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Evaluation of Intimate Partner Violence Screening in a Metropolitan Public Health Department

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Abstract

Routine intimate partner violence (IPV) screening has been recommended for all health care settings to prevent subsequent short and long term health consequences of survivors. However, provider adherence remains low. The purpose of this quality improvement project is to evaluate current screening practices, identify the needs of, and provide resources to three family planning clinics within a metropolitan public health department. The project utilized Donabedian's Structure, Process, and Outcomes Model to map current protocols within three family planning clinics to identify current practices. A chart review including 105 patient charts was done to identify documentation of IPV screening/discussion as well as referrals following a positive victim response. A focus group composed of three clinic managers and seven individual interviews with clinical staff members were conducted to identify key themes and any barriers to screening. The mapping of practices revealed the overall clinic flow, resources within the clinics, and questions regarding IPV asked. The chart review revealed 47% patients were not asked about IPV and no information regarding subsequent referrals was provided. Five key themes were identified for both the focus group and the individual interviews. The focus group revealed only patient disclosure barriers, while the individual interviews revealed institutional and personal provider barriers, in addition to patient disclosure barriers. Following the individual interviews and focus group an educational session was conducted, resources were provided, and a post-intervention survey was distributed to assess readiness to screen. The post-intervention survey from the managers revealed more psychiatric support resources could be provided to enhance readiness. The clinical staff members had sufficient scores to consider them ready to screen. Overall the study found that additional interventions are needed to ensure providers are prepared to screen and appropriately refer survivors.

Evaluation of Intimate Partner Violence Screening in a Metropolitan Public Health Department

Approximately 23 million women and 1.7 million men will experience intimate partner violence (IPV) in their lifetime (Centers for Disease Control and Prevention [CDC], 2017). To address this alarming incidence of IPV, the Department of Health and Human Services has responded by guaranteeing access to preventive services, including IPV screening, under the Affordable Care Act (Ramachandran et al., 2013). Routine screening for IPV is now recommended by the American Medical Association, the American Nurses Association, the CDC, and many more (DeBoer et al., 2013; Sormanti & Smith, 2009; Thackeray, Stelzner, Downs, & Miller, 2007). Despite national recommendations for routine intimate partner violence screening, provider adherence remains low. Studies assessing emergency departments reported that only 13% of patients were asked about IPV (Waalén et al., 2000). Additionally, studies found that only 10 to 39% of patients were screened for IPV at women's health visits (Renker, 2008). Consequently, intimate partner violence is often underreported, unidentified, and improperly managed by health care providers.

Problem Statement

The state of Tennessee's Incident Based Reporting System found that approximately 78,000 cases of IPV were reported in 2016 (Tennessee Bureau of Investigation Criminal Justice Information Services Support System, 2016). This 0.4 % increase from 2015 supports that fact that IPV is a growing societal problem (Tennessee Bureau of Investigation Criminal Justice Information Services Support System, 2016). Intimate partner violence has been linked to both physical and emotional health consequences. These various consequences can negatively impact a patient's health status if not identified and appropriately managed. The initiation of routine IPV screening methods in primary care is an opportunity that providers have to identify and

subsequently refer victims to the services they need; however, screening rates remain unsatisfactory. Studies within primary care assessing provider adherence to IPV screening indicate that only 1.5 to 12% of patients were asked about abuse (Waalén, Goodwin, Spitz, Petersen, & Saltzman, 2000; Sutherland, Fantasia, & Hutchinson, 2016). The Tennessee Bureau of Investigation has acknowledged the rising rate of IPV, the lack of routine screening, and the negative health consequences that abuse is associated with. They as an organization have stated that they are committed to increasing all efforts that provide prevention training, intervention services, and counseling to victims (Tennessee Bureau of Investigation Criminal Justice Information Services Support System, 2016). The hope is that by increasing these efforts they will bring awareness to the statewide prevalence of IPV and ensure that local communities remain safe.

Purpose/Objective

The purpose of this quality improvement project was to evaluate current screening practices, identify the needs of, and provide resources to three family planning clinics within a metropolitan public health department in the southeastern United States. The project leader mapped the current practices and protocols based on Donabedian's Structure, Process, and Outcomes Model so that barriers to routine screening could be identified, and resources could be delivered based on the identified needs of the organization. The aims of this project was to address current gaps in care, add to the current body of knowledge, and to ultimately shape clinical practice so that quality services can be delivered to previous and current victims of IPV.

Review of Evidence

The CDC (2016) defines intimate partner violence as physical, sexual, or psychological abuse by a current or past partner or spouse. Approximately 5.3 million women, ages 18 and

older, experience IPV each year (Houry et al., 2016). Amongst identified victims, 40% have experienced physical abuse and 90% of victims have experienced psychological abuse (Nathanson, Shorey, Tirone, & Rhatigan, 2012). Additionally, IPV is the second leading cause of death in the United States among women of childbearing age (DeBoer, Kothari, Kothari, Koestner, & Rhos Jr., 2013). The lifetime prevalence and incidence of intimate partner violence is undoubtedly a public health concern.

Victims of IPV undergo significant physical and emotional sequelae. These sequelae include acute and chronic health consequences such as anxiety, depression, alcoholism, substance abuse, suicidal ideation, chronic pain, and sexually transmitted infections (DeBoer et al., 2013; Ramachandran, Covarrubias, Watson, & Decker, 2013; Renker, 2008). Studies show that an average of 18.5% of IPV victims abuse alcohol and 8.9% abuse drugs (Weaver, Gilbert, El-Bassel, Resnick, & Noursi, 2015). IPV results in nearly 2 million physical injuries and nearly 1300 cases result in deaths (Houry et al., 2016; Hamberger, Rhodes, & Brown, 2015).

These acute and chronic health consequences can be reduced with routine screening of IPV and appropriate subsequent referrals to resources in the community. Healthcare providers who fail to screen for IPV miss a vital opportunity to positively impact the physical and psychological well-being of survivors, thus the opportunity to improve victims' overall quality of life. As a health care professional, it is our responsibility to conduct routine screening of IPV to appropriately identify and manage these irreparable adverse health sequelae that are associated with abuse. Intimate partner violence and the subsequent associated health consequences remain a global health concern; however, addressing screening barriers and creating solutions to increase provider adherence can aid in the deliverance of quality services to IPV survivors in need.

Provider Barriers

Institutional provider barriers. Throughout the review of literature three key themes emerged that contributed to decreased rates of routine screening. The first theme addressed institutional provider barriers. The primary institutional barrier identified that prevented providers from routinely screening was due to time constraints (Baig, Ryan, & Rodriguez, 2012; Colarossi, Breitbart, & Betancourt, 2010; Furniss, McCaffrey, Parnell, & Rovi, 2007; Kirst et al., 2012; Renker, 2008; Waalen et al., 2000). Additionally, providers believed the primary responsibility of routine screening was best suited to social workers or nurses. Providers felt that other disciplines had a greater amount of privacy and time to build rapport, and therefore the providers did not routinely screen (Baig et al., 2012; DeBoer et al., 2013; Ramachandran et al., 2013; Sormanti & Smith, 2009). The lack of training, available personnel, and resources prevented providers from routinely screening were also identified institutional provider barriers (Baig et al., 2012; Furniss et al., 2007; Sormanti & Smith, 2009; Colarossi et al., 2010; Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Waalen et al., 2000; Kirst et al., 2012; Ramachandran et al., 2013; DeBoer et al., 2013; Renker, 2008).

Personal provider barriers. The second theme that emerged in the literature addressed personal provider barriers. Providers reported that they did not routinely screen for IPV due to lack of rapport and/or fear that current patient-provider rapport would be hindered (Baig et al., 2012; Waalen et al., 2000). Providers also felt the chief complaint was more important at the visit than screening for intimate partner violence (Furniss et al., 2007; Sormanti & Smith, 2009). Several providers expressed that they were generally uncomfortable screening and lacked preparedness (Baig et al., 2012; Furniss et al., 2007, Sormanti & Smith, 2009). Additionally, many providers did not want to become involved with legal consequences associated with

positive victim responses, and therefore did not routinely screen (Baig et al., 2012; Sormanti & Smith, 2009; Renker, 2008).

Patient Disclosure Barriers

In contrast to the two previous themes identified, the third and final theme found in the literature addressed patient disclosure barriers. Renker (2008) and Kirst et al. (2012) both identified various barriers that prevented patients from disclosing intimate partner violence such as: fear of retaliation from partner, fear of partner incarceration, fear of losing custody of their children, and overall embarrassment. Kirst et al. (2012) and Thackeray et al. (2007) both found that patients possessed cultural barriers that prevented them from disclosing previous IPV. For example, Kirst et al. (2012) found that some women feared that disclosing previous abuse would jeopardize their immigration status. Additionally, patient noncompliance and unwillingness to utilize resources were factors contributing to disclosure (Waalén et al., 2000; Colarossi et al., 2010).

All three identified themes are barriers that contribute to decreased provider adherence to routine intimate partner violence screening. These barriers are causing physical, emotional, and mental health consequences to go unreported and undetected. The commonalities found in the literature review supports this projects' importance and relevance in healthcare. To mitigate these negative consequences, specific workplace barriers to routine screening and community resources that can be integrated into clinical practice need to be identified to manage the detrimental health consequences associated with intimate partner violence.

Theoretical Model

The Donabedian Structure, Process, and Outcomes Model of program evaluation has had a long-standing history in evaluating healthcare programs and healthcare services (Chan,

Gardner, Webster, & Geary, 2010). The diverse model focuses on the evaluation of structures, processes, and outcomes that mold institutional programs in hopes of improving the overall quality. Each aspect of the model provides a guide to ensure that a certain caliber of care is being delivered to patients.

In 1965, shortly after the Medicare and Medicaid programs were enacted, healthcare professionals met in Chicago to discuss public health research, community health organizations, and quality healthcare services (Ayanian & Markel, 2016). Avedis Donabedian, an immigrant physician and professor at the University of Michigan, was one of the healthcare professionals that met to assess quality care. His article “Evaluating the Quality of Medical Care” was the turning point in evaluating quality healthcare, and in fact is has been one of the most frequently cited articles over the last 50 years. It was in this article where Donabedian first introduced his concepts of structure, process, and outcome. His assumptions of the model depict structure as the setting and administrative systems in which care takes place, process as the components of the care being delivered, and outcome as the recovery and restoration of an organization (Ayanian & Markel, 2016).

All three elements of the model are still relevant in the deliverance of quality health care services. For example, structure is assessed by board certifications of providers and the Joint Commission accreditation of hospitals (Ayanian & Markel, 2016). Additionally, the assessment of processes and outcomes has influenced the Institute of Medicine’s reports geared to improve quality assurance (Ayanian & Markel, 2016). His model continues to address and assess the daily challenges that arise in the deliverance of quality healthcare.

The first aspect of the Donabedian model assesses the structure of a program. Structure includes any tools that an institution uses to accomplish their goals and to deliver health care

services (Chen, Hong, & Hsu, 2007). Structure may incorporate the tools and resources that are available in the institution (Chen, Hong, & Hsu, 2007). A stable structure ensures that everything that is needed to deliver exhaustive health care services is available.

The structure of the project includes identifying current policies in place at the metropolitan public health department. The number of staff, level of training, and resources within the clinic and community will be assessed. Reviewing each clinic's structure will unveil what tools are currently in place to screen for intimate partner violence. Additionally, a retrospective chart review will be conducted to unveil the nature of the health department's structure. The chart review will identify whether the nurses and providers are documenting the discussion of IPV or referring to any outside community resources.

The second aspect of the Donabedian model assesses the process or processes of a program. There is a technological aspect to process as well as an interactive aspect (Chen, Hong, & Hsu, 2007). The technological aspect ensures that measures are taken to minimize health care consequences, while the interactive aspect focuses on the communication amongst health care professionals as well as the communication that occurs between health care professionals and patients (Chen, Hong, & Hsu, 2007).

The process of the project will be to determine what is currently being done in the health department. Needs and barriers to screening will be assessed, and known community resources will be identified. The process will be analyzed by conducting a focus group with nurse managers and separate individual interviews with clinical nursing staff at three separate family planning clinics within the public health department. Staff members will share attitudes towards routine screening and offer recommendations to increase screening rates within the clinics.

The third and final aspect of Donabedian's model evaluates a program's overall outcomes that contribute to the patients' improved health status. Outcomes include both positive and negative aftereffects of the processes (Chen, Hong, & Hsu, 2007). Outcomes may entail any methods of transformation that can be made to the status of a patient's health. Health status specifically encompasses physical, emotional, mental health as well as the patient's generalized satisfaction (Chen, Hong, & Hsu, 2007).

Outcomes include the provision of any resources that will improve overall health status of patients. The outcomes of the project include providing an educational session to all available staff members. This will address any potential barriers to screening and identified needs. The final survey will also be a part of outcomes and will be used to evaluate staff members' overall readiness to screen.

The Donabedian Structure, Process, and Outcomes Model for program evaluation has been used to evaluate healthcare services for numerous decades. The model's core components call for providers and administrators to become more engaged in delivering quality care. Using all aspects of the model as a guide, the structures, processes, and outcomes within the public health department can be appropriately evaluated and intimate partner violence screening can be improved. See Figure 1.

Evaluation Plan

The quality improvement project has an iterative approach based on Donabedian's Structure, Process, and Outcomes Model. Approval from both the Institutional Review Board at Belmont University and the Metropolitan Health Department was obtained prior to the conduction of this study. First, current screening practices and procedures were mapped in three family planning clinics within the metropolitan public health department. Following the mapping

of current practices and policies, a retrospective chart review was conducted. The charts were selected by using the Query method. A completed randomized and de-identified list of encounter numbers that met the inclusion and exclusion criteria were used to create the convenience sample of 105 patients. The sample size included patients that were seen at all three family planning clinics between May 2017 and July 2017. Charts were assessed for frequency of documentation of screening, referral to services following a positive screening, and any discussion related to intimate partner violence. No patient identifiers were recorded throughout the chart review. The project leader used the original randomized and de-identified list of encounter numbers that met the inclusion and exclusion criteria to replace any originally selected charts that were not available to review upon arrival to the clinic.

Following the retrospective chart review, voluntary individual interviews took place at each of the family planning clinics with clinical staff members to assess barriers to intimate partner violence screening. No managers were present, no job descriptions were revealed, and no associated clinic names were reported. All clinical staff member participants were required to sign informed consents to participate in the individual interviews. All consents were stored in a locked box that was only accessible to the project leader. All clinical staff was informed prior to participation that responses derived from the interviews would not in any way affect their status of employment.

A separate focus group took place with the nurse managers at all three family planning clinics. The goal of the nurse manager focus group was also to assess barriers to intimate partner violence screening. Nurse managers were required to sign informed consents prior to participation in the focus group. All consents were stored in a locked box that was only

accessible to the project leader. All managers were informed prior to participation that responses derived from the focus group would not in any way affect their status of employment.

Five main open-ended questions were asked during the focus group and individual interviews to determine staff's overall knowledge base regarding intimate partner violence.

These questions included the following:

1. How prepared do you feel to screen and appropriately refer an IPV victim?
2. What are barriers to routine screening for IPV?
3. What community resources are available for IPV victim referral
4. What are your attitudes and perceptions towards routine screening
5. What recommendations do you have to increase IPV screening?

Questions were considered completed once data saturation had been reached. All staff members and clinical managers who participated were given a handout with the anonymous hotline number to Adult Protective Services (APS) and link to the APS website so that if they wished to anonymously disclose they would have an opportunity to do so. All responses to both the individual interviews and focus group were audio-recorded and transcribed verbatim. A consent form was also signed for the audio recordings. Following the interviews and focus group a qualitative analysis was conducted to identify common themes.

After the identification of current practices and barriers to screening, the project leader contacted two metropolitan health departments to gather information regarding their intimate partner violence screening process for comparison. The project leader then found an expert in the community to consult for screening recommendations. Based off the information gathered from both the manager focus group and the individual interviews, the project leader then provided an educational session. During the educational session, all previous barriers were addressed and

recommendations from both the expert within the community and other health departments of similar size were provided. All information was placed in a resource binder created by the project leader so that staff members would have the information available to them in clinical practice. Following the educational session the project leader administered voluntary paper surveys. These surveys were used to assess staff's perception of information provided during the educational session and to determine overall readiness to screen.

Clinical Setting

The project was conducted in three family planning clinics within a metropolitan public health department in the southeastern United States. Each family planning clinic is composed of roughly two general clinic staff members, a nurse manager, and a provider. Charts reviewed were from patients that visited the clinic for pregnancy tests, family planning needs, the management of sexually transmitted infections, or for medical supplies such as birth control.

Project Population

Patient's charts that were reviewed reflected the varying demographics in the metropolitan area. Charts reviewed included patients that were primarily minorities, men and women of reproductive age, and patients with low socioeconomic statuses. The clinics primarily serve patients who have Arabic, Hispanic, and African American backgrounds and those receiving federal and state funded healthcare assistance such as Women, Infants, and Children (WIC) and TennCare Medicaid.

Charts used to conduct the retrospective chart review were randomly selected from encounters within three family planning clinics that occurred between May 1, 2017 and July 31, 2017 by using the Query method. Patient charts reviewed included both male and females who

were at least 18 years of age. Thirty-five charts were selected from each family planning clinic for a total sample size of 105.

The Quality Improvement Coordinator at the public health department solicited all participants of the focus group, surveys, and interviews via e-mail. Participant criteria for the nurse managers focus group included both male and female licensed staff members that were routinely involved in patient care. The participant criteria for the individual interviews included both male and female licensed clinical staff members. Three managers were solicited and participated in the final focus group. Roughly ten clinical staff members from the clinics were solicited and approximately eight staff members participated in the individual interviews. For the focus group and interviews, managerial staff members were kept separate from general clinic staff to maintain clinic flow, maintain staff anonymity, and ensure that no staff members would be reprimanded for the responses provided.

Sources of Data/Data Collection Instruments

The project leader was the sole data collector and completed National Institutes of Health (NIH) human subjects protection training prior the initiation of this scholarly project. Data from the retrospective chart review was collected only to assess frequency of documentation of screening, referral to services following a positive screening, or discussion related to intimate partner violence. All deidentified data recorded was stored in an excel spreadsheet.

Each patient chart was examined to review the initial intake form that allows patients to reveal any past medical history. The project leader also referred to the encounter form to assess the documentation of IPV screening or any documentation of referral following a positive response. There were three main categories found on the back on the encounter form that related

to IPV. The three categories include the following: domestic violence and personal safety; safe sleep, Zika Virus, and domestic violence; and informed consent

During the manager focus group, data was audio recorded and transcribed after written consent was obtained. The voluntary focus group was conducted to assess barriers to intimate partner violence screening. The focus group responses and participants were anonymous and de-identified. No job descriptions were revealed and no associated clinic was reported. Results were reported in aggregate. Following the focus groups an analysis was conducted to identify common themes.

During the individual interviews with the clinical staff members, data was audio recorded and transcribed after written consent was obtained. The voluntary interviews were also conducted to assess barriers to intimate partner violence screening. The interview responses and participants were anonymous and de-identified. No job descriptions were revealed, no managers were present, and no associated clinic was reported. Results were reported in aggregate. Following the individual interviews an analysis was conducted to identify common themes.

A post-project paper survey was administered to all available staff members. The project leader used a modified version of the Domestic Violence Healthcare Provider Survey Scales (DBHPSS) to assess the participants' readiness to screen. This survey was chosen to correlate with the main themes of the questions asked in both the focus group and individual interviews. Perceived self-efficacy, fear of offending patients, and psychiatric support are all items from the original survey that are being measured. The internal reliability of subscale items extracted from the original survey were as following: perceived self-efficacy (0.71), fear of offending patients (0.76), and psychiatric support (0.60) (Lawoko, Sanz, Helström, & Castren, 2012). See Appendix A.

The project leader went to each family planning clinic to administer the paper surveys. The health department recommended paper surveys instead of electronic surveys to protect participants' anonymity. Paper surveys were distributed to all the staff members regardless of participation in the individual interviews to ensure that management was not able to identify those staff members that did or did not participate. All surveys were anonymous and de-identified and were included along with a manila envelope. Following the survey, the sealed manila envelope with the survey inside was directly handed to the project leader. The envelope was then placed in a locked box that was only accessible to the project leader and was shredded following analysis. All participants were informed about surveys being anonymous, voluntary, and staff having no consequences for not participating.

Data Collection Process/Procedures

The mapping of current practices, retrospective chart review, focus group, individual interviews, and educational session all took place at the metropolitan health department from August 2017 to November 2017. The project leader mapped current practices and conducted the retrospective chart review in August 2017 in all three family planning clinics. All focus group and individual interview responses were conducted and audiotaped in October 2017 so that the data could later be transcribed and coded. The education session and post-survey took place following the final analysis of data in November 2017.

Analysis

The project leader was sole data collector for this scholarly project. Descriptive statistics were utilized to analyze current intimate partner violence screening and documentation from the retrospective chart review. The audio recordings from the interviews and focus group were transcribed verbatim then thematically analyzed. The qualitative analysis of the transcribed data was performed to identify trends regarding screening, barriers, referral to services, and the

discussion of IPV. The paper survey administered post-educational session was analyzed utilizing descriptive statistics to determine readiness to screen. All quantitative data for this project was analyzed using IBM SPSS 24.0 statistical analysis software.

Assessment Results

Structure: Mapping of Current Practices

Current practices were mapped by observation of all three family planning clinics. At the family planning clinics either a clinical staff member or nurse manager will bring the patient back for the visit. Once brought back to a patient room, the clinical staff member or nurse manager reviews the intake form that patient is responsible for filling out in the lobby. It is here where the patient has the opportunity to reveal any past medical or social history. The encounter form is the form used to document what services occur during the patient's visit. The back of the encounter form contains an area where all staff members are required to document at least three state-mandated topics of their choice that were discussed with patients over the course of the year. Of those pertaining to intimate partner violence, the staff member has the option to choose between three categories. The three categories include the following: domestic violence and personal safety; safe sleep, Zika Virus, and domestic violence; and informed consent. Once discussed, the staff members write the date or their initials next to the topic. If a patient discloses intimate partner violence then staff members have a resource tear-off handout posted with the YWCA's contact information in restrooms, patient rooms, and on several walls within the health department. The YWCA has been regarded as the health department's primary referral resource.

Structure: Chart Review

Of the 105 total patient charts reviewed 49 (47%) of the family planning patients were not asked about intimate partner violence. Of the 56 (53%) family planning patients asked, 14

(54%) discussed domestic violence and personal safety. Additionally, of those patients that were asked 25 (96%) of patient charts indicated that safe sleep, Zika virus, and domestic violence were discussed and 24 (92%) were asked about informed consent. No information was provided in the chart about subsequent referrals. See Table 1.

Process: Manager Focus Group

A total of three total managers participated in the focus group. Five main themes were identified in response to the focus group questions. The manager focus group was conducted separate from the clinical staff members to protect the anonymity of staff members and to protect staff members from being reprimanded for their answers. All statements taken from the focus group are verbatim and misnomers have been used to conceal the identity of all participants. The first theme identified in response to the first focus group question relayed managers overall preparedness to screen. Based on the responses it can be concluded that the majority of managers felt prepared to intervene and refer following a positive screening. Glenda stated, "I have a list of people to call that's in a folder. There's been one where we have had to call for in the clinic, and the lady reported intimate partner violence. So we called the YWCA and then we found someone that spoke Spanish. They would talk and I would put her on the phone with them. We've had to call 911 before because a lady didn't feel comfortable leaving. Olivia nodded in agreement with Glenda and added, "And we do the same thing." The second theme in relation to the second focus group question identified barriers to screening. Most of the managers felt that there were barriers involving the partner that prevented the patient from disclosing. Olivia stated, "We had one about two weeks ago. She was basically afraid to leave her partner." Similarly Glenda stated, "With the Arabic population the husband is always there. He answers all of the questions even down to the questions about her period." Brittany added that she had a patient who every time

she came in she was with her husband, who did not want the patient to go back by herself. She conveyed that the patient was extremely fearful of her partner and felt that this prevented her from disclosing any past or current intimate partner violence. When asked about available resources for intimate partner violence and victim referrals the third theme was identified. Most managers felt that there were adequate resources to refer patients following a positive screening. Olivia shared, “We actually had one about two weeks ago. She was basically afraid to leave her partner. She said he left to go out of town. We gave her the number to the YWCA and let her know to contact a brother or somebody that can come and help her move. If he was to show up while she was in the process of moving, you just never know what’s going to happen. So on our end we’ve done what we could do. After she’s left the clinic it’s really on her. But we’ve gave her the resources that are available to her.” The fourth theme identified was in response to the focus group question pertaining to comfort level with routine screening for IPV. The majority of managers when asked about their current preparedness to screen stated, “I feel comfortable”. The last theme identified was related to managers’ thoughts and attitudes towards routine IPV screening. Most managers also felt that routine screening was necessary. Glenda stated, “I think that it is necessary. They won’t say anything if no one asks. To some of them, this is their normal. They don’t know that it is not normal unless you bring it up. To some of them this is the only time that they get out of the house because they are coming for birth control pills, WIC, and immunizations, so that is their escape”. See Table 2.

Process: Individual Interviews

Seven clinical staff members chose to participate in the individual interviews. Two clinical staff members opted out. Five main themes were identified following the individual interviews. Individual interviews were conducted as opposed to a focus group to not interrupt the

overall flow of each clinic. All statements taken from individual interviews are verbatim and misnomers have been used to conceal the identity of all participants. The first theme was related to the focus group question regarding overall preparedness. Based on the responses it can be concluded there were an equal number of participants from the individual interviews that did not feel prepared and that felt prepared. When Gabrielle was asked how prepared she feels to screen she replied, "Not that prepared." Bailey stated, "I feel like kind of in the middle." The second theme identified was related to barriers to screening. Most participants felt that decreased rates of disclosure were correlated to patients' overall fear of law enforcement consequences, fear of partner, and the patient's partner being physically present at the visit. Amanda stated, "Sometimes if the patient comes in by herself, she may not want any problems. Maybe she will think that reporting someone who harasses her or abuses her will result in the person being deported or something. She may not want to say anything or get him in trouble." Frankie added, "A lot of the time their mate comes with them so you really can't ask. That's a hindrance because they don't want to step out and they don't have the courage to say I want to talk to her alone." Frankie also added, "Sometimes there is enough time to screen and sometimes there is not. It all depends on how heavy the flow is and what we have to do. Because we are short staffed that makes a problem right there. There are just two of us." Emily also shared, "Well, we try to make time for it, but I wouldn't necessarily say that there is enough time to screen." The third theme identified was pertaining to community resources available to clinical staff members. The majority of staff members identified a main resource but felt that more resources, training, and handouts were needed. Amanda stated, "Sometimes domestic violence is only looked at from the female perspective. The males sometimes are also going through domestic violence, and gay people. So, I think that it's an area that should also be looked at because we have those

forms in the female form and is it not in the male.” Chelsea added, “I would love more handouts, definitely! I hate saying call this number and maybe they’ll answer. You always feel like, are they really going to help them, and we can’t make them go necessarily. Having something brand new that we can say here, take this, and something with everything together. That would be perfect”. The fourth theme identified was in relation to the focus group question assessing clinical staff members’ comfort with routine screening. The individual interviews revealed that an equal number of participants felt uncomfortable as those who felt comfortable. Amanda stated, “I think I’m comfortable with everything, and the resources according to the public health departments’ policy. I can refer anybody that I notice that has experienced domestic violence.” Another participant, Bailey when asked the same question stated, “We have a reference card to the YWCA and we post them in the bathrooms, and if people feel like that’s somewhere they want to reach out to, they can take their phone number because they have the things that you can pull off. Other than that I don’t really feel confident in anything.” The last theme identified was related to managers’ thoughts and attitudes towards routine screening. Most participants felt that routine screening was necessary. When Amanda was asked about routine screening she replied, “That is how it is supposed to be. I think it’s not too much. It’s appropriate. It’s the best thing to do.” See Table 3.

Outcomes: Barriers to Screening and Identified Needs

The mapping of current practices revealed that there are various state-mandated educational topics depending on the encounter form and type of visit. Due to only a minimum of three topics needing to be chosen at each visit, in addition to the nature of the health department family planning clinics with patients only periodically scheduling visits, it is possible for a manager or clinical staff members to not have the opportunity to cover or discuss all items.

Additionally, the encounter form only showed the anatomy of a female. The chart review revealed that there were still opportunities to screen and discuss intimate partner violence in all three planning clinics. There is no current standardized screening tool in place for intimate partner violence on encounter forms or intake forms. Additionally, of the three available state-mandated categories pertaining to IPV, two of the categories had multiple topics to discuss within that one category. For example, one category to discuss was safe sleep, Zika virus, and domestic violence. There are three different topics within this one category, however there is only one available box to check to signify the topic was discussed. There is not a current way to differentiate whether one topic was discussed, or if all three were discussed. The chart review also revealed that there was no appropriate place on the encounter form to document IPV referrals. This identified a need for an appropriate standardized screening tool to be put in place, an appropriate way to document the discussion of each individual state-mandated topic, an encounter form with both the male and female anatomy present, and a suitable area on the encounter form to document subsequent referrals following a positive response to IPV.

From the manager focus group three main barriers were identified. From the individual interviews seven main barriers were identified. The barriers can be further delineated into categories based on the type of barrier. Those main categories are barriers that are congruent with those discussed in previous literature which include: institutional provider barriers, personal provider barriers, and patient disclosure barriers. Only patient disclosure barriers were identified in the manager focus group. All three categories of barriers were identified in the individual interviews.

For the managers those three barriers included the following: partner present at visit, fear of repercussion from the law, and fear of repercussion from the partner. These were themes

previously identified as barriers in the literature. Kirst et al. (2012), Renker (2008), and Sormanti & Smith (2009) all similarly found that fear of losing custody of children, fear of being deported, and fear of repercussions from the patients' partner were barriers that prevented patients from disclosing IPV. Furniss et al. (2007) also found privacy and the patients' abuser being present at the visit as a barrier.

For the individual interviews the institutional provider barriers were inadequate time, inadequate staff, and inadequate resources. All three of which were identified in literature as institutional provider barriers. Baig et al. (2012) and Waalen et al. (2000) both similarly found time constraints as an institutional barrier to screening. The personal provider barriers were staff discomfort with screening and unpreparedness. These two barriers were identified in the literature as well (Baig et al., 2012; Furniss et al., 2007; Sormanti & Smith, 2009; Colarossi et al., 2010). Lastly, patient disclosure barriers included fear of repercussion from the law and fear of repercussion from partner. These were similar to the themes found in the manager focus group. See Table 4.

In comparison to the individual interviews, the manager focus group revealed that they felt there were adequate referral resources, increased levels of comfort screening, and increased level of preparedness screening. A severe disconnect was noted between the clinical staff members' institutional provider barriers and the managers' institutional provider barriers. The managers found no institutional barriers while the clinical staff members' disclosed that there was inadequate time, staff, and resources to screen. This finding may be attributed to managers not being the primary individuals who are screening in the clinics.

Additionally, outliers were found. These are findings did not appropriately fit into any of the identified themes. All outliers were identified from the individual interviews. All statements

taken from individual interviews are verbatim and misnomers have been used to conceal the identity of all participants. Unlike most her peers Amanda stated, “I think I’m comfortable with everything and the resources provided according to the public health’s policy.” Additionally, when asked about routinely screening Frankie stated, “It all depends on the situation and what kind of clients you see. For something minor where you won’t see them that often like strep throat you can turn them off. I think they come in for more medical reasons and you have some type of relationship with them it’s different. If you came in and asked me, and I had a strep throat, I would think I’m not going back there.” Also, when Danielle was asked about IPV screening she stated that she there was adequate time within the clinic flow to screen. These three responses would need to be further investigated to determine the differences in answers in comparison to the other clinical staff members.

Outcomes: Quality Improvement Implementation

After the identification of current practices and barriers to screening, the project leader contacted two metropolitan health departments of similar size to gather information regarding their intimate partner violence screening process for comparison. The Shelby County public health department suggested using the Quality Family Planning guideline to screen due to the guidelines having several open-ended questions regarding sexual coercion. Additionally, it was recommended that staff members refer to the YWCA and to create resource information printed small enough that a female victim can place inside her bra. The last recommendation was to focus on cultural competency to enhance patient comfort when screening.

The Wayne County public health department suggested having a sexual assault nurse examiner on site and connecting all victims with a sexual assault forensic examiner’s program within 5 days post assault/ disclosure. Additionally, it was recommended that shelter cards and

resource information be placed in tampons for female victims and PREP prescriptions and samples be offered to any victim post-assault.

The project leader then found an expert in the community to consult. The expert recommended the Tennessee Coalition to End Domestic & Sexual Violence and the YWCA as community resources. Additionally, it was recommended that staff members screening be upfront and ensure to screen every visit to increase overall comfort. Her recommendations also included suggestions of screening questions related to both emotional and verbal abuse and having resource cards that can be easily slid into a victims' wallet. The last recommendation suggested that all nurses and staff members participate in additional training.

Based off the information gathered from both the focus group and the individual interviews, the project leader then provided an educational session to the staff members. The educational session addressed the provider barriers and needs that were previously identified. Additionally, staff members were educated about the various screening tools that are available for both men and women and that are culturally competent for the demographic that the public health department primarily serves. During the educational session, resources within the community were provided as well as recommendations from the selected two other health departments that are similar in size. The information was placed in a resource binder created by the project leader so that staff members would have the information available to them in clinical practice. Following the educational session, the project leader administered voluntary and anonymous paper surveys. These surveys were used to assess staff's perception of information provided during the educational session and to determine overall readiness to screen. Prior to the deliverance of paper survey to the managers, the overall results of the known barriers, identified needs, gap in care, and practice recommendations were presented at the monthly managerial

meeting. It was suggested that the public health department identify a screening tool and decide where in the clinic flow the tool will be most appropriate, decide if in-house social workers should become involved with referral and/or screening care, increase training to every 3 years and as needed, and role play or utilize scripts to increase comfort screening.

Outcomes: Post-Intervention Readiness to Screen

Manager survey results.

Three total managers participated in the survey. Scores for means range between 1-5. A score of 3 represents a neutral middle score. For the manager surveys the mean calculated for perceived self-efficacy was 3.83 representing a higher perceived self-efficacy post-educational session due to the number being over the middle score of 3. The mean calculated for fear of offending patients was 2.00. This mean indicated that managers has less fear of offending patients following the educational session due to the score being less than the middle score of 3. The means measuring psychiatric support was 2.67 indicating that managers felt that there were inadequate mental health services for victims of intimate partner violence following the educational session. Overall responses indicated that managers had sufficient scores in self-efficacy and fear of offending patients, however, had insufficient scores in psychiatric support post-educational session. These results indicate that more psychiatric support resources could be provided to enhance readiness to screen. See Table 5.

Individual interview survey results.

Eight total clinical staff members participated in the survey. Scores for means range between 1-5. A score of 3 represents a neutral middle score. For the individual interview surveys the mean calculated for perceived self-efficacy was 4.22 representing a higher perceived self-efficacy post-educational session due to the number being over the middle score of 3. The mean

calculated for fear of offending patients was 1.81. This mean indicated that participants had less fear of offending patients following the intervention due to the number being less the middle score of 3. The means measuring psychiatric support was 3.31 indicating that participants felt that there were adequate mental health services following the educational session for victims of intimate partner violence due to the number being over the middle score of 3. Overall responses indicated that clinical staff members had sufficient scores to consider them ready to screen post-educational session. See Table 6.

Practice Recommendations

Increased training for all family planning clinics every three years, and as needed, is recommended so that evidenced-based practices can be reviewed. This should be the time where resources, protocols, and patient support information can be reviewed and updated. Additionally, to enhance comfort, screening at every visit is recommended. Role-playing exercises during training or creating scripts may be useful. Another recommendation for nurse managers would be establishing responsibility for screening and clarifying when other disciplines such as social work need to become involved. This should eliminate role confusion when screening and enhance continuity of care. Lastly, it is recommended that an official screening tool be added to either the intake form or encounter form. This will aid in the facilitation of routine screening for intimate partner violence and include the practice of screening in the day-to-day clinic workflow.

Strengths and Limitations

The focus group and individual interviews provided themes and richness about intimate partner violence screening that could not have been solely captured from surveys. This qualitative data was able to provide verbatim attitudes, thoughts, and barriers from those that are actively involved in patient care. However, the focus group with all three family planning

managers could have affected the diversification of managerial responses. Due to timing and an overall staff shortage the metropolitan health department requested that managers participate in a focus group, as opposed to individual interviews like the clinical staff members. As a result, managers' lack of anonymity during the focus group may have influenced answers amongst peers and contributed to themes identified. Additionally, due to staff shortage for both the managers and clinical staff members, there was a small sample size. The small size may have also contributed to the diversity of responses. Lastly, the focus groups and individual interviews were conducted using a semi-structured format. All participants were given enough time to answer focus group questions in detail and complete the post-intervention survey. This effort reiterated the quality improvement educational session intervention and was able to evaluate staff members' overall readiness to screen. However, there was no pre-intervention readiness to screen survey used within this study. A pre-intervention readiness to screen survey may have provided a comprehensive baseline, in addition to the focus group responses, that would have added to the depiction of clinical needs within the health department. Also, due to time constraints a post implementation evaluation of changes was not made in the health department. It is highly recommended that this be done in the future to ensure that the necessary implementations are in place to address all identified needs.

Conclusion

Despite previous literature and national recommendations for intimate partner violence there continue to be missed opportunities to screen. As health care providers it is our responsibility to routinely screen so that subsequent acute and chronic health concerns can be appropriately managed. By screening, adverse health consequences can be reduced and

survivors' overall quality of care can be improved. Bridging this gap will ensure that all aspects of care are addressed and will help eliminate perceived barriers to intimate partner violence.

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Figure 1. Structure, Process, and Outcomes of the Public Health Department

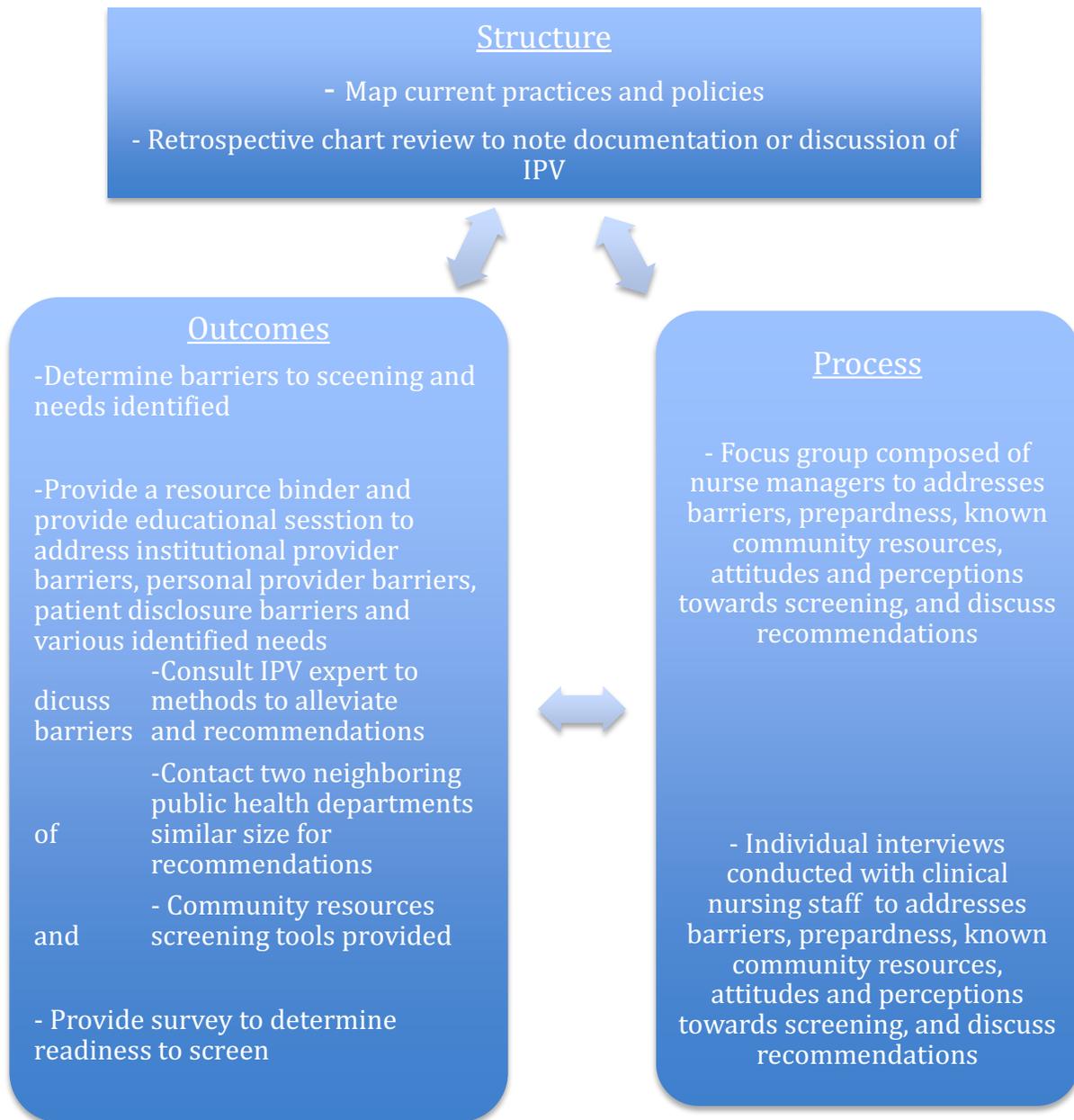


Table 1. Retrospective chart review results

Percentage of patient charts who did not have discussion about intimate partner violence	49%
Percentage of patients charts who had documentation of the discussion of intimate partner violence	53% Of the percentage of patient charts who had documentation of the discussion of intimate partner violence: <ul style="list-style-type: none"> • 54% discussed about domestic violence and personal safety • 96% discussed safe sleep, Zika virus, and domestic violence • 92% discussed informed consent
Percentage of patient charts that indicated that subsequent referrals were done	0%

Table 2. Themes from manager focus group

Theme 1: Level of Preparedness	Increased level of preparedness
Theme 2: Barriers to routine screening	Patient fear of repercussion, Patient partner present
Theme 3: Resources	Adequate resources
Theme 4: Comfort level	Increased level of comfort screening
Theme 5: Thoughts/ Attitudes towards routine screening	Routine screening necessary

Table 3. Individual Interview Themes

Theme 1: Level of Preparedness	Equal number of increased and decreased levels of preparedness
Theme 2: Barriers to routine screening	Patient fear of repercussion, Patient partner present, inadequate time, inadequate staff
Theme 3: Resources	Inadequate Resources
Theme 4: Comfort level	Equal number of increased and decreased levels of comfort screening
Theme 5: Thoughts/ Attitudes towards routine screening	Routine screening necessary

Table 4. Barriers to Screening

	Manager focus group	Individual interviews
Institutional provider barriers		<ul style="list-style-type: none"> • Inadequate time • Inadequate staff • Inadequate resources
Personal provider barriers		<ul style="list-style-type: none"> • Staff discomfort with screening • Unpreparedness
Patient disclosure barriers	<ul style="list-style-type: none"> • Partner present at visit • Fear of repercussion from the law • Fear of repercussion from partner 	<ul style="list-style-type: none"> • Fear of repercussion from the law • Fear of repercussion from partner

Table 5. Manager survey means

	Mean
Perceived self-efficacy	3.83
Fear of offending patients	2.00
Psychiatric support	2.67

Table 6. Individual interview survey means

	Mean
Perceived self-efficacy	4.22
Fear of offending patients	1.81
Psychiatric support	3.31

Appendix A. Modified Domestic Violence Healthcare Provider Survey

Factor 1. Perceived self-efficacy

1. I have no time to ask about IPV in my practice
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
2. There are strategies I can use to help victims of IPV change their situation
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
3. I feel confident that I can make the appropriate referrals for abused patients.
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
4. I have ready access to information detailing management of IPV.
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
5. I have ready access to medical social workers or community advocates to assist in the management of IPV.
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
6. I feel that medical social work personnel can help manage IPV patients
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree

Factor 2. Fear of offending patients

1. I am afraid of offending the patient if I ask about IPV
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
2. Asking patients about IPV is an invasion of their privacy.
(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree
3. It is demeaning to patients to question them about abuse

(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree

4. If I ask non-abused patients about IPV, they will get very angry

(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree

Factor 6: Psychiatric support

1. I have ready access to mental health services should our patients need referrals.

(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree

2. I feel that the mental health services at my clinic or agency can meet the needs to IPV victims in cases where they are needed.

(1) strongly disagree (2) disagree (3) neither (4) agree (5) strongly agree