INTIMATE PARTNER VIOLENCE PRENATAL AND POSTPARTUM SCREENING
AT WAIANAE COAST COMPREHENSIVE HEALTH CENTER

A SCHOLARLY INQUIRY PROJECT SUBMITTED TO THE OFFICE OF GRADUATE
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ABSTRACT

BACKGROUND: Intimate partner violence (IPV) is a worldwide epidemic that is often overlooked, ignored, and underreported. However, it greatly affects the health of women, especially in pregnancy. Healthcare providers and other staff may be in the optimal positions to screen and to identify victims of IPV. The objective of this project is to implement an evidence-based IPV screening tool and protocol for all pregnant and postpartum women, visiting the Women’s Health Department at Waianae Coast Comprehensive Health Center (WCCHC).

METHODS: Based on a literature review, the Abuse Assessment Screen (AAS), a five-item tool that assesses for physical, emotional, and sexual abuse, was implemented in the Women’s Health department from August to November 2014. In addition, an updated IPV screening and intervention protocol was implemented. Data was collected prior to and after the implementation of the new screening tool and protocol. Descriptive statistics and trend analysis was completed.

OUTCOMES: The AAS, used to screen pregnant women during initial OB visits, revealed an overall IPV rate of 14.6% (6% current IPV, 9% history of IPV), when screened by APRNs. The APRNs had an overall 90.2% screening rate. The perinatal case managers revealed a 6.7% current IPV rate and 10.8% history of IPV in pregnant women, with an overall 63.2% screening rate. Postpartum screening by APRNs revealed an overall 56.5% screening rate, with a 9.8% IPV rate. The most common interventions for women who screened positive for IPV were being counseled directly by the provider and being given a phone resource card, which includes the IPV shelter numbers and local IPV information line. A small percentage of women were referred to Behavioral Health.
CONCLUSION: Routine IPV screening for all women seeking prenatal and postpartum care is critical in order to identify and help victims of IPV. Use of the AAS and the new screening and intervention protocol has increased the identification of victims of IPV. Providers should continue to screen for IPV and provide services to pregnant and postpartum women.
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Chapter 1: Introduction

The issue of intimate partner violence (IPV) can no longer be ignored or minimized in the State of Hawai‘i, nor in our country. It is a silent epidemic that sweeps throughout our communities in Hawai‘i, the U.S. and internationally. Since IPV does not discriminate, the importance of screening every woman must be emphasized. Healthcare providers and support staff are the frontline players in being able to identify and provide interventions for women affected by IPV.

An evidence-based IPV screening tool must be utilized in order to identify survivors of IPV, followed by interventions that may empower them, guide them to seek additional resources in the community, and to prevent re-victimization and associated diseases and other related morbidities. IPV screening and interventions are very important to implement in all healthcare settings, not only to protect women, but also their children and, when women are pregnant, their fetuses. As healthcare providers, it is our duty to be well informed, trained, and culturally competent when screening and providing interventions for victims of IPV.
Chapter 2: Problem

Background

Definition and Overview of Intimate Partner Violence

Intimate partner violence (IPV) is synonymous with the term domestic violence (DV) and can be used interchangeably. The National Coalition Against Domestic Violence (NCADV) concisely defines the issue as:

Domestic Violence is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another […] Violence against women is often accompanied by emotionally abusive and controlling behavior, and thus is part of a systematic pattern of dominance and control. (para. 1)

Contrary to some myths about the causes of DV, the underlying issues are not anger, stress, financial crisis, drugs, or alcohol. Instead, it is about power and control over the victim (Domestic Violence Action Center, 2012).

Statistics: An International, National, and Local Problem

A World Health Organization (WHO) multi-country study on women’s health and domestic violence against women reported an international range of lifetime IPV prevalence from 15-71%, with estimates in most sites ranging from 30-60% (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Women living in provincial settings in Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania reported the greatest amount of violence. The lowest reported physical or sexual violence prevalence occurred among women in Japan (Garcia-Moreno et al., 2005).

In the U.S., about one in four women will experience IPV by a current or former spouse or boyfriend at some point in her life (Futures Without Violence, 2009; NCADV, 2007). However, the NCADV Survey conducted in the United States in 2011 results indicated a
reported prevalence of 31.5% for female lifetime physical violence and 47.1% for female lifetime psychological aggression (Centers for Disease Control and Prevention, 2014).

Additionally, more than three women are murdered each day by their boyfriend or husband in the U.S. (Futures Without Violence, 2009). An estimated 1.3 million women are victims of IPV (NCADV, 2007), with an IPV events count of 5.3 million among adult females in America each year (Magnussen, Shoultz, Oneha, Hla, & Brees-Saunders, 2007). Both the U.S. and Canada have revealed a female physical violence prevalence of 8% to 14%, which occurred within the prior year by a husband, boyfriend, or ex-partner (Kataoka, Yaju, Eto, Matsumoto, & Horiuchi, 2004).

Economically, IPV-associated costs exceed $8.3 billion each year in the U.S., which includes $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives (Zink, Lloyd, Isham, Mathews, & Crowson, 2007). Female IPV victims were found to triple the physician cost, double the physician claims, double the hospital costs, and have a one-third greater pharmaceutical cost, than non-victims (Zink et al., 2007). In the workplace, employers pay $3-5 billion per year in increased health care costs, absenteeism, decreased productivity, and increased security (Roark, 2010).

Hawai‘i is not exempt from these statistics. In fact, Hawai‘i has topped the U.S. in DV murders on a per-capita basis. From December 14, 2008 to December 20, 2008, The Honolulu Advertiser featured a seven-day consecutive special on domestic violence in Hawai‘i because of the number of murders that had occurred the prior year. According to The Honolulu Advertiser, in 2000, there were a total of 15 murders in Hawai‘i alone directly related to DV per 100,000 population, those murders due to IPV were double the national numbers (Perez, 2008). Domestic abuse calls, arrests and misdemeanor criminal prosecutions have dropped substantially
since the mid-1990s. However, the number of civil protective orders has increased by 81%; and hotline calls and shelter calls have also increased by 158% since 1998 (Perez, 2008).

According to the National Network to End Domestic Violence (NNEDV), on September 17, 2013 alone, 575 victims of abuse were served in Hawai‘i and 113 hotline calls were answered. Of the 575 victims that were served, 217 found refuge in emergency shelters or transitional housing and 358 received other services such as counseling, legal advocacy, and children’s support groups (NNEDV, 2013).

Magnussen, Amundson, and Smith (2008) state that IPV is greatly underreported in Hawai‘i and there is also a lack of statistics from the police, prosecutors, judges, and other service-providers. Additionally, homeless women are reported to have an IPV prevalence ranging between 30-90% (Vijayaraghavan et al., 2011).

The prevalence of reported IPV at four Oahu community health centers was investigated in 2004 (Magnussen et al., 2004) through a retrospective chart review. Review of the medical records of women aged 19-64 seen during a five-year period from 1998-2002 revealed that 9.1% of 337 charts had notes about IPV being disclosed and documented (Magnussen et al., 2004).

Table 2.1 represents the rates of IPV for pregnant women visiting the Waianae Coast Comprehensive Health Center, a community health center, from 2008 through 2012. The data depicted in this table represents the total number of women screened, as well as the disclosure of both current IPV, as well as a history of IPV, for pregnant women counseled by perinatal case managers in the Women’s Health department.
Table 2.1

2008-2012 Intimate Partner Violence Screening Statistics for Pregnant Women

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
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<tbody>
<tr>
<td>Total pregnant women</td>
<td>778</td>
<td>830</td>
<td>857</td>
<td>847</td>
<td>857</td>
</tr>
<tr>
<td>screened</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive for IPV in</td>
<td>23 (3%)</td>
<td>34 (4%)</td>
<td>33 (4%)</td>
<td>34 (4%)</td>
<td>27 (3%)</td>
</tr>
<tr>
<td>current pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive history of IPV</td>
<td>5 (0.6%)</td>
<td>22 (3%)</td>
<td>49 (6%)</td>
<td>44 (5%)</td>
<td>48 (6%)</td>
</tr>
</tbody>
</table>

(T. Gonsalves, personal communication, August 29, 2013)

Cultural Issues for Domestic Violence Screening and Interventions in Hawai‘i

The Hawai‘i State Department of Health’s fact sheet on IPV claims that the Chinese and Japanese groups reported the lowest rate of IPV. Intermediate estimates of IPV were reported by the Filipino, Hispanic, Other Asian, and Pacific Islander ethnic groups. The highest rates of reported IPV were found among women who identified as being Caucasian, Hawaiian, and those who reported more than one race (Shor, Hayes, Roberson, & Fuddy, 2010). However, Oneha, Magnussen, and Shoultz (2010) stated that between 2000 and 2009, there were 58 IPV-related female murders and 70% of the victims were Filipino or Native Hawaiian.

Magnussen et al. (2011) state that Asian and Pacific Islander (API) women report a lower rate of IPV in comparison to other cultural groups. However, the IPV prevalence has been reported to be as great in the API groups. Magnussen et al. (2007) noted that ethnocentric behavior of women survivors of IPV and their health care providers could lead to barriers to disclosure and interventions. The authors completed a systematic review of literature focusing on
the different cultures of Hawai‘i including the API cultures. They devised an ecological model to understand responses to IPV. There are cultural norms and expectations such as gender expectations, socio-economic forces such as education or crowded living situations, and relationship factors such as patterns of decision-making that may interface with individual behavior in men and women, and determine perpetration of and responses to IPV. For example, a recently immigrated Chuukese victim may believe it is her duty to endure suffering, and she may have no social support because of newly immigrating to Hawai‘i. In addition, she may feel ashamed and blame her husband’s violence on his alcohol abuse, thereby causing her to stay in the relationship instead of seeking help. Therefore, Magnussen et al. (2007) conclude that when devising screening tools and interventions, there must be an awareness of all these factors.

Magnussen and her team (2011) also conducted a cross-sectional, descriptive study, in order to further assess for reasons for the lack of IPV reporting in the API groups. The results clearly depicted cultural barriers to reporting violence, which supports their previous findings. Therefore, one of the authors’ conclusions is that a culturally sensitive screening instrument needs to be developed and utilized with the API populations (Magnussen et al., 2011). However, a gap still exists in research focused on studying the use of different screening tools among the API populations in Hawai‘i.

**The Health Concern**

Domestic violence (DV) is a major health concern in the U.S. that affects many women, regardless of age, ethnicity, profession, economic status, religion, educational accomplishments or social status (NCADV, 2007). According to the Center for Disease Control and Prevention (CDC) (2012), many victims will incur injuries that range from minor cuts, scratches, bruises and welts, to broken bones, internal bleeding, head trauma, and death. However, it may also
cause emotional harm, which can include flashbacks, panic attacks, insomnia, low self-esteem, difficulty in trusting others and being in relationships, eating disorders, depression, and suicidal ideations (CDC, 2012; Feder et al., 2011; Hegarty et al., 2010). In fact, women have indicated that the emotional forms of abuse are often more difficult to endure than the physical abuse (Feder et al., 2011). In order to cope with the ongoing trauma, victims may also smoke, drink, take drugs, or engage in risky sexual behaviors (CDC, 2012; Hegarty et al., 2010; Roark, 2010).

Women of childbearing age are especially prone to significant morbidity and mortality, as DV may adversely affect their ability to participate in occupational, social, and familial life events (Hegarty et al., 2010). Roark (2010) mentions an IPV prevalence range from 6% to 22% during pregnancy, with up to 45% of pregnant women reporting a history of IPV. In high-income countries, the IPV prevalence rate is reported to range from 3% to 11%, and 3% to 66% in low-income countries (Hassan, Kashanian, Hassan, Roohi, & Yousefi, 2014). Twenty-five percent of women that experienced abuse during pregnancy reported that the violence either commenced during pregnancy or worsened in pregnancy compared to when they were not pregnant. One-third of those women experienced a miscarriage (Hegarty et al., 2010). In addition to the many emotional effects and unhealthy coping mechanisms of pregnant woman who experience DV, there are other maternal and fetal effects including low maternal weight gain, anemia, infections, first- and second-trimester bleeding, fetal injury, pre-term birth, and even death of the mother and fetus (Hegarty et al., 2010; Roark, 2010). A cross-sectional study conducted in Iran found a significant association between IPV and adverse maternal outcomes, including preterm labor, caesarean section, antenatal hospitalization, and vaginal bleeding (Hassan et al., 2014).
Domestic violence can also be a risk factor for other devastating health effects on the woman, long after the abuse ends or the victim leaves the abuser. Female victims of DV are 80% more likely to suffer from stroke, 70% more likely to have heart disease, 60% more likely to have asthma, and 70% more likely to drink heavily, in comparison to women who have not experienced DV (Futures Without Violence, 2009). Additionally, other chronic sequelae of DV include gynecological symptoms/conditions, chronic pain, neurological symptoms, gastrointestinal disorders, and post-traumatic stress disorder (Feder et al., 2011; Zink et al, 2007).

Healthy People 2020 has responded to this epidemic by encouraging and emphasizing a need to reduce the incidence of DV through specific objectives including reducing physical, sexual, and psychological abuse, as well as reducing stalking by current or former intimate partners (HealthyPeople.gov, 2012).

**Screening for Intimate Partner Violence**

In 2013, the U.S. Preventative Services Task Force (USPSTF) published a new recommendation regarding IPV screening for all women who do not have signs or symptoms of abuse, based on new evidence (Moyer, 2013). The recommendation (Grade B) calls for all clinicians to screen women of childbearing age (14-46) for IPV and provide or refer women who screen positive to intervention services (Moyer, 2013). The benefits noted by the USPSTF include the findings that interventions are able to reduce violence, abuse, and physical or mental harm for adult women. With moderate certainty, the USPSTF concludes that such IPV screening for women of childbearing age has a moderate net benefit (Moyer, 2013). In addition, support for screening for IPV also comes from the Institute of Medicine, the National Advisory Council on Violence and Abuse, the American Congress of Obstetricians and Gynecologists, and the Committee on Child Abuse and Neglect (Nelson, Bougatsos, & Blazina, 2012).
Furthermore, a cross-sectional study using 2006-2007 data from Behavioral Risk Factor Surveillance System (BRFSS) surveys concluded that IPV victims were twice as likely to have had an HIV test or breast examination (Brown, Weitzen, & Lapane, 2013). Therefore, IPV screening in settings that offer HIV testing and breast examinations should be adopted (Brown, Weitzen, & Lapane, 2013).

**Conceptual Framework**

The Planned Care Model (PCM) is an adaptation of Wagner’s Chronic Care Model for IPV (Zink et al., 2007). The PCM improves the management of a variety of chronic illnesses, including improvement in patient outcomes, while also reducing health care costs. However, Zink et al. (2007) state major differences in applying PCM to IPV, in comparison to chronic illnesses such as congestive heart failure. In IPV, the patient does not have control over the abuser’s behavior. Therefore the patient can only take steps to create safety for herself. In fact, avoiding or leaving the abuse can place a victim at the greatest risk of being murdered (Zink et al., 2007). Secondly, while randomized controlled trials (RCTs) are the gold standard for evidence-based practice (EBP), the difficult and unique dynamics of IPV may not allow for RCTs. Therefore, research on IPV is usually based on other types of study designs (Zink et al., 2007). Through the use of PCM, the health organization must make IPV a priority through the implementation of policies and systems in order to identify and track IPV. Additionally, the health organization should train staff, as well as measure, monitor, and provide feedback on outcomes. Social services and advocacy agencies provide many services for victims of IPV. Therefore, the community is a critical component to addressing IPV and the health organization may collaborate with community agencies in order to improve patient outcomes, quality of care, and to reduce costs (Zink et al., 2007). Other critical components within the health system of
PCM are: patient self-management support, practice delivery system design, evidence-based decision support, and data information systems (Zink et al., 2007).

The EBP model that will be used to construct the methodology for this project is the Rosswurm and Larrabee’s EBP model. This model guides healthcare professionals through a systematic process for evidence-based practice change (Rosswurm & Larrabee, 1999).

According to Facchiano, Snyder, & Nunez (2011), this model includes six stages:

1. Assess the need for change
2. Link problem interventions and outcomes
3. Synthesize best evidence
4. Design practice change
5. Implement and evaluate practice change
6. Integrate and maintain practice change

**Literature Search, Critique, & Synthesis**

**Search Strategy**

Assistance from a nursing research librarian was sought in order to complete a literature search of articles that examined various types of IPV screening tools and modes of administration utilized for adult females. The databases and websites searched included PubMed, The Cochrane Library, and CINAHL, American Congress of Obstetricians & Gynecologists (ACOG), National Guideline Clearinghouse, and the Center for Disease Control and Prevention (CDC). In addition, the reference lists of chosen studies were also searched for additional articles of interest. Search terms included ‘domestic violence’, ‘intimate partner violence’, and relevant MeSH terms such as ‘domestic violence/prevention and control’, ‘domestic violence/trends’, and ‘domestic violence, intimate partner violence, battered women,
violence’ were included. These terms were linked with the term ‘screening’. The PubMed search was initially narrowed to articles published since 2002 (13 years), along with other inclusion criteria such as articles only regarding humans, written in English, and including subjects that were females 19+ years old. This search yielded 535 articles. The CINAHL search was narrowed to those published within the last eight years (2007-2015), with adult female subjects. This search yielded 620 articles. The Cochrane Library search terms included ‘domestic violence’ OR ‘intimate partner violence’, which yielded only eleven articles, of which only one was relevant. The three databases yielded a total of 1164 articles.

Titles and abstracts quickly eliminated the majority of the articles searched. Further examination of each study eliminated more articles. Inclusion criteria were as follows: only females as victims of IPV, with a specific screening tool(s), or a mode of administration. The acceptable settings were local, national, or international, in primary care clinics, rural health clinics, prenatal clinics, and family practice clinics. The study was chosen if it focused on adult females, whether pregnant or not. Articles were excluded for the following reasons: if perpetrators were females or combined females and males, if victims were males, if the study was conducted solely in the emergency department setting, if the study focused solely on sexual abuse, if no specific IPV screening tool was mentioned, if all other types of abuse were included in same study (such as elder abuse, child abuse, workplace abuse), if the study focused more on IPV interventions over screening, if the study focused on re-assault of previously identified victims of IPV, if the study was a quality improvement project, or if the focus of the article was regarding the comfort of the mother in being screened in front of her children. In addition, one literature review was also excluded. Eighteen articles met all the inclusion criteria. Other guidelines regarding IPV screening were not included at this time. The articles included five
descriptive, cross-sectional analysis, seven RCTs, and seven systematic reviews of literature. One article was a combined systematic review of literature and a partial meta-analysis.

**Grading Criteria**

Mosby’s Research Critiquing Tool was used to determine the level of evidence and internal validity of all articles. The levels of evidence are as follows:

- **Level I**: Meta-analysis
- **Level II**: Experimental design aka Randomized Controlled Trial
- **Level III**: Quasi-experimental design
- **Level IV**: Case controlled, cohort studies, longitudinal studies
- **Level V**: Correlation studies
- **Level VI**: Descriptive studies including surveys, cross-sectional design, developmental design, and qualitative studies
- **Other**: Review of Literature and Performance Improvement

The systematic reviews used in this literature synthesis were not assigned a level of evidence. Internal validity of each study design was graded using the Mosby’s Research Critiquing Tool. Good internal validity was defined as meeting all the criteria for the particular study design; fair internal validity was defined as meeting most of the criteria but is judged to have no fatal flaw that invalidates the results; and poor was defined as a study that contains a fatal flaw.

**Literature Synthesis**

**Study design.** Overall, the levels of evidence for studies regarding IPV screening were lacking in the literature. In the databases searched, there was only one partial meta-analysis (Level I) that met the inclusion criteria. Level III, IV, V, and VII studies were also lacking in
regards to the specific inclusion and exclusion criteria set forth by the researchers. Only three studies were rated as possessing ‘good’ internal validity (Chen et al., 2007; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; Kataoka et al., 2004), meeting all the criteria for an RCT or a systematic review. Another four studies were rated with ‘good-fair’ internal validity (Ahmad et al., 2009; Hassan, Kashanian, Hassan, Roohi, & Yousefi, 2014; Kataoka, Yaju, Eto, & Horiuchi, 2010; Nelson et al., 2012). Ten studies were rated as ‘fair’ quality (Calderon, Gilbert, Jackson, Kohn, & Gerbert, 2008; Coker et al., 2007; Klevens, Sadowski, Kee, Trick, & Garcia, 2012; MacMillan et al., 2009; O’Reilly, Beale, & Gillies, 2010; Paranjape, Rask, & Liebschutz, 2006; Sohal, Eldridge, & Feder, 2007; Taft, O’Doherty, Hegarty, Ramsay, Davidson, & Feder, 2013; Velasco, Luna, Martin, Cano, & Martin-De-Las-Heras, 2014; Wathen, Jamieson, & MacMillan, 2008) and only one study, a systematic review, was rated as having ‘poor’ internal validity for its study design (Renker, 2008).

**Subject characteristics.** All of the RCTs and cross-sectional descriptive studies involved females over the age of 18 (Ahmad et al., 2009; Calderon et al., 2008; Chen et al., 2007; Coker et al., 2007; Kataoka et al., 2010; Klevens et al., 2012; MacMillan et al., 2009; Paranjape et al., 2006; Sohal et al., 2007; Wathen et al., 2008). The combined meta-analysis and systematic review involved females over 16 (Taft et al., 2013).

Seven fair to good RCTs were found, involving a range between 126 to 6743 subjects (Ahmad et al., 2009; Calderon et al., 2008; Chen et al., 2007; Kataoka et al., 2010; Klevens et al., 2012; MacMillan et al., 2009; Wathen et al., 2008). The meta-analysis and systematic review reported a total of 13,027 subjects from 11 different studies (Taft et al., 2013). Three RCTs (Calderon et al., 2008; Chen et al., 2007; Klevens et al., 2012) and one cross-sectional study (Paranjape et al., 2006) involved mainly African American women; and five studies mentioned
subjects having low household incomes (Chen et al., 2007; Coker et al., 2007; Klevens et al., 2012; MacMillan et al., 2009; Paranjape et al., 2006). Two RCTs, two systematic reviews, and two cross-sectional studies focused on pregnant women, with three being conducted in Japan (Kataoka et al., 2004; Kataoka et al., 2010, O’Reilly et al., 2010), one in Iran (Hassan et al., 2014), one in Spain (Velasco et al., 2014), and one in the U.S. (Calderon et al., 2008).

**Settings.** The studies were conducted in different locations nationally and internationally. Nine practice settings within the studies were located on the U.S. mainland (Calderon et al., 2008; Chen et al., 2007; Coker et al., 2007; Klevens et al., 2012; Kataoka et al., 2004; O’Reilly et al., 2010; Paranjape et al., 2006; Rabin et al., 2009; Renker, 2008), five in Canada (Ahmad et al., 2009; MacMillan et al., 2009; Nelson et al., 2012; Rabin et al., 2009; Taft et al., 2013; Wathen et al., 2008), three in Japan (Kataoka et al., 2004; Kataoka et al., 2010; O’Reilly et al., 2010; Taft et al., 2013), two in London (Sohal et al., 2007; Nelson et al., 2012), two in Brazil (Nelson et al., 2012; Rabin et al., 2009), one in Sri Lanka (Rabin et al., 2009), one in Australia (Rabin et al., 2009), one in Hong Kong (O’Reilly et al., 2010), one in Spain (Velasco et al., 2014), one in New Zealand (Taft et al., 2013), and one in Iran (Hassan et al., 2014).

A total of 88 practice settings were included in the 18 articles. The studies were mainly conducted at general (25 studies) and family medicine (19 studies) clinics. Twenty-two studies were conducted at prenatal, postpartum, women’s health, family planning, obstetric/gynecology (OB/GYN) clinics, or hospital OB departments. Rural clinics were the site for eight studies and another five were conducted in emergency departments. However, as stated in the exclusion criteria, none of the articles covered in this review of literature focused solely on screening for IPV in the ED. Other sites included acute and urgent care clinics; a pediatric clinic; a hospital setting; and a public health clinic.
**Purpose.** The main purposes for the individual studies or systematic reviews differed, although they all generally described the results of using various IPV screening tools. In fact, it seems that only five articles were written with a purpose of either estimating the sensitivity and specificity of a tool, or comparing screening tools (Kataoka et al., 2004; Nelson et al., 2012; Rabin et al., 2009; Sohal et al., 2007; Wathen et al., 2008). Three of these studies were systematic reviews.

Furthermore, one RCT and three cross-sectional studies purposed to identify the prevalence of abused women (Hassan et al., 2014; Paranjape et al., 2006; Velasco et al., 2014; Wathen et al., 2008). Surprisingly, seven studies (5 RCTs and 2 systematic reviews) focused more on comparing different modes of administering the IPV screeners (Ahmad et al., 2009; Calderon et al., 2008; Chen et al., 2007; Kataoka et al., 2010; Klevens et al., 2012; Renker, 2008), including face-to-face interviews, written, and computer-assisted forms of the screeners.

Another common purpose among the studies was to measure the effectiveness of IPV screening, mainly in terms of decreasing IPV amongst women (MacMillan et al., 2009; Nelson et al., 2012; O’Reilly et al., 2010; Taft et al., 2013). Two systematic reviews also focused on interventions studied, including referrals made, and counseling once a woman had a positive screen for IPV (Kataoka et al., 2004; O’Reilly et al., 2010; Taft et al., 2013).

Other purposes for the studies included characterizing women with positive screens for IPV (Wathen et al., 2008), studying adverse effects of screening (Nelson et al., 2012; Taft et al., 2013), studying adverse maternal outcomes (Hassan et al., 2014), and identifying associated risk factors for IPV (Velasco et al., 2014). Lastly, Coker et al. (2007) were unique in their purposes for their cross-sectional, descriptive study. Their aims were to describe their efforts at implementing universal IPV screening, to describe the frequency of victimization of IPV, to
examine the relationship between past and current violence by IPV type, and to examine the extent to which women perceive violence to be a problem in their relationship.

As mentioned previously, four RCTs and systematic reviews focused specifically on screening instruments, modes of administration, and/or interventions used for pregnant adult females (Calderon et al., 2008; Kataoka et al., 2004; Kataoka et al., 2010; O’Reilly et al., 2010). However, other articles may have included prenatal or OB/GYN clinics as one of the sites of research for IPV screening.

**Screening tools utilized and psychometric properties.** The most commonly mentioned IPV screening tool in the 18 articles was the Abuse Assessment Screen (AAS), a five-item tool, listed in eight articles (Hassan et al., 2014; Kataoka et al., 2004; Nelson et al., 2012; O’Reilly et al., 2010; Rabin et al., 2009; Renker, 2008; Taft et al., 2013; Velasco et al., 2014). This particular instrument is used for pregnant women and covers physical, emotional, and sexual abuse (Basile, Hertz, & Back, 2007). Only Rabin et al. (2009) and Kataoka et al. (2004) included a sensitivity of 93-94% and specificity of 55-99%, in comparison to the Index of Spouse Abuse (ISA). According to Kataoka et al. (2004), the ISA and the Conflict Tactics Scale (CTS) have been used as the ‘gold standards’ for validity and reliability of IPV screening instruments, since they measure the frequency, type, and extent of partner abuse.

The Violence Against Women Screen (VAWS) is a seven-item Japanese IPV screening tool for use in the perinatal setting in order to detect physical, sexual, or psychological violence during pregnancy (Kataoka et al., 2004). The authors claim a sensitivity of 86.7% and a specificity of 80.2% with this tool.

The Women Abuse Screening Tool (WAST), a seven-item tool assessing for physical and emotional IPV (Basile et al., 2007), was used and mentioned in two studies (MacMillan et al.,
Wathen et al. (2008) reports a WAST sensitivity of 88% and a specificity of 89%, whereas MacMillan et al. (2009) reports a sensitivity of 92% and specificity of 100%. Furthermore, Rabin et al. (2009) reports a WAST sensitivity of only 47% and a specificity of 96%. Psychometric properties of tools mentioned in Renker’s systematic review were not reported. The shorter version (2 items) of WAST (WAST-Short) was utilized in Chen et al.’s (2007) RCT. Chen et al. reported a higher correlation (Cronbach’s alpha 0.81, p<.001) between the Hurts, Insult, Threaten, and Scream (HITS) screener and WAST-short, than between the HITS and WAST (Cronbach’s alpha 0.77, p <.001).

The HITS screener, a four-item screener that measures physical, emotional and verbal abuse (Basile et al., 2007), was also mentioned in two systematic reviews. Nelson et al. (2012) cited the use of both the English and Spanish versions of HITS, while Rabin et al. (2009) only mentions the use of the English version of HITS. The sensitivity of the HITS (English) was reported to be between 30-100% (Rabin et al., 2009) and 86% (Nelson et al., 2012). The specificities were reported to be between 86-99% (Rabin et al., 2009) and 99% (Nelson et al., 2012). The HITS (Spanish) had an even greater sensitivity of 100% and specificity of 86% (Nelson et al., 2012).

The Partner Violence Screen (PVS) is a three-item tool that assesses for physical IPV in the last year and current safety (Basile et al., 2007). It was utilized in a RCT by Klevins et al. (2012) and mentioned in three systematic reviews. Renker (2008) does not report the sensitivity or specificity of this tool in her article. The other authors vary in their ranges of sensitivities and specificities of the PVS. The sensitivities include 65-71%, 35-71%, and 65.4-71.4% (Klevins et
al., 2012; Rabin et al., 2009; Kataoka et al., 2004; respectively). The specificities of the PVS range from 80-94% (Kataoka et al., 2004; Klevins et al., 2012; Rabin et al., 2009).

The Humiliation, Afraid, Rape, Kick (HARK) tool was utilized by Sohal et al. (2007) and mentioned in Nelson et al.’s (2012) systematic review. This four-item tool, with yes and no answers, was found to have a sensitivity of 81%, a specificity of 95%, and a test accuracy of 92%, when utilized in 12 general practice waiting rooms in London. The HARK tool was found to have an optimal cut off score of ≥1, indicating that if four questions asked, if the woman answers yes to one or more questions, 81% of woman affected by IPV will be identified (Sohal et al., 2007).

Nelson et al. (2012) included studies in their systematic review that included other tools such as the Ongoing Violence Assessment Tool (OVAT) with a sensitivity of 93% and specificity of 86%; and the Modified CTQ-SF (Childhood Trauma Questionnaire – Short Form) with a sensitivity of 82% and a specificity of 89%. In addition, the STaT (Slapped, Threatened, and Throw) tool displayed a sensitivity of 89% and specificity of 100% with ≥2 positive responses. Paranjape et al. (2006) also reports a sensitivity of 84.8% and a specificity of 54% for the STaT tool, with a cut off point of two. According to Nelson et al. (2012), these three tools, along with the HARK, WAST, and HITS (English and Spanish versions), were the six instruments in their systematic review that demonstrated a sensitivity and specificity of >80% in clinical populations of asymptomatic women.

The Women’s Experience with Battering Scale (WEB) was utilized by Coker et al. (2007), in eight rural clinics in South Carolina, located in areas of medical scarcity. This ten-item tool assesses for emotional IPV or battering (Basile et al., 2007). Coker et al. (2007) combined the WEB with two assault questions and two violence history questions (within 5 years), for a
total of 14 questions. Overall, this combination also assesses for physical and/or sexual abuse. It was shown to have a strong internal consistency (Cronbach’s alpha of 0.95).

**Modes of administering screening.** Four articles specifically aimed at computerized screening methods for IPV victimization (Ahmad et al., 2009; Calderon et al., 2008; Klevens et al., 2012; Renker, 2008). Ahmad et al. (2009) and Calderon et al. (2008) utilized computer-assisted methods to administer their unique screening tools adapted and derived from the AAS. However, Calderon et al. (2008) utilized this method in five prenatal clinics in San Francisco, offering a $30 gift card, whereas Ahmad et al. (2009) used this touch-screen method in one urban, academic hospital-affiliated family practice clinic in Canada, without monetary compensation. Despite the differences in settings and incentives, the authors of both RCTs agreed that this method increased opportunities for women to discuss IPV with their provider. Calderon et al. (2008) claims that 85% of the women in the computer program group reported discussions with their provider, in comparison to only 23.5% in the control group. In addition, Ahmad et al. (2009) reported an increased detection of IPV by using the computer-assisted screening method. In both RCTs, reports were generated by the computer, for the providers, and were attached to the patient’s medical chart right before the visit. These reports summarized the patient’s risks for the provider. The actual interventions differed. In Calderon et al.’s (2008) study, the cueing sheet suggested possible counseling statements, whereas the printout in Ahmad et al.’s (2009) study provided appropriate contact numbers of community agencies. Furthermore, the patients were assessed for safety, offered referrals, and advised about follow-up visits (Ahmad et al., 2009). The authors of both trials concluded that computer screening effectively detects IPV in women.
Renker’s systematic review of literature (2008), focused on computer-assisted screening versus a face-to-face oral, and written screening formats in a variety of settings in the U.S. Besides one study, the other eight studies included in this article revealed a higher prevalence of IPV by using the computer-assisted method versus the written or interview formats (Renker, 2008). Klevens et al. (2012) also utilized different strategies used to screen women for IPV, including the computer-assisted screening, and healthcare provider oral screening, using the PVS tool. Overall, Klevens et al. (2012) found that women in the computer-assisted screening group disclosed IPV two and a half times more often than those screened by their healthcare provider. Klevens et al. (2012) advocates for the use of computer-assisted screening methods, as it consistently screens all women, whereas the providers may not, despite training, screen prompts, and availability of advocacy services on site.

Two other RCTs were designed to compare different ways of screening for IPV. Both studies compared a self-administered, written survey with an oral interview (Chen et al., 2007; Kataoka et al., 2010). Chen et al. (2007) discovered a similar rate of IPV disclosure with self-administered screening, medical staff interview, and physician interview. In contrast, Kataoka et al. (2010) found that the identification rate of IPV was significantly lower in the interview group versus the self-administered questionnaire group (19.4% vs. 29.4%). Kataoka et al. also conducted a systematic review (2004), comparing the same modes of administration. Besides the findings from the studies mentioned above, a third study actually showed a fourfold higher identification rate of IPV, as a result of face-to-face interviewing (29.3%) versus a written questionnaire (7.3%). Perhaps different ethnic groups may prefer different modes of screening.

**IPV prevalence.** The rates of IPV prevalence varied across articles and studies within the articles. The lowest rate was reported to be between 13-15% (Calderon et al., 2008; Chen et al.,
2007; Coker et al., 2007; MacMillan et al., 2009; Paranjape et al., 2006; Wathen et al., 2008) although different screening tools were used in each study. These rates were reported from studies conducted in the U.S. and Canada, and included heterogeneous samples of women of mainly African American, Hispanic/Latina, and White racial and ethnic backgrounds. A higher IPV prevalence rate of 22-23% was reported in three studies (Ahmad et al., 2009; Sohal et al., 2007; Wathen et al., 2008). These rates were reported in Canada and in London, using different screening tools, and included women of British, Canadian, African, Caribbean, Indian, Pakistani, or Bangladeshi racial and ethnic backgrounds. In Kleven et al.’s study (2012), IPV prevalence rate was detected at 8.7% in healthcare provider-interviewed method, versus at 21.3% in the computer-assisted screening method. Similarly, Kataoka et al. (2004) and Kataoka et al. (2010) reported a 19.4% prevalence rate among pregnant Japanese women, using the interview method, versus 29.4% in the self-administered questionnaire group.

Additionally, two cross-sectional studies, conducted in Spain (Velasco et al., 2014) and Iran (Hassan et al., 2014), reported IPV prevalence in pregnancy. Velasco et al. (2014) reported an overall IPV lifetime prevalence of IPV as 24.2% and 7.7% in the 12 months prior to delivery. In contrast, Hassan et al. (2014) reported an overall IPV prevalence in pregnancy of 72.8% (Emotional 48%, Physical 44.1%, Sexual 30.2%).

Summary of Literature Review

**Strengths, quality, quantity.** The strengths of the studies included in this literature review and synthesis include the use of previously validated, short, IPV screening tools. Many of these tools can be used in fast-paced primary care practices. While many of the RCTs did not meet all the criteria of the study design to be deemed ‘good’, they were well designed overall. The RCTs represented level II evidence. Another strength of the combination of studies,
regarding IPV screening, is that many of these studies were conducted in many different settings, from the ED to a public health clinic. In addition, the studies offered national and international data from a number of female subjects (up to 6743 women in one study). In a number of studies, no significant differences in subject characteristics were found between the intervention and control groups.

**Weaknesses, limitations, gaps.** This review only included one combined systematic review and meta-analysis (Taft et al., 2013). However, there were many flaws with this review, as studies with different objectives were compared. While the review/meta-analysis did show that screening increases the identification of women afflicted by IPV, the authors stated that it was inconclusive whether universal screening should be upheld, due to a lack of conclusive outcomes of screening. It is evident that more studies need to be conducted which specifically defines the objectives in order to detect statistical significance.

In addition, most of the articles were rated as ‘fair’ due to a lack of certain criteria appropriate for the study’s design. The most common limitation of the studies included in this literature synthesis is the attrition rates of the subjects in the studies. However, one would expect attrition rates to be higher in studies involving IPV, due to the nature of the issue. In fact, one RCT reported an attrition rate of 42% (MacMillan et al., 2009).

Many articles did not define IPV. Therefore, reported rates of IPV may be greatly skewed, depending on the screening tool used and the IPV definition used for that particular study. Some studies may only report IPV as positive if there is physical abuse, while ignoring emotional, psychological, verbal, and sexual abuse. Furthermore, there is no one true ‘gold standard’ to compare all other screening tools to, in order to determine which tool is best for screening certain populations. Many authors admitted the possibilities of selection bias or self-
selection. For example, in many IPV cases, the perpetrator may refuse to leave the room. Therefore, although a woman is supposed to be screened or included in the study, she may not be able to participate due to the presence and influence of the perpetrator. Additionally, some studies reported that if a woman was with a child over three or four years of age, she was also excluded for her own safety, being that the child may inadvertently prevent the woman from disclosing IPV or inform the perpetrator about the discussion. Self-selection may also be an issue, as many true victims of IPV may be reluctant to participate in a study, for fear of retaliation by the perpetrator, or personal shame and guilt about having experienced IPV.

Another limitation of the studies is the high rate of a specific ethnic or income group in the sample in a single study. This may affect the generalizability of the findings to other locations and populations. Self-reported findings were another limitation mentioned in different articles, as this could lead to reporting bias. Lastly, the inconsistency of offering compensation or incentives to participate in certain studies may affect the overall results.

A single, operational definition of IPV should be used across all studies, in order to grasp a more precise view of the issue in its entirety. Furthermore, tools should all screen for the different types of IPV, including physical, emotional, psychological, verbal, and sexual abuse. Magnussen et al. (2011) state that API women report a lower rate of IPV in comparison to other cultural groups. However, the IPV prevalence has been reported to be equal in the API groups when compared to other ethnic, racial groups of women. Therefore, Magnussen and her team conducted a cross-sectional, descriptive study, in order to assess the reasons for the lack of IPV reporting in the API groups. The results clearly depicted cultural barriers to reporting violence. Therefore, one of the authors’ conclusions is that a culturally-sensitive screening instrument needs to be developed and utilized with the API populations (Magnussen et al., 2011). However,
a gap still exists in research focused on studying the use of different screening tools in the API populations in Hawai`i.

**Preliminary recommendations for practice change.** Although there are numerous IPV screening tools available, the right tool must be chosen carefully, in order to fit the characteristics and culture of the population being screened for IPV. The recommended tool for pregnant women is the AAS, which is a five-item tool that assesses for physical, emotional, and sexual abuse. For all other women, other IPV screening tool recommendations include the WAST, HITS, HARK, OVAT, and STaT screening tools.

In regards to the mode of screening, the computer-assisted screening method is recommended if funding at the site allows for the implementation of this change. Computer-assisted screening of all women may save the provider time, while assessing for many risk factors in addition to IPV. The use of a computerized screening system will also provide the health center an easy way to collect and keep track of information. In addition, outcomes of interventions and patient satisfaction rates can be measured continuously, without adding to the burden of the provider. However, if the cost of implementing a computer-assisted screening program is too high, further assessment needs to be completed in order to determine the most effective way of administering a screening tool for IPV at the site. The minimum requirements would be privacy for the woman being interviewed or filling out a self-administered questionnaire. All women, between the ages of 18-64 should be screened routinely for IPV.

**Summary**

Clearly, IPV is a concern not only in Hawai`i, but also across the nation and throughout the world. The issue poses a threat to men, women, and children through direct acute and chronic health consequences. In addition, IPV imposes large healthcare costs on employers, tax-payers,
and healthcare systems and individual providers. The USPSTF’s new recommendation for all clinicians to screen women of childbearing age for IPV and to provide or refer those who screen positive to intervention services, prompted the undertaking of a literature critique and synthesis regarding IPV screening tools. The Planned Care Model and the Rosswurm and Larrabee Evidence Based Model were used as the conceptual frameworks for this DNP project.
Chapter 3: Methods

Introduction

This chapter will present Waianae Coast Comprehensive Health Center’s (WCCHC) services, the Women’s Health Department’s current domestic violence screening procedure, as well as the problem with their current procedure. Additionally, the specific objectives and the planned activities of the Doctor of Nursing Practice (DNP) project will be introduced. A logic model, timeline of events, and implementation methods will be presented. Furthermore, program evaluation methods, including specific indicators, methods to gather data, and an analysis and dissemination plan will be discussed in this chapter. Lastly, this chapter will also discuss ethical considerations and limitations of the methodology that will be used.

Purpose Statement

The purpose of this DNP project is to implement an updated, evidence-based domestic violence screening tool to be used for pregnant females of all ages, during their initial prenatal visits and during their postpartum visits at WCCHC’s Women’s Health Department. The goal would be to increase the detection of domestic abuse in pregnancy or a history of abuse, in order to provide these women with appropriate intervention services currently in place at the Waianae Coast Comprehensive Health Center’s (WCCHC’s) Women’s Health Department. Other intended outcomes would be to increase the staff’s overall knowledge and understanding about DV dynamics, as well as to increase their understanding and participation regarding updated screening and intervention practices.

Definitions

For the purpose of this DNP project, The NCAVD’s definition of domestic violence will be used. This definition encompasses intimidation, physical assault, battery, sexual assault,
and/or other abusive behavior perpetrated by an intimate partner against another, including emotionally abusive and controlling behavior. A prenatal visit is any visit that the pregnant female is specifically seen for a routine initial or followup obstetric (OB) appointment. In addition, the postpartum visit is defined as any visit that occurs from three to eight weeks after delivery.

The providers that will conduct the screening for the purposes of this project will include any nurse practitioner or certified midwife.

**Setting**

**Waianae Coast Comprehensive Health Center**

**Program context & resources.** The WCCHC is a non-profit, patient-centered medical home (PCMH), consisting of four different campuses including the main Waianae Coast campus, Kapolei Health Care Center, Nanakuli James & Abigail Campbell Clinic, and Waipahu Family Health (Waianae Coast Comprehensive Health Center, 2013). WCCHC strives to address health disparities, improve population health, and to reduce health inequalities despite financial and cultural barriers (WCCHC, 2013).

Services include general practice, family practice, dental care, emergency services, pediatrics, women’s health, and pharmacy. In addition, WCCHC includes a Native Hawaiian Healing Center, which promotes culturally-sensitive, traditional Native Hawaiian healing and cultural education, practices, and traditions (WCCHC, 2013).

As of 2010, the total population on the Waianae Coast was 48,519 (WCCHC, 2014). The majority of the population is made up of Hawaiians (58.5%), Whites (38.3%), Filipinos (28.3%), Chinese (18.6%), and Japanese (11.1%). The average per capita income is $17,300, with 49.2% of households with children receiving assistance (WCCHC, 2014).
Specifically, the Women’s Health Department at the main campus on the Waianae Coast provides reproductive health care, including visits for well woman exams, problem visits, sexually transmitted disease screening and treatment, anonymous Teenclinic visits, obstetric services, ultrasounds, mammograms, DEXA scans, dietary counseling, and behavioral health.

Currently, in the Women’s Health Department, women receiving prenatal care range in age from 13 to 42 (P. McKenzie, personal communication, March 17, 2014). There is an average of 12-13 prenatal visits per pregnancy. Ethnicities of the female patients seen for prenatal care include Caucasians, African-Americans, Hawaiians, other Pacific Islanders, and Asians (P. McKenzie, personal communication, March 17, 2014). In regards to maternal and child health indicators from 2005-2010, the crude birth rate (per 1,000) on the Waianae Coast is 19.8%. Eight percent of births resulted in low birth weights on the Waianae Coast and 5.5% of births occur to women under 18 years of age (WCCHC, 2014).

Five University Clinical, Education, and Research Associates (UCERA) OB/GYN physicians see patients for prenatal care at the WCCHC main campus Women’s Health Department. Three UCERA OB/GYNs provide care for pregnant women at the Kapolei and Waipahu campuses. Currently, there are four nurse practitioners (NPs) and one certified nurse-midwife (CNM) that provide prenatal services for pregnant women at the main campus. There is one CNM at the Kapolei campus and one NP at the Waipahu campus that provide prenatal care.

**Assessment of the Need for Change in Practice**

**Current Procedures for Intimate Partner Violence Screening of Pregnant Women at Waianae Coast Comprehensive Health Center**

Currently, different screening tools for domestic violence are used at WCCHC. First of all, there is no self-administered IPV screening tool given to women at the Women’s Health
Department. For non-pregnant women, the Electronic Medical Records (EMR) system includes a button, which displays three questions that solely assess for physical and sexual abuse.

![DOMestic Abuse SCREEN](image)

**Figure 3.1. Current EMR DV Screening Tool for Non-pregnant Women**

For pregnant women, a checkbox is included on a paper chart, which includes three checkboxes and not does include specific questions to assess for IPV (see Figure 3.2). One box says, ‘Abuse screen’, the second box says, ‘DV screen,’ followed by ‘Type of Abuse,’ and the third box says, ‘Abuse Screen Completed.’ If the woman admits to some type of abuse, the provider will further assess the situation and determine if there is a need to call for immediate help from outside resources or the perinatal team. The perinatal team consists of three case managers. If the provider determines that the situation is not lethal, he/she may do continuous follow-ups upon each prenatal visit. Currently, only the advanced practice registered nurses (APRNs) conduct initial prenatal visits. Therefore, in terms of providers, the initial DV screening is always completed by an APRN.

![Initial OB Screen](image)

**Figure 3.2. Current Initial OB Screening Questions for Pregnant Women**
The perinatal case managers, consisting of Bachelor’s degree-prepared professionals, use a more consistent IPV screening tool during the first prenatal visit, which assesses the existence of physical, verbal, emotional, and sexual abuse (see Table 3.1). If a woman admits to abuse in some form, the perinatal case managers will then assess the lethality and immanency of the situation and help the woman to create a safety plan. If the situation is lethal, they will provide a safe place in the clinic for the victim until appropriate calls are made for the safety of the victim. If the situation is not deemed to be lethal, the perinatal case managers will follow-up on every prenatal visit thereafter, which occurs at least once a month. The case managers also provide the victim with resources such as Temporary Restraining Order (TRO) information, as well as IPV shelter numbers.

Table 3.1

*Current Intimate Partner Violence Screening Questions Used by Perinatal Case Managers*

<table>
<thead>
<tr>
<th>At any time has your partner or someone close to you ever:</th>
<th>NO</th>
<th>YES</th>
<th>Within the last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Controlled or isolated you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Been verbally abusive to you in public/private?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Threatened you or your family members?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Hit, punched, slapped, kicked, or frightened you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Forced you to have sex or perform sexual acts against your will?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Current Intimate Partner Violence Screening Statistics from the Perinatal Case Managers

Table 3.2

2008-2012 Intimate Partner Violence Screening Statistics for Pregnant Women

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total pregnant women</td>
<td>778</td>
<td>830</td>
<td>857</td>
<td>847</td>
<td>857</td>
</tr>
<tr>
<td>screened</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive for IPV in current pregnancy</td>
<td>23 (3%)</td>
<td>34 (4%)</td>
<td>33 (4%)</td>
<td>34 (4%)</td>
<td>27 (3%)</td>
</tr>
<tr>
<td>Positive history of IPV</td>
<td>5 (0.6%)</td>
<td>22 (3%)</td>
<td>49 (6%)</td>
<td>44 (5%)</td>
<td>48 (6%)</td>
</tr>
</tbody>
</table>

(T. Gonsalves, personal communication, August 29, 2013)

Current Problems with Intimate Partner Violence Screening at Waianae Coast

Comprehensive Among Pregnant Women

Although Waianae Coast Comprehensive Women’s Health Department is using an IPV screening tool for non-pregnant patients through the EMR system, providers are not consistent in their assessment of IPV during the initial prenatal visit and during follow-up visits. There is currently no standardized screening tool being used by providers for pregnant women. In addition, every provider assesses for abuse in her own way of questioning. The purpose of this project is to standardize care so that every provider uses an evidence-based standardized screening tool for all pregnant women and an appropriate protocol following a positive screen.

While the perinatal case managers play a crucial role in identifying and following up with pregnant victims of IPV, the ongoing care from the medical provider may present additional opportunities to screen and to identify victims during pregnancy as well as in the postpartum
period. In addition, well baby checks may present yet another opportunity to screen women for IPV in the postpartum period. It is hoped that a woman, who has established trust throughout her pregnancy with the provider and the perinatal team, would be more likely to admit to IPV in the postpartum period.

**Linkage of the Problem with Interventions and Outcomes**

**Overall Program Goals**

The goal of this program would be to identify and address pregnant and postpartum female victims of IPV, visiting WCCHC’s Women’s Health Department, through routine, efficient, and effective IPV screening. In addition, this program would also seek to increase awareness about domestic violence in the clinic and to provide victims with appropriate services in the clinic and in the community.

**Program Objectives**

In order to fulfill the overall goals of this program at WCCHC, a number of objectives will be met. These include:

1. Assessing the needs of WCCHC staff for IPV screening and interventions
2. Obtaining the current, baseline prevalence (as a result of screening) of IPV amongst pregnant women at WCCHC
3. Developing educational interventions about IPV for the staff and patients
4. Developing an updated screening protocol for pregnant women, to be used by the providers, based on a literature review of current IPV screening tools.
5. Implementing educational interventions (e.g. training sessions regarding screening and updated protocols for staff)
6. Evaluating the impact of a new protocol for standardized, consistent IPV screening among pregnant women, as well as the impact of educational interventions.

7. Improving overall IPV screening practices at WCCHC

**Overall Implementation Methods per Objective**

1. Assessing the needs of WCCHC staff for IPV screening and interventions
   a. Providers and perinatal case managers will be informally interviewed regarding current IPV screening and intervention practices with pregnant women

2. Obtaining the current, baseline prevalence (as a result of screening) of IPV amongst pregnant women at WCCHC
   a. Current IPV screening data from perinatal case managers will be obtained from the case management supervisor

3. Developing educational interventions about IPV for the staff and patients
   a. New discrete resource phone number card will be designed for WCCHC
   b. An IPV training Powerpoint presentation will be developed for all staff in the Women’s Health department at WCCHC

4. Developing an updated screening protocol for pregnant women, to be used by the providers, based on a literature review of current IPV screening tools.
   a. Literature review will be completed regarding evidence-based IPV screeners
   b. IPV protocols and procedures will be updated according to evidence-based research

5. Implementing educational interventions (e.g. training sessions regarding screening and updated protocols for staff)
a. IPV screening tools may be changed according to evidence-based review of literature
b. Training sessions will be held for WCCHC staff, in order to inform them of new screening practices, protocols, and procedures

6. Evaluating the impact of a new protocol for standardized, consistent IPV screening among pregnant women, as well as the impact of educational interventions.
   a. A pre- and post-survey will be administered before and after staff training sessions
   b. The number of resource cards handed out and taken will be calculated

7. Improving overall IPV screening practices at WCCHC
   a. Updated IPV screening data will be obtained from case management supervisor at the end of the implementation period

Marketing Plan

The five APRN’s currently employed at the main campus will be the providers targeted for the implementation of the DV screening tool with pregnant and postpartum females for the purposes of this DNP project. The training session, with recent current events and true stories of victims of IPV, will also be used to trigger an emotional connection to the subject of screening for IPV. In addition, simplified, informational handouts will be provided for the staff, in order to decrease certain barriers related to complexity of DV and time consumption.

Synthesis of the Best Evidence

Chapter two presented the literature search and review of domestic violence screening tools. The Abuse Assessment Screen (AAS) is a five-item tool used for pregnant women and screens for physical, emotional, and sexual abuse. The sensitivities and specificities ranged
throughout the studies from 93-94% and 55-99%, respectively, in comparison to the Index of Spouse Abuse (ISA). This tool was chosen to be the DV screening tool for all pregnant and postpartum women, upon all initial obstetric and postpartum visits.

**Design for a Change in Practice**

**Elements of Practice Change**

The main activity of the program was to be able to implement an evidence-based screening tool to accurately identify pregnant women afflicted by domestic violence at WCCHC by August of 2014. The current screening and intervention practices, as well as training needs of WCCHC’s staff and providers were assessed. WCCHC’s procedures and clinical protocols for domestic violence screening, intervention, and referrals were updated. Furthermore, a simple, one-page, colored algorithm was created for providers to follow as they screen patients for DV. In-clinic and community resources were simplified and presented to staff. Pertinent staff was trained regarding new screening tools, interventions, protocols, algorithms, referrals, and proper documentation prior to implementation.

Prenatal records are completed on paper-form charts at this time. Therefore, the screening tool was implemented as part of the APRN’s initial prenatal packet. A simplified safety planning guide was printed on the back of the screener in case the providers needed to create a plan with current victims of IPV. Additionally, staff were given discrete IPV contact numbers referral cards and an updated community resource referral list.

**Characteristics of the practice change.** The element of the Diffusion of Innovation Model (Rogers, 2003) that may present the most barriers is the Social System element. It was likely that there would be no problem with opinion leaders in the adoption of a new or updated tool, since it comes through “authority innovation-decisions” (Rogers, 2003, p. 28). Fortunately,
the Director of Women’s Health agreed with the innovation and assisted in its implementation. Therefore, providers were much more likely to adopt an innovation because the implementation was communicated and supported by the director. A fast rate of adoption can occur due to this authority decision (Rogers, 2003).

However, the sub-elements of the Social System element that may pose a threat are the “consequences of innovations” (Rogers, 2003, p. 30). The provider using the screening tool may find a positive screen to be “undesirable” (p. 30), as it may increase the time spent with the patient and may complicate the visit. Additionally, the provider may personally feel uneasy with executing interventions or may not feel there is enough support in place. Secondly, the provider may not see direct positive consequences (Rogers, 2003) of detecting more women afflicted by DV. For example, staff and providers may feel that it is a waste of time to detect and attempt to intervene if they do not see the woman out of the abusive relationship.

In order to overcome these barriers to the project, one of the critical steps was to train all staff and providers in the purpose of detecting more women in DV and what we hoped to accomplish. The fact that a provider is able to listen, believe, and validate her is a large form of success. If the woman has found the one person that she can openly talk to, who will not judge her, and who will encourage her, success has been partially achieved.

Secondly, a simple protocol that providers can easily access may help them feel comfortable in beginning to intervene. Additionally, having a perinatal case manager trained and ready at all times may be an alternative to interfering with the provider’s clinical productivity in regards to time spent with the patient.

Fourthly, bi-monthly data sheets were generated to show staff and providers our increase in detection (Mitchell, Fisher, Hastings, Silverman, & Wallen, 2010). Most importantly,
testimonies that protect the identity of the woman helped were sought and shared in order to link the screening tool to a life saved. Buy-in must be sought during the training session in order to increase the rate of adoption and in order to increase the chances of long-term sustainability.

Table 3.3

*Characteristics of the Practice Changes at Waianae Coast Comprehensive*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Advantages</th>
<th>Barriers</th>
<th>Ways to Overcome Barriers</th>
</tr>
</thead>
</table>
| **Relative Advantage** | • Hardcopy screener as part of initial OB packet  
• Minimal cost: 1 extra paper  
• Screener should take less than 5 min to complete | • There may not be immediacy of reward | • Remind providers purpose for screening and success is not measured by woman leaving partner but by adding a support system |
| **Compatibility** | • Patients are already being screened for DV at each initial visit if partner is not at visit | • May take more time with patient while providers are being pushed for increased productivity  
• Some providers may not perceive DV to be a significant issue | • Provide/coordinate support in the clinic  
• Speak to perinatal case mers in order to gain buy in and listen to their barriers  
• Allow for 3 simple steps if woman admits to DV  
• During training session, find ways allow staff to connect emotionally through statistics, testimony, health consequences, & visuals |
| **Complexity** | • Relative ease, straightforward screening tool on paper | • What happens if the woman admits to DV?  
• Difficulty in asking partners to leave the room | • Ensure providers and staff are trained with algorithm and protocols  
• Discuss perinatal role in assisting providers  
• Create a policy to ensure providers have at minimum 5-10 minutes alone with patient at the beginning or end of initial OB visit |
| **Trialability** | • Allow 1 full week for piloting screening tool, get verbal feedback and make changes by the next week | • Timeline pushed back | • Be flexible regarding timeline of events for SIP |
| **Observability** | • Providers and staff will receive data report to show results after implementation period of 12 weeks | • Providers may not see immed results or results that they would want to see such as hearing that the woman has left her abusive partner | • Remind providers purpose for screening and success is not measured by woman leaving partner but by adding a support system |
Program Logic Model

Intimate Partner Violence Evidence-Based Screener Logic Model for Waianae Coast Comprehensive Women’s Health

**Figure 3.3. Program Logic Model**

### Implementation and Evaluation of the Practice Change

#### Proposed Methodology

**Planning**
- Assessing staff needs regarding IPV current screening & intervention practices

**Work on designing tool, methods of education, creating of educational materials**
- Training Begins Followed by Implementation
- Implementation Period = 16 weeks
- Program Evaluation Begins
- Collect Data

**Report**
- Write Up
- Prepare to Defend
- Presentation of Evaluation to WCCHC & DNP committee at UH-Manoa

**External Factors:** New staff will need to be trained immediately regarding IPV screening, interventions, protocols and procedures. Guidelines for IPV screening and interventions may change. Grants may be sought in order to develop more expensive methods of screening and interventions.

**Assumptions:** Implementing Evidence-Based IPV Screeners and Interventions will identify, prevent, and help to address intimate partner violence among pregnant women in the Waianae Coast Community

**Figure 3.4. Timeline of Implementation Events**
Target audience. All teenage and adult pregnant females who are visiting WCCHC Women’s Health Department (main campus) for any prenatal or postpartum visit were to be screened routinely for intimate partner violence. Only females who are planning to continue their pregnancies were included in this project.

The five APRN’s currently employed at the main campus were the providers targeted for the implementation of the DV screening tool with pregnant females for the purposes of this DNP project. The official implementation interval spanned 16-weeks, from the beginning of August 2014 – the end of November 2014.

Instrumentation

Domestic violence screening tool. According to a literature critique and synthesis on DV screening tools (Morita, 2012, unpublished), the AAS, a five-item tool that assesses for physical, emotional, and sexual abuse, is the recommended tool for pregnant women. It also includes a body map to document areas of injury. This AAS (see Appendix E), a clinician administered DV screening tool, was developed by McFarlane, Parker, Soeken, and Bullock in 1992 (Basile, Hertz, & Back, 2007).

The populations in which this tool was studied included abused pregnant and non-pregnant African-American, Hispanic, and white women in health and prenatal clinics and emergency departments. The test/retest reliability across the same trimester for pregnant women is 83%. Using the Index of Spouse Abuse (ISA) as the gold standard, the sensitivity of the AAS is 93% and the specificity is 55% (Basile, Hertz, & Back, 2007). The ISA is a longer, established IPV tool that is used mainly for research to assess IPV frequency and severity (Rabin, Jennings, Campbell, & Bair-Merritt, 2009).
Specific indicators. The indicators that were used to measure activities and participation, as part of the process evaluation included:

- Quantitative Data
  - # of women presenting for initial OB or postpartum visits
  - # of women screened for IPV
  - # of women afflicted by IPV identified
  - # of providers, perinatal case managers, & other staff trained
  - # of DV resource cards or taken or distributed in clinic
  - Change in WCCHC’s staff knowledge and understanding about DV as a result of training sessions
  - Change in WCCHC’s staff comfort level in screening for DV as a result of training sessions
  - Change in WCCHC’s staff attitudes towards DV screening as a result of training sessions
  - Change in WCCHC’s staff understanding of new protocols, & procedures regarding DV screening and interventions as a result of training sessions
Gathering the Data

Table 3.4

Methodology to Gather Evaluation Data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Who &amp; How</th>
<th>Specific Tool/Log Used?</th>
<th>When</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. # of providers &amp; staff trained</td>
<td>DNP student will keep a written log with names of attendees at each session</td>
<td>See Appendix A for training session log</td>
<td>Aug 2014</td>
<td>Descriptive Statistics</td>
</tr>
<tr>
<td>2. Change in staff/provider knowledge, attitudes, comfort level with screening &amp; understanding of new protocols &amp; procedures</td>
<td>Pre &amp; Post Survey of staff/provider training sessions</td>
<td>See Appendix B for Pre/Post Training Survey</td>
<td>Before and after (Pre/Post) training session</td>
<td>Descriptive Statistics &amp; Trend Analysis</td>
</tr>
<tr>
<td>3. # of women presenting for initial OB or Postpartum visits</td>
<td>• Providers will be asked to manually log # of Initial OB or Postpartum visits • DNP student will also manually count # of schedule appointments for Initial OB or Postpartum visit during implementation period</td>
<td>See Appendix L &amp; M for Provider IPV Screening Log</td>
<td>Nov 2014</td>
<td>Descriptive Statistics &amp; Trend Analysis</td>
</tr>
<tr>
<td>4. # of women screened by perinatal case managers (Prior to and after implementation)</td>
<td>• Current #s from case mgmt. • #s from case mgmt from time of implementation to end of evaluation period • Providers will be asked to manually log # of women screened daily</td>
<td>None</td>
<td>Feb 2014 &amp; Nov 2014</td>
<td>Descriptive Statistics &amp; Trend Analysis</td>
</tr>
<tr>
<td># of women screened by providers (After implementation)</td>
<td></td>
<td>See Appendix L &amp; M for Provider IPV Screening Log</td>
<td>Nov 2014</td>
<td></td>
</tr>
<tr>
<td>5. # of women afflicted by IPV identified</td>
<td>Providers will be asked to manually log # of women screening + for IPV each day (anonymously) and check off if woman was counseled, given phone card, referred to BH or perinatal case manager</td>
<td>See Appendices N &amp; O for Provider + IPV Log</td>
<td>Nov 2014</td>
<td>Descriptive Statistics &amp; Trend Analysis</td>
</tr>
<tr>
<td>6. # of DV resource cards taken or distributed</td>
<td>Count # of cards printed, distributed based on how many left in an area &amp; how many left at end of implementation period</td>
<td>See Appendix P for resource card log</td>
<td>Nov 2014</td>
<td>Descriptive Statistics</td>
</tr>
</tbody>
</table>
Analysis Plan

Analysis regarding DV screening was completed to determine if there has been an increase in DV screening by staff and providers, following the implementation of a new screening tool and protocol. Descriptive statistics and trend analysis will be used.

Changes in the staff and provider’s knowledge of DV, attitudes toward screening, comfort levels with screening, and understanding of WCCHC’s DV protocols were analyzed using descriptive statistics. Most of the survey question responses used a Likert scale.

The number of resource cards distributed, number of staff and providers that attended the training session, the number of women screened, and the number of DV victims identified were reported.

Feedback

The final full written report was given to the Women’s Health Director and the perinatal case management supervisor at WCCHC and it was submitted to the Doctor of Nursing Practice (DNP) committee at the University of Hawaiʻi at Mānoa (UHM). In addition, a Powerpoint presentation took place that was open to the public at UHM on April 14, 2015.

Summary data sheets were provided to the management, staff, and providers at the clinic and included:

- Data regarding the percentage of staff educated and trained
- Data regarding # and change in # of women screened
- Data regarding # of women identified as a victim of DV
- Changes in staff knowledge, attitudes, understanding, and competency in DV screening and interventions
Integration and Maintenance of the Practice Change

Once the presentation is completed and full reports have been disseminated, final feedback will be obtained from various stakeholders. The specific stakeholders will include the UHM DNP committee and staff at WCCHC Women’s Health department, including the perinatal case managers. If the staff determines that the new DV screener and protocol has been effective for pregnant women at WCCHC, they will be permanently implemented in the Women’s Health department for all pregnant and postpartum women. The screening tool and protocol will also be expanded to all satellite clinics that offer prenatal care.

In order to ensure sustainability of the project, the DV screening tool will be integrated into the EMR system for all postpartum and prenatal visit templates. The DNP student will also continue to be an in-clinic resource for providers, case managers, and patients. Ensuring continued staff education about DV will further sustain the project. Furthermore, sustainability of the project can be encouraged by maintaining policies to allow providers and perinatal case managers privacy to screen pregnant and postpartum women for DV.

Ethical Considerations

This proposal was designed in such a way as to protect the rights of any human subjects involved in the project. As a quality improvement initiative, there were no plans to randomize subjects to different treatments. Instead a standard, evidence-based screening tool was implemented and person-identifiable information was not collected.

The author completed the University of Hawai‘i required Collaborative Institutional Training Initiative (CITI) course in Human Subjects Protection. This proposal was reviewed by a committee consisting of faculty and clinical experts in order to ensure that there was adequate human subjects protection.
The most obvious ethical dilemma that may affect the implementation of an evidence-based domestic violence screener is the involvement of a vulnerable population, which includes all pregnant women, including pregnant teenagers.

The ethical tenets of non-maleficence and beneficence may interfere with this project, especially with this delicate issue. For example, some providers may feel that screening may put their patients in more harm, especially if they have to ask the male to step out of the room in order to conduct the screening. The male may become highly suspicious or even jealous and may abuse the patient after the visit is completed. However, the provider may struggle with lack of beneficence if they choose to not screen or ignore the issue, which can certainly result in harm to the patient and her fetus or newborn.

The ethical tenet of autonomy may also be called into question. While a practice protocol and guideline for screening pregnant women will be established, the APRNs who will be utilizing the screener may need to tailor their approach at times, according to the patient-provider relationship that has or has not been established. The provider has the autonomy to decide what may be best for the patient or how to tailor the visit to present an opportunity to speak to the woman alone. In regards to the trainings, providers and other staff may not desire to complete the pre- and post-surveys, which may result in low response rates. Providers may also refuse to utilize the DV screener if they find difficulty in overcoming barriers such as time or uncertainty with interventions if the woman screens positive for DV.

**Limitations**

This project had many limitations. First of all, the implementation period occurred over 16 weeks, which may not have been adequate time to accurately evaluate the project to ensure all staff was properly trained and to result in sustained practice change. The practice change was
implemented in a fluid environment, with conditions that were not constant. There was no control for certain variables that may affect the implementation of the screener. During the short time of implementation, the sample size that will actually be screened may be too small and may not be representative of the Waianae coast population. The tools used for the evaluation of this practice change have not been deemed to be valid or reliable in this population.

In regards to data collection and analysis, providers that were on vacation during the training and implementation period will not be included in the data collection. The staff performed self-ratings after the trainings, which may not accurately reflect changes in their understanding or knowledge. Descriptive and trending analysis was completed and there was no control for any variation.

Finally, WCCHC serves a large percentage of Native Hawaiians and other Pacific Islanders. This site also offers unique and comprehensive services. Therefore, this project may not translate to other community health centers in other regions, states or countries that do not serve similar patient populations or have comprehensive services readily available on site for their patients.

Summary

The purpose of the DNP project was to accurately identify domestic violence occurrence or history in pregnant and postpartum victims. The goal was to properly intervene and to decrease poor health outcomes for both the fetus and the mother. The Rosswurm and Larrabee Evidence Based Model was used to design this project. The innovation was the introduction and utilization of an evidence-based domestic violence screening tool that was utilized during the initial prenatal visit and during the postpartum visit.
Chapter 4: Results

Objectives

In this chapter, the results of this project are presented including the staff training and implementation of the domestic violence screening tool. A description of the sample, as well as trend analysis for process and outcome variables, are included. Expected versus actual outcomes are discussed, along with facilitators and barriers to the completion of this DNP project.

Description of Sample

All teenage and adult pregnant females, who were visiting the Waianae Coast Comprehensive Women’s Health Department (main campus) for any prenatal or postpartum visits were screened routinely for intimate partner violence. Only females planning to continue their pregnancies (130 women) were included in this project.

All staff was included in the training, including seven receptionists, ten medical assistants, two perinatal case managers, and four advanced practice registered nurses (APRNs) (i.e., three nurse practitioners [NPs] and a certified nurse midwife [CNM]). The five APRN’s currently employed at the main campus were the providers targeted for the implementation of the DV screening tool with pregnant females for the purposes of this DNP project. The original implementation interval was planned to span 12 weeks, from the beginning of July 2014 through the end of September 2014. However, the actual implementation interval spanned 16 weeks, from August 6 through November 26, 2014.

Results

Training of the WCCHC Women’s Health Department staff included overall IPV training, as well as an introduction to the new screening tool (Appendix D) and a new protocol for IPV screening and interventions (Appendix E). Data were collected pre-implementation and
post-implementation. Overall, in most areas, the actual outcomes were very similar to or exceeded expected outcomes.

**Trend Analysis for Process & Outcome Variables**

**Staff trained.** As noted in Table 4.1, a total of 23 of 28 (82%) of the WCCHC Women’s Health Department staff received training about IPV and administration of the screening tool and the IPV protocols. The reasons for the remaining staff not attending the training sessions were absences due to vacation and other conflicting events.

Table 4.1

<table>
<thead>
<tr>
<th></th>
<th># Trained</th>
<th>Total # of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRNs</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Receptionists</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Perinatal Case Managers</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Staff Trained = 23 (82%)</strong></td>
<td></td>
<td><strong>Total Staff = 28</strong></td>
</tr>
</tbody>
</table>

**Pretest and posttest training data.** There were eight questions that were part of the staff training surveys that were administered prior to and immediately after completion of the training. These surveys were developed to assess the staff’s baseline knowledge of IPV, IPV screening competence, IPV intervention competence, resources available, interest in implementing a new screening tool and protocol, as well as concerns, barriers, and comments regarding IPV screening and intervention practices. A Likert scale was used to obtain a response for each item from all
staff members who attended the training (e.g., 1 = Strongly Disagree to 5 = Strongly Agree) (see Appendix B). The results for each of the survey questions are presented below.

**Survey questions.**

Question #1 *I have received adequate education and training on domestic violence at WCCHC.*

Of the four APRNs who were trained, only two pretest and posttest surveys were received (Figure 4.1). The first APRN felt neutral (3) about receiving adequate education and training on DV prior to the training. After the training, she strongly agreed that she had received adequate education and training on DV. Similarly, the second APRN initially disagreed (2) about having received adequate prior training. Her opinion changed to agreeing (4) that she had received adequate DV education and training after the training.

![Figure 4.1. APRN Pretest and Posttest Survey Responses (Question 1)](image)

Figure 4.1. APRN Pretest and Posttest Survey Responses (Question 1)
Ten of eleven (91%) medical assistants were trained. As depicted in Figure 4.2, on average, their responses to question one increased from 2.8 to 4.6.

*Figure 4.2. Medical Assistant Pretest and Posttest Average Survey Responses (Question 1)*

All seven (100%) medical receptionists were trained (Figure 4.3). On average, their responses increased from “Disagree” (2) to “Strongly Agree” (4).

*Figure 4.3. Receptionist Pretest and Posttest Average Survey Responses (Question 1)*
Question #2: *It is important for me to screen all women for domestic violence.*

Both APRNs surveyed “Strongly Agreed” (5) before and after the training, that it is important to screen all women for DV (Figure 4.4).

![Figure 4.4. APRN Pretest and Posttest Survey Responses (Question 2)](image)

As depicted in Figure 4.5, on average, the medical assistants’ responses to question two increased from 3.3 to 4.8 indicating their understanding about the importance of screening all women for DV.

![Figure 4.5. Medical Assistant Pretest and Posttest Average Survey Responses (Question 2)](image)
On average, the medical receptionists’ responses to question two increased from 3.3 to 4.5 (Figure 4.6) which is similar to the medical assistants’ change in responses after completing the training.

![Figure 4.6. Receptionist Pretest and Posttest Average Survey Responses (Question 2)](image)

**Question #3:** *I feel competent in assessing all women visiting the clinic for the presence of domestic violence in their lives.*

The first APRN agreed (4) both before and after training, that she felt competent in assessing all women for DV. The second APRN initially felt neutral (3) about her competence in assessing all women for DV. However, post-training, she agreed (4) that she felt competent in this area (Figure 4.7).

![Figure 4.7. APRN Pretest and Posttest Survey Responses (Question 3)](image)
On average, the medical assistants’ responses to question three increased from 2.7 to 4.1 (Figure 4.8) reflecting an increased sense of competence in assessing all women for DV had increased.

![Bar chart showing medical assistant pretest and posttest average survey responses (Question 3)](image)

*Figure 4.8. Medical Assistant Pretest and Posttest Average Survey Responses (Question 3)*

On average, the medical receptionists’ responses to question three increased from 2.7 to 3.8 (Figure 4.9) which reflects a similar change in their sense of competence to the medical assistants.

![Bar chart showing receptionist pretest and posttest average survey responses (Question 3)](image)

*Figure 4.9. Receptionist Pretest and Posttest Average Survey Responses (Question 3)*
Question #4: *I feel competent in knowing what to say or do if a woman screens positive for domestic violence, according to WCCHC’s current protocol.*

The first APRN response indicated that she had an increase in her feelings of competence in knowing what to say or do if a woman screened positive for DV, from an intermediate feeling of neutrality and agreement (3.5) to being in agreement (4) with feeling competent. The other APRN also increased from disagreement (2) to an intermediate feeling of neutrality and agreement (3.5) in feeling competent in this area (Figure 4.10).

![Figure 4.10. APRN Pretest and Posttest Survey Responses (Question 4)](image)

On average, the medical assistants’ responses increased from 2.6, an intermediate level of disagreement, to 4.1 indicating feeling confident about what to say and do when a woman screened positive for DV.
Similar to the medical assistants’ change in responses, the medical receptionists’ responses to question four increased on average from 2.8, an intermediate level of disagreement, to 4.3, indicating that they felt confident about what to say and do when a woman screened positive for DV (Figure 4.12).

Figure 4.11. Medical Assistant Pretest and Posttest Average Survey Responses (Question 4)

Figure 4.12. Receptionist Pretest and Posttest Average Survey Responses (Question 4)
Question #5 *I feel that I know about all the domestic violence resources available for women at WCCHC.*

The first APRN indicated an increase in her knowledge about DV resources, from feeling neutral (3) to agreeing (4) that she knows about those resources as a result of the training. The second APRN also indicated an increase in her knowledge from disagreeing (2) to agreeing (4) that she has knowledge about WCCHC DV resources for women (Figure 4.13).

Figure 4.13. APRN Pretest and Posttest Survey Responses (Question 5)

On average, the medical assistants’ responses to question five increased from 2.3, intermediate disagreement, to 4.3, agreement that they had knowledge about the DV resources available to women (Figure 4.14).

Figure 4.14. Medical Assistant Pretest and Posttest Average Survey Responses (Question 5)
The medical receptionists’ responses to question four were similar to those of the medical assistants, with an average change from 2.3 (pre-training) to 4.5 (post-training), reflecting that their knowledge about DV resources for women increased (Figure 4.15).

![Bar chart showing average pretest and posttest survey responses for question 5.](image)

*Figure 4.15. Receptionist Pretest and Posttest Average Survey Responses (Question 5)*

**Question #6: How interested are you in implementing a new IPV screener for pregnant women at WCCHC?**

A new Likert Scale was used for the sixth question, which ranged from “Very Uninterested” (1) to “Very Interested” (5). The first APRN decreased in her interest in implementing a new IPV screening tool for pregnant women, from being very interested (5) prior to the training to feeling interested (4) in implementing a new tool after the training. The second APRN remained very interested (5) in implementing a new screening tool before and after the training (Figure 4.16).
As depicted in Figure 4.17, on average, the medical assistants’ responses to question six increased from 3.7, an intermediate level of neutral, to 4.5, an increased interest in implementing a new DV screening tool.

On average, the medical receptionists’ responses to question six increased from 4.2 to 5 reflecting a change from being interest to being very interested in implementing a new DV screening tool (Figure 4.18).
Question #7: How interested are you in implementing an updated IPV protocol for pregnant women at WCCHC?

The same Likert Scale was used for the sixth question, which ranged from “Very Uninterested” (1) to “Very Interested” (5). Both APRNs remained very interested (5) in implementing an updated IPV protocol for pregnant women (Figure 4.19).
The medical assistants’ average responses to question six increased from 3.4, being neutral, to 4.3, being interested in implementing an updated IPB protocol for pregnant women (Figure 4.20).

Figure 4.20. Medical Assistant Pretest and Posttest Average Survey Responses (Question 7)

The medical receptionists’ overall average of the responses to question six increased from 4.5, indicating that prior to the training they were uninterested in implementing a new IPV protocol for pregnant women, to an average response of 5, indicating that they were very interested in doing this, after attending the training (Figure 4.21).

Figure 4.21. Receptionist Pretest and Posttest Average Survey Responses (Question 7)
Question #8: *What are some concerns or barriers that you have about screening women for domestic violence?*

Table 4.2 includes the actual statements made by the staff, about their concerns, barriers, or comments before and after the DV training. Three staff members commented about their concerns with patient privacy and patients being reluctant to discuss violence in their lives, with the medical assistants or with providers. One staff member expressed the concern about women having a positive DV screen feeling shame, because some patients personally know staff members. Two staff members felt that the training was informative.

Table 4.2

*Pre- and Post-Training Concerns, Barriers, and Comments to Screening and IPV*

<table>
<thead>
<tr>
<th>PRE TRAINING</th>
<th>POST TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Some patients may feel we are being nosy to open up to us as MA’s regarding their problems, so it might not get anywhere”</td>
<td>“Patients not being open about DV with Medical Assistants”</td>
</tr>
<tr>
<td>“Want to learn more”</td>
<td>“I've learned a lot in this meeting about DV. Great presentation”</td>
</tr>
<tr>
<td>“There's a lot of people I know who comes here for care and if they are ashamed of me seeing their weight, I'm pretty sure their personal life of DV will be inaccurate information”</td>
<td>“Same as before, knowing the person and they give wrong info because they're shame”</td>
</tr>
<tr>
<td>“Need knowledge about DV”</td>
<td>“A lot of information given. Very informative”</td>
</tr>
<tr>
<td>“They (patients) won't feel comfortable discussing violence”</td>
<td></td>
</tr>
</tbody>
</table>
Intimate Partner Violence Screening Data

**Perinatal case manager screening pre data.** The data presented in Table 4.3 was obtained from the perinatal manager prior to the implementation of the project. Data from WCCHC’s satellite clinics (Kapolei and Waipahu) were also included in this data set. The data is strictly based on IPV screening by the perinatal case managers, at the main campus, Kapolei, and Waipahu. From 2008 to 2012, the overall percent of women that screened positive for IPV during pregnancy ranged from 3-4%. The range of women that screened positive for a history of IPV was 0.6 to 6%.

Table 4.3

**Perinatal Case Management Initial OB Screening Summary (2008-2012)**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total pregnant women screened (1 year)</strong></td>
<td>778</td>
<td>830</td>
<td>857</td>
<td>847</td>
<td>857</td>
</tr>
<tr>
<td><strong>Positive for IPV in current pregnancy (1 year)</strong></td>
<td>23 (3%)</td>
<td>34 (4%)</td>
<td>33 (4%)</td>
<td>34 (4%)</td>
<td>27 (3%)</td>
</tr>
<tr>
<td><strong>Positive history of IPV (1 year)</strong></td>
<td>5 (0.6%)</td>
<td>22 (3%)</td>
<td>49 (6%)</td>
<td>44 (5%)</td>
<td>48 (6%)</td>
</tr>
</tbody>
</table>

**Post implementation data.** The five APRNs at WCCHC main clinic used the new IPV screening tool. Overall, 130 pregnant women were screened over a 16-week period, which represents 90.2% (n = 144) of the overall number of women seen for an initial OB visit (Table 4.4).
Nineteen women (14.6%) screened positive for IPV (i.e., current and/or a history of IPV). Eight women (42%) reported current IPV and 12 women (63%) reported a history of IPV. There may have been some error or misreporting of screening rates by APRNs, as there was a difference of five women that were not recorded as being screened or not screened for a given reason because the total new OB visits per APRN was 139 but the EMR scheduling for an initial OB visit was 144. The electronic medical records’ (EMRs) scheduling calendar was hand-counted, per APRN, for “Initial OB” visits in which the patient showed up for her appointment. This number was compared with those recorded directly by the APRNs, with a discrepancy of five women.

Table 4.4

APRN Initial New OB (NOB) Visit Screening Summary (16 weeks: Aug 6 – Nov 26, 2014)

<table>
<thead>
<tr>
<th>Total NOBs screened</th>
<th>130 women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Positive NOBs</td>
<td>19</td>
</tr>
<tr>
<td>Current IPV</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>History IPV</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NOB visits per providers</td>
<td>139</td>
</tr>
<tr>
<td>Total NOB visits per EMR</td>
<td>144</td>
</tr>
</tbody>
</table>

Data representing screening completed by the perinatal case managers was obtained from the perinatal supervisor (Table 4.5). The data represents only screening completed at WCCHC’s main campus, during the same interval as the APRNs’ screening of women. Overall, the perinatal case managers screened 74 women, 49.7% of total NOB visits, or 63.2% of those that had an initial assessment by the perinatal case managers during their NOB visit. The other 36.8%
of women who were seen for NOB visits and had an initial prenatal case management assessment, were not screened for IPV by the case manager. An overall positive IPV screening rate was not recorded by perinatal case managers. Instead, the data was recorded as current and/or history of IPV. The overall percentage of pregnant women who screened positive for current IPV was 6.7% (n = 5) and 10.8% (n = 8) screened positive for a history of IPV.

Table 4.5

Perinatal Case Management Initial OB Visit Screening Summary (16 weeks: 8/6 – 11/26/2014)

<table>
<thead>
<tr>
<th>Total NOBs screened</th>
<th>74 women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Positive NOBs</td>
<td>Not recorded as a total by perinatal</td>
</tr>
<tr>
<td>Current IPV</td>
<td>5</td>
</tr>
<tr>
<td>History IPV</td>
<td>8</td>
</tr>
<tr>
<td>Total Initial Assessments by Perinatal Case Managers</td>
<td>117</td>
</tr>
<tr>
<td>Total NOB visits</td>
<td>149</td>
</tr>
</tbody>
</table>

During the same 16-week interval, 61 women were also screened for IPV during their postpartum visits, with an overall 56.5% (n = 108) postpartum actual screening rate (Table 4.6). There may have been underreporting of the missed postpartum screenings, as the APRN reported rate was 80.2% (n=76). The EMRs’ scheduling calendar was hand-counted, per APRN, for “Postpartum Visit,” in which the patient showed up for her appointment. This number was compared with those recorded directly by the APRNs, with a discrepancy of 32 women.

The overall positive screening rate was 9.8% (n=6). The current IPV rate for postpartum women was 8% (n = 5) and the IPV history rate was 5% (n = 3). Two of the women who
screened positive for IPV only had a history of IPV, not current IPV. There were no postpartum visit IPV screenings completed by the perinatal case managers.

Table 4.6

APRN Postpartum Visit Screening Summary (16 weeks: Aug 6 – Nov 26, 2014)

<table>
<thead>
<tr>
<th>Total Postpartums screened</th>
<th>61 women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Positive Postpartums</td>
<td>6</td>
</tr>
<tr>
<td>Current IPV</td>
<td>5</td>
</tr>
<tr>
<td>History IPV</td>
<td>3</td>
</tr>
<tr>
<td>Total PP visits per providers</td>
<td>76</td>
</tr>
<tr>
<td>Total PP visits per EMR</td>
<td>108</td>
</tr>
</tbody>
</table>

Intimate Partner Violence Intervention Data

Interventions provided for initial OB positive IPV screens. Overall, there were 144 pregnant women who had initial OB visits with 130 of these being screened for IPV by APRNs. Of these, 19 women (14.6%) screened positive for current or a history of IPV during their initial OB visits (Table 4.7). The majority of the women who screened positive for IPV (n=17, 89.5%) was counseled by the provider and given a phone resource card. A safety plan was created for 11(57.9%) of the women. However, only 9 (47.4% ) of the women were referred immediately to the perinatal case manager, and only 2 (10.5%) were referred for Behavioral Health services. Other women who were referred to Behavioral Health may have declined their services.
Table 4.7

APRN Initial OB Visit Intervention Summary (16 weeks: Aug 6 – Nov 26, 2014)

<table>
<thead>
<tr>
<th>IPV Intervention</th>
<th># of women offered intervention</th>
<th>% of women offered intervention (of positive current and/or history of IPV = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseled by Provider</td>
<td>17</td>
<td>89.5%</td>
</tr>
<tr>
<td>Safety Plan Created</td>
<td>11</td>
<td>57.9%</td>
</tr>
<tr>
<td>Resource Card Given</td>
<td>17</td>
<td>89.5%</td>
</tr>
<tr>
<td>Referred to Perinatal Case Management</td>
<td>9</td>
<td>47.4%</td>
</tr>
<tr>
<td>Referred to Behavioral Health</td>
<td>2</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

Interventions provided for postpartum positive IPV screens.

Six women (9.8%) screened positive for current or a history of IPV during their postpartum visit (Table 4.8). All women (100%) who screened positive for IPV during their postpartum visits were counseled by the provider and given a phone resource card. A safety plan was created for 5 (83.3%) of the women. In addition, 33.3% (n=2) of these women were directly referred to the perinatal case manager, and 16.7% (n=1) were referred to Behavioral Health.

Table 4.8

APRN Postpartum Visit Intervention Summary (16 weeks: Aug 6 – Nov 26, 2014)

<table>
<thead>
<tr>
<th>IPV Intervention</th>
<th># of women offered intervention</th>
<th>% of women offered intervention (of positive current and/or history of IPV = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseled by Provider</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Safety Plan Created</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>Resource Card Given</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Referred to Perinatal Case Management</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Referred to Behavioral Health</td>
<td>1</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
**Phone resource cards.** Over 500 phone resource cards were initially printed. Over the 16-week interval, there was a total distribution of 109 phone resource cards to patients visiting the WCCHC’s Women’s Health Department.

**Evolution of Project**

Prior to the IPV training and implementation of a new screening tool and protocol, expected outcomes were predicted. These predictions and goals involved all aspects of the project, from the timeline of the project, to data trends pre- and post-training of the staff and pre- and post-implementation of the new screening tool and protocol. In addition, the facilitators and barriers to this DNP project were analyzed pre- and post-implementation of the new IPV screening tool and protocol.

**Expected versus Actual Outcomes**

Table 4.9 lists the expected and actual outcomes of the different aspects of the DNP project. A longer implementation interval was feasible, over a span of 16 weeks, instead of 12 weeks. Overall, IPV training outcomes exceeded the original expectations. Furthermore, the IPV screening rate, by APRNs, also exceeded the goals of this project. However, most of the intervention goals were lower than expected.
Table 4.9

**Expected versus Actual Outcomes of Project**

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Actual Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeline</strong></td>
<td></td>
</tr>
<tr>
<td>• Implementation period July – Sept 2014 (12 weeks)</td>
<td>• Implementation period Aug 6 – Nov 26, 2014 (16 weeks)</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td></td>
</tr>
<tr>
<td>• At least 50-75% of staff will be trained</td>
<td>• 82% of total Women’s Health staff trained</td>
</tr>
<tr>
<td>• Trained staff will demonstrate increased knowledge and understanding about IPV dynamics</td>
<td>• Average overall increase in staff knowledge and understanding about IPV dynamics</td>
</tr>
<tr>
<td>• Trained staff will report understanding of new IPV screeners, procedures, &amp; protocols</td>
<td>• Average overall increase in staff understanding of new IPV screeners, procedures, protocols</td>
</tr>
<tr>
<td>• Comfort level in screening for DV will result from the training session</td>
<td>• Average comfort level increase in screening for DV</td>
</tr>
<tr>
<td>• Trained staff will report an increased awareness of IPV community resources</td>
<td>• Average overall increase in awareness of IPV community resources</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td></td>
</tr>
<tr>
<td>• Providers will have a higher IPV screening rate than perinatal</td>
<td>• Overall provider screening rates were higher than perinatal team screening rates</td>
</tr>
<tr>
<td>• More pregnant women afflicted by IPV will be identified and helped</td>
<td>• 90.2% overall provider screening rate of NOB visits</td>
</tr>
<tr>
<td>• At least 85% of pregnant women will be screened for IPV upon the initial OB visit</td>
<td>• 56.5% overall provider screening rate of Postpartum visits</td>
</tr>
<tr>
<td>• At least 75% of Postpartum women will be screened for IPV</td>
<td>• Higher % of positive IPV (increase 3% to 6% positives)</td>
</tr>
<tr>
<td>• The % of positive IPV will increase due to better screening practices and a better screening tool</td>
<td>• Perinatal team with the same positive current IPV rate as providers (6%)</td>
</tr>
<tr>
<td>• Providers will have a higher positive IPV screening rate than perinatal</td>
<td>• Perinatal team with similar positive history IPV rate as providers (11% vs 10%)</td>
</tr>
<tr>
<td><strong>Interventions (for OB initial screenings)</strong></td>
<td></td>
</tr>
<tr>
<td>• At least 75% of all women who screen positive for IPV will be referred to BH by providers</td>
<td>• 10.5% of all women who screened positive for IPV was referred to BH</td>
</tr>
<tr>
<td>• At least 75% of all women who screen positive for IPV will be counseled by providers</td>
<td>• 89.5% of all women who screened positive for IPV was counseled by the provider</td>
</tr>
<tr>
<td>• 100% of all women who screen positive for IPV will have a safety plan completed</td>
<td>• 57.9% of all women who screened positive for IPV had a safety plan created</td>
</tr>
<tr>
<td>• 100% of all women who screen positive for IPV will be given a resource card</td>
<td>• 89.5% of all women who screened positive for IPV was given a resource card</td>
</tr>
<tr>
<td>• 25% of all women who screen positive for IPV will be referred to perinatal case management</td>
<td>• 47.4% of all women who screened positive for IPV was referred to perinatal case management</td>
</tr>
<tr>
<td>• At least 100 resource cards will be distributed over the 16 weeks</td>
<td></td>
</tr>
</tbody>
</table>
Facilitators and Barriers

Facilitators and barriers to this DNP project were identified prior to, during implementation, and following the data collection (Table 4.10). Although the staff seemed interested in learning about IPV dynamics, some providers still did not feel comfortable with the interventions. The greatest barrier to implementing a new screening tool was that it would be more time consuming for providers to utilize. There seemed to be barriers related to referring the patients to Behavioral Health services immediately after a woman screened positive for IPV.

Overall, the data was easily collected through the use of logs (Appendices L, M, N, O, P) and the EMR.

Table 4.10

Facilitators and Barriers of Project

<table>
<thead>
<tr>
<th>Training</th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
</table>
|          | • Staff seemed interested in learning more about DV dynamics  
|          | • The training was completed during the normal monthly women’s health meeting  
|          | • Low cost for training supplies | • Some providers still did not feel 100% comfortable in knowing how to intervene if a woman screened positive for DV |
| Screening| • Hardcopy screener as part of initial OB packet  
|          | • Minimal cost with 1 extra paper  
|          | • Screener took less than 1 minute to complete  
|          | • Patients were already being screened for DV at each initial visit if partner is not at visit | • Using a 5-question screening tool was more time consuming than 1-2 questions used by providers previously  
|          | | • More time was utilized by the provider if the woman screened positive for DV  
|          | | • Some MAs were more helpful than others in asking partners to stay out |
| Interventions | • Safety plan visual cues for providers copied on back of screening tool  
|          | • Resource cards were printed at a relatively low cost and placed in every exam room  
|          | • Perinatal case managers were readily avail | • BH in-office provider only in on Mondays  
|          | | • Difficulty with warm-handoff to more BH providers located in different building |
| Collection of Data | • DNP student working F/T at facility allowing ease of data collection  
|          | • DNP student was able to easily access EMR data  
|          | • Perinatal case mgmt. supervisor was easily able to obtain data from case mgmt screening | • DNP student collected majority of the data, besides perinatal case mgmt data  
|          | | • No double-checking to be sure data accurately collected  
|          | | • Providers did not keep consistent records of screening and + screenings.  
|          | | • DNP student did not have direct access to perinatal case mgmt screening data; Overall positive IPV data missing |
Summary

As a result of the implementation of this DNP project, there was an overall increase in IPV screening for pregnant women by APRNs. In addition, IPV training increased staff knowledge and attitudes about IPV dynamics, screening, and interventions. Screening by perinatal case managers and APRNs resulted in having similar positive IPV rates in pregnant women visiting WCCHC’s Women’s Health Department. Finally, the most commonly utilized interventions for women who screened positive for IPV included counseling by the provider and distribution of a phone resource card.
Chapter 5: Discussion

This DNP Project was initiated to address an important issue in the provision of health care to childbearing women, specifically. The objective of this project was to implement an evidence-based IPV screening tool and protocol for all pregnant women, visiting the Women’s Health department at WCCHC. The design, implementation, and evaluation of the project was based on an extensive literature review to identify an appropriate screening tool to use in a busy community-based women’s clinic and to review and select a model to design the project. In addition, an assessment of the population of women receiving services through the clinic as well as documented rates of IPV prior to the project’s initiation.

There were several important outcomes that were observed as a result of this project’s implementation. One of the primary outcomes was that the majority (82%) of all staff in the Women’s Health Department at the Waianae Coast Comprehensive Health Center (WCCHC) was trained on IPV dynamics, signs, screening, appropriate interventions, and resources. The staff included APRNs, medical assistants (MAs), receptionists, and perinatal case managers. Overall, the training was successful in increasing the knowledge and need for screening women for IPV. The APRNs, MAs, and the receptionists reported increased understanding of a new IPV screening tool and protocol, as well as an increase in their comfort levels with screening and knowing what to do if a woman screened positive for IPV. Lastly, the training increased their awareness of community IPV resources.

In general, the APRNs responsible for IPV screening during initial obstetrical (OB) visits and postpartum visits had a higher screening rate than the perinatal team. One reason for this difference may be the presence of the male partner during the perinatal assessment, since males were allowed to be in the examining room once the patient completed the initial OB history and
physical examination. Therefore, it may have been more difficult for the APRNs to ask the male partner to leave the room once they were already present in the room.

Currently, the perinatal case managers do not screen postpartum women for IPV. The postpartum screening rate was much lower than the initial OB screening rate. An explanation may be that all of the prenatal visits are documented on paper charts, and the screening tool is part of the packet that is completed for all initial OB visits. In contrast, the postpartum visits are documented via the EMR system. Therefore, unless the medical assistant or APRN remembered to utilize the screening tool during the exam, screening was not completed.

In comparison to the 2008-2012 data obtained from the perinatal team, in terms of rates of current IPV or history of IPV, there has been an overall two-fold increase (3% to 6%) in women identified during the 16 week interval of this project. This finding may be a result of a number of different factors including: an increase in the incidence of IPV in the community; an increase in the identification of victims due to the increased awareness of IPV through this project’s staff trainings; and/or through other current events.

Overall, the perinatal case managers were found to identify the same percentage of victims of IPV as the APRNs, of the women that were screened. However, since there was a higher APRN IPV screening rate, the APRNs overall identified more women who experienced IPV during their current pregnancies. When comparing rates of identification of women experiencing IPV, the perinatal case managers had a very similar rate of women reporting a positive history of IPV than APRNs. However, the APRNs screened more women overall, and, as a result, identified more pregnant women with histories of IPV. It can be argued that APRNs should have the IPV screening performed by the perinatal case managers, since this can save provider time and because it seems that the women are just as likely to admit current of a history
of abuse to their perinatal case managers. However, there may be other unknown factors that allow APRNs to screen more women for IPV. Perhaps logistical changes need to be made, to enable the perinatal case manager to perform their assessment without the partner present.

The most common interventions included counseling by the APRN and supplying the victim with a phone resource card. Safety plans were created only with patients who were in current IPV situations, which may explain the lower percentage of safety plans as an intervention for women who screened positive for IPV. This number included those who only screened positive for a history of IPV and many of these patients were not longer in contact with the previous abuser(s). Less than half of the victims were directly referred to their perinatal case managers.

Prior to the implementation of this new screening tool and protocol, the previous perinatal director specifically voiced a concern with providers being able to intervene in case case managers were not readily available for assistance. For this reason, staff and providers were trained to be able to intervene and create a safety plan with the patient. Therefore, the APRNs may have relied less on the perinatal case managers to assist immediately. Only a small percentage of victims were referred for Behavioral Health services. The data did not reflect Behavioral Health services that were offered but may have been declined at the time of screening and identification.

**Implications and Recommendations Based on the DNP Essentials**

The eight DNP essentials listed in Table 5.1 guided the development, implementation, and evaluation of this DNP project. These essentials cover the foundational competencies all APRNs must possess when graduating from any DNP program (American Association of Colleges of Nursing, 2006).
The objectives of this DNP project were created through a prevention and population health perspective, in order to identify more pregnant and postpartum victims of IPV, in order to decrease the risks of IPV-associated chronic illnesses (Essential VII). The Planned Care Model and Rosswurm & Larrabee’s Evidence-Based Practice Model was used to guide this practice change (Essential I).

Furthermore, leadership skills, by the DNP student, were utilized in order to design, implement, and promote change within the Women’s Health department at WCCHC (Essential II and Essential VIII). One of the first steps in this project included a full literature review, in order to identify an effective, evidence-based IPV screening tool (Essential III and Essential IV). A new screening tool and protocol was implemented and used to screen pregnant and postpartum women (Essential V).

Data were collected using EMRs, in order to obtain pre- and post-implementation data (Essential IV). Finally, interprofessional collaboration was important throughout the implementation period, especially with our perinatal case managers, and will continue to be important in sustaining the goals and objectives of this DNP project (Essential VI).
Table 5.1

*Implications and Recommendations Based on the DNP Essentials*

<table>
<thead>
<tr>
<th>DNP Essentials</th>
<th>Implications &amp; Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESSENTIAL I:</td>
<td></td>
</tr>
</tbody>
</table>
| Scientific Underpinnings for Practice | • Planned Care Model to improve chronic illnesses adapted for this project, to be applicable to IPV  
• Rosswurm & Larrabee’s Evidence-Based Practice (EBP) Model to guide practice change |
| ESSENTIAL II:  |                                |
| Organizational & Systems Leadership for QI & Economics | • Promoting change in the clinic through leadership skills such as identifying barriers and facilitators, motivating staff to accept and make changes, conflict resolution, role modeling importance of screening  
• Designing a simple protocol for providers to be able to follow with ease and minimal time  
• Choosing an intimate partner violence (IPV) screening tool that can be utilized in 1 minute or less  
• Implementing a low cost screening tool and protocol |
| ESSENTIAL III: |                                |
| Evidence-Based Practice/Translation Science | • Exhaustive literature review completed to find EB IPV screening tool  
• Critiquing different levels of literature  
• Understanding practical and clinical meanings of literature  
• Translating research of IPV screening tools to practice  
• Evaluating the implementation activities and outcomes  
• Analyze data from practice  
• Predict and analyze outcomes |
| ESSENTIAL IV:  |                                |
| Information Systems/Technology | • Literature review conducted using various electronic databases (CINAHL, PubMed, Cochrane Reviews)  
• Electronic medical records (EMRs) used to gather data  
• Development and execution of an evaluation plan involving data extraction  
• Use EMR to evaluate accuracy of provider-reported IPV screening for initial OB visits and Postpartum visits |
| ESSENTIAL V:   |                                |
| Health Care Policy & Ethics | • Design, implement, and advocate for a new, updated IPV screening protocol for pregnant women |
| ESSENTIAL VI:  |                                |
| Inter-professional Collaboration | • Collaboration with Behavioral Health to provide services to victims of IPV  
• Collaboration with Social Services in the community in order to understand social impacts of IPV  
• Collaboration with perinatal case managers, in order to design, implement and evaluate the IPV training outcomes |
| ESSENTIAL VII: |                                |
| Prevention and Population Health | • Identifying more victims of IPV in order to decrease the risks of chronic illnesses associated with IPV  
• Educating staff regarding IPV dynamics to assist in identifying patients experiencing IPV, as well as increasing awareness of our own staff afflicted by IPV |
| ESSENTIAL VIII:|                                |
| Advanced Nursing Practice & Education | • Design, implement, and evaluate an updated IPV screening protocol  
• Become an added support system for patients experiencing IPV  
• Educate, guide, and mentor other APRNs to achieve excellence in nursing practice |
**Plans for Dissemination**

Summary data sheets will be provided to the management, staff, and providers at the WCCHC Women’s Health Department and will include data regarding the percent of staff educated and trained, changes in staff knowledge, attitudes, understanding, and competency in DV screening and interventions, numbers of women screened for IPV, and numbers of women identified and aided as victims of IPV.

The final full written report will be given to the WCCHC’s Women’s Health Director, the perinatal manager and case management supervisor. Additionally, it will also be submitted to the Doctorate in Nursing Practice (DNP) committee and the Graduate Division at the University of Hawai‘i at Mānoa (UHM). A final public oral defense including power point slides will occur at UHM on April 14, 2015. Finally, consideration is being given to presenting this project and its results at a professional conference that is focusing on women’s health, as well as a manuscript to be submitted for publication in an appropriate professional journal.

**Future Expansion**

The same IPV training, current IPV screening tool, and protocol will be expanded to WCCHC’s satellite clinics in Kapolei and Waipahu, where prenatal and postpartum care is offered. Mothers bringing their infants to see pediatricians for care should also be screened during these types of visits. Therefore, WCCHC’s pediatric department may be a future target audience for this intervention.

This screening tool and protocol can also be utilized in other community health clinics or health care settings. The AAS screening tool can be utilized with different cultural populations, including Native Hawaiian women in Hawai‘i and on the mainland. In addition, this tool and
protocol can be used or adapted to be utilized with other cultural populations in Hawai‘i, the mainland and in Pacific Rim territories and countries (e.g., the Federated States of Micronesia).

Conclusion

Physical IPV affects about one-third of U.S. women, while psychological IPV can affect almost half of all U.S. women during their lifetime (CDC, 2014). Moreover, detrimental obstetric outcomes can occur as a result of IPV during pregnancy (Hassan, Kashanian, Hassan, Roohi, & Yousefi, 2014; Hegarty et al., 2010; Roark, 2010). Therefore, routine IPV screening for all pregnant women remains a critical component of their assessment by healthcare providers, in order to identify and help victims of IPV. The overall long-term goal in identifying more victims is to be able to reduce violence, abuse, and physical or mental harm for adult women (Moyer, 2013).

The AAS is a simple, five-question tool that can be used for pregnant women during their prenatal and postpartum care visits. While support staff may be able to effectively utilize and identify victims of IPV, the healthcare provider has consistent, direct contact with these patients throughout their pregnancy. Therefore, it may be best for the provider to continue to screen all pregnant females, using a consistent, validated IPV screening tool, such as the AAS.
Appendix A – Training Attendance Log

IPV Training Session Attendance Sign In Sheet

Date of Training Session _________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Role at WCC (e.g. provider, perinatal case manager, MA, receptionist, other)</th>
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Appendix B – Pre and Post Training Survey

Pre & Post Provider/Staff IPV Training Survey

Purpose of Instrument: To evaluate a short-term outcome of training of staff in DV and screening. The desired short-term outcome is that trained staff will demonstrate increased knowledge and understanding about DV dynamics, as well as comfort in screening and intervening for all women in DV. In addition, they will report understanding of new DV protocols & procedures.

Administration: Survey will be administered in-person (paper & pencil) to WCCHC staff (management, providers, perinatal, MAs, receptionists, referral clerks, others) prior to implementation of new/updated screener and trainings/education sessions.

IPV Staff Pretest Survey

1. I have received adequate education and training on domestic violence at WCCHC.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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2. It is important for me to screen all women for domestic violence.

<table>
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<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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3. I feel competent in assessing all women visiting the clinic for the presence of domestic violence in their lives.

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<tr>
<th>Strongly disagree</th>
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<th>Neutral</th>
<th>Agree</th>
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4. I feel competent in knowing what to say or do if a woman screens positive for domestic violence, according to WCCHC’s current protocol.

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5. I feel that I know about all the domestic violence resources available for women at WCCHC.

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</table>
6. How interested are you in implementing a new IPV screener for pregnant women at WCCHC?

Very uninterested 1 2 Neutral 3 4 Very Interested 5

7. How interested are you in implementing an updated IPV protocol for pregnant women at WCCHC?

Very uninterested 1 2 Neutral 3 4 Very Interested 5

8. What are some concerns or barriers that you have about screening women for domestic violence?

9. What is your current position at WCCHC?

Management APRN MA Perinatal Other ________________
Appendix C – Original Abuse Assessment Screen (AAS) Tool

Abuse Assessment Screen

Instructions: Circle Yes or No for each question

1. Have you ever been emotionally or physically abused by your partner or someone important to you? 
   YES NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? 
   YES NO
   If YES, who? (Circle all that apply) 
   Husband Ex-Husband Boyfriend Stranger Other Multiple 
   Total no. of times

3. Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? 
   YES NO
   If YES, who? (Circle all that apply) 
   Husband Ex-Husband Boyfriend Stranger Other Multiple 
   Total no. of times

Mark the area of injury on the body map. Score each incident according to the following scale:

SCORING
1 = Threats of abuse including use of weapon
2 = Slapping, pushing; no injuries and/or last living pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon

4. Within the last year, has anyone forced you to have sexual activities? 
   YES NO
   If YES, who? (Circle all that apply) 
   Husband Ex-Husband Boyfriend Stranger Other Multiple 
   Total no. of times

5. Are you afraid of your partner or anyone you listed above? 
   YES NO

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Appendix D – IPV Screening Form for NOB and Postpartum Visits

Prenatal Intimate Partner Violence Screening Form

IPV Screen

_____ Positive
_____ Suspected

Date __________________________
Patient Name ____________________

PRE-SCREENING ASSESSMENT:
Is partner in room?  No ☐  Yes ☐ If so, ask partner politely to leave during the physical exam

FRAMING STATEMENT: We know that experiencing violence places women at risk for a number of health conditions especially in pregnancy so we’ve begun asking all our patients about it

SCREENING QUESTIONS:
1. Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? YES NO
   If YES, who?  Husband  Ex-Husband  Boyfriend  Stranger  Other  Multiple
   Total # of times ________ (Mark body map below)

3. Since you’ve been pregnant, have you been slapped, kicked, or otherwise physically hurt by someone? YES NO
   If YES, who?  Husband  Ex-Husband  Boyfriend  Stranger  Other  Multiple
   Total # of times ________ (Mark body map below)

4. Within the last year, has anyone forced you to have sexual activities? YES NO
   If YES, who?  Husband  Ex-Husband  Boyfriend  Stranger  Other  Multiple
   Total # of times ________

5. Are you afraid of your partner or anyone listed above? YES NO

Mark the area(s) of injury on the body map if abuse visible

ASSESS PATIENT SAFETY:
Is abuser here now? ☐ Yes  ☐ No
Threats of homicide/suicide? ☐ Yes  ☐ No
Any guns in home? ☐ Yes  ☐ No
Alcohol or substance abuse? ☐ Yes  ☐ No

INTERVENTIONS:
☐ Validate her, Listen
☐ Safety Plan
☐ Discrete #s card given

REFERRALS:
☐ Perinatal referral
☐ BH referral offered
   ☐ Patient declined BH
☐ Other referral _____
Appendix E – IPV Screening and Intervention Protocol

Intimate Partner Violence Screening and Intervention Algorithm for Pregnant Women (By APRNs)

Is it safe to screen her here and now?
- Inquiry should be done by APRN during initial OB visit and if signs/symptoms present if patient is ALONE
- Discuss confidentiality & reporting requirements

YES

INQUIRY: All pregnant women
- Use framing statement: “Because domestic violence happens to so many women, we are asking ALL women”
- Screen Privately 1:1, orally using AAS form

Patient Discloses Abuse

ASSESSMENT (Immediately assess safety)
- Health impact of abuse
- Type & Pattern of abuse
- Danger/Lethality Assessment

+ Danger Assessment

IMMEDIATELY assess for suicide or homicide

INTERVENTIONS (Immediately)
- Remind her of Confidentiality
- Listen, Support, Validation
  - “You are not alone” “Help is available”
  - “I believe you” “What can I do for you?” “It is not your fault” I am concerned for your safety
- Create a safety plan!!
- Provide IPV discreet phone card, point out IPV hotline #s
- Explain services at WCCHC and community resources
- Consider perinatal case mgmt referral
- Offer Behavioral Health
  - Inquire and assess for safety during all followup visits

FOLLOWUP & REPORT
- Identify followup strategy including Postpartum visit (Next visit, safe contact #, address)
- Report if injuries inflicted by gun or firearm, knife, or other sharp object OR if injuries likely to cause death

Desired Outcomes
- Short Term: Increase in pregnant victims identified & Increase in provider comfort inquiry, assessment, and immediate interventions for victims.
- Long Term: Reduction in episodes of violence & IPV exposure; Support for victim, Increase in safety for women and children, including fetus.
Appendix F – Training Handout on IPV Assessment and Interventions

IPV Assessment and Intervention for Providers

**If Abuse is Denied...**
If abuse is denied and no indicators of abuse are present, document the findings in the medical record and offer referral information for future reference.

What to do if a patient says "no":
- Respect her/his response;
- Let the patient know that you are available should the situation ever change;
- Assess again at regular intervals as an indication that it is safe to disclose to you;
- Display information and resources in exam and waiting rooms, or bathrooms;
- If patient says "no" but you believe she/he may be at risk, discuss the specific risk factors and offer information and resources;
- Let patient know that experts and help are available. Offer a crisis card/safety card. Tell them that even if they don't need it that they can give it to a friend or family member who might use it.
- Discuss possible repercussions if their partner finds the card.
- Do not write any domestic violence referral on discharge papers that will be taken home with the patient. If patient has obvious or suspected abuse but cannot communicate to acknowledge abuse (i.e. unconscious or impaired), schedule a follow-up appointment or initiate appropriate consult to ensure follow up.

**If Abuse is Identified...**
If a patient discloses that they are currently being abused, at a minimum their immediate safety should be assessed. This could include asking:

1. Are you in immediate danger?
2. Is your partner in the facility now?
3. Has the violence escalated or gotten worse over the past year?
4. Has your partner threatened to kill you or your children?
5. Does your partner have access to guns or other deadly weapons?

If the patient answers yes to any of these, help the patient to develop a personal safety plan even if she does not intend to leave her abuser or encourage her/him to speak with a domestic violence advocate to develop a safety plan.

Provide a phone and a safe place for her to contact an advocate. Offer to make the call for them if they would prefer that. Be mindful that your phone may be the only link a survivor has to a domestic violence advocate since cell phones and land lines are easily traceable.

Appendix G – Training Handout on Responding to IPV Disclosure
Key Elements for Responding to a Domestic Violence Disclosure

Empathy
• "I believe you and I am sorry this has happened to you."
• "No one deserves to be treated like that and it is not your fault."

Generalize
• "This happens to many people, and we often feel alone with it."
• "Domestic violence happens more frequently than we know and in all types of relationships."

Empowerment
• "I believe you know what is best for you and your children. I have information that can be helpful now and later."
• "When you are ready, I can help connect you with [advocate’s name]. She is very knowledgeable about domestic violence and really knows how to help in situations like yours."

Autonomy
• Resist being directive (i.e. “You should,” “You need to”).
• "What would be helpful right now?"
• "Is there one person, be it a family member or friend, that you can tell in case you need help one day?"

Confidentiality
• Explain limits of confidentiality;
• Adults: "Everything you tell me is confidential unless you tell me someone has harmed your children or if you intend to harm yourself or someone else."
• Teens: "Everything you tell me is confidential unless you tell me someone is harming you or if you intend to harm yourself or someone else. Depending on your age there are instances where I may need to report sexual contact or conduct."

Linking to resources
• "I want to give you the number to the National Domestic Violence Hotline, and the number to DVAC and shelters"
• "I can have your perinatal case manager follow up with you"
• "I can help you make an appointment with one of our behavioral health experts if you need someone to talk to"
Appendix H – Training Handout on IPV Complaints and Red Flags

IPV Vague Complaints & Red Flags

The following information developed by Futures Without Violence represents findings that may suggest abuse. This list suggests some, but not all, of the indicators of abuse. Any person seen in a health care setting may be a victim of abuse and should be screened.

Common Complaints
• Miscarriage, sexually transmitted diseases, and non-specific gynecologic complaints (e.g. pelvic pain, painful intercourse), as well as rapid repeat pregnancies and abortions;
• Indication of having been hurt physically, sexually, and/or emotionally;
• Unexplained injuries or injuries inconsistent with the history given;
• Assaulted by alleged stranger;
• Chronic pain syndrome, migraine headaches, fibromyalgia;
• Overdose/suicide attempts;
• Anxiety, depression, insomnia, multiple somatic complaints;
• Multiple motor vehicle and single vehicle accidents.

Red Flags in Medical History
• Unintended pregnancy and rapid, repeat pregnancies;
• Drug/alcohol addiction (partner and/or patient);
• Any old unexplained injuries;
• Delay in seeking care;
• “Accident prone” patient;
• Documented history of family violence;
• High stress in family;
• Frequent emergency department, urgent care, or office visits;
• Request for medication for anxiety, sleep, or “nerves.”

Red Flags of Patient Presentation
• Partner answers questions for patient; Partner refuses to leave patient alone;
• Patient is evasive/guarded; Patient defers to partner;
• Patient appears embarrassed and/or exhibits poor eye contact;
• Patient presents with injuries and appears depressed;
• Patient has financial concerns; Patient has a recent loss of job, close family member or intimate relationship;
• Patient experienced a recent separation with partner;
• Patient seems upset by recent unemployment of partner or patient;
• Patient denies abuse too strongly;
• Patient minimizes injury or demonstrates unexpected responses (e.g. cries, laughs);
• Patient has intense and/or fearful behavior when partner is present;
• Patient appears angry and defensive “last straw phenomena”;
• Patient presents with psychiatric and/or suicidal ideation.

Physical Findings:
• Breast/abdomen (particularly during pregnancy)
• Injuries to areas not prone to injury by falls;
• Injuries to multiple sites; Symmetrical injuries;
• Wounds in varying stages of healing;
• Mid arm injuries (defensive); Injuries to hidden sites (covered by clothes);
• Strangulation marks: petechiae, ligature marks, and subconjunctival hemorrhage;
• Weapon injuries or marks;
• Bites/burns (scald and cigarette); Black eyes; Dental injuries; Mid-face injuries; Neck injury; Internal injuries
• Fibromyalgia and chronic pain syndromes
Appendix I – Safety Planning for Positive Current IPV Screens

Safety Plan for IPV Victims

WHO will you tell?

WHAT will you take?

WHEN will you go?
WHERE will you go?
HOW will you go?

WHY? Safety First

Tell those you can trust about the violence

- Develop a code word that tells them you and your children need to get out
- Ask them to call the police if they hear suspicious noises coming from your house
- You can also ask the police to protect you while you gather your belongings to leave
- If you have nowhere to go, call a shelter.

Plan to take what you need

- Talk to a friend, family, or co-worker about your situation. Leave $10 or more, car keys, extra clothes and important documents with a neighbor or friend.

Decide now how you will escape more violence

- Decide where you will go and how you will get there.

Always take you children with you. Your safety and the safety of your children comes first!

- Let your children’s school know enough about your situation to respond supportively in a crisis.
- If necessary, leave with nothing. If you can’t leave safely, keep your back toward an open space, not a corner. Avoid the bathroom, the garage, the kitchen, and other places where there are weapons or sharp, heavy objects.
## Appendix J – Phone Resource Cards

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<td>DV Shelters</td>
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<td>Physician’s Exchange</td>
<td>697-3375</td>
</tr>
<tr>
<td>Perinatal Case Mgmt</td>
<td>697-3386</td>
</tr>
<tr>
<td>Patient Annex Services</td>
<td>697-3405</td>
</tr>
<tr>
<td>Transportation</td>
<td>697-3436</td>
</tr>
<tr>
<td>Dental Services</td>
<td>697-3476</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>697-3495</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>697-3599</td>
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<tr>
<td>Gym</td>
<td>697-3588</td>
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<tr>
<td>VRC</td>
<td>697-3594</td>
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<tr>
<td>697-3699</td>
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</tr>
<tr>
<td>DV Hotline</td>
<td>697-3771</td>
</tr>
<tr>
<td>DV Shelters</td>
<td>356-2200, 841-6821</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>697-3469</td>
</tr>
<tr>
<td>Fetal Diagnostic Center</td>
<td>983-8559</td>
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<table>
<thead>
<tr>
<th>Main Line</th>
<th>697-3300</th>
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<td>Women’s Health</td>
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</tr>
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<td>697-3495</td>
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<td>Smoking Cessation</td>
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<td>DV Hotline</td>
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<tr>
<td>DV Shelters</td>
<td>356-2200, 841-6821</td>
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<tr>
<td>Behavioral Health</td>
<td>697-3469</td>
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<tr>
<td>Fetal Diagnostic Center</td>
<td>983-8559</td>
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</tbody>
</table>
Appendix K – IPV Resource List

Intimate Partner Violence Complete Resource List for Providers

IPV Information
Domestic Violence Action Center (8:30am-4:30pm) 531-3771
Hawaii State Coalition Against Domestic Violence 832-9316
National Domestic Violence Hotline (24/7) 800-799-SAFE

Shelters
Honolulu & Leeward Shelter Hotline: 841-0822
Windward (Olia PACT) Hotline: 526-2200, 528-0606

Temporary Restraining Orders
538-5959

Counseling and Support
Child & Family Service 585-2712
Family Peace Center 832-0855
Crisis Counseling 585-7944

Child Protective Services
832-5300

Sex Abuse Center
524-7273 (24-hour hotline)

Hawaii Immigrant Justice Center
536-8826
Appendix L – New OB IPV Screening Log

**NEW OB Intimate Partner Violence Screening Log**

Provider Name _____________________________ Weeks _____________________

Please log the number of NOBs per day and how many were screened using the new screener. If a patient does screen positive, please log on the **POSITIVE Pregnant female IPV screens table**. Do NOT write any patient identifying information.

<table>
<thead>
<tr>
<th>DATE</th>
<th># of NOBs</th>
<th>Screening completed</th>
<th>If No, why?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Appendix M – Postpartum IPV Screening Log

**POSTPARTUM Intimate Partner Violence Screening Log**

Provider Name _____________________________ Weeks _____________________

Please log the number of Postpartum Visits per day and how many were screened using the new screener. If a patient does screen positive, please log on the **POSITIVE Postpartum female IPV screens table**. Do NOT write any patient identifying information.

<table>
<thead>
<tr>
<th>DATE</th>
<th># of Postpartum Visits</th>
<th>Screening completed</th>
<th>If No, why?</th>
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</thead>
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</table>
Appendix N – Positive New OB IPV Log

Positive Pregnant Female Intimate Partner Violence Screening
Initial OB IPV Screening Log

Provider Name ___________________________________________

Please log any POSITIVE Pregnant female IPV screens into table below. Do NOT write any patient identifying information. Sheets will be collected by DNP student weekly. If none of your female patients screen + for IPV, please write in 0.

<table>
<thead>
<tr>
<th>DATE &amp; TIME OF VISIT</th>
<th>METHOD OF SCREENING (written tool, oral)</th>
<th>Was patient counseled by you?</th>
<th>Was patient given a resource card?</th>
<th>Was the patient referred to Perinatal or BH today?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Appendix O – Positive Postpartum IPV Log

Positive Postpartum Female Intimate Partner Violence Screening
Postpartum IPV Screening Log

Provider Name ____________________________________________________

Please log any **POSITIVE Postpartum female IPV screens** into table below. Do NOT write any patient identifying information. Sheets will be collected by DNP student weekly. If none of your female patients screen + for IPV, please write in 0.

<table>
<thead>
<tr>
<th>DATE &amp; TIME OF VISIT</th>
<th>METHOD OF SCREENING (written tool, oral)</th>
<th>Was patient counseled by you?</th>
<th>Was patient given a resource card?</th>
<th>Was the patient referred to Perinatal or BH today?</th>
</tr>
</thead>
<tbody>
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</table>
Appendix P – IPV Phone Resource Card Log

IPV Resource Card Log

Date of Count _____________________________

<table>
<thead>
<tr>
<th>AREA</th>
<th># Cards Given to Staff/Area</th>
<th>- # Cards Left</th>
<th>= # Cards Handed Out to Patients</th>
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</thead>
<tbody>
<tr>
<td>Patient Room #1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patient Room #2</td>
<td>25</td>
<td></td>
<td></td>
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<tr>
<td>Patient Room #3</td>
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<td>Patient Room #4</td>
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<td>Patient Room #5</td>
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<td>Patient Room #6</td>
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<td>Patient Room #7</td>
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<td>Patient Room #8</td>
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<tr>
<td>Patient Room #9</td>
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<tr>
<td>Patient Room #10</td>
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</tr>
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</tr>
<tr>
<td>Providers (25 x 5)</td>
<td>125</td>
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<tr>
<td>Perinatal (50 x 3)</td>
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<tr>
<td>Behavioral Health</td>
<td>50</td>
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<tr>
<td>Other _________</td>
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<td>Other _________</td>
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<tr>
<td>Other _________</td>
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</tbody>
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TOTAL # OF CARDS TAKEN BY PATIENTS OR GIVEN
References


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http://www.futureswithoutviolence.org/content/action_center/detail/754

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