Spring 2023

Improving Knowledge and Awareness for Providers and Staff on Intimate Partner Violence

Blessie Clontz
Regis University

Improving Knowledge and Awareness for Providers and Staff on Intimate Partner Violence

Blessie Clontz

Submitted as Partial Fulfillment for the Doctor of Nursing Practice Degree

Regis University

April 24, 2023

Abstract

Intimate partner violence (IPV) is a national and global health issue where women and men have experienced contact sexual violence, physical violence, or stalking by an intimate partner. A health-care provider is likely to be the first professional contact for survivors of IPV or sexual assault. The purpose of this quality improvement (QI initiative was to use a mixed study design to examine the impact of an educational session on provider and staff knowledge and awareness of intimate partner violence at a small primary care practice setting in a southeastern area of the United States. The primary objective was to measure knowledge and awareness of IPV using a modified version of the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) pre-and post-educational session on IPV. A secondary objective was to obtain participant perspectives on IPV screening strategies, barriers, and resources through a post-intervention short survey. A convenience sample of 25 staff and providers participated in the study with a 100% response rate. The PREMIS survey results were statistically significant ($t=-24.219$, $p = <.001$). The mean score for the pretest was 1.75 and 2.91 in the posttest. Responses to the open-ended questions revealed that the staff would contact the practice manager and the provider if a patient expressed being a victim of IPV. In addition, most participants wanted more practice to do a better job and felt the greatest barrier that prevented them from screening for IPV was lack of time. After completion of this DNP project, the goal is to integrate an IPV screening tool into this clinic's electronic medical record and collate a list of resources that can be shared with patients who are at risk of abuse or those who have experienced abuse.

Key words: DNP Project, intimate partner violence, PREMIS

Executive Summary

Problem

The Centers of Disease Control (CDC) (2015) reported that 34.6% of women and 33.6% of men have experienced at least one form of intimate partner violence (IPV), including contact sexual violence, physical violence, or stalking by an intimate partner. Most recently Weil (2020) purported >32 million Americans have experienced IPV. Women who have been subjected to violence often seek health care, including for their injuries, even if they do not disclose the associated abuse or violence. A health-care provider is likely to be the first professional contact for survivors of IPV or sexual assault. The PICO question for this quality improvement (QI) study was: Among primary care providers and staff, will an educational session enhance their knowledge and awareness of IPV?

Purpose

The purpose of this QI initiative was to examine the impact of an educational session on provider and staff knowledge and awareness of intimate partner violence.

Goal

The primary goal of this DNP project was to improve provider and staff knowledge and awareness of IPV following an educational intervention, represented by an increase in knowledge and awareness of IPV and patient's safety. The secondary goal was to ensure providers and staff have resources to offer those who screen positive for IPV. Following this study, the intent is to integrate a screening tool into the electronic medical record and collate a list of resources that can be shared with patients who are at risk of abuse or those who have experienced abuse.

Objective

The objectives of this project were to 1) develop an educational intervention to inform providers and staff about screening strategies used to assess IPV and recognize resources/referrals directed at assisting IPV victims, 2) evaluate provider and staff knowledge and awareness of IPV using an adapted abbreviated version of the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) before and after the educational intervention on IPV, and 3) obtain participant perspectives on IPV screening strategies, barriers, and resources post-intervention.

Plan

Using a convenience sample of 25 health care workers, the study plan followed a mixed study design using a pre-post survey and post-open-ended questions. After taking the pre-PREMIS survey, participants attended an educational session on IPV, which was then followed by a post-PREMIS survey with additional open-ended questions. Descriptive and inferential statistics were used to analyze the data. A thematic analysis was performed on the open-ended questions.

Outcomes

There was 100% participation by the staff in the project. The PREMIS survey results were statistically significant ($t=-24.219$, $p = <.001$). The mean score for the pretest was 1.75 and 2.91 in the posttest. Responses to the open-ended questions revealed that the staff would contact the practice manager and the provider if a patient expressed being a victim of IPV. In addition, most participants wanted more practice to do a better job and felt the greatest barrier that prevented them from screening for IPV was lack of time.

Acknowledgements

I would like to thank my God above for watching over me and for guiding me through life. I want to offer a sincere thank you to my project Chair, Dr. Kathleen Whalen, who has guided me through my project and has kept me on target for completion; I could not have completed this project without her. I would also like to thank Dr. Cheryl Kruschke for helping me with the statistical analysis and interpretation. I want to send my appreciation to Dr. Lora Claywell, Dr. Patsy Cullen, and Dr. Susan Meier for their assistance through this journey.

I want to send my appreciation to the primary care practice for giving me the support I needed to finish my project. The providers and staff have been very gracious to allow me their precious time.

I dedicate this project to my late husband, Rich, who has been loving me and supporting me from Heaven. I also want to thank my friends and family for their love and support.

Table of Contents

List of Tables

List of Appendices

Improving Knowledge and Awareness for Providers and Staff on Intimate Partner Violence

The staggering statistics surrounding intimate partner violence (IPV) screening practices are related to rising incidence and prevalence of IPV. The inconsistent or lack of screening practices plus the significant victim, provider, and systemic barriers prevent a collaboration of change for the victim and provider attitudes, an increase in provider education, training, consistent screening techniques, and availability of resources, (CDC, 2015). There are a variety of factors that increase the risk of IPV, such as unemployment, substance abuse, marital difficulties, economic hardships, and the recent COVID-19 pandemic. This Doctor of Nursing Practice (DNP) Quality Improvement (QI) project intended to address educational needs for IPV screening and prevention practices to providers at one primary care practice setting. The paper defines the practice problem, summarizes the theoretical foundation and literature review that supports the project question, presents a market/risk analysis, and describes the methodology and evaluation plan for this QI initiative. Lastly, the project findings and implications for change are discussed.

Problem Recognition and Definition

Statement of Purpose

The purpose of this QI initiative is to examine the impact of an educational session on provider and staff knowledge and awareness of intimate partner violence. The DNP student will analyze data from self-assessments before and after the educational intervention. Teaching providers about how to screen for domestic violence and find support resources will promote appropriate care and safety of patients. This DNP student will take the first step by educating providers and staff about IPV. The goal is to eventually integrate a screening tool into the EMR

and collate a list of resources that can be shared with patients who are at risk of abuse or those who have experienced abuse. This project is not meant to create or develop new knowledge and cannot be generalized outside of the study practice setting.

Problem Statement

The CDC's National Intimate Partner and Sexual Violence Survey found that 34.6% of women and 33.6% of men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetimes (CDC, 2015). The survey also showed that 21.4% of women and 14.9% of men who have experienced IPV have suffered severe physical violence by an intimate partner — like being hit with a fist or something hard, beaten, or slammed against something, (CDC, 2015). Most recently, Weil (2020), purported that greater than 32 million Americans experience IPV. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) also reported an increase of IPV during the COVID-19 pandemic.

The Institute of Medicine (2011) and U.S. Preventive Services Task Force recommend intimate partner violence screening and counseling as a core part of health visits (CDC, 2015). During the COVID pandemic, social distancing fostered isolation exposing personal and collective vulnerabilities while limiting accessible and familiar support options (CDC, 2015). Providers should recognize the need to change ways in which they can inquire and prevent harm. This study site does not currently have a systematic approach for assessing IPV in their patient population. The medical director is aware of the need for screening and supports the first phase of this project. The DNP prepared nurse practitioner must be aware of the patient's needs even if they are not spoken. The nurse practitioner must also make sure the other staff members have

what they need to ensure the patient's safety. Patients may be reluctant to share the possible abuse in their home which can contribute to the reasons for their medical issues.

In summary, the practice problem statement for this DNP Project is that intimate partner violence is a serious, preventable public health problem affecting millions of Americans (Weil, 2020). IPV is a social problem that affects not only women but men, children, and communities. As noted by Lehman and McCall-Hosenfield, (2017), low rates of screening emphasize the importance of educating providers on screening techniques, increasing availability of community resources, establishing practices that promote IPV screening, dialog, and referrals after disclosure. Primary care providers and their staff provide an environment for patients to feel safe to share and discuss violence and abuse in the home during their medical appointment. According to the CDC (2015), providers should concentrate on changing awareness and begin to change their clinical practice to find and document the abuse so they can be a part of the improvement of a patient's life.

PICO

The capstone project utilizes the "P.I.C.O." question format rather than a formal research hypothesis. The P.I.C.O. acronym stands for: Population or Patient (P), Intervention (I), Comparative Intervention (C), and Outcome (O) (House & Oman, 2011). The P.I.C.O. statement for this project was:

- **Population**: Primary care providers, medical office assistants, and nurses
- **Intervention:** Intimate partner violence education
- **Comparison:** Pre-post self-assessment survey
- **Outcome:** Increase knowledge and awareness of IPV

The study question for this project was: Among primary care providers and staff, will an educational session enhance their knowledge and awareness of IPV?

Project Significance and Scope of Project

The American Association of Colleges of Nursing's (AACN) DNP Essential II Organizational and Systems Leadership for Quality Improvement and Systems Thinking, and Essential III Clinical Scholarship and Analytical Methods for Evidence-Based Practice, best apply to this DNP project (Zaccagini & White, 2017). Implementing evidence-based action plans and acting as a systems thinker enables this DNP practitioner to make meaningful changes in one primary care practice setting. IPV screening is essential in providing quality and safe patient care. In addition, one of the objectives of Healthy People 2030 is to reduce intimate partner violence (i.e., sexual violence, physical violence, and stalking) across the lifespan. "This objective currently has developmental status, meaning it is a high-priority public health issue that has evidence-based interventions to address it, but it does not yet have reliable baseline data" (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Once baseline data are available, this objective may be considered to become a core Healthy People 2030 objective. The scope of this pilot project was limited to a small convenience sample, specifically at one primary care practice located in a southeastern area of United States.

Theoretical Foundation

Two theories served as frameworks for guiding the project intervention. Relationship Based Care (RBC) is grounded in caring for and healing for the patient and those around the patient. The Adaptation Model by Sister Callista Roy promotes adaptive responses and continuous interaction with the changing environment.

Relationship Based Care (RBC)

One of the theoretical frameworks, Relationship Based Care (RBC), that guided the project is based on the work of Mary Koloroutis (2004), CEO of Creative Care Management (Koloroutis, 2004). The foundation of RBC is relationships within a caring and healing environment with the patient and family in the center (Koloroutis, 2004). Surrounding the patient and family are a caring culture of leaders, strong collaboration and teamwork, nurses' therapeutic relationship with the patient that is key to the nursing professional practice, shared responsibility of the managers and nurses for the resources they need to provide patient care, and the responsibility for driving great quality outcomes (Koloroutis, 2004). Relationship based care consists of leadership, teamwork, professional practice, patient care delivery, resource practices and outcomes which are essential in the process of evaluation and screening for IPV in the primary care setting (Koloroutis, 2004). Professional nursing practice is one portion. Advanced practice nurses can assist with patient safety by starting to break down barriers for IPV screening. Advance practice nurses' perception of IPV is designed to understand the resources, teamwork, and practice so that patients' outcomes include safety, (Koloroutis, 2004). The application of this relation-based care model aligns with the potential implementation of an IPV screening tool following this DNP project.

Sister Callista Roy's Adaptation Model

Another theoretical framework that can be beneficial is Sister Callista Roy's Adaptation Model's major concepts, including the definition of the nursing metaparadigm as defined by the theory (Roy, 2009). The Roy Adaptation Model of Nursing was developed by Sister Callista Roy in 1976. This prominent nursing theory aims to explain or define the provision of nursing. In her theory, Roy's model sees the individual as a set of interrelated systems that maintain a balance

between these various stimuli (Roy, 2009). The five major concepts of this model include person, environment, health, nursing, and adaptation and each will be discussed below as they relate to the practice issue of IPV.

The "person" or human system focus of this project will be individuals at the primary care provider office who may be at risk for or who have experienced IPV. Roy recognizes humans as holistic beings who respond either negatively or positively to environmental stimuli. IPV is a negative stimulus, best categorized as a "focal stimulus" that confronts the human system and requires the most attention (Roy, 2009). If the IPV victims cannot adapt and remove this part of their life, they will continue to be affected negatively. Health care providers and nurses can serve as facilitators of adaptation (Roy, 2009). They have an opportunity to help patients adapt to the IPV situation by finding solutions to keep themselves safe and healthy. The DNP student recently applied the Roy Adaptation Model as a nurse practitioner when caring for a patient who was a victim of IPV. A female patient who had experienced IPV in her past relationship shared during a clinic visit that she continues to have some post-traumatic stress. The patient was referred to a local women's refuge center and to a local mental health counselor for assistance.

The Adaptation Model can be used as a conceptual framework with abused women through research and clinical examples. Some research with abused women focuses on their help-seeking patterns, whereas the clinical practice with a larger sample focuses on the interrelationships of the constructs. One strength of the model is its provision of a framework for identifying the client's complex health needs. The model can be modified such that the self-concept, role function, and interdependence modes can define the psychosocial self, and the physiological mode defines the biological self (Roy, 2009).

Review of Evidence

Literature Selection/Systematic Process

A literature search began in 2020 with a focus on intimate partner violence and barriers related to the success of the assessment of knowledge and providing safety and how to provide local information to the IPV victims. Multiple databases were reviewed and yielded approximately 45 articles that met the search criteria. After further review, 32 articles were selected for this project. Databases included PubMed, Google Scholar and CINAHL. Some of the key words were IPV, domestic violence, battered women, violence against women, health care providers screening for IPV, IPV screening practices in primary care and IPV screening and intervention, and IPV screening tools. Including best practices and clinical guidelines from the CDC were also part of the literature review. For this DNP project, peer-reviewed articles and professional resources published between 2018-2021, were chosen to support the study. Older articles (2009-2015) were included if they contributed to the understanding of the P.I.C.O., and if they were pertinent to the current practice environment. Articles that primarily discussed IPV against men, and non-primary care clinics or emergency rooms were excluded. There were few articles that referenced IPV against men. IPV screening tools were found to be gender neutral.

Background of Problem and Systematic Review of the Literature

Emergent Themes

The systematic review of the literature provided additional background of the DNP's proposed study. Three themes related to the practice issue are: major barriers of provider and staff knowledge of IPV, screening tools and resources, and COVID-19 pandemic that has triggered a negative impact on IPV.

Major Barriers. The first theme addressed major barriers of provider and staff knowledge of IPV. Providers felt the chief complaint was more important at the visit than screening for IPV. They also felt the IPV screening could hinder the patient-provider rapport. The providers related that a lack of training, available personnel and time prevent providers from performing routine screening for IPV (Kalra et al., 2021; Morse et al., 2012; Penti et al., 2018; Portnoy et al., 2020). Health care professionals are not usually trained on how to prevent IPV; only how to take care of a patient when they have experienced it (Jackson et al., 2020; Sossenheimer et al., 2021). They are taught how to take care of a patient when they have experienced an injury from the violence. Providers expressed being uncomfortable with screening and lacked preparedness (Martin-Engel et al., 2021; Palmieri & Valentine, 2020; Roark, 2010).

The barriers to identifying IPV victims are causing physical, emotional, and mental health challenges for survivors of IPV (CDC, 2015). The barriers to screening also cause IPV incidents to go unreported and undetected. The commonalities found in the literature review support this projects' importance and relevance in healthcare. Acute and chronic health consequences can be reduced with routine screening of IPV and appropriate subsequent referral to resources in the community (Office of Disease Prevention, 2020). Healthcare providers who fail to screen for IPV miss a vital opportunity to positively impact the physical and psychological well-being of survivors, thus the opportunity to improve the victims' overall quality of life (CDC, 2015). It is the responsibility of health care professionals to conduct routine screening of IPV to appropriately identify and manage these irreparable adverse health sequelae that are associated with abuse. IPV and the subsequent associated health consequences remain a global health concern. However, addressing screening barriers and creating educational solutions to

increase provider knowledge can aid in the deliverance of quality services to IPV survivors in need.

Screening Tools and Resources. The second theme that emerged in the literature addressed screening tools and resources. Providers reported that they did not routinely screen for IPV due to a lack of an appropriate screening tool (Arback & Bobbio, 2018; Christiansen, 2020; Feltner et al., 2018; Gomez-Brito, 2021; Lippy et al., 2019; MacMillan et al., 2009; Miller et al., 2021; Sohal et al., 2007; Saboori, Gold, Green, & Wang, 2021). The Humiliation, Afraid, Rape, Kick (HARK) questionnaire devised by Sohal et al. (2007) and *Physician Readiness to Manage Intimate Partner Violence Survey* (PREMIS) (Short, et al., 2006) are examples of screening tools that can easily be used by providers during office visits. The questions identify risk factors for those who are a victim or a potential victim of abuse. Some providers expressed that routine screening was best suited for other staff due to the lack of knowledge of community resources (Grimani et al., 2020; Hamberger et al., 2015; Huecker et al., 2021; Miller et al., 2015).

Impact of COVID-19 Pandemic. The third theme dealt with the COVID-19 pandemic that has triggered a negative impact on IPV. IPV is a global problem that has grown worse since the COVID-19 pandemic began (CDC, 2015). Next to physical and geographical isolation, IPV survivors describe social isolation as a relevant risk during the pandemic that has increased the incidence of IPV. The survivors during their isolation have not made appointments for their routine health checks so the opportunity for IPV screening has decreased. The United Nations has urged the governments to continue combatting IPV in the time of COVID-19, ensuring continued access to legal services, safe shelters, and support phone lines for individuals who have experienced IPV. While quarantines are an effective measure of infection control, they can

lead to significant social, economic, and psychological consequences. Social distancing fosters isolation exposing personal and collective vulnerabilities while limiting accessible and familiar support options. The pandemic has brought to light inequities related to social determinants of health (Bradley et al., 2020; Evans et al., 2020; Gelder et al., 2020; Lyons & Brewer, 2021; World Health Organization, 2021, Institute of Medicine, 2011).

Scope and Quality of Evidence

In the articles that were researched, there were a variety of evidence types. The DNP student categorized the selected 32 articles based on the Melnyk and Fineout-Overholt (2015) level of evidence table. All levels were represented except for V Systematic Review of Qualitative or Descriptive Studies. Most articles (11) were recognized as I: Systematic Review and metanalysis of RCTs, clinical guidelines based on systematic review or meta-analyses. The articles included an analysis and interpretation of their work. There was discussion of the findings and recommendations and recognition of opportunities for future studies. Refer to Appendix A to view a complete list of articles and their associated level of evidence.

In summary, the purpose of the literature review was to address screening barriers, staff education, screening resources, and to consider the challenges that COVID-19 has contributed to IPV (CDC, 2015). Providers should recognize the need to change the ways in which they can inquire about safety and prevent harm, (Koloroutis, 2004). Staff should have specific ways and resources to intervene for their patients. Also, staff should concentrate on raising awareness and begin to change their clinical practice to find and document the abuse so they can be a part of the improvement of the patient's life. These barriers are causing physical, emotional, and mental health consequences to go unreported and undetected. To decrease these negative consequences, specific workplace barriers to routine screening and providing community resources can be

integrated into clinical practice to manage the detrimental health consequences associated with intimate partner violence.

Project Plan and Evaluation

Market/Risk Analysis

The SWOT analysis for the IPV project guided the direction and solutions of the project. The greatest **strengths** of the IPV project were the internal engagement and support by the office staff and leadership where the DNP student works as a nurse practitioner. Another strength included the DNP student's experience helping IPV victims. A possible **weakness** to the internal validity of the project could be the self-assessed knowledge, beliefs, and attitudes of IPV. Other weaknesses considered were attrition of participants during the study and delay in the Regis University Institutional Review Board (IRB) review of the project submission. The one **threat** that could pose the biggest challenge during the IPV project is the time element that providers and staff can offer to participate in the project. In addition, as stated, IPV is potentially a sensitive issue to discuss when a patient is identified as experiencing abuse. The project could provide multiple **opportunities** including provision of resources in the community for IPV victims, meeting the Healthy People 2030 initiative to mitigate the occurrence of IPV, additional evaluations of male patients with IPV, and screenings for patients in emergency departments. Most importantly, lives could be saved when providers and staff are aware of the risk factors, assessment findings of IPV and available resources. Refer to Table 1 for a complete list of strengths, weaknesses, opportunities, and threats that were important to this project.

Table 1

SWOT Analysis

Strengths (internal)	**Weaknesses** (external)
• Currently work as NP in Primary Care Setting • DNP student expertise on subject and experience helping IPV victims • Significant interest in this topic by the providers and staff • Leadership support of project	• Possible threats to internal validity could be the self-assessed knowledge, staff attitudes about IPV or staff attitudes about my project and beliefs about IPV • Provider/Staff attrition • Delay in IRB review
Opportunities (external)	**Threats** (internal)
• Available resources in the community to share with patients who test positive for IPV • Healthy People 2030 initiative to reduce IPV • Inclusion of the inpatients and emergency room patients other primary care provider offices • Evaluation of male patients for IPV • Save lives	• Potentially sensitive issue within the practice if a patient is identified as experiencing abuse • Competing priorities to attend the educational session and taking pre-post assessments

Driving and Restraining Forces

A **driving force** was provider and staff positive attitudes about the pre-post self-assessment survey and educational sessions as they related to the opportunity to assist in the safety of their patients. Another driving force was the staggering statistics on IPV and the impact that it has on the patient, family, and community. Recognizing the need to help patients stay safe was another driving force. **Restraining** forces to assist the IPV victims were potentially inadequate neighborhood assistance, coordination of resources and services among community agencies, and communities with access to safe and stable housing. Another restraining force could be limited time for staff to participate as the medical office is busy whereby providers see

patients about every 15 minutes. In addition, providers, and staff my lose interest in the project which could affect their participation.

Need, Resources, and Sustainability

The need for the project was to address the problem of IPV in the community and provide education to providers and staff concerning IPV screening and resources to help IPV victims. As outlined in the Logic Model, one of the major resources for designing the educational intervention was the CDC's technical package for IPV strategies and prevention. Other resources included the medical office's conference room and computer for the PowerPoint presentation and printed versions of the PREMIS survey and lecture handouts. Data analysis was performed using SPSS-Version 28. The DNP student was the lead in developing all project materials. Time was needed for the development and implementation of the project which was built within the DNP program curriculum. Time was made available during working hours for participants to attend educational sessions and take surveys. To increase the success of the DNP project, one major sustaining force was providing different days and times to give participants an opportunity to attend an educational session on IPV. Post project, the DNP can offer ongoing educational sessions on IPV, and as stated previously submit a proposal to add an IPV screening tool in the EMR with a list of community resources.

Feasibility, Risks and Unintended Consequences

The DNP project was feasible to complete as the DNP student is a nurse practitioner who currently works at the study site and the medical staff see patients who have experienced or who are at risk for IPV. The medical office leadership provided ongoing support throughout this project by providing space and allowing time for staff to attend the educational sessions. In addition, the short timeframe needed to conduct the study and the minimal cost for the teaching

and survey supplies made it possible to implement this study. Potential risks for conducting the project were staff feeling frustrated by lack of time to participate in the study on days where the medical office was especially busy. Even though staff see patients with multiple health care problems, they could feel uncomfortable talking about IPV due to the sensitive nature of this topic. Lastly, there were no unintended consequences identified during the implementation of the project.

Stakeholders and Project Team

The stakeholders for this project were the providers, office staff and office practice managers and the patients who are at risk or who have experienced IPV, family members and the surrounding community at large. Other stakeholders are the IPV advocacy organizations, community support groups and women's shelters.

The project team consists of the DNP student, the DNP Chair, the site mentor, and the providers and staff who attended the educational session and who will potentially be involved in the second phase (post-DNP project) of IPV screening of patients visiting this clinic.

Cost-Benefit Analysis

IPV creates a substantial cost to families, communities, and governments. Primary care settings with a high disclosure rate of IPV may further reduce the cost of IPV due to the screening practices. Universal screening to all patients will be less expensive compared to other screening practices for other diseases in the primary care practice. If a female patient screens positive for IPV, the cost will be increased. In addition to the IPV cost of injury, the other healthcare costs include the costs of depression, posttraumatic stress disorder, anxiety disorders, substance abuse, suicidal ideation, and sexually transmitted diseases (STDs). The largest proportion of the costs is derived from physical assault victimization because that type of IPV is

the most prevalent. The largest component of IPV-related costs is health care, which accounts for more than two-thirds of the total costs (CDC, 2015).

Most of the benefits for this DNP project were immeasurable. It is expected that the providers and staff will have a greater understanding of IPV and implement best practices in this office setting for identifying and managing IPV. The patient is the major recipient of any benefits derived from the project. The intent is to keep the patient safe and healthy, preventing physical and psychological harm. Family members and the surrounding communities will also be safer and healthier. Other benefits include the reversal of some of the costs identified in the preceding paragraph such as an increase in paid work days and household productivity and a decrease in costs of medical and mental health care services.

The costs were insignificant to conduct the educational session and administer pre-post self-assessment surveys and a post-open-ended survey. See Appendix B for an itemized list of resources and projected costs for this project.

Mission and Vision Statement and Goals for Project

The **mission** for this project was to ensure every patient is screened for IPV and provide or refer those who screen positive to ongoing support to ensure safety. The **vision** was that all patients within the primary care practice are screened, identified, treated, and referred for IPV. The **primary goal** of this DNP project was to improve provider and staff knowledge and awareness of IPV following an educational intervention, represented by an increase in knowledge and awareness of IPV and patient's safety (Roark, 2010). The secondary goal was to ensure providers and staff have resources to offer those who screen positive for IPV. Ultimately, the desired result is safe, healthy, patients with access to quality health care services.

Project Outcomes/Objectives

To meet the goals of the project the DNP student addressed the following outcomes/ objectives below and the timeline as shown in Appendix C.

1. Develop an educational intervention to inform providers and staff about screening strategies used to assess IPV in the patient population served, and to recognize resources/referrals directed at assisting IPV victims.
2. Evaluate provider and staff knowledge and awareness of IPV using an adapted abbreviated version of the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) before and after the educational intervention on IPV.
3. Obtain participant perspectives on IPV screening strategies, barriers, and resources post-intervention.

Logic Model

Setting target goals and benchmarks for this DNP project were performed using the logic model as shown in Appendix D (W.K. Kellogg Foundation, 2004). Learning and using tools like logic models can serve to increase the practitioner's voice in the domains of planning, design, implementation, analysis, and knowledge generation. The process of developing the model is an opportunity to chart the course. It is a conscious process that creates an explicit understanding of the challenges; the resources available is the first step, the next step is to identify the project outcomes, the output, short- and long-term outcomes, and impact are outcome measures. A logic model helps keep a balanced focus on the big picture as well as the component parts (W.K. Kellogg Foundation, 2004), and the application of the logic model to this DNP student's capstone project is evident throughout this final written report.

Population and Sampling Parameters

Total population sampling was used whereby the DNP student recruited a convenience or purposive sample of approximately 25 members including medical office assistants, licensed practical nurses, nurse practitioners, physician assistants, and physicians. Front desk schedulers were excluded since they are not involved in assessments of patients during office visits. Convenience sampling was most appropriate for the project due to the accessibility of the office staff. The only sampling issue that could be involved was getting all the staff through the process, (Elfil & Negida, 2017). Power analysis and effect size were not calculated.

Setting

The setting for the project was a general medical primary care practice in a rural setting in a southeastern state. It is a busy practice where providers see 20 to 30 patients per day. Lunch was scheduled at the same time for all employees from 12PM to 1PM. Most patients are women over 60 who have annual Medicare Wellness exams, in addition to general health care problem visits. The office can provide in-house diagnostic imaging and lab work services.

QI Project Study Design and Variables

A mixed method design was employed with the collection of quantitative and qualitative data. For the quantitative portion, a one-group pre-post survey was used. The pre-posttest (survey) is a type of quasi-experimental study design in which the outcome of interest is measured two times: once before and once after exposing a non-random group of participants to an intervention, as in in this study, an educational session on IPV (Brophy, 2019). The DNP student expected that scores will be higher for most participants on the post survey. In addition, qualitative data were obtained on a short questionnaire post intervention. The IPV educational

session was the independent variable, while the scores on the post-PREMIS survey were the dependent variable (Martin-Engel et al., 2021).

Description of Educational Intervention

The training was performed in-house, with the DNP student serving as the trainer. The training program was tailored to reach the office staff and providers, with the class offered on multiple days and at various lunch times to allow everyone an opportunity to attend. The plan was to conduct educational sessions in person using a PowerPoint presentation, with a supplemental handout; the session lasted for approximately 20-30 minutes. Examples of topics covered included: intimate partner violence, including definition of the term, statement of the problem, the cycle of violence, and a women's perspectives focus; screening and assessment strategies including questions to ask, what to look for on assessment, documentation, referrals, and safety behaviors; with a conclusion and summary (Martin-Engel et al., 2021). The educational session was interactive, giving participants time to ask questions. The DNP student did not need to provide an alternative way to deliver content in the form of a recorded presentation to give staff another opportunity to receive the IPV information.

Treatment Protocol Processes and Data Collection

The DNP student followed the protocol as written below when carrying out this QI initiative:

1. Created the educational intervention on IPV based on current evidence (summer/early fall 2022)
2. Received site approval letter from medical director and final review from Regis University Institutional Review Board (IRB) (End of summer/beginning of fall 2022)

3. Introduced the DNP project and distributed the information sheet to providers and staff (during staff meetings and/or blind copied via office email system) (mid-September 2022)
4. Distributed the PREMIS Survey by email (blind copied) or printed version by office mail to providers and staff (mid-September 2022) (2-4 weeks with reminders)
5. Implemented IPV training (October-early November 2022)
6. Distributed the PREMIS Survey by email (blind copied) and short questionnaire (3 questions) or printed version by office mail to providers and staff (end of November-early December 2022) (2-4 weeks with reminders)
7. Performed data analysis with Regis University statistics faculty (spring 2023)
8. Presented project defense to DNP Chairs (spring 2023).
9. Disseminated findings to providers and staff (spring 2023)

Protection of Human Subjects

There were no risks to the participants. Due to the sensitivity of the topic of IPV there could have been minimal risk for the staff members to become uncomfortable or uneasy during the educational session or administration of the surveys. However, the staff did not express any discomfort or uneasiness during this study when they attended the educational session or took the surveys. Participation in the educational session and pre-post surveys and post-questionnaire were on a voluntary basis. The DNP student provided an information sheet at the beginning of the study (see Appendix E) and the DNP student was available throughout the QI project to answer any questions. Data collected were confidential (and reported as de-identified aggregate data). Printed surveys were administered before and after the educational sessions with each participant placing their testing materials in a sealed envelope. There were no identifiers

collected on any surveys or on the post-intervention questionnaire. The Collaborative Institutional Training Initiative (CITI) for Social Behavioral Researchers was completed by this DNP student. The CITI training enhances the integrity and professionalism of higher education for investigators conducting research. The Regis University Institutional Review Board (IRB) determined the project as a QI initiative. The project site does not have an IRB or QI/PA Committee; however, a site approval letter was obtained from the clinical site medical director.

Description of Measurements and Validity and Reliability

PREMIS

The DNP student administered a modified/abbreviated version of the *Physician Readiness to Manage Intimate Partner Violence Survey* (PREMIS) (Short, et al., 2006) before and after the educational intervention. As noted in Appendix F, permission to use and modify the PREMIS tool was granted. Questions were revised in the survey to be applicable to all the office staff, as well as adding qualitative questions at the end of the post-survey. To protect participant privacy, demographics were limited to educational/professional level. The PREMIS tool is a comprehensive and valid and reliable tool. For this study, the modified version was used to measure how well health care providers and staff were prepared to manage IPV. However, modifications of the PREMIS could "compromise reliability and validity of the tool" (Short, et al., 2006, p. 180). Reliability and validity of the revised tool were assessed during data analysis. The reliability statistic was evaluated using Cronbach's Alpha through SPSS and the result was 0.658. For tool reliability, 0.7 is an acceptable score. Content and face validity of the revised tool were assessed by the DNP student and DNP faculty.

PREMIS includes four categories: background, knowledge, opinions, and practice issues. The original survey had 67 questions and was revised to a 23-item survey to best address the

expectations of the practitioners and staff workers at the primary care practice. Refer to Appendix G to view the modified version of the PREMIS instrument. It was noted that Saboori, et al. (2021) modified the PREMIS tool for their study to better address the community health worker's roles and responsibilities. A shorter survey will minimize the subject burden for the participants, making it possible to complete the assessment in a few minutes (10 to 15 minutes). Questions were carefully selected in each category to provide reliable data to determine whether the office staff feels prepared to question patients about intimate partners. Questions used a combination of a Likert scale and a True-False format, interval, and nominal level of measurements respectively. Scoring of the PREMIS was based on recommendations from the PREMIS Tool-Kit, in the Saboori, et al. (2021) article, and consultation with the research faculty. Short, et al. (2006) noted that some items need reverse scoring. By comparing pre-posttest results, the DNP student was able to identify that the participants had an improvement in their overall knowledge of IPV and their understanding on how to assess and manage the patient if they disclosed that they were not safe at home.

Open-ended Questionnaire

Qualitative data were collected in the form of an open-ended questionnaire. The DNP collected this data to gain the participant's perspectives on IPV and insights to what they thought were barriers/facilitators related to IPV screening. It was used to better understand quantitative data collected from the PREMIS survey (Tenny, Brannan, & Brannan, 2022). In the post-self-assessment PREMIS, participants were also asked to provide their perspectives on IPV related to the questions below:

1. Who do you contact if your patient shares with you they are a victim on IPV?
2. What do you need so that you can do a better job with IPV?

3. What barriers prevent you from screening for IPV?

Questions were developed by the DNP with feedback from the DNP Chair and research faculty. The time to complete was estimated at 5 minutes or less. Participant responses to these questions will assist the DNP student in moving forward to phase two of the QI project that will begin after graduation.

Planned Data Analysis

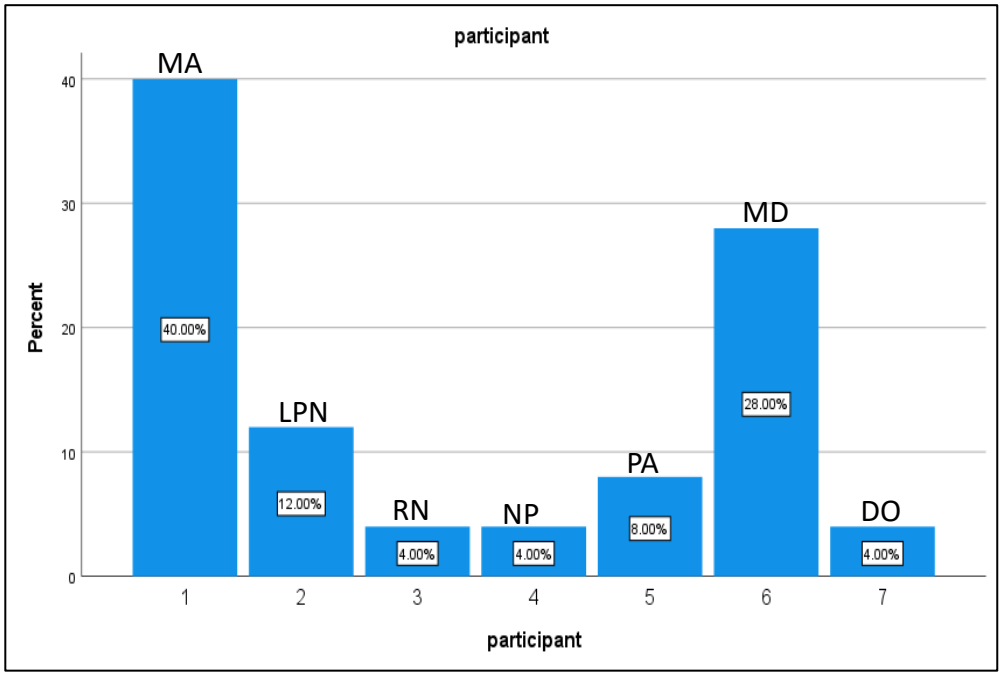
The DNP student planned to use descriptive and inferential statistics for data analysis in consultation with the research/statistics faculty. Descriptive statistics presented in this paper is primarily in the form of frequencies and percentages. The project used a paired samples t-test to determine if there was a difference in pre- and pos-survey scores with a p= <.05 (Brophy, 2019). Other tests were conducted based on SPSS prompts. A thematic analysis was performed on the open-ended questions. A thematic analysis is formulated by starting first with the basic themes and then working inward toward the global themes, (Brophy, 2019). The qualitative data were organized in a systematic way by coding the data into small chunks of meaning.

Project Findings and Results

Twenty-five or 100% of the office staff and providers attended the educational session and took the PREMIS pre-and post-surveys. As shown in Table 2, demographic data on professional degrees are displayed in the bar graph. Most of the participants (10) were medical assistants followed by eight physicians. Other participants included three licensed practical nurses, one registered nurse, one nurse practitioner and two physician assistants.

Table 2

Professional Degree



Note. MA= Medical Assistant; LPN= Licensed Practical Nurse; RN=Registered Nurse; NP= Nurse Practitioner; PA=Physician Assistant; MD=Medical Doctor; and DO= Doctor of Osteopathic Medicine.

The following results are organized as they relate to each study objective. Objective 1 which addressed the educational intervention has already been discussed in previous sections of this paper.

Objective 2: Staff Knowledge and Awareness of IPV with Pre-Post PREMIS Survey

The second objective was to evaluate provider and staff knowledge and awareness of IPV using an adapted abbreviated version of the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) before and after the educational intervention on IPV. As shown in Table 3, the Paired Samples Statistic compared the means of the pre- and post-surveys, with the pre-mean of 1.75 and the post-mean at 2.91.

Table 3

Paired Sample Statistics

	Mean	N	Std. Deviation	Std. Error Mean
Pair 1				
Pre-Aggregate	1.75	575	.658	.027
Post-Aggregate	2.91	575	.880	.037

As displayed in Table 4, further analysis using the Paired Samples "t" test showed statistical significance between the two scores (t= -24.219, p= <.001)

Table 4

Paired Samples "t" Test

Paired Samples Test										
		Paired Differences					t	df	Significance	
		Mean	*Std. Deviation*	*Std. Error Mean*	*95% Confidence Interval of the Difference*				*One-Sided p*	*Two-Sided p*
					Lower	*Upper*				
Pair 1	*pretotalaggr - posttotalaggr*	*-1.151*	*1.140*	*.048*	*-1.245*	*-1.058*	*-24.219*	*574*	*<.001*	*<.001*

In addition, comparisons were made for three of the domains on the PREMIS survey that used a Likert scale or interval data. Pre- and post-aggregate data were collected for the domains

of background (Pair 1), opinion (Pair 2), and practice (Pair 3). As shown in Table 5, there were significant improvements from the pre- to the post-survey means in all areas (p= <. 001).

Table 5

PREMIS Results by Domain

Domains	t	Two-sided p	Mean
Pair 1 prebaggr - postbaggr	-34.752	<.001	1.23 3.41
Pair 2 preoaggr – postoaggr	-5.809	<.001	2.42 3.03
Pair 3 prepaggr – postpaggr	-13.834	<.001	1.94 2.99

As noted in Table 6, the non-parametric results for the fourth domain of knowledge on the PREMIS survey are displayed. The knowledge questions required only a true or false response (nominal data). Using the Wilcoxon Signed Rank Test for the pre-post survey, results were significant (p= <.001) and the percentage change from the pre- to the post-survey in correct responses showed a 64% improvement.

Table 6

Wilcoxon Signed Rank Test

Domain Knowledge	**Z**	**Two-Sided p**
Pre-Posttest	-6.856	<.001
Pre/Post Tests	**Frequency**	**Percent**
Pre-Test Correct Responses	74	59.2%
Post-Test Correct Responses	121	96.8%

Percentage change in correct responses = 64%

Objective 3: Perceptions of IPV

The third objective for this DNP project was to obtain participant perspectives on IPV screening strategies, barriers, and resources post-intervention with the use of three open-ended questions on the post-survey. Reponses were analyzed with the DNP research faculty using thematic analysis. However, when reviewing participant answers to the questions they were to the point, mostly with single word replies. When asked who they would contact if a patient shares with them they are a victim of IPV, 13 of the respondents indicated the "practice manager" and 12 "the provider". The second question inquired about what they needed in order to do a better job with IPV. Fifteen wrote that they needed "practice," five stated "time," and the remaining participants had dissimilar responses. The last question pertained to barriers that prevented them from screening for IPV. All 25 participants, wrote "time" as the barrier.

This DNP project's intent was to explore if an educational session to primary care providers and staff would enhance their knowledge and awareness of IPV. The results of pre- and post-PREMIS surveys did show a significant improvement in post-surveys after attending the educational session. The participants also recognized that time was needed to implement screening techniques for IPV and to discuss available resources with patients during office visits.

Limitations, Recommendations, and Implications for Change

Limitations of the project were the small sample size of 25 at a singular primary care practice located in the southeastern part of the United States. Time restrictions placed on staff and providers could also be another limitation moving forward with future educational sessions and integration of IPV screening techniques during patient encounters. One recommendation from this project includes reaching out to other practices, such as women's services to further investigate how screening techniques could be addressed and how access to essential patient

services can be guaranteed for women who are at risk or have experienced IPV. If this study was replicated, the DNP student recommends retesting with an additional PREMIS survey about three to six months after the intervention to assess for r knowledge of the IPV content. An opportunity for improvement is to partnership with information technology (IT) services to imbed the IPV screening tool and a list of resources into the EMR. This would give providers and staff a convenient way to ask patients if they feel safe at home and determine their safety needs related to IPV.

Conclusion

Intimate partner violence against women is common and causes short and long-term ill health. The impact of intimate partner violence is multi-dimensional and occurs across all aspects of the lifespan. Knowing the incidence of occurrence, the signs, risk factors, and prevention measures can help a person to effectively end the cycle and break the silence involved in intimate partner violence. Deliberately seizing every opportunity to properly screen for IPV in healthcare settings is a cornerstone to address this public health issue effectively. This DNP project is taking the first step through an educational intervention on IPV, with the outcome of improving awareness and knowledge of providers and staff on assessment and management.

References

Arbach, K., & Bobbio, A. (2018). Intimate partner violence risk assessment in community health facilities: A multisite longitudinal Study. *Psychosocial Intervention*, *27*, 105-112. https://doi.org/10.5093/pi2018a13

Bradley, N., DiPasquale, A., Dillabough, K., & Schneider, P. (2020). Health care practitioners' responsibility to address intimate partner violence related to the COVID-19 pandemic. *Canadian Medical Association Journal*,192: E609-10. https://doi:10.1503/cmaj.200634; early released May 1, 2020

Brophy, T. (2019). *Module 5B: Pre and Post Testing for Student Learning*. Assessment, University of Florida. Retrieved 2/14/22 from https://teach.ufl.edu/wp-content/uploads/2019/05/Module-5b_-Pre-and-Post-Testing-for-Student-Learning.pdf

CDC (2015). *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief – Updated Release*. Retrieved 9/8/2020 from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Christiansen, S. (2020). How to identify and prevent intimate partner violence. *Very Well Health*. Retrieved 11/12/2021 from https://www.verywellhealth.com/intimate-partner-violence-prevention-4429117?print

Elfil, M., & Negida, A. (2017). Sampling methods in clinical research: An educational review. *Emergency (Tehran, Iran)*, *5*(1), e52.

Evans, M., Lindauer, M., & Farrell, M. (2020). A pandemic within a pandemic – Intimate partner violence during COVID-19. *New England Journal of Medicine*; *383*, 2302-2304. https://doi:10.1056/NEJMp2024046.

Feltner, C., Wallace, I., Berkman, N., & Kistler, C., Middletone, J., Barclay, Higginbotham, L, Green, J., & Jonas, D. (2018). Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: Evidence report and systematic review for the US preventive services task force. *Journal of American Medical Association*.*320*(16), 1688-1701. https:doi:10.1001/jama.2018.13212.

Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., & Oertelt-Prigione, S. (2020). COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. Retrieved 11/11/2021 from https://www.journals.elsevier.com/eclinicalmedicine

Gomez-Brito, I. (2021). Implementing a screening tool for intimate partner violence to increase screening rates in primary care. Retrieved 11/05/2021 from https://ttps://doi.org/doi:10.7282/t3-rx4d-2160gov/books/NBK499891/?report=printable

Grimani, A., Gavine, A., & Moncur, W. (2020). An evidence synthesis of covert online strategies regarding intimate partner violence. *Trauma, Violence and Abuse Journal*. Retrieved 10/30/2021 from https://www.doi.org/10.1177/1524838020957985

Hamberger, L. K., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *Journal of Women's Health, 24*(1), 86-91. https://doi:10.1089/jwh.2014.4861

Huecker, M., King, K., Jordan, G., & Smock, W. (2021). *Domestic Violence*. Retrieved 11/01/2021 from https://www.ncbi.nlm.nih.

Institute of Medicine. (2011). *Clinical Preventive Services for Women: Closing the Gaps*. Washington, DC: The National Academies Press. Retrieved 9/8/2020 from https://doi.org/10.17226/13181./10.1002/14651858.CD012423.pub2

Jackson, E., Renner, L., Flowers, N., Logeais, M., & Clark, C. (2020). Process evaluation of a systemic intervention to identify and support partner violence survivors in a multi-specialty health system. *Biomedcentral Health Services Research, 20*,746. https://doi.org/10.1186/s12913-020-05809-y

Kalra, N., Hooker, L., Reisenfofer, S., Luca Di Tanna, G., & Garcia-Moreno, C. (2021). Training healthcare providers to respond to intimate partner violence against women. Retrieved 10/30/2021 from https://doi.org

Koloroutis, M. (2004). Professional nursing practice. In M. Koloroutis (Ed.), *Relationship-based care: A model for transforming practice* (pp. 117–158). Creative Health Care Management, Inc.

Lippy, C., Jumarali, S., Nnawulezi, N., Williams, E., & Burk, C. (2019). The impact of mandatory reporting laws on survivors in intimate partner violence: Intersectionality, help-seeking, and the need for change. *Journal of Family Violence, 35*, 255-267. https://doi.org/10.1007/s10896-019-00103-w

Lyons, M., & Brewer, G. (2021). Experiences of intimate partner violence during lockdown and the COVID-19 pandemic. *Journal of Family Violence, 26*,1-9. https://doi.org/10.1007/s10896-021-00260-x

Martin-Engel, L., Allen, J., & Alencar, A., Scott, L., Udezi, V., Pagels, P., & Eary, R. (2021). Improving readiness to manage intimate partner violence in family medicine clinics by

collaboration with a community organization. *PubMed*. Retrieved 11/01/2021 from https://doi:10.22454/PRiMER.2021.717020

MacMillan, H., Wathen, N., & Jamieson, E. (2009). Screening for intimate partner violence in health care settings. *Journal of the American Medical Association*, *302*(5), 493-501.

Melnyk, B.M. & Fineout-Overholt, E. (2015). "Box 1.3: Rating system for the hierarchy of evidence for intervention/treatment questions" in *Evidence-based practice in nursing & healthcare: A guide to best practice (3rd ed.)* (pp. 11). Wolters Kluwer Health.

Miller, C., Adjognon, O., Brady, J., Dichter, M., & Iverson, K. (2021). Screening for intimate partner violence in healthcare settings: An implementation-oriented systematic review. *Implementation Research and Practice*, *2*, 1-47. https://doi: 10.1177/26334895211039894

Miller, E., McCaw, B., Humphreys, B., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women's Health, 24*(1), 92-99. https://doi.org/10.1089/jeh.2014.4870

Morse, D., Lafleur, R., Fogarty, C., Mittal, M., & Cerulli, C. (2012). "They told me to leave": How health care providers address intimate partner violence. *Journal American Board Family Medicine, 25*,333-342. https://doi: 10.3122/jabfm.2012.03.110193

Office of Disease Prevention and Health Promotion. (2020). Reduce intimate partner violence. *Healthy People 2030*. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/browse-objectives/violence-prevention/reduce-intimate-partner-violence-ivp-d04

Palmieri, J., Valentine, J. (2020). Using trauma-informed care to address sexual assault and intimate partner violence in primary care. *The Journal for Nurse Practitioners.* Retrieved 10/19/2021 from https://doi.org/10.1016/j.nnrpra.2020.08.028

Penti, B., Timmons, J., & Adams, D. (2018). The role of the physician when a patient discloses intimate partner violence perpetration: A literature review. *Journal American Board Family Medicine.* https://doi: 10.3122/jabfm.2018.04.170440

Portnoy, G., Colon, R., Gross, G., Adams, L., Bastian, L., & Iverson, K. (2020). *Biomedcentral Health Services Research, 20,*746; https://doi.org/10.1186/s12913-020-05595-7

Roark, Sybil (2010). Intimate partner violence: Screening and intervention in the health care setting. *The Journal of Continuing Education in Nursing*, *41*(11). https://doi: 10.3928/00220124-20100601-02

Roy, C. (2009). *The Roy adaptation model* (3rd Ed.). Prentice-Hall Health.

Substance Abuse and Mental Health Services Administration (2020). *Intimate partner violence and child abuse considerations during COVID-19* [Brief]. https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf

Saboori, R., Gold, K., Green, M., & Qi Wang, M. (2021). Community health worker knowledge, attitudes, practices, and readiness to manage intimate partner violence. *Journal of Community Health*, *47*, 17-27. https://doi.org/10.1007/s10900-021-01012-0

Short, L.M., Alpert, E., Harris, J.M. Jr, & Surprenant, Z.J, (2006). A tool for measuring physician readiness to manage intimate partner violence. *American Journal of Preventive*

Medicine, *30*(2):173-180. https://doi: 10.1016/j.amepre.2005.10.009. PMID: 16459217; PMCID: PMC1451776.

Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. *BMC Family Practice*, *8*,49; https://doi:10.1186/1471-2296-8-49.

Sossenheimer, L., Troyer, J., & Johnson, E. (2021). Preventing intimate partner violence. Retrieved 10/20/2021 from https://accelerate.uofuhealth.utah.edu/improvement/preventing-intimate-partner-violence

Voxco (2021). *Thematic Analysis: Definition, Methods & Examples*. https://www.voxco.com/blog/thematic-analysis-definition-methods-examples/

Tenny, S., Brannan, J.M., Brannan, G.D. (2022). *Qualitative Study*. Retrieved 4/20/2023 from: https://www.ncbi.nlm.nih.gov/books/NBK470395/

W. K. Kellogg Foundation. (2004). *Logic Model Development Guide*. https://wkkf.issuelab.org/resource/logic-model-development-guide.html

World Health Organization (2021). Violence against women. Retrieved 11/11/2021 from https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Appendix A

Scope and Quality of Evidence

Level of Evidence	Number of Articles	Authors and Dates
I Systematic Review and Metanalysis of RCTs, clinical guidelines based on systematic review or meta-analyses	11	• CDC (2015) • Feltner, Wallace, Berkman, et al. (2018) • Grimani, Gavine, & Moncur (2020) • Hamberger, Rhodes, & Brown (2015) • Huecker, King, Jordan, & Smock (2021) • Kalra, Hooker, Reisenhofer, Tanna, & Garcia-Moreno (2021) • Miller, McCaw, Humphreys, & Mitchell (2015) • Miller, Adjognon, Brady, Dichter & Iverson (2021) • Office of Disease Prevention and Health Promotion (2020) • Palmieri & Valentine (2021) • Penti, Timmons, & Adams (2018)
II One or more Randomized, Controlled Trial	1	• MacMillan, Wathen, & Jamieson. (2009)
III Controlled Trial without Randomization	5	• Gomez-Brito (2021) • Martin-Engel & Allen (2021) • Short, Alpert, Harris, & Surprenant (2006) • SAMHSA. (2020) • Roark (2010)
IV Case-control or Cohort Study	2	• Arbach & Bobbio (2018) • Saboori, Gold, Green, & Wang, (2021)
V Systematic Review of Qualitative or Descriptive Studies	0	
VI Single Qualitative or Descriptive Study	7	• Jackson, Renner, Flowers, Logeais, & Clark (2020) • Lippy, Jumarali, Nnawulezi, Williams, & Burk (2019) • Lyons & Brewer (2021) • Morse, Lafleur, & Gogarty (2011) • Portnoy, Colon, Gross, Adams, Bastian, & Iverson (2020) • Sohal, Eldridge, & Feder (2007) • World Health Organization (WHO) (2021)
VII Expert Opinion or Consensus	6	• Bradley, DiPasquale, Dillabough & Schneider (2020 • Christiansen (2020) • Evans, Lindauer, & Farrell (2020) • Gelder, Peterman, Potts, O'Donnell, Thompson, Shah, & Oert-Rigione (2020) • Institute of Medicine (2011) • Sossenheimer, Troyer, & Johnson (2021)

Melnyk, B.M. & Fineout-Overholt, E. (2015).

Appendix B

Budget and Resources

Resource Item (Personnel, Time, & Equipment)	**Projected Cost to Conduct DNP Project**
1. DNP student time to develop/implement DNP project (Creation of toolkit of educational content & survey instruments)	Part of DNP Clinical Practice Hours
2. Time for Provider/Staff Engagement 3. Orientation to project (with information sheet) (10 minutes) 4. Participation in educational session (20-30 minutes during lunch) 5. Participation in pre-post surveys and post-questionnaire (10 to 15 minutes each)	Time will be available for providers/staff to participate during lunchtime or breaks. Participation is voluntary and there will be no monetary compensation from employer. Educational session will be offered multiple times over a 4-week time period.
6. Cost to Print Information Sheet, Educational Handouts and Surveys	$25.00
7. Conference Room with Computer/Screen	Provided by employer
8. SPSS-Version 28	$48.95
9. Time for Data Analysis with Research Faculty	Provided by DNP program
Total Cost	**$73.95**

Appendix C

Project Timeline

Intimate Partner Violence Educational Project Plan						
Legend: Plan Partial Complete		Fall 2021	Spring 2022	Summer 2022	Fall 2022	Spring 2023
	Percentage Complete					
Literature Review	100%					
Project Timeline	100%					
Organizational Readiness/Preparation	50%					
Problem Statement	100%					
Finalize PICO	100%					
Intervention Decisions	100%					
Theoretical Underpinnings	100%					
Choose Methodology	100%					
Budget	100%					
Write Proposal	0%			x		
Proposal Presentation	0%			x		
Evaluation Plan	0%			x		
IRB Approval	0%			x	x	
Educate Staff	0%				x	
Implement Intervention	0%				x	
Data Collection	0%				x	
Data Analysis	0%					x
Write Capstone	0%					x
Defend	0%					x
Dissemination	0%					x

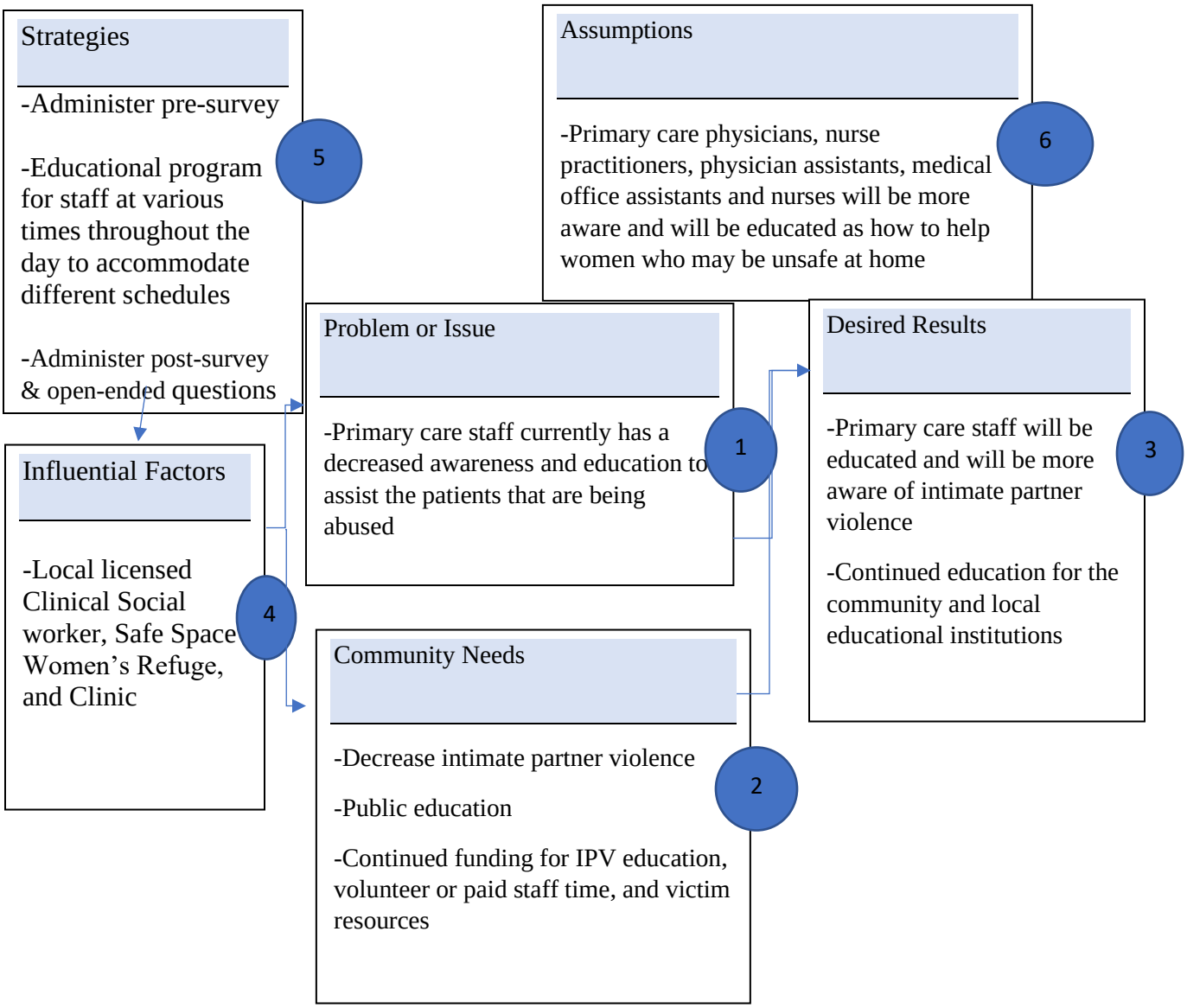
Appendix D

Logic Model

Resources	Activities	Output	Short and Long-term Outcomes	Impact
-License Clinical Social Worker Cleveland Clinic -CDC developed a technical package that includes multiple strategies and approaches to prevent IPV. It also includes approaches that provide support to survivors and lessen harm. The strategies and approaches are meant to be used in combination with each other at many levels of society to prevent IPV. -Safe Space Women's Refuge Administrator - Clinic Administrative Support	-Pre-self-assessment survey for primary care practice -Educate primary care providers, medical office assistants, and secretaries how to screen for domestic violence which promotes appropriate care and safety for their patients -Post-self-assessment survey and post-open-ended questionnaire for primary care practice	-Create presentation on IPV Create and hand out reference cards for all staff --Scores of pre-surveys -Scores of post-surveys	-Short-term outcome is to increase knowledge and awareness of IPV following an educational session. For providers/staff to apply what they have learned and to apply it to the patient they are working with -Long-term outcomes: 1. Integrate a screening tool into the EMR with list of resources **2.** Expand the educational program to include the acute care areas of the hospital after the outpatient settings are educated.	-Patient safety because of the education and awareness of all clinic staff in all settings -Publicize local community resources available -Future opportunities to expand the education and awareness to prevent IPV

W.K. Kellogg Foundation, 2004

Program Planning for Intimate Partner Violence



W.K. Kellogg Foundation, 2004

Appendix E

Information Sheet

Dear Clinic Providers and Staff,

I am Blessie Clontz, and I have been working as a Nurse Practitioner at the Clinic since May of 2020. I am finishing my Doctor of Nursing Practice (DNP) degree at Regis University in Denver, Colorado. One of the requirements for the degree is the completion of a Quality Improvement Project (QI). My project titled, Improving Knowledge and Awareness for Providers and Staff on Intimate Partner Violence, is seeking to examine the impact of an educational session on provider and staff knowledge and awareness of Intimate Partner Violence (IPV). IPV is a serious, preventable public health problem affecting millions of Americans; it is a social problem that affects not only women but men, children, and communities. Primary care providers and staff have the potential to provide an environment for patients to feel safe to share and discuss violence and abuse in the home during their medical appointment.

The educational session on IPV will run for 20 to 30 minutes during lunch time in the clinic conference room. The same content will be offered at different times/dates to give employees an opportunity to attend. Examples of topics include IPV definition and national statistics, cycle of violence, women's perspective, screening and assessment strategies, referrals, and documentation. Time for questions and answers at the end of the session will be available.

If you choose to participate in this quality improvement project, you will be asked to:

1. Complete a pre-PREMIS survey (24 questions) prior to the educational session. PREMIS or Physician Readiness to Manage Intimate Partner Violence Survey measures how well health care providers and staff are prepared to manage IPV. The survey takes 10 to 15 minutes to complete.

2. Attend a 20 to 30-minute session on IPV during one lunch time.

3. Complete a post-PREMIS survey (24 questions) and three open-ended questions following the educational session. The survey takes 10 to 15 minutes to complete with less than 5 minutes to answer open-ended questions.

This QI project has been approved by the Regis University Institutional Review Board (IRB) and reviewed by the Clinic Director. Participation is completely voluntary, and participation or non-participation will not impact employment. Accessing and completing the surveys and open-ended questions implies consent. There are no risks associated with participating in this project. Data collected from surveys and open-ended questions will be confidential without any personal identifiers. Findings will be disseminated as de-identified data in aggregate form. The major benefit of this project is that it will serve as an initial step to inform you about best practices for managing IPV. Evidence from the literature emphasizes the importance of educating providers

and staff on screening techniques, establishing practices that promote IPV screening and dialog, and increasing availability of community resources and referrals after disclosure.

I am grateful for your time and support as we strive to improve the care of patients who are at risk for or who have experienced abuse. For questions, concerns, and clarifications, you may contact me at 772-567-6340 or clontzb@ccf.org. You may also contact the Regis University Capstone Chair, Dr. Kathleen Whalen, at kwhalen@regis.edu.

Sincerely,

Blessie Clontz, APRN

Appendix F

Permission to Use PREMIS

From: Lynn M. Short, PhD, MPH <LMShort@comcast.net>
Sent: Friday, July 29, 2022 6:36 PM
To: Clontz, Blessie S
Subject: RE: PREMIS

Hi Blessie,

Yes, of course you may use the PREMIS instrument. I'm attaching the toolkit we put together to help people who would like to use it. It was updated with a few corrections in 2018, but the original article was published in 2006, and the toolkit was put together and made available not long after that.

The reliability and validity testing of the instrument was done on the instrument as provided in the toolkit. If you modify it, you will need to retest the reliability and validity to ensure the instrument is still reliable and valid. That testing should be done on a separate group prior to use with the group you are intending to train.

I wish you success with your project.

All the best,

Lynn

From: Clontz, Blessie S
Sent: Friday, July 29, 2022 3:14 PM
To: LMShort@comcast.net
Subject: PREMIS

Dear Dr. Scott,

I am reaching out to you to ask for permission to use and modify the *Physician Readiness to Manage Intimate Partner Violence Survey* (PREMIS) that was published in the 2021 PRiMER article, "Improving Readiness to Manage Intimate Partner Violence in Family Medicine Clinics by Collaboration with a Community Organization".

I am attending the Regis University Loretto Heights School of Nursing for my Doctorate in Nursing Practice degree. I plan to conduct a Quality Improvement (QI) project to evaluate the readiness of the physicians, nurse practitioners, physician assistants, and medical office assistants to address intimate partner violence (IPV) in a family practice setting. I intend to modify the survey to accommodate the time restraints of the providers and staff since I will be providing a pretest, education, and posttest during their lunch time over a one-month time frame. I will be evaluating the IPV readiness during the Fall 2022 semester. I will submit the QI project to the Regis University IRB for approval prior to the start of the study.

At your convenience, please advise if I have permission to use and modify the PREMIS tool for this upcoming QI project. Please also let me know if you need further information or have questions that I did not address in this email.

Thank you for your time and consideration,

Sincerely,

Blessie Clontz, DNPc, MBA, MSN, FNP-C

Appendix G

Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS)

Section I: Respondent Profile

Professional Degree () MA ( ) LNP ( ) RN ( ) NP ( ) PA ( ) MD ( ) DO

Section II: Background

Please circle the number which best describes how prepared you feel to perform the following: (1=not prepared; 2=minimally prepared; 3=moderately prepared; 4=well prepared)

	Not Prepared			Well Prepared
1. Ask appropriate questions about IPV	1	2	3	4
2. Identify IPV indicators based on patient history and physical examination	1	2	3	4
3. Assess an IPV victim's readiness to change	1	2	3	4
4. Help an IPV victim create a safety plan	1	2	3	4
5. Make appropriate referrals for IPV	1	2	3	4
6. Referral sources for IPV victims	1	2	3	4
7. What to say and not say in IPV situations with a patient	1	2	3	4

Section III: Knowledge

*Circle **T** for 'true' or **F** for 'false' to answer the following:*

1. Alcohol consumption is the greatest single predictor of the likelihood of IPV.	T	F
2. When asking patients about IPV, office staff should use the words 'abused or 'battered'	T	F
3. Victims of IPV can make appropriate choices about how to handle their situation	T	F
4. Victims of IPV are at greater risk of injury when they leave the relationship	T	F
5. Allowing partners or friends to be present during a patient's history and physical exam Ensures safety for an IPV victim.	T	F

Section IV: Opinions

For each of the following statements, please indicate your response on the scale from 'Strongly Disagree' (1) to 'Strongly Agree (4).

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. If an IPV victim does not acknowledge the abuse, there is little that I can do to help.	1	2	3	4
2. I ask all new patients about abuse in their relationships.	1	2	3	4
3. My workplace encourages me to respond to IPV.	1	2	3	4
4. I can make appropriate referrals to services within the community for IPV victims.	1	2	3	4
5. I am capable of identifying IPV without asking my patient about it.	1	2	3	4

Section V: Practice

For each of the following statements, please indicate your response on the scale from 'Strongly Disagree' (1) to 'Strongly Agree (4).

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I feel comfortable discussing IPV with my patients.	1	2	3	4
2. I am able to gather the necessary information to identify IPV as the underlying cause of patient illness (e.g., depression, migraines).	1	2	3	4
3. Screening for IPV is likely to offend those who are screened.	1	2	3	4
4. I can recognize victims of IPV by the way they are acting.	1	2	3	4
5. I can match therapeutic interventions to an IPV patient's readiness to change.	1	2	3	4
6. My practice setting allows me adequate time to respond to victims of IPV	1	2	3	4

Section VI: Qualitative (For Post-survey only)

1. Who do you contact if your patient shares with you they are a victim on IPV?

2. What do you need so that you can do a better job with IPV?

3. What barriers prevent you from screening for IPV?

Adapted from Short, L.M., Alpert, E., Harris, J.M. Jr, & Surprenant, Z.J, (2006). A tool for measuring physician readiness to manage intimate partner violence. *American Journal of Preventive Medicine, 30*(2):173-180. doi: 10.1016/j.amepre.2005.10.009. PMID: 16459217; PMCID: PMC1451776.