez et al., 2017; Alvarez et al., 2018; Bender, 2016; Clark et al., 2020; Iverson et al., 2019; Tavrow et al., 2017). This was echoed in the study of patients undergoing an IPV survivor program, in which several women reported wishing that they had been connected with more resources and supports (Hamberger et al., 2020). Lack of policies or procedures for IPV screening and response to positive screens were seen as barriers to screening (Alvarez et al., 2017; Iverson et al., 2019). Lack of IPV screening and intervention policies and procedures also was associated with providers feeling inadequately prepared to respond to a positive screen (Alvarez et al., 2018), and negatively influenced screening rates (Bender, 2016; Clark et al., 2020).

An additional barrier identified was the provider's discomfort when discussing IPV with patients, or fear of offending the patient (Alvarez et al., 2017; Iverson et al., 2019; Meredith et al., 2017). Interestingly, the two studies that focused on female patients as participants found that they appreciated being asked about IPV and having the opportunity to discuss it (Hamberger et

al., 2020; Latta et al., 2016). Furthermore, lack of time was also identified as a barrier to screening (Alvarez et al., 2017; Alvarez et al., 2018; Clark et al., 2020; Iverson et al., 2019).

Response to Positive IPV Screen

There are many approaches that can be taken in response to disclosure of IPV and the literature shows that a variety of methods are used. Unfortunately, some positive IPV screenings are not addressed at all (Alvarez et al., 2017). The main option discussed for responding to IPV included referring to social support services (Alvarez et al., 2017; Alvarez et al., 2018; Iverson et al., 2018; Latta et al., 2016; Tavrow et al., 2017). In one systematic review, authors discussed other approaches may consist of empathetic listening, only addressing physical injuries, or recommending that the patient leave the abusive partner (Alvarez et al., 2017).

Evidence Based Practice: Verification of Chosen Option

Screening rates for IPV are variable, but most studies documented a screening rate of less than 50%, which is suboptimal given IPV screening is recommended for all women of a childbearing age (USPSTF, 2018). This review supports the need for implementing standardized IPV screening in healthcare settings.

Theoretical Framework

Lippit's Seven-Step Change Theory was used as the theoretical framework for implementing IPV screening into the primary care setting. Lippit's theory has been used to implement new policies into practice. It has been compared to the nursing process, which makes it particularly an appropriate choice for the DNP project (Appendix B). Lippit posits that change can fail if not carefully planned (Mitchell, 2013), and implementing a new screening and intervention policy into a busy primary care clinic was a challenge. Phases one through three require the problem to be identified and an assessment of the motivation and resources for

change (Mitchell, 2013). Phases four and five determine the change objective and the role of the change agent (Mitchell, 2013). Phases six and seven maintain the change and end the change agent's role (Mitchell, 2013).

In this DNP project, phases one and two were accomplished in the gap analysis. Phase three identifies the change agent, which is the DNP student collaborating with key members of the primary care clinic. The motivation for change was identified as commitment to quality improvement initiatives in the primary care clinic and to provide evidence-based care. The objective of the change (phase four) was established as the purpose of the project, to increase IPV screening in the primary care practice. The role of the change agents in the project, particularly of the DNP student, was communicated to clinicians and staff. Maintaining the standardized screening at the completion of the DNP project, phases six and seven, was encouraged through a clinician and staff feedback survey after project implementation.

Goals, Objectives, and Expected Outcomes

The overall purpose/goal of this DNP project was to increase IPV screening in the primary care setting. Two objectives focused the project and led to measurable outcomes, which is outlined in Table 1.

Table 1

Goals, objectives, and outcomes

Goal	Objective	Outcome
<i>-To increase IPV screening in the primary care setting.</i>	<i>-The DNP student worked with other members of the primary care clinic to implement an IPV screening policy. -Women ages 18-55 completed the E-HITS screening during annual physical exams.</i>	<i>-90% of eligible patients (women ages 18-55 at annual physical exams) completed the E-HITS screening. -80% of clinicians and staff agreed that the screening was efficient and that they would</i>

		<i>like to see the practice continue the screening.</i> <i>-80% of nursing staff reported that there were not any barriers to administering the screening.</i>
<i>-To equip the primary care clinic with resources to provide interventions for positive screens.</i>	<i>-The DNP student organized an educational session regarding IPV prevalence and resources.</i> <i>-The DNP student supplied the exam rooms with domestic violence hotline information</i>	<i>-80% of clinicians reported that they feel very or extremely confident in providing resources and responding to patients who may disclose IPV.</i>

Methods

To accomplish the purpose of this project, an educational intervention was provided to clinicians and staff regarding IPV and available resources. A screening and intervention policy was also implemented. Measured outcomes include clinician and staff self-report of efficiency of screening and confidence in providing resources to patients. Outcomes also include screening rates over a 6-week period and documented interventions provided for positive screens. A cost-benefit analysis was completed as it described in Appendix D.

Project Site and Population

This project took place at a family practice clinic in Vermont. The clinic is a physician owned, independent practice with six primary care clinicians and serves patients who live in several counties in Vermont. The practice is a certified patient centered medical home (PCMH), which is designated by the National Committee for Quality Assurance (NCQA). The clinicians serve patients of all ages, providing preventative care through the lifespan, acute care as needs arise, and management of chronic conditions.

The project participants were both clinicians and staff, as well as a subset of the patient population. The staff participants were six primary care clinicians (three family medicine physicians and three family nurse practitioners) as well as nursing staff members; four registered nurses (one of which is the nurse manager), and two medical assistants.

The target patients for screening were women between ages 18-55 who attended the clinic for an annual physical exam. This age range is consistent with previous studies of IPV screening that have been completed in these age ranges (USPSTF, 2018). Women of all races, ethnicities, and sexual orientation were included.

Instruments

To measure the outcomes of this DNP Project, the following instruments were used (Appendix C):

- A 5 question IPV screening tool with a 5-point Likert scale, known as the E-HITS tool, was used to detect IPV among women. The questions in the E-HITS covers physical, verbal, emotional, and sexual violence and has been found to have a sensitivity of 75% and a specificity of 82% (USPSTF, 2018).
- A 4-question survey for clinicians and nursing staff members to complete to evaluate for barriers to screening, confidence in responding to positive screens, screening efficiency, and desire to continue the screening.
- Electronic health record (EHR) report to determine a.) number of E-HITS tools administered per the number of eligible women seen in the clinic between January 31st and March 11th, 2022, b.) demographic data, including age and race, and c.) number of positive E-HITS screens.

Data Collection Procedures

The key members of the project team were the DNP student, the nurse manager, the office manager, and one staff physician, who is also one of the practice owners. The DNP student led the team in discussing the implementation of the screening into the primary care clinic's workflow by identifying and selecting an IPV screening tool and discussing available resources for patients who are identified as experiencing IPV. Next, the DNP student arranged 2 educational sessions with the local domestic violence organization which focused on education regarding IPV and intervening when IPV is identified and resources available for patients.

Following the educational sessions, the administration of IPV screening occurred over a 6-week period. The registered nurses (RNs) and medical assistants (MAs) distributed the E-HITS screening tool to eligible women who came in for an annual physical exam. RNs and MAs were instructed to ask that patients be seen alone for the visit if they were accompanied by a partner and advised to not screen the patient if they are not alone for the visit. The patients completed the screening tool while in the exam room with the RN or MA, and the RN or MA indicated in the note whether it was a positive or negative screen using an EHR function that is trackable and reportable. Any positive screen prompted the RN or MA to verbally inform the clinician, so they were able to discuss the situation with the patient and provide appropriate interventions based on that discussion. The DNP student was available throughout the intervention timeframe for any questions.

Following the 6-week screening period, an electronic anonymous survey was administered to clinicians and nursing staff members via Google Forms to evaluate for perceived efficiency of screening and confidence in providing IPV resources to patients, as well as to

evaluate for any identified barriers to screening, and overall desire to continue using the screening.

The DNP student performed an EHR report to determine the screening rate, which could be used to determine if there were associations between overall efficiency of screening, confidence in providing resources, barriers to screening, and rates of screening. The EHR report was also used to determine the number of positive screens.

Data Analysis

Descriptive statistics (mean, standard deviation, frequency, and percentage) were used to describe the demographics (age and race) of the patients who were seen in the clinic during this 6- week period, which was gathered during the EHR report. Descriptive statistics (frequency and percentage) was also used to determine the number of screens that were completed by the entire eligible population. The clinician and staff survey responses regarding efficiency of screening, confidence in providing resources, and barriers to screening were also analyzed using descriptive statistics (frequency and percentage).

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project (Appendix F). IPV is a sensitive topic, and screening for IPV could be upsetting for a patient. Therefore, the screening questions were prefaced by a paragraph regarding the importance of IPV in health outcomes but how the screening is optional and may be declined. The benefits of screening include increased detection of IPV and opportunity to provide interventions and no adverse effects from screening have been identified (USPSTF, 2018). The risk to patients who participated in this project is no different

from the risks of patients receiving standard primary care since routine IPV screening is recommended by many professional organizations (USPSTF, 2018).

All participant's health information was protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). This includes identifiable information such as name, date of birth, insurance information, as well as diagnoses (including a victim of partner violence). Additionally, the DNP student and practice staff involved in this project followed the Standards of Care for screening and intervening for IPV within the primary care setting. No identifying information was collected on patient or clinician and staff participants. All data collected was confidential. This was made possible using the secure, password protected EHR to report on patient demographics and number of screenings completed, as well as the use of Google Forms for clinicians and staff to anonymously respond to the survey questions.

Results

The educational component of this project took place over a 2-week period for clinicians and staff of a primary care clinic. This included 3 physicians, 3 nurse practitioners, 4 RNs, and 2 MAs. The screening component of this project took place over a 6-week period and included female patients ages 18-55 who came into the clinic for an annual physical exam. Following the 6-week screening, the 6 clinicians and 6 nursing staff members completed a feedback survey via an anonymous Google Form to respond to the efficiency of screening, barriers to screening, confidence in responding to positive screens, and desire to see the practice continue using the screening tool.

Table 2 describes the demographics, specifically age range and race, of the total population of women ages 18-55 who came into the clinic for an annual physical exam from

1/31/22-3/11/22. Most patients (n=30, 54.5%) seen during this time were in the 40-55 age range. The mean age of the sample was 40.17 years old (SD 6.36). Almost all patients (n=53, 96.4%) were white (see Table 2).

Table 2

Patient Characteristics

Demographic	Number	%
<i>Age</i>		
18-30	10	18.2
31-40	15	27.3
40-55	30	54.5
Total	55	100
<i>Race</i>		
American Indian/Alaska Native	0	0
Asian	2	3.6
Black or African American	0	0
Hispanic or Latino	0	0
Native Hawaiian/Pacific Islander	0	0
White	53	96.5
Total	55	100

During this timeframe, 55 eligible patients were seen in the office, and 44 of these patients completed the screening tool, for a screening rate of 80% (see Table 2). Out of the 44

screening tools completed, there were 2 positive screens, for a positivity rate of 0.5%. These results are depicted in Table 4.

Table 3

Number of Eligible Patients Screened

Screening completed	Number	%
Yes	44	80
No	11	20
Total	55	100

Table 4

Screening Results

Result	Number	%
Positive	2	0.5
Negative	42	95.5
Total	44	100

Only three clinicians (n=3, 50%) and four nursing staff members (n=4, 66.67%) responded to the feedback survey. Clinicians and nursing staff members were asked about the efficiency of screening and whether they'd like the practice to continue using the screening. Almost all participants (n=6, 85.71%) strongly agreed that the screening was efficient, and that time was not a significant barrier to the screening, with one participant (n=1, 14.29%) that somewhat agreed. Almost all participants (n=6, 85.71%) responded "yes" to wanting to see the practice continue the screening, with one participant (n=1, 14.29%) reporting they liked the

screening but would need a system so it is administered consistently. This data is reflected in Table 5.

Table 5

Clinician and Staff Feedback on Efficiency and Continuing Screening

Survey Question	Number	%
<i>Screening is efficient</i>		
Strongly disagree	0	0
Somewhat disagree	0	0
Neither agree nor disagree	0	0
Somewhat agree	1	14.29
Strongly agree	6	85.71
Total	7	100
<i>Desire for the practice to continue the screening</i>		
Yes	6	85.71
No	0	0
Uncertain at this time	0	0
Other	1	14.29
	“I like it but would need to have a system so that it is delivered consistently”	
Total	7	100

Additionally, nursing staff members were asked about specific barriers to administering the screening, including time, discomfort with administering the screening tool, patient refusal, and difficulty remembering to administer the screening. Most of the nursing staff (n=3, 75%)

reported there were no barriers to screening, with one participant (n=1, 25%) reporting it was difficult to remember to administer the screening tool as a barrier to screening. These results are reflected in Table 6.

Table 6

Barriers to Screening Identified by Nursing Staff

Barrier Identified	Number	%
Time	0	0
Difficult to remember to administer screening	1	25
Patient refusals	0	0
Discomfort with administering screening	0	0
No barriers	3	75
Total	4	100

Clinicians were asked about their overall confidence in providing resources and responding to someone who discloses IPV, which is reflected in Table 7. Most clinicians felt very confident (n=2, 66.67%) and 1 clinician (n=1, 33.33%) felt extremely confident in responding to disclosed IPV and providing resources to patients.

Table 6

Clinician Confidence in Providing Interventions and Resources

Confidence Level	Number	%
Not at all confident	0	0
Somewhat confident	0	0
Moderately confident	0	0

Very confident	2	66.67
Extremely confident	1	33.33
Total	3	100

Discussion

Result Summary and Interpretation

More than half (54.5%) of patient participants were in the 40-55 age group, which is consistent with the notion that Vermont has an aging population. However, data from 2019 Vermont Department of Health population studies showed that within the ages that were included in the DNP study (ages 18-55), women ages 20-24 made up more of the population, followed by women ages 50-54 (Vermont Department of Health, 2020). This may indicate this clinic either has less women in the younger age category or patients in this age range may be less likely to come in for annual physical exams. It could also be because of an overall small sample size in the project (n=55). Almost all (96.4%) of patients were white, however, this finding is consistent with the demographics of Vermont with 94.2% of Vermonters identifying as white (United States Census Bureau, 2021).

The key finding from this study is that 80% of eligible patients were screened for IPV during the implementation period. This screening rate greatly exceeds the typical rate for IPV screening in healthcare settings identified in the literature. One study which had a similar method to this study of determining IPV screening rates by chart review found only 36% of patients were screened for IPV (Clark et al., 2020).

Another key finding in the feedback survey was the limited number of barriers that were identified to screening, the desire to continue the screening in practice, the efficiency of screening, and the clinician confidence in responding to disclosed IPV. These factors likely led

to the high screening rate. The only barrier identified by a nursing staff member (n=1, 14.29%) was difficulty remembering to screen. Almost all clinician and staff participants (n=6, 85.71%) reported they wanted to see the practice continue the screening, which exceeded the 80% goal. One participant (n=1, 14.29%) reported they like the screening but would need a system so it is done consistently, which also speaks to the difficulty of remembering to screen.

All clinicians and staff (n=7, 100%) somewhat or strongly agreed the tool was efficient, which exceeded the goal of 80%. Additionally, all clinicians who responded to the survey (n=3, 100%) reported they felt very or extremely confident in providing adequate resources and interventions for patients who disclose IPV, which also exceeded the 80% goal. Lack of time and lack of confidence are common barriers referenced to in the literature and were likely avoided due to the planning done by the DNP student to ensure that the screening tool selected was quick and efficient and clinicians and staff were properly educated on IPV and resources available for patients who disclose IPV. These higher levels of confidence likely led to the relatively high screening rate achieved of 80%, considering the consistent literature findings that higher levels of clinician confidence are associated with higher levels of IPV screening (Alvarez et al., 2017).

Although the main outcome was not the positivity rate of the screenings, it seems that a positivity rate of 0.5% is lower than expected, since 33% of women in the U.S. experience IPV at some point during their life (USPSTF, 2018). However, this screening tool asks specifically about the last 12 months, not over the entire lifetime. Also, the positivity rate could be lower than expected due to a small sample size of only 44 patients screened and because the screening was only administered to women ages 18-55. Additionally, it can take women up to eight screenings before they will disclose IPV, so a longer screening period may show a higher positivity rate.

Response to Research Question

The DNP student sought to determine if clinician and staff education, as well as implementing a standardized screening tool, increased IPV screening rates in the primary care clinic to 90%. Prior to this project, screening for IPV in this primary care practice was inconsistent and unstandardized, which is similar to other healthcare settings per literature findings. Following the implementation of this project, clinician, and staff education, as well as the introduction of a standardized screening tool led to an 80% screening rate. Although the goal screening rate was not met, the intervention was successful in increasing screening and exceeded literature findings, which was the overarching research question.

Setting Facilitators and Barriers

This family practice clinic provides evidence-based, comprehensive care to their patients across the lifespan and are a designated PCMH, which requires active involvement in quality improvement initiatives. Having a team already involved in quality improvement initiatives was helpful in facilitating the implementation of this project.

There were several barriers identified throughout the project planning and implementation. There was a long delay in the educational presentation for clinicians and staff, which was due to staffing shortages within the local domestic violence organization which is likely attributable to the Covid-19 pandemic. This led to a shorter implementation period, which may have contributed to a limitation of the study in terms of data collection and analysis. The only identified barrier of difficulty remembering to administer the screening could be addressed by implementing chart alerts to notify the nursing staff member of patients who are eligible for screening and coming in for an appointment that day.

Limitations and Future Recommendations

Several study limitations have been identified. The 6-week implementation period was shorter than the desired 3-month implementation period due to educational delays likely related to the Covid-19 pandemic. This led to a smaller and non-diverse patient sample, which decreases the generalizability of results. If the implementation period was extended over a longer period, that would have increased the sample size and potentially the diversity of the sample.

Limitations of the study also include study design. Working within a small primary care practice with only 6 primary care clinicians and 6 nursing staff members limited the strength of methods that could be used. For example, no comparison group was able to be used to draw stronger conclusions regarding the use of education and standardized screening in increasing rates of IPV screening. A pre-test and post-test confidence survey completed by clinicians may have been helpful in determining the influence of the educational session on clinician confidence. Additionally, there was limited feedback and participation in the survey at the end of the implementation period. The DNP student used Google Forms to have participants anonymously fill out the survey, however, a different anonymous format, perhaps using a paper form, or reminding participants in person, may have led to an increased sample size. Having just half of participants respond, 6 clinicians and nursing staff members rather than 12, limited the conclusions that were able to be drawn.

Conclusion

IPV is a highly prevalent problem in the U.S. and leads to a variety of negative health outcomes. There are screening tools available that accurately detect IPV in women of a reproductive age, and healthcare providers are recommended by a variety of professional organizations to implement screening into practice. Despite this recommendation, screening in the healthcare setting remains low for a variety of reasons, including lack of provider training or

confidence, lack of time, lack of screening policies, and inadequate resources available to respond to positive screens.

In this project, the DNP student addressed the problem of lack of IPV screening in a primary care clinic by providing clinician and staff education on IPV and available resources for patients, as well as implementing a standardized screening tool for women ages 18-55 at annual physical exams over a 6-week period. Overall, this was an effective strategy to improve IPV screening in the primary care setting and led to a screening rate of 80%, which greatly exceeds typical screening rates found in the literature. Clinicians and nursing staff felt the screening tool was efficient and that time was not a barrier to screening. Clinicians also reported feeling very or extremely confident in responding to disclosed IPV and only 1 barrier to screening was identified by a nursing staff member. This positive feedback likely contributed to the high screening rate.

Future efforts to support IPV screening should include workflow practices to remind the responsible screeners of when the screening is due and to continue efforts to keep clinicians informed on resources for patients who experience IPV. This two-part intervention was designed with the recommendations in mind from professional organizations to provide IPV screening in the healthcare setting, as well as with the literature findings in mind to help reduce the barriers to screening to provide women with a screening that could lead to life saving interventions.

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Appendix A

Gap Analysis

Best Practice Solutions	Best Practice Strategies	Differences Between Clinical Site and Best Practices	Barriers/Facilitators to Best Practices
IPV screening for women of a reproductive age	Implement a verified tool for IPV screening for women of a reproductive age into a primary care practice	Unstandardized, general safety screening is conducted for most patients at wellness visits, but this doesn't specifically address IPV and therefore is likely ineffective	<p><i>Barriers:</i></p> <ul style="list-style-type: none"> -Time constraints for patients to complete screening -Lack of comfort/confidence among staff for providing the screening -Patients may decline filling out more forms <p><i>Facilitators:</i></p> <ul style="list-style-type: none"> -Using a brief screening tool -Staff education on IPV and available resources
Providing appropriate resources for ongoing support for positive IPV screens	Develop a standardized plan for intervention for positive screens	Unstandardized interventions take place that are largely based on each clinicians' individual preference and time	<p><i>Barriers:</i></p> <ul style="list-style-type: none"> -Clinicians may not have enough time or resources to appropriately respond to IPV screens <p><i>Facilitators:</i></p> <ul style="list-style-type: none"> -Resources provided from domestic violence organization, including hotline number, will help to quickly access supports needed

Appendix B

Ronald Lippitt's Seven-Step Change Theory

Box 2 Lippitt's theory compared with the nursing process	
Nursing process elements	Lippitt's theory
Assessment*	<i>Phase 1. Diagnose the problem</i>
	<i>Phase 2. Assess motivation/capacity for change</i>
	<i>Phase 3. Assess change agent's motivation and resources</i>
Planning†	<i>Phase 4. Select progressive change objective</i>
	<i>Phase 5. Choose appropriate role of the change agent</i>
Implementation‡	<i>Phase 6. Maintain change</i>
Evaluation‡	<i>Phase 7. Terminate the helping relationship</i>
Key:	* Assessment = Lewin's unfreezing stage † Planning/implementation = Lewin's moving stage ‡ Implementation/evaluation = Lewin's refreezing stage
(Lewin 1951, Lippitt et al 1958, Pearson et al 2005)	

(Mitchell, 2013)

Appendix C

Measurement Instruments

- Clinician and staff survey

Intimate Partner Violence Screening Survey

This anonymous survey is to determine any barriers to screening and to gather general feedback on the project. Thanks!

* Required

1. This screening tool can be administered efficiently and time is not a significant barrier to the screening. *

Mark only one oval.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

2. For nursing staff members, what did you find to be a barrier to screening? (select all that apply)

Check all that apply.

- Time
- Difficult to remember to administer screening
- Patient refusals
- Discomfort with administering screening
- No barriers

Other: _____

3. For clinicians, how confident do you feel in providing adequate interventions and resources to a patient who may disclose partner violence?

Mark only one oval.

- Not at all confident
- Somewhat confident
- Moderately confident
- Very confident
- Extremely confident

4. Would you like to see the practice continue intimate partner violence screening with this screening tool? *

Mark only one oval.

- Yes
- No
- Uncertain at this time
- Other: _____

5. Please share any additional feedback about what has worked well or needs improvement for this project.

- Extended Hurt Insult Threaten Scream (E-HITS)

Over the last 12 months, how often did your partner:

1. Physically hurt you?
2. Insult you or talk down to you?
3. Threaten you with harm?
4. Scream or curse at you?
5. Force you to have sexual activities?

Each item is answered on a 5-point Likert scale:

- 1=never
- 2=rarely
- 3=sometimes
- 4=fairly often
- 5=frequently

Score range: 5–25. Cutoff for IPV: ≥ 7

(Iverson et al., 2018)

Appendix D

Cost-Benefit Analysis

Costs	Benefits
<p>1 hour of paid time for clinicians and staff to review IPV presentation 2 medical assistants at approximately \$25/hour=\$50 4 registered nurses at approximately \$35/hour=\$140 3 nurse practitioners at approximately \$55/hour=\$165 3 physicians at approximately \$80/hour=\$240 Total=\$595</p>	<p>Clinicians will likely be able to bill for the IPV screening and any subsequent interventions if it includes counseling/safety planning and this is required to be covered by commercial insurance companies. Although the DNP student is not able to quantify this currently, it is an expected benefit and expected to offset the costs of training</p>

Appendix E

Timeframe Table

Task	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022
Educational presentations			x			
Meeting with key team members to discuss implementation of the screening policy into the workflow	x	x				
Distribute evaluation surveys and analyze data					x	
Implement IPV screening (E-HITS) for women ages 18-55 age at annual physical exams and new patient visits and standardized interventions for positive screens				x	x	
Gather data regarding screening rates					x	
Share information with clinicians and staff and discuss long-term adoption of the policy into practice						x

Appendix F

Institutional Review Board Approval

UMassAmherst

Human Research Protection Office

Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035
Telephone: 413-545-3428

Memorandum – Not Human Subjects Research Determination

Date: August 6, 2021

To: Deirdre Howard, Nursing

Project Title: *Implementing intimate partner violence (IPV) screening into the primary care setting.*

HRPO Determination Number: 21-145

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:

- The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(f)].
- The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f)(1), (2)].
- The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes. **Researchers should NOT include contact information for the UMass Amherst IRB on any project materials.**

A project determined as “Not Human Subjects Research,” must still be conducted ethically. The UMass Amherst HRPO strongly expects project personnel to:

- treat participants with respect at all times
- ensure project participation is voluntary and confidentiality is maintained (when applicable)
- minimize any risks associated with participation in the project
- conduct the project in compliance with all applicable federal, state, and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.



Iris L. Jenkins, Assistant Director
Human Research Protection Office