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Stephanie Ralston
Eastern Kentucky University, Stephanie_Ralston4@mymail.eku.edu

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Eastern Kentucky University

College of Health Sciences

School of Nursing

Doctor of Nursing Practice Program

DNP Project Final Report

Intimate Partner Violence Screening in the Veteran Affairs' Ambulatory Care Clinics: A Quality Improvement Project

DNP Student: Stephanie W Ralston

Date: 4/27/2023

The DNP Project Final Report is submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice (DNP) at Eastern Kentucky University (EKU).

Student Acknowledgement

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EKU DNP Student: Stephanie W Ralston

Signature: **Date: 4/27/2023**

______________________________________ ____________

Review & Approval of DNP Project Final Report

The DNP Project Final Report has been reviewed and approved by the DNP Project Team, which includes the DNP Project Chair and the DNP Project Team Member(s). The DNP Project meets the satisfactory requirements for the DNP Project Final Report outlined in the EKU DNP Project Guidelines. The EKU DNP Project Guidelines are based on best practices outlined by the American Association of Colleges of Nursing (AACN) and external evidence-based sources. The DNP Committee develops, maintains, and monitors these standards on behalf of the Department of School of Nursing at Eastern Kentucky University.

List of DNP Team Members for this Project:

Dr. Melanie Johnson and Dr. Molly Bradshaw O'Neal

Abstract

Intimate Partner Violence is a type of Domestic Violence (DV), referring to physical, verbal, emotional, or sexual violence, or stalking between current or former intimate partners. Veterans may be at higher risk than those identified in the civilian population. The rate of IPV across military populations ranges from 13.5% to 58% with rates among female Veterans ranging from 29% to 74% (Veterans Affairs, 2023). This project's purpose was to evaluate the effectiveness of an awareness campaign on IPV screening and referral rates in a federal healthcare facility. Results from this DNP project indicate that ongoing training and education are vital in improving intimate partner violence (IPV) screening outcomes.

Keywords: Intimate Partner Violence training, Interventions, Screenings, Veterans affected by IPV, healthcare providers, Relationship Health and Safety Screening, universal education, and awareness.

Table of Contents

Table of Contents 4

Intimate Partner Violence Screening in the Veterans Affairs' Ambulatory Care Clinics: A Quality Improvement Project 10

Background and Significance 10

Proposed Evidence-Based Interventions 15

Purpose Statement 16

Review of Literature 16

Evidence #1 17

Evidence # 2 18

Evidence # 3 19

Evidence # 4 19

Evidence # 5 21

Evidence # 6 21

Synthesis of Literature 22

Guiding Theory 23

Organizational Description 25

Setting, Mission, Goal, Strategic Plan 26

Relevant Policy 26

Stakeholders 27

Organizational Stakeholders 27

Intervention Group 27

Impact Population 27

Organizational Assessment 27

Figure 1 29

Congruence to the Organization 29

Statement of Mutual Agreement 30

Methodology 30

Aim One 31

Aim Two 31

Project Design 32

Setting 32

Conceptual Framework 32

Intervention(s) Description 33

Recruitment 36

Subjects 37

Inclusion/Exclusion Criteria....37

Access....37

Recruitment Strategies /Flyer....38

IRB, Ethics, & Consent....38

Data....38

Instruments....39

Three surveys were sent to the staff about the project:....39

Demographic Data....39

Data Collection Process....40

Timeline, Resources, & Budget....41

Results....41

Results of pre and post survey....42

Results of the Demographic Survey....44

Relationship Health and Safety Screening Clinical Reminder....44

Descriptive Statistics....46

Discussion....46

Limitations....47

Interpretation....48

Implications 48
Clinical Practice 48
Policy 49
Quality and Safety 49
Education 49
Feasibility for Sustainability 50
Future Scholarship 50
References 54
Table 1 58
Figure 1 59
Universal Education Intervention 59
Figure 2 60
Universal Screenings Data 60
Figure 3 61
Universal Screening Data 61
Appendix A 62
Hierarchy Table of Evidence 62
Appendix B 63

Summary of Evaluations Tables 63
Table B1 63
Table B2 64
Table B3 65
Table B4 66
Table B5 67
Table B6 68
Appendix C 69
Appendix D 70
Statement of Mutual Agreement 70
Appendix D1 70
Appendix D2 71
Appendix D3 72
Appendix E 73
Re-Aim Theoretical Model 73
Appendix F 74
Staff Training 74
Appendix G 75

Recruitment Flyer 75

Appendix H..76

E-HITS/RHSS..76

Appendix I 77

Demographic Survey...77

Intimate Partner Violence Screening in the Veterans Affairs' Ambulatory Care Clinics: A Quality Improvement Project

Intimate partner violence (IPV) is a public health issue across the entire population. On average, 20 people per minute are physically abused by an intimate partner in the United States. For one year, this equates to more than 10 million women (about half the population of New York) and men (National Coalition Against Domestic Violence, 2020). The Veterans Affairs System (VA) is invested in the identification of IPV victims and committed to offering support and resources. However, at present, goals for screening and identification may not be fully achieved. This project evaluated the effectiveness of an education and awareness campaign on IPV screening and referral rates in a federal healthcare facility.

Background and Significance

Intimate Partner Violence (IPV) is a health and safety crisis in the United States, a major health problem that can be associated with adverse health consequences. IPV is defined as any acts of physical violence, stalking, psychological aggression, and sexual violence, by a former or current partner (Ogbe, et al., 2020). Nationally, IPV affects between 2.7% and 13.9% of women and 2.0% and 18.1% of men each year (Hemberger et al., 2015). IPV is part of a systemic pattern of assaultive behavior and control perpetrated by one intimate partner against another. From 2016 through 2018, intimate partner violence victimization in the United States increased 42% (National Coalition Against Domestic Violence).

Past research findings concluded that the prevalence of intimate partner violence (IPV) survivors that seek care in emergency departments and primary care ranges from 12% to 45%

(DeHart, 2017). Approximately 10% of women and 3% of men in the United States are stalked by an intimate partner during their lifetimes (Breiding, 2014). In the United States, stalking victimization occurs in approximately 1 in 3 women (31.2% or about 38.9 million). Eight percent of women reported stalking victimization at some point in her lifespan, during which she felt threatened, fearful, or concerned for the safety of herself, her family, or others around her (Centers for Disease Control and Prevention, 2022).

The Centers for Disease Control (CDC), United States Preventive Services Taskforce (USPSTF), and several major medical and public health organizations, have found IPV as a significant public health issue. Research shows that the implementation of routine examination or screening for IPV in healthcare settings can identify those experiencing IPV and survivors of past IPV. Recent evidence supports the use of designated IPV Screening tools such as the HITS, with female Veterans. Training providers on this tool can aid health care providers in detecting IPV-related symptoms. Universal screening for IPV offers many opportunities for successful interventions.

In 2019, the Veteran's Health Administration (VHA) issued Directive 1198, which established VHA policy about the Intimate Partner Violence Assistance Program (IPVAP). The Robley Rex VAMC (RRVAMC) requires staff to follow this directive, including guidelines that set forth roles and responsibilities for developing, supporting, and setting up an Intimate Partner Violence program. Guidance for routine intimate partner violence (IPV) screening and provision of screening interventions by Veterans Affair (VA) facilities are major components of Veteran Health Administration (VHA) Directive 1198.

Screening tools used with female Veterans concluded that the Hurt/Insult/Threaten/Scream (HITS) screening tool may help VA, and other healthcare providers detect past-year IPV and equip staff to deliver proper care for female Veterans (Iverson et al., 2013). Evidence presented by Iverson et al, found that creating sustainable system-level programs is best implemented in outpatient settings. System-level interventions are needed to address barriers to routine screening for intimate partner violence (IPV). Preferably, the healthcare setting provides opportunities for private communication with healthcare staff and supplies information emotional support, and comfort measures. Primary care settings are important in identifying and helping individuals affected by IPV (Hemberger et al., 2015). Earlier research showed that fewer than 2% of patients were assessed for IPV by a healthcare provider working in a primary care setting. This percentage is staggering considering the Joint Commission on hospital accreditation published performance criteria for hospitals to educate staff on finding IPV, provide resources, and help with referrals.

The Affordable Care Act (ACA) supplies recommendations for preventative care which includes IPV screening and counseling for all adolescents and adult women. The Institute of Medicine (IOM), U.S. Preventative Services Task Force and Department of Health and Human Services have all adopted these recommendations as part of preventative care. Screening for Intimate Partner Violence in medical settings offers many opportunities for the providers/staff to be successful in delivering better care outcomes to their patients. The U.S. Preventive Services Task Force (USPSTF) recommendations for IPV screening supplies the gold standard for staff needing guidance on IPV screening interventions.

The National Center for Injury Prevention and Control, Division of Violence Prevention (2021) reports there are millions of people in the United States each year changed by Intimate Partner Violence (IPV). Intimate Partner Violence accounts for 15% of all violent crime (National Statistics Domestic Violence Fact Sheet, 2022). Female Veterans are at higher risk for IPV compared to the general US population due to spouses being hesitant to leave abusive relationships because of the risks of losing access to medical, mental health benefits, housing, and finances (Hinton, 2020). IPV is a health and safety crisis in the United States, a major health problem that can be associated with adverse health consequences. Intimate Partner Violence (IPV) is defined as any acts of physical violence, stalking, psychological aggression, and sexual violence, by a former or current partner (Ogbe, et al., 2020). From 2016 through 2018 Intimate Partner Violence (IPV) victimization in the United States increased 42% (National Coalition Against Domestic Violence).

The Department of Defense (DOD) reported nearly seventeen thousand acts of abuse against a spouse or intimate partner among active-duty service members (Congress Research Service, 2019). In 2018, 15 fatalities involving military personnel were confirmed due to domestic abuse. Of those cases, three had reported prior acts of domestic abuse to military authorities (U.S. Department of Defense, 2019).

Over the past decades, Congress has taken several actions to address risk factors for IPV among the military population to raise awareness, protect victims, and to hold offenders accountable. While both men and women are at risk for IPV, women are at higher risk of physical injury, mental health consequences, and intimate partner homicide (Messing et al. 2020). It is also important to remember that males are affected by intimate partner violence (IPV) and opportunities

for screening should not be overlooked. Brain injury is one of the physical risk factors that is often shown in women exposed to physical abuse. VA Boston Healthcare System conducted research on Traumatic Brain Injuries (TBI) in women because of intimate partner violence. Research findings concluded that TBIs (Traumatic Brain Injuries) are common, and women exposed to IPV have repetitive TBIs. Such injuries are linked with a range of mental health problems, for example, anxiety, depression and structural and functional brain damage (Valera et al, 2019).

Literature supplies evidence supporting the role of staff in helping their patients affected by IPV by reducing adverse outcomes. This project provided an opportunity for Robley Rex VAMC to gain information about Screening for IPV and better equipped staff to provide care individuals affected by intimate partner violence (IPV). Nearly 20% of women treated in VA primary care clinics reported experiencing IPV within the last 12 months (U.S. Department of Veterans Affairs, 2022). VA's Office of Women's Health (OWH) and the intimate partner violence (IPV) assistance program collaborated with VA primary care stakeholders, developed recommendations for national implementation for intimate partner violence (IPV) screening programs carried out by staff delivering primary care. Expanding intimate partner violence (IPV) screening in all ambulatory care settings is vital. Intimate partner violence (IPV) in the United Sates (US) is a public health crisis. The expectation for IPV screening by primary care providers working in the ambulatory care setting is consistent with clinical prevention guidelines put in place by the United States Prevention Services Task Force (USPSTF). Women, who are the most vulnerable population, are often seen in primary care settings. In the public health setting, the Affordable Care Act (ACA) requires private plans and Medicaid expansion programs to cover

preventative screening for IPV, therefore, reimbursement is provided to clinicians when they provide IPV screening and brief intervention services to women as part of their preventative care, at no added cost to women (Ramaswamy et al, 2019).

The Department of Veterans Affairs (VA) has encouraged evidenced-based IPV screening programs since 2014. All VA Medical Centers (VAMC) and ambulatory care clinics must conduct universal IPV screening interventions. VHA Directive 1198 stated that IPV awareness and education will be provided to staff ongoing with every attempt to raise awareness about IPV and the effects IPV has on health. Competing priorities, COVID-19 pandemic, countless responsibilities, inadequate training and discomfort in addressing IPV are common contributors to gaps in IPV training.

Proposed Evidence-Based Interventions

Standards of care within the VA healthcare system for IPV is for VA staff to use the official Intimate Partner Violence Assistance Program Relationship Health, and Safety Screen (RHSS), and document the outcomes in the Veterans electronic health record (EHR) found in the Computerized Patient Record System (CPRS). The VA health system incorporated a Clinical Reminder (CR) tool within the electronic health record. The clinical reminder (CR) allows staff to easily access EHRs (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record) (Electronic Health Record), and view when certain tests or evaluations are performed. Staff can also track and document when care has been delivered.

Purpose Statement

Intimate Partner Violence (IPV) is a global crisis that can have a major impact on one's physical and mental health. An evidenced-based synthesis program conducted by the Department of Veterans Affairs Health Services Research & Development Service reported that Military service men and women have unique psychological, social, and environmental factors that may contribute to an elevated risk of IPV among active-duty soldiers and Veterans (Gierisch et al., 2013). IPV is a safety concern. IPV in the Veteran population may involve depression, military sexual trauma (MST), and Post Traumatic Stress Disorder (PTSD). Increasing IPV screening rates with the implementation of evidenced-based IPV screening tools will improve the quality of care for IPV. Given the significant negative impact of IPV, healthcare organizations continue to implement quality improvement projects for the best standards of care for individuals affected by IPV. This DNP Project supported the ongoing efforts of the VA health system to improve IPV care practices for their unique patient population.

Review of Literature

Current literature supplies evidence of effective interventions that will improve health and safety outcomes related to Intimate Partner Violence (IPV). A formal review of the literature was conducted to answer the question, "Among VA health providers (P) what interventions (I) improve the rate of Intimate Partner Violence (IPV) screenings (O)?" The databases searched included Cumulative Index to Nursing and Allied Health Literature (CINAHL) complete, Cochrane Databases of Systematic Reviews, Academic Search Ultimate, APA PsycInfo, APA PsycArticles, and Medline. The keywords used were *Intimate Partner Violence*, *Domestic*

Violence, *Partner Abuse*, *effects of Intimate Partner Violence*, *screening Intimate Partner Violence*, *evidence-based practice* and *IPV, EBP* or *best practice for IPV*, *Women's Health* and *Veteran screening for Intimate Partner Violence*. In total 783 studies were found. After completing a hand search of the titles and abstracts 6 studies were selected for inclusion. All evidence was appraised using the Melnyk-Fineout Overholt Rapid Critical Appraisal Forms.

Evidence #1

Travers et al., (2021) conducted a systematic review (SR) and meta-analysis (MA) to evaluate the effectiveness of interventions to prevent recidivism in perpetrators of intimate partner violence. Risk needs responsivity (RNR) treatments showed assurance in the short to medium term but sustaining effects in the long term remains to be seen. In this study, the researchers described one-size-fits-all interventions as unsuitable for all IPV offenders. The researchers used a systemic search strategy to find studies examining the effectiveness of IPV interventions. It has been reported that thirty-one studies met the inclusion criteria. An extensive meta-analysis concluded that interventions produce minimum positive effects on recidivism that equates roughly to a 5% reduction in offending (Travers et al.,). The reduction is an inconsiderable amount but still showed the potential for developments in IPV interventions.

The quality assessment of each article minimized bias from other designs that had comparable results. RNR is not categorized as an intervention, it is a treatment framework that requires evidenced-based intervention elements that target all pertinent risk factors for IPV offending (Travers et al.,). It is important to note that the review presented several limitations. Some studies used general versus IPV-specific recidivism for the outcome measure. In this study,

the researchers included studies that only used an objective measure of IPV as the outcome measure to enhance the findings validity (Travers et al.,). Risk benefit interventions need to be enhanced.

Evidence # 2

In a Random Control Trial (RCT), Easton et al (2018), evaluated therapy for substance-dependent offenders of intimate partner violence. The study evaluated a therapy for substance-dependent perpetrators of partner violence. Sixty-three males that were arrested for violence against their partners were randomized to a cognitive behavioral substance abuse-domestic violence (SADV; n= 29) or identified as having drug counseling (DC; n=34) condition. SADV shows promise in decreasing addiction and partner violence among substance-dependent male offenders. The RCT introduces two approaches that have used Cognitive Behavior Th co-occurring addiction and IPV. Behavioral couples therapy (BCT) and domestic-violence-focused couples therapy (DVFCT). BCT may not be the best approach for IPV offenders who are single or dealing with court-ordered stipulations. For those couples that are trying to keep their union, DVFCT may be a better approach.

Pre and post treatment of SADV showed a significant decline in aggressive behavior compared to the control participants (Easton et al.,). The researchers found through this RCT one of the first integrated group treatments to bring about notable effects around IPV (Easton et al.,). This research supplies added interventions for the DNP project. Substance Abuse is common in Veterans using IPV. More treatment options are foundational for individuals using substance use and IPV.

Evidence # 3

In a random control trial (RCT), Taft et al. evaluated the efficacy of the Strength at Home Men's Program (SAH-M). SAH-M is a trauma-informed group intervention based on social information processing model that has been used with Veterans to end intimate partner violence (IPV), (Taft et al., 2016). The researchers used Revised Conflict Tactics Scales and randomly assigned participants to an enhanced treatment of SAH-M. Participants randomized to SAH-M took part in a 12-week group promptly after baseline and those randomized to enhanced treatment as usual (ETAU) received clinical referrals and resources for mental health and IPV services. The researchers guessed that men who were assigned to SAH-M would have an increased reduction in psychological and physical IPV use than men enrolled in ETAU.

All Veteran Affairs Medical Centers (VAMCs) are charged with supplying services for Veterans who use IPV. This study provides sustainable evidence of the impact of SAH-M. VA strongly encourages the use of SAH as the only therapeutic intervention that has shown efficacy in randomized controlled trials with the Veteran population. This 12-week therapeutic group intervention is designed to reduce or even end IPV and prevent future IPV by helping Veterans to develop effective conflict resolution skills and reduce the impact of stress in their relationships. SAH, being VA's evidence-based treatment of choice, supplies a clear connection to the DNP project.

Evidence # 4

Iverson et al., (2020) performed a clinical trial to assess the effectiveness of a randomized hybrid type 2 implementation. This study aimed to show the impact of the proposed stepped wedge

design compared to the impact of two implementation strategies that offer distinct levels of intensity. The researchers proposed a mixed-method approach using both quantitative and qualitative data. Qualitative data collection and analysis were guided by the i-PARIHS framework, and the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) framework analyzed the summative data collection (Iverson et al.,). The clinical trial did conclude that there is an urgent need to better support female Veterans impacted by IPV and VA=based primary care clinics are an ideal setting to implement evidence based IPV screening programs. Mixed quantitative and qualitative data collection will allow clear guidelines on program implementation and sustainability.

The researchers acknowledged that lack of information about Veteran's experience with IPV screening programs and unforeseeable circumstances such as staff turnover may impact the execution of IPV-related care programs. Other findings included lack of use in clinical reminders and note templates related to IPV-related care. The stepped wedge design presented the researchers with subject-level randomization. The finding showed that IPV screening programs are in primary care, thereby increasing IPV detection.

Evidence # 5

In a qualitative research study, Adjognon et al. (2021) described IPV implementation strategies used in the Veterans Health Administration (VHA) Primary Care (PC). The qualitative study showed implementation strategies that were used to combine IPV screening programs with VHA primary care clinics for women. The researchers recruited 11 VAMCs and 32 clinicians and administrators that were supplied with in-depth qualitative interviews. Non-probability sampling was used to select the VA sites for the study. The research team developed a semi-structured interview guide based on the integrated-Promoting Action on Research Implementation in Health Services (i-PARIHS) framework (Adjognon et al.,). Evidence showed that well defined strategies are needed for effective IPV screenings. Identifying provider education and personal discomfort with IPV as primary barriers to IPV screenings. These themes support the DNP project by confirming the gaps and importance of IPV screening in the primary care setting.

Evidence # 6

In an evidence-based quality improvement initiative, Portnoy et al. (2021) implemented a multistate initiative to enhance the acceptance of IPV screening practices in the Veterans Health Administrations' comprehensive women's health clinics (CWHCs). of the QI project included responders' feedback from 63 CWHC sites. Feedback supplied information about IPV screening practices and barriers. For sites that responded to both surveys (n = 47), the number of sites that executed recommendations for screening practices increased by 66.7%, from 15 at baseline to 25 at follow-up (P = .02). Participants of this study supplied the researchers' information on intimate

partner violence screening practices, perceived usefulness of implementation support strategies and ongoing barriers to IPV screening interventions (Portnoy et al).

Veteran Health Administration is the largest integrated health care system in the United States. Female Veterans are increasingly seeking access for quality care. With the increase in IPV prevalence in women and Veterans, improvement in IPV screening practices is critical. Intimate partner violence (IPV) experience in women often is associated with negative physical and mental health outcomes. VA Primary Care providers play a vital role in coordinating IPV screening during routine appointments. IPV screening practices are foundational in the care provided in the VA and women health care settings are the idea setting for implementing IPV quality improvement initiatives.

Synthesis of Literature

The formal literature review and selected studies collaborated strength included statistical and clinical significance, strongly supports the importance of IPV screenings and IPV screenings within the VA healthcare systems. A special emphasis on women's care and female Veterans noted throughout due to being impacted by IPV at staggering rates. All the studies emphasized the sensitivity that surrounds IPV and the comfort of the staff screening for IPV. All the studies emphasized the need for improvements in IPV screening process and enhancement of interventions. A similarity in the findings includes using the integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to guide qualitative data

collection and analysis (Iverson et al., 2019 & 2020). Overarching themes in all studies revealed that IPV is a complex health issue, women are the most vulnerable and screening interventions are catalyst to detection of IPV. Literature supplied evidence that supports clinical effectiveness of IPV screening programs (Adjognon et al., & Portnoy et al.,).

A gap in IPV prevention in the private sector and in the VA healthcare system included primary care providers' knowledge deficits regarding IPV screening and the consultation process. Common gaps throughout literature reviews included decreased knowledge, process, and comfort level in Primary Care Providers. More evidence is needed about evidence-based trauma care. (Taft et al., & Travers et al.,) acknowledge the impact Evidenced Based Trauma (EBT) informed care has on IPV.

Guiding Theory

This quality improvement project used Lewin's Theory of Planned Change as a framework to inform and guide the development of the DNP project. The Change theory framework was developed by Kurt Lewin, father of social psychology. One of Lewin's biggest contributions to the world of social psychology is about the way that people behave and change in organizations (Theodore, 2019). Lewin's Change Theory includes three stages; Unfreeze, Move and Refreeze. During the unfreeze stage the organization acknowledges the problem and how the problem impacts healthcare delivery. To implement a new process that involves ensuring that patients are screened for Intimate Partner Violence (IPV), there will need to be a shift in the way individuals

behave in receiving information regarding IPV, providers "buy-in" to the organization's policies and provider compliance with mandates related to processes for IPV interventions.

The healthcare organization will need to implement a multidisciplinary approach in overcoming barriers that surround finding individuals that are experiencing IPV. Lewin's Change Theory supplies the framework needed to start these changes. This theory will help a provider find his/her current beliefs and values related to IPV. This theory is foundational in assisting healthcare providers adapt to changes in a more positive light and aid with making these changes sustainable (Theodore). Lewin's change theory is designed to improve the adoption and implementation of effective evidence-based interventions. IPV being recognized as a public health issue is the driving force for change.

Evaluating gaps in care helps with finding missed opportunities. IPV missed opportunities arise from lack of screening. Interventions must be implemented system wide to help with overcoming barriers in naming symptoms related to IPV. Implementation of a system redesign that ends barriers to treating IPV is crucial for inpatient and outpatient care settings with the VA healthcare system.

Lewin's Change Theory model calls for the organization to complete the 3-step model. The three stages include Unfreeze, Move, and Refreeze (Lewin, 1947). During the unfreeze stage the organization acknowledges that IPV interventions need improvement. The current process presents us with a problem (IPV interventions) and the impact that the problem (IPV interventions) has on healthcare delivery. The next phase of Lewin's change theory is moving. The moving stage is the stage of initiating and implementation that involves all the stakeholders such as the VA

primary health care providers. Healthcare providers must have a knowledge base of the intricacy of the effects of IPV on survivors. It is imperative to adequately address the patient's needs. Healthcare providers must be familiar with the laws in place for victims of IPV. Healthcare providers need to be familiar with her local reporting guidelines and all necessary screenings. Healthcare providers must be informed of the necessary screening tools and understand how to start proper referrals for added services as needed. The CDC has published guidelines for clinicians that focus on the prevention of IPV (Niolon et al., 2017). During the last stage of refreezing, the healthcare organization will make certain there is sustainability with changes that have been implemented and find positive outcomes. (Appendix C).

Organizational Description

The partnering organization for this project is a federal healthcare system in Louisville, Ky. The federal organization is affiliated with many academic programs for nurses, physicians, psychologists, psychiatrists, social workers, dieticians, and pharmacists. The main facility is near the Kentucky-Indiana border. The facility supplies services to eight community-based outpatient clinics throughout Central Kentucky and Southern Indiana.

The organization serves more than 47,000 Veterans. The Veterans are predominately male; however, the female population is growing. The age of the Veterans served rage from age 18 to 100, with a mean age of 65 years old.

Setting, Mission, Goal, Strategic Plan

Show and address Intimate Partner Violence (IPV) in the Veterans Affairs (VA) Ambulatory Care Setting. The Organization's mission was to implement and sustain a comprehensive Veteran-centric, person-centered, trauma-informed, recovery-oriented help program for Veterans, their families, caregivers and VA employees who use or experience intimate partner violence. VA's goal is to have 100% of Veterans seen screened for IPV. To achieve this goal, staff must be willing to complete these assessments at the point of contact. Quality improvement initiatives are needed to strengthen current IPV screening policies and procedures. IPV prevention is a national goal derived from the organization's Strategic Plan for FY22. The VA Health Care system is committed to addressing IPV and building healthy relationships for Veterans, their significant others, and staff changed by IPV.

Relevant Policy

Veteran Health Administration's National Directive 1198, Intimate Partner Violence Assistance Program (IPVAP) was executed on January 24, 2019. This policy promotes safety and awareness for those who experience and/or use IPV (United States Department of Veterans Affairs, 2022). The National Intimate Partner Violence Assistance Program recommends the use of Strength at Home (SAH), therapeutic intervention, as the only evidence-based therapeutic intervention proven to be effective for the Veteran population (U.S. Department of Veterans Affairs). This policy is relevant to the continuum of care provided to patients and employees affected by IPV. Veterans Affairs Intimate Partner Violence Assistance Program is a vital part to the organization's mission and values.

Stakeholders

Organizational Stakeholders

For this quality improvement initiative, the key stakeholders included the Ambulatory Care Nurse Manager, Ambulatory Care Staff, IPV Program Manager, Ambulatory Care Chief, Health Information Management Service (HIMS) Chief, PCC staff, VA Police Chiefs and Women's Health Program Manager.

Intervention Group

The intervention group included all healthcare staff directly engaged with Veterans seeking care at the outpatient ambulatory care clinics.

Impact Population

The population affected by the implementation and outcome of this project included the staff working in the identified outpatient clinics, Veterans, family members of the Veterans and staff affected by Intimate Partner Violence.

Organizational Assessment

Prior to the project proposal, the Principal Investigator assessed the organization's current state on IPV screening interventions, IPV policy and procedures and VA national guidelines regarding IPV related care. The project's host was a federally funded healthcare facility guided by national and local policies available electronically. In acknowledgment of the high prevalence of IPV among Veterans, in 2013, the Department of Veterans affairs (VA) embarked on a systematic health care transformation to integrate IPV screening, prevention, and treatment into the health care offered to Veterans. A key part of this project's success was successfully completing IPV

encounters at point of care in the Ambulatory Care Setting. The facility policy for Intimate Partner Violence guidelines and standards of care mandates Veterans are offered same-day safety planning, education on risks and supplied resources as they can accept them.

The principal investigator for this project performed a SWOT analysis of the facility looking at the strengths, weaknesses, opportunities, and threats that would affect the project. The Strengths of the Department of Veterans Affairs (VA) recognizes that Intimate Partner Violence (IPV) is a serious health concern among the Veteran population that can be prevented. Getting buy-in from VA staff supplying care in the ambulatory care setting. VA staff that present barriers for IPV screenings and interventions are considered a weakness. Opportunities included developing IPV health promotion campaigns for increasing the VA staff's awareness for IPV assessments and interventions. Also, increasing education on IPV for hospital staff, community partners, patients, and caregivers. Threats include Lack of buy-in from stakeholders, failure to address health behavior and the challenges of chronic IPV could strain ambulatory care services. Please refer to figure 1 for snapshot of SWOT analysis.

Figure 1

Swot Analysis

STRENGTHS	WEAKNESSES
The Department of Veterans Affairs (VA) recognizes that IPV is a serious health concern among the Veteran population that can be prevented.	Getting buy in from staff that present with barriers for IPV screenings and interventions.
OPPORTUNITIES	**THREATS**
Develop IPV health promotion campaigns for increasing the staff's awareness for IPV assessments and interventions. Increase education on IPV for hospital staff, community partners, patients and caregivers.	Lack of buy in from stakeholders Failure to address health behavior and the challenges of chronic IPV could strain outpatient ambulatory care services. Difficulty recruiting IPV Champions. Negative reviews from intervention group.

Congruence to the Organization

Educating ambulatory care staff on Intimate Partner Violence (IPV) was in congruence with the organization's desire to supply a safe and supportive environment for both its staff and Veterans. The Veteran population has a high prevalence of IPV, and the VA system wholeheartedly recommends that staff screen for IPV. To decide the need for right interventions, screening is the first step in identifying and deciding the needs of the Veteran. Nationally, Veteran Health Association recommends screening all Veterans annually (U.S. Department of Veterans Affairs). Integrity, commitment, advocacy, respect, and excellence are tenets of VA's core values. These values are aligned with VA's mission to "To fulfill President Lincoln's promise to care for

those who have served in the United States (Veteran Health Administration, 2023). This project incorporated goals and values that are patient-centered and meet the patients by supplying all levels of care.

Statement of Mutual Agreement

A Statement of Mutual Agreement describing the project's purpose provided clear goals and was agreed upon with the Principal Investigator and the facility Director. The partnering organization for this quality improvement initiative has signed a Statement of Mutual agreement. (Appendix D).

Methodology

This DNP project assessed the effect of intimate partner violence (IPV) education and awareness on VA staff working in the ambulatory care. Intimate partner violence (IPV) knowledge, skill and confidence in intimate partner violence (IPV) screening interventions. After securing Institutional Review Board (IRB) approval, staff working in the ambulatory care clinics, delivering primary care services were recruited for the quality improvement initiative. In a virtual email setting, staff that implied voluntary consent completed a series of surveys, which included an Initial Virtual Pre-IPV Knowledge IPV Survey that implied voluntary anonymous consent, Virtual Demographic Survey, and Virtual Post-Test. Respondents were assigned numbers to ensure full transparency of anonymity. The primary investigator (PI) delivered interventions on virtual IPV educational awareness IPV materials and screening interventions for IPV. Education and training interventions were all delivered electronically. Immediately following the intervention, staff completed a Post-Test Intervention. Using descriptive statistics, the data

collected was downloaded VA Program Evaluation and Resource Center (PERC) into Minitab (Minitab Statical Software) and analyzed. To capture IPV screening interventions and clinicals responses to positive IPV screens the PI conducted a manual chart review of the screening data and developed an abstraction tool to capture and documented responses to a positive screen, including referrals or interactions with the Intimate Partner Violence Assistant Program manager.

Aim One

Evaluate current interventions in place for screening IPV in the VA healthcare system.

Aim Two

Analyze the components of the Relationship Health and Safety Assessment factors

Objective

This project's purpose was to create and implement a multi-strategic IPV screening and awareness campaign at the Robley Rex VAMC that will increase IPV screenings by 10% by the end of the DNP project.

An analysis of de-identified data on IPV screenings and referrals was used to evaluate the effectiveness of the campaign in a pre-test and post-test design.

Raising awareness and providing ambulatory care staff with the necessary tools to effectively assess intimate partner violence (IPV) requires education and training. It was hypothesized that raising awareness, education and training are clearly connected to the impact of patient outcomes.

Project Design

Setting

This quality improvement project was conducted in the Robley Rex Veteran Affairs Medical Center's (RRVAMC) outpatient ambulatory care clinics. The Newburg, Greenwood and Stonybrook outpatient ambulatory care clinics were the focused clinics due to the increase rates with exposure to Intimate Partner Violence (IPV). Each primary care team functions as a Patient Aligned Care Team (PACT). Each team consists of physicians, nurse practitioners, registered nurses, licensed practical nurses and health techs. Each clinic could have 80 to 200 patients scheduled on any given day. The PI examined data on the Relationship Health and Safety Screening data over a 6-week span, post dissemination of bundle IPV interventions.

Conceptual Framework

A pre-knowledge and post-knowledge test design were used to evaluate the effectiveness of the IPV educational awareness interventions as a training tool to improve staff's knowledge, empathy, attitudes, and awareness of behaviors commonly seen in IPV-related care. This quality improvement project used RE-AIM as the framework for the process improvement/change (Glasgow et al., 2019). RE-AIM is a model designed to improve the adoption and implementation of effective evidenced-based interventions. The five tenets of RE-AIM are Reach, Effectiveness, Adoption, Implementation, and Maintenance. Reach relates to the target population. Who would be affected by the implementation of a new process or enhancement of existing process? For this quality improvement initiative, the target population includes VA's primary care providers use evidence-based processes to assess intimate partner violence (IPV) and initiate IPV interventions

in the outpatient setting. Effectiveness refers to the impact or the change that occurs. The refinements or changes that appear can be either positive or negative depending on the primary care providers involved. Adoption embodies the number of providers willing to adopt the intervention among the PCPs and other ambulatory care staff. Implementation includes the setting of the process change the interventions need to make the vision occur. Implementation will include health awareness pop up booths across all outpatient clinics, educational training on the importance of the E-HITS screening tool. The last step in the model is maintenance. Assessing if the enhancements or any changes are sustainable and will its foundational protocols for the organizations (Glasgow et al., 2019). (Appendix E).

Intervention(s) Description

Interventions included providing information and enhancing skills by conducting a multi-strategic awareness campaign to educate staff about IPV and provide evidence-based solutions on how to address screening interventions. The Primary Investigator executed a multi-strategic awareness campaign using educational tools from the Joint Accreditation for Interprofessional Continuing Education (JA IPCE). In support of improving patient care, Veteran Affairs Employee Education System (EES) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The Primary Investigator sent staff an e-blast regarding IPV Awareness and Education Symposium. This free, virtual, half-day educational event on Intimate Partner Violence was

provided to all staff during the intervention phase of the DNP project. The education symposium provided staff with education on 1) IPV and maternity, IPV and parenting, and moral injury among combat Veterans. An educational event was provided to staff at no cost through Veterans Health Administration Employee Education System (VHAEES) (Appendix F).

An electronic intimate partner violence (IPV) fact sheet was disseminated to staff about evidenced-based programs for survivors of IPV and their children. The fact sheet included details about a 10-week once-week parent empowerment program aimed at improving parenting and disciplinary skills and enhancing social and emotional adjustments to reduce behavioral and adjustment responses to children impacted by IPV. This intervention supported research that showed intimate partner violence (IPV) rates are highest in families with young children. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women (Agency for Healthcare Research and Quality, 2015).

All VA healthcare providers were offered a virtual education power point presentation on IPV screening and assessment. Virtual education was emailed twice during the intervention phase of the DNP project to ensure providers could review. The Presentation was provided virtually due to the COVID-19 social distance guideline restrictions. The content was based on Intimate Partner Violence Assistance Program's (IPVAP) national guidance (VHA Directive 1198), CDC's guideline (CDC, 2017, the National Coalition Against Domestic Violence (Ncadv, National Coalition Against Domestic Violence, n.d.), Futures without Violence (Futures Without Violence, 2020) and the National Health Resource Center on Domestic Violence (National Resource Center on Domestic Violence, n.d.). The presentation goals were;

- Describe Intimate Partner Violence (IPV) statistics on Veterans,
- Define intimate partner violence,
- Identify health risk for IPV and common risks found in military service members and the Veteran population,
- Discuss barriers to IPV reporting and screening,
- Identify IPV screening techniques,
- Describe the Relationship, Health and Safety Screening (RHSS) Clinical Reminder (CR),
- Identify available resources to support survivors of intimate partner violence,
- Describe the referral process for positive IPV screening and the role of the Intimate Partner Violence Assistance Program Manager.

During the intervention phase, staff were provided with an Intimate Partner Violence (IPV) pocket card. Pocket cards were delivered through VA email accounts and sent to the clinic managers for dissemination to staff. This tool provided staff with quick reference for IPV resources and contact information readily available for proper referrals. All staff received IPV pocket cards (Appendix F) that they could refer to as needed. The purpose of IPV pocket card was to provide quick access to vital information. These pocket cards are suitable for front line staff and essential to quick access to important IPV-related care information. Pocket cards are an excellent tool for health care staff who are conducting routine assessments for Intimate Partner Violence. The card includes a validating message on how VA staff can help build health relationships, which also provides reinsurance to staff that may not be comfortable with providing IPV-related care. The card also lists the number of the National Hotline on Domestic Violence and contact name for the

organizations Intimate Partner Violence Assistance Program Coordinator to streamline referrals as needed (Appendix F).

To help improve IPV screening initiatives, added interventions included Monthly IPV eBlast (*VA electronic messaging*) with resources on IPV training modules in VA's Talent Management Educational System that is free and accessible to all VA staff. An IPV informational flyer was given for staff to have readily for review and resource tool as needed.

Throughout the intervention phase, staff were encouraged to stay in compliance with completing the evidenced-based intervention, the Relationship Health and Safety Screening (RHSS) Clinical Reminder (CR).

To help staff better understand primary care staff are uniquely positioned to respond to patients' disclosure of intimate partner violence, the Primary Investigator disseminated a systematic review that evaluated the benefits of IPV interventions in primary health settings. The results showed that 76% of interventions resulted in at least on statistically significant benefit in reductions of violence, safety promoting behaviors, improvement in emotional and physical health and access to IPV community-based resources (Bair-Merritt et al, 2014). Access to IPV resources and using a collaborative multidisciplinary approach to IPV interventions supports enhancing IPV screening interventions.

Recruitment

Using electronic communication through VA email, 196 staff were included in an Intimate Partner Violence (IPV) informational email blast. Followed by a second email requesting identified staff to complete IPV Pre-Survey IPV Knowledge Check. The purpose was for the

Primary Investigator to assess staff's understanding of IPV related care. Veterans Affair (VA) staff that took part additionally received a demographics survey. Completing the first survey confirmed *voluntary, implied consent to take part*. No personal identifying information was part of the survey tools. Each virtual survey was de-identified and marked with a participant number that allowed before and after surveys to be compared.

Subjects

Participants included full- and part-time staff working in the ambulatory care outpatient clinics. Participants from all disciplines were encouraged to attend for intimate partner violence (IPV) related care occurs in all healthcare settings. Participation was voluntary.

The Intimate Partner Violence Assistance Program (IPVAP) Manager announced the IPV educational program for staff in the Intimate Partner Violence Assistance Program's monthly stakeholder meeting. An electronic informational flyer was emailed to all outpatient ambulatory staff with the virtual event date and time (Appendix G). Target population included ambulatory care staff who work in the VA outpatient setting.

Inclusion/Exclusion Criteria

All staff working in VA's outpatient clinics met the inclusion criteria to take part in the quality improvement project.

Access

VA staff already had access to VA email accounts and the facility's online education system known as Talent Management System (TMS). Participants for this quality improvement initiative were voluntary.

Recruitment Strategies /Flyer

Participants were sent an initial informational email about the project through VA email to review. Participants received a follow up email including a demographic survey and post knowledge survey. Participants were informed that by completing the first survey implied consent to take part.

IRB, Ethics, & Consent

Robley Rex Veteran Affairs Medical Center (RRVAMC) recommended the Institutional Review Board (IRB) of record for this Quality Improvement initiative be provided by Eastern Kentucky University. The project was granted Expedited IRB approval on December 1, 2022. Please refer to Appendix H.

Data

The data sources that were used for this quality improvement initiative included the pre and post IPV knowledge survey, demographic survey, and Veterans Affairs evidenced-based tool for intimate partner violence screening, Relationship Health and Safety Screening (RHSS). Relationship Health and Safety Screening (RHSS) data extraction through Veteran Affairs National IPV Clinical Data Warehouse's (CDW) Health Factor Screening Patient Detail Reporting System.

Instruments

Three surveys were sent to the staff about the project**:**

- Pre-Survey tool assessing current intimate partner violence (IPV) knowledge and screening and practices; 1) How often do you work with patients impacted by Intimate Partner Violence (IPV), 2) Have you received previous Intimate Partner Violence screening training? 3) Have you completed a Relationship Health and Safety Screening Clinical Reminder? and 4) How many times have you made a referral to the facility's Intimate Partner Violence Program Coordinator (IPVAPc) within the last 12 months? Pre-survey tool also secured implied consent.
- Demographic Survey – A brief demographic tool was used to supply widespread characteristics of the participants such as age, profession, how long they have worked in their current role, and confirmation of prior IPV training.
- Post Survey to compare pre-post IPV intervention. Assess acknowledgments of IPV knowledge and how often IPV screenings are occurring compared to pre-intervention initiatives.

Demographic Data

Each participant completed the 8-item demographic questionnaire to understand the population, healthcare role, educational experience, and exposure to IPV-related care (see Appendix I). A brief demographic tool was used to determine the characteristics and background of participating providers and to secure implied consent. Minitab statistical programming was used by the PI to analyze the project data. Health care staff demographics and their reported experience

in working with patients at risk for IPV were examined. Sixty-eight (91%) VA healthcare staff completed the demographic survey. Most participants were female (78%), nurses (RN/APRN/Nurse Managers) (56%), and an overwhelming majority (93%) reported being involved with IPV-related care (Appendix I).

Data Collection Process

The VA health system's Relationship Health and Safety Health Factor Screening report supplies a detailed report for the facility. This report supplies specific details as it relates to IPV; health factor assignment location, shows the staff, date, time, division, and clinic name the patient was seen. In addition, the data details are provided on the screening status, primary screening, secondary risk assessment, resolution of consults, and universal education and intervention encounters are identified during which IPV risks are assessed and generate an alert when IPV risks are not assessed. Veteran Health Administration's (VHA), Corporate Data Warehouse (CDW) houses all intimate partner violence data information. The Relationship Health and Safety Screening tool informs the Intimate Partner Violence Assistance Program Manager with details regarding if staff is providing the patient with universal IPV education, interventions, and safety planning.

During the quality improvement initiative, the PI extracted IPV screening data from VA's Corporate Data Warehouse (CDW) Relationship Health and Safety Screening data were collected through Veteran Health Administration's (VHA) intimate partner violence reporting system. For this quality improvement initiative, the Primary Investigator pulled data on Thursdays for six consecutive weeks. Of the 654 (ℕ = 654) total Veterans seen by primary care staff, 370 (57 %)

received primary screening that focused on screaming, insults, threats, physical harm, and unwanted sexual contact. A total of 284 (43 %) were not screened. A total of 257 (39 %) Veterans received universal education interventions.

Timeline, Resources, & Budget

The site approval was granted, and IRB was approved through Eastern Kentucky University IRB approval process. Budget for proposal determined no added cost. Resources made available through Veterans Affairs. This project was completed during April of 2023. Participants completed surveys at the time of the 6 weeks (about 1 and a half months) of Relationship Health and Safety Screening data collection, March 20th, 2023, survey window closed. Findings were analyzed by the principal investigator and reviewed with facility stakeholders and EKU (Eastern Kentucky University) DNP Chairs in April 2023.

Results

Out of the 196 (N=196) identified participants, 75 (n=75) employees participated in this project, which represented 38% of the total population. The findings of the project are presented and discussed in sections: 1) combined results of Pre-Test, Post-Test, 2) results of Demographic survey, and 3) results of the Relationship Health and Safety Screening (RHSS) data over a 6-week period. Within each section, quantitative results will be presented first followed by qualitative results where applicable. The intervention and data collected began on February 9, 2023, and continued over a series of dates until the data collection was closed on March 17, 2023. At the end, all survey information was downloaded from VA's survey information center into Microsoft Excel. The PI reviewed to ensure a clean transfer of data. A codebook was developed for each item

and the information was transferred to Minitab Statistical Software with the help of Dr. Michell Smith. Minitab statistical software was used to analyze data by performing descriptive statistics; paired t-test, and frequency analysis.

Results of pre and post survey

A pre-test/survey that was virtually disseminated to 196 (N=196) staff on December 28, 2022, and again on January 27, 2023, due to low response rate closed on January 31, 2023. A total of 75 (38%) participants responded to the pre-IPV knowledge survey. Participants were asked 1) How often do they assess patients changed by IPV? 2) Have they received previous Intimate Partner Violence screening training? 3) Have they completed a Relationship Health and Safety Screening (RHSS) clinical reminder (CR)? Each participant was assigned a participant number to analyze pre- and post-data.

After the intervention phase, the primary investigator issued a post- IPV knowledge test/survey on March 17, 2023, and closed on March 20, 2023, supplying staff 3 full days to complete post- IPV knowledge test/survey.

From a qualitative perspective, participants were asked to respond to four questions that were formulated to determine the IPV knowledge in pre and post design. The questions included: how often do you work with patients impacted by Intimate Partner Violence (IPV), have you received previous Intimate Partner Violence screening training, have you ever completed a Relationship Health and Safety Screening Reminder, and if yes, how many times have you made a referral to the facility's Intimate Partner Violence Program Coordinator within the last 12 months?

Response options for each question included none=0, seldom=1, often=2, and very often=3. Providers' IPV knowledge on the post-test was 73.3 % compared to pre-test 53. 3%, a 34% increase (Table 2). A paired-sample t-test was used to determine pre-test and post-test results after the interventions were administered showing significant differences between the pre-test and post-test. In the results, the mean difference in the pre and post-test was 0.3867 (M=0.3867). Standard deviation 0.7146 (SD = 0.7146). The population mean difference is between 0.2223 and 0.5511 (95% CI (Confidence Interval) for u difference).

In the results, the null hypothesis states that the mean difference in the pre and post-test after the multi-strategic IPV screening and awareness campaign are equal to zero. The p-value is 0.000, which is less than the significant level of 0.05, the decision is to reject the null hypothesis and conclude that there is a difference in the IPV screening responses after a screening and awareness campaign.

Pre and post results were analyzed for staff response to IPV knowledge. A paired-sample t-test resulted in the mean being 0.2000 (M = 0.2000) and the standard deviation was 0.6975 (SD = 0.6975). The population mean difference was between 0.0395 and 0.3605 (95% CI for u difference). Using a .05 significant level the null was rejected with p = 0.015.

The PI completed Paired T-Test to compare pre and post responses for each question answered by all participants (n=75). (Please refer to table 1).

Data analysis was computed using Minitab Statistical Software, all participants (n=75) of the intervention group volunteered to take part in the DNP project. Participants completing the

first survey were following voluntary anonymous consent. A total of returned responses rate 75 (38%). (Please refer to Appendix I).

Results of the Demographic Survey

The Demographic Survey was completed by 68 (91%) participants. Most of the participants (n = 52, 76%) were females. A total of 26 (n = 26, 38%) identified as non-licensed personnel (nurse, nurse manager and others). Further results showed that 43 (63 %) of participants seldom treated patients impacted by IPV (Appendix I).

Relationship Health and Safety Screening Clinical Reminder

The Primary Investigator conducted weekly IPV screening audits for 6 weeks (about 1 and a half months). Data collection started on Thursday, February 9, 2023, with the final collection date on Thursday, March 16, 2023. The Primary Investigator analyzed screening data to verify staff compliance with Veteran Health Administration (VHA) mandate for IPV screening interventions by completing Relationship Health and Safety Screening Clinical Reminders and supplying universal education intervention.

Intimate Partner Violence Assistance Program’s Clinical Reminder, Relationship Health, and Safety Screen (RHSS) is the recommended evidenced-based intervention to screen Veterans for Intimate Partner Violence. Results were documented in the patient’s Computerized Patient Record System (CPRS). VA ambulatory care staff were made aware of and received education on how to use this tool. Intimate Partner Violence awareness events, staff training, education and information on outreach events were other interventions executed to increase staff’s involvement

in IPV-related care (Appendix F). Intervention subjects included ambulatory care staff in the outpatient setting. 196 (N=196) staff were identified for the proposed interventions.

Descriptive statistics were used to analyze the data by creating bar graphs using Minitab Statistical Software. The association between 6 weeks (about 1 and a half months) data analysis for Relationship Health and Safety Screening Clinical Reminders and Universal Education Interventions were analyzed. On February 23, 2023, a spike in dissemination of universal education interventions, with a decline that plateaus for the remaining screening dates. (Figure 1).

On February 16th, 2023, there was an increase in the Relationship Health and Safety Screening clinical reminders, more than expected. On February 23rd, 2023, there was a significant decrease in screening, more than expected. The remaining screening dates remained steady. An overall snapshot of the total percentages of patients screened and provided with universal education interventions.

The Primary Investigator extracted Relationship Health and Safety Screening Data from February 2022 through March 2022 to compare it to Relationship Health and Safety Screening Data from 2023 (Figure 3). Descriptive statistics from a Paired T-Test analyzed using Minitab Statistical Software showed the P-value of 0.383 showed the result is not significant at any acceptable level and a 95% confidence interval (T-Value 0.96). The PI could not conclude that a significant difference exists.

Descriptive Statistics

A total of 196 (N=196) participants were included in the project, 75 (n=75) (38%) consented to participate. Many of the participants were female (78%) and has been employed at the facility for one to greater than five years. Participants employed in nursing made up 37% of the total number. The target population included all staff working in the identified ambulatory care areas.

Discussion

Intimate Partner Violence screening interventions for patients seen by primary care providers have been recommended for a decade but implementation into primary care remains low. To address this practice gaps in care and to get a baseline snapshot of screening practices in the ambulatory care setting, the PI gathered baseline data from the Relationship Health and Safety Screening clinical reminder tool during February 1, 2019, through February 1, 2021 (Appendix J). The total number of patients seen during this time was 681 (N=681). Of the 681 (N=681), 146 (21%) received universal IPV screening. Data analysis showed gaps remain with IPV screening interventions. Intimate partner violence (IPV) awareness campaigns are effective, but there are noted variables depending on the location of the clinic and the staff delivering the accountable for delivering the interventions.

Primary care services in ambulatory health centers are key to violence prevention. Improving how VA staff identifies and responds to intimate partner violence and promotes prevention are tenets to carrying out the mission and values of the organization. Ongoing education on intimate partner violence and training on the Relationship Health and Safety Screening clinical

reminder needs to be revisited and enhanced to provide a comprehensive and sustainable response to intimate partner violence. The participants' intimate partner violence knowledge score on completing a Relationship Health and Safety Screening (RHSS) clinical reminder (CR) scores improved by 15% after the PI intervention phase. A multi-strategic awareness campaign is necessary to equip staff with the tools needed to identify, respond to and promote intimate partner violence prevention. For staff to be confident in their ability to provide IPV-related care, they must be able to help with prevention, assess, and respond to IPV to positive screenings. This DNP project was to assess the outcomes of multi-strategic interventions on intimate partner violence awareness, training tools and educational resources.

Consistent with literature, this multi-strategic awareness program enhanced staff knowledge regarding IPV-related care. IPV awareness and education are key components in promoting staff resiliency. Sustaining a comprehensive response to intimate partner violence states that screening for intimate partner violence, (particularly in women) is increasingly expected in primary care (Iverson et al, 2019). This is consistent with clinical prevention guidelines defined by the United States Preventive Services Task Force and supports the PI focus on intimate partner violence interventions to improve the rates of intimate partner violence screening.

Limitations

The population consisted of a convenient sample of those that opted to attend. Not all staff identified (N=196), responded to initial survey that provided implied consent. The program offered training and awareness opportunities to 196 staff members, 75 staff took part (38%) in the pre and post survey. The demographic survey had 68 staff members to participate (34.69%). First,

competing priorities presented providers with limited availability to complete surveys, Secondly, COVID-19 pandemic restrictions limited face to face trainings and educational seminars. All awareness and training were provided virtually, through electronic platforms. To rectify these limitations in the future, the IPV awareness campaign will move to in person sessions, face to face trainings with virtual platforms being offered for those that have mitigated factors that prevent taking part in person trainings.

Interpretation

Interventions to increase intimate partner violence awareness should increase screening interventions. The operations for this quality improvement project occurred during the COVID-19 pandemic which prevented in person led awareness campaigns versus virtual. This may negatively affect the core benefits of awareness and 100% participation.

Implications

Clinical Practice

The evidenced-based DNP project enhanced the knowledge of participants and supplied awareness to the staff that did not wish to take part. Intimate Partner Violence prevention is necessary for all staff. The Program Director for Intimate Partner Violence encourages ongoing awareness and education. There are national initiatives across the VA health care system focused on quality improvement for IPV screening in initiatives.

Information about the need for IPV training, handouts and other assessment tools were shared with all providers throughout the facility. All staff are provided with education during the

new employee hospital orientation. There is a national push to enhance IPV related care provided by VA staff.

Policy

Veterans' Health Administration (VHA) is committed to ensuring that Veterans, their partners, and VA employees who are directly impacted by intimate partner violence are provided with a comprehensive network of services to include education, assessment, and intervention, and all are treated with dignity and respect (VHA Directive 1198).

Quality and Safety

Developing and implementing screening protocols for intimate partner violence are foundational for safety and quality for the population served. It is crucial to equip staff with the necessary in-depth knowledge of IPV assessment, screening and treatment interventions. Providing this training will ensure that Veterans at risk of experiencing or using intimate partner violence are found, supplied care which will increase safety and risks reduction

Education

Multi-strategic IPV screening and awareness campaigns enhance staff awareness and comfort levels. Supplying on-going efforts to raise awareness about IPV and the effects of IPV through facility wide campaigns are important for improving care outcomes. Coordinating local training for all staff on IPV service during new employee orientation at minimum annually thereafter is critical to being successful in increasing screening interventions. Staff should be provided with many opportunities to receive in-depth training in assessment, screening, and

treatment interventions. Effective training will help with staff comfort levels in treating intimate partner violence.

Feasibility for Sustainability

This quality improvement initiative was implemented at the VA Medical Center in Louisville, KY. Ambulatory Care staff will have annual Intimate Partner Violence training and ongoing education provided on Intimate Partner Violence assessment and interventions. Rounding to each outpatient clinic will be provided with education pop-up health and safety fairs annually. To sustain continued efforts toward increasing Interventions for IPV, the Chief of Ambulatory Care Services and facility executives will need to supply support to all efforts implemented to enhance current IPV guidelines.

Future Scholarship

The Veterans Health Administration (VHA), currently have ongoing initiatives to integrate intimate partner programs in primary care. This is a national initiative. The facility for this quality improvement project has already implemented integration of IPV screening within the primary care setting. Initiatives to improve screening outcomes including the PI quality improvement project.

In the spirit of making a positive impact, the PI understands that dissemination of knowledge and research is imperative to initiative quality improvement effectively. The PI will present a proposal to the Intimate Partner Violence Assistance Program manager, Melinda Collett, about developing informational sessions to disseminate to all ambulatory clinics annually. Development of an IPV workshop that can be held during domestic violence awareness month will

allow interactive conversation with staff and subject matter experts. Ongoing use of technology will be the main source of communication to reach as many staff as possible. Virtual flyers, digital monitors throughout the facilities and monthly IPV Learning EBlast, (*electronic educational communication*) through Veteran Affair's employer educations system, will be used to provide quality workforce education and training that facilitates excellence in the delivery of IPV-related care.

This mixed method design was used for the QI initiative. IPV screening were primary quantitative outcomes. Pre and Post-tests for IPV knowledge showed a 20% to 23% increase in participants (n-75) receiving IPV training and completion of Relationship Health and Safety Clinical reminders. Data analysis was conducted by the PI over a 6-week period by extracting screening information from Veterans Affairs Support Service Center (VSSC). Client that was seen by providers throughout the project duration. Of the eligible visits (N=654), 50% received universal IPV screening and 38% received universal IPV screening interventions. The QI project had many beneficial outcomes. While universal IPV screening was not achieved at 100%, a screening rate of 50% is a step in the right direction. The interventions provided to staff will need to be ongoing to solidify sustainability in providing efficient IPV-related care.

To help build a platform of future scholarship, the DNP student will develop an inter-professional, cross-functional, quality improvement team that will use the findings from the DNP project as it's foundation to move the facility to 100% universal IPV screening rate. Quality improvement is a team sport, improving quality is everyone's job (Agency for Healthcare Research and Quality, 2018). The cross-functional team will consist of experts from the front line to data

management staff. The participants will be provided with clear expectations that will empower clinicians and non-clinicians alike.

Conclusion

Intimate partner violence is a prevalent issue among the Veteran population. Staff working in ambulatory care settings are often the first point of contact to identifying patients presenting at health clinics with experience of IPV. Identification of victims may lead to early intervention and prevent short-term and long-term intimate partner violence complications. IPV awareness is highly supported in the Veteran Health Administration. Evidence supports that staff play a key role in identifying IPV. More education, training and awareness is needed for the staff to effectively supply universal screening interventions. Veteran Affairs staff that use the Relationship Health and Safety Screening per Veteran Health Administration's policy 1198 will help sustain current safety guidelines and improve patient outcomes. The project results showed an increase in identifying patients with screening interventions and using the Relationship Health and Safety Clinical Reminder. Ongoing training sessions will be needed, and gaps need to be addressed related to VHA's mandated policy that screening should be completed at 100%.

Other Observations

Respondents may not feel encouraged to provide exact, honest answers to surveys or comfortable answering questions that may not be aligned to their comfort level. Excerpt from the PREMIS: Physician Readiness to Manage Intimate Partner Violence did not return with the expected responses. Repeated requests to complete surveys for the DNP project may lead to participants feeling annoyed. The PI did receive feedback from a physician that thought the focus

was great, but more support staff is needed to keep up with all the mandated screenings. Other observations included feedback on how to complete the Relationship Health Safety Screening intervention and where does one find the Relationship Health and Safety Screening clinical reminder in the electronic health record. The Intimate Partner Violence Assistance Program Manager does a fantastic job, but she cannot do it alone. The organization would benefit in identifying more IPV champions to work in a supporting role. Ongoing education and awareness are called for.

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Table 1

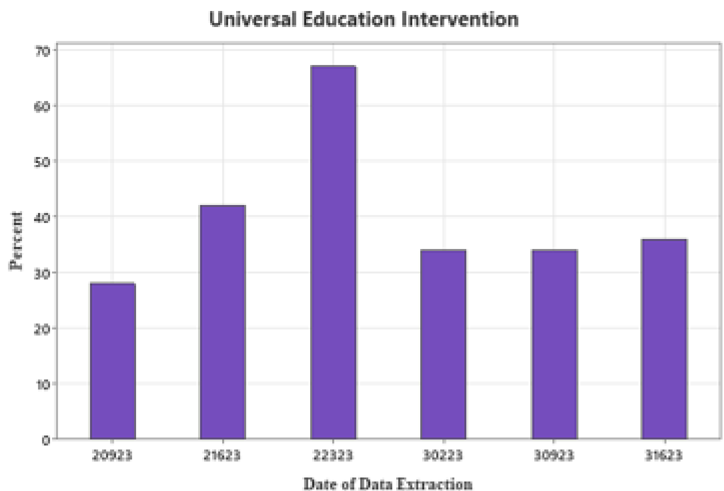
Statistical Findings for Pre and Post IPV Knowledge Test

Descriptive Statistics for Pre and Post IPV Test	Pre-Results SD	Post-Results SD	P-Value	Statistical Findings
How often do you work with patients affected by Intimate Partner Violence (IPV)?	0.8366	0.06954	0.001	Statistically significant
Have you received previous Intimate Partner Violence Screening Training?	0.0958	0.0726	0.000	Statistically significant
Have you completed a Relationship Health and Safety Screening Reminder?	0.958	1.566	0.025	Statistically significant
How many times have you made a referral to the facility's (IPV) Program Manager	0.880	1.566	0.025	Statistically significant

Note. N=75

Figure 1

Universal Education Intervention



Note. Percentage of Universal education interventions over a six weeks' time span.

Figure 2

Universal Screenings Data

2023 Dates for Extracted Data from VHA Support Service Center (VSSC)	Total Number of Patients Seen	Percentage of Relationship Health and Safety Screenings (RHSS) completed	Percentage of Universal Education Interventions provided at point of care (POC)
February 9, 2023	130	38%	28%
February 16, 2023	84	61%	42%
February 23, 2023	90	43%	67%
March 2, 2023	118	63%	34%
March 9, 2023	120	64%	34%
March 16, 2023	112	61%	36%

Note. Percentage of IPV Universal Screenings

Figure 3

Universal Screening Data

2023 Dates for Extracted Data from VHA Support Service Center (VSSC)	Total Number of Patients Seen	Percentage of Relationship Health and Safety Screenings (RHSS) completed	Percentage of Universal Education Interventions provided at point of care (POC)
February 10, 2022	132	71%	48%
February 17, 2022	115	69%	49%
February 24, 2022	114	65%	52%
March 3, 2022	123	67%	38%
March 10, 2022	132	69%	50%
March 17, 2022	119	64%	46%

Note. Percentage of IPV Universal Screenings

Appendix A

Hierarchy Table of Evidence

Melnyk Level	Evidence **1** (Travers, et al., 2021)	Evidence **2** (Easton, et al.,2018)	Evidence **3** (Taft, et al., 2016)	Evidence **4** (Iverson, et al., 2019)	Evidence **5** (Adjognon, et al., 2021)	Evidence **6** (Portnoy, et al.,2021)
I	**X**					
II		**X**				
III			**X**			
IV				**X**		
V						
VI					**X**	
VII						**X**

Note. This table proves the selected studies, categorized by the level of evidence using the Melnyk System of Hierarchy of Evidence for Intervention

Appendix B

Summary of Evaluations Tables

Table B1

First Author	Conceptual Framework	Design/Method	Sample/Setting	Major Var & Def	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Travers, et al. Clinical Psychology Review 2021	Risk-need Responsivity framework	SR Purpose: assess evidence for intervention situated in a risk need responsivity framework in comparison with trade 1 size fit all intervention approach. Searched 6 databases (psych info, Web of Science, PubMed, EMBASE, SCOPUS, PILOTS). Conducted 6/2018. Included studies, 5/2019 & 10/2020	N = 17 studies Or N = 14, no trmt CG	IV: Interventions used to prevent IPV recidivism. DV: Acceptance and Commitment Therapy.	Actuarial & Structured clinical tools	RNRT	RNRT shows Promise in Short-med term Longer = challenge	Strength- limited studies on interventions to prevent recidivistic Weakness- study size Contribution- access to pretreatment. Decrease In IPV cycle

Table B2

First Author	**Conceptual Framework**	**Design/Method**	**Sample/ Setting**	**Major Var & Def**	**Measurement**	**Data Analysis**	**Findings**	**Appraisal: Worth to Practice**
Easton, et al.,2018	IPV risk assessment within an EBP framework	RCT Purpose: SADV effects of IPV risk assessment on IPV survivors and perpetrators. Argued IPV risk ass should be used in context of EBP SW practice.	Setting: VA	IV: SW impleme nt ng IPV risk Assessment Tool CBT BCT Group and non-group setting	IPV risk assessment			Level of Evidence-II Strength-RCT, EB

Table B3

First Author	Conceptual Framework	Design/Method	Sample/Setting	Major Var & Def	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Taft C, et al. Journal of Consulting & clinical Psychology 2016; 84(11), 935-945.		. RCT Purpose: examine the efficacy of SAH-C & SP. Participants were recruited from Feb 2010 – Aug 2013. Specific inclusion criteria. Participants were paid $50 dollars for completing each assessment	Veteran or service member & his partner. Greater than 18 yrs. of age. Data collected from 2 VA hospitals.	IV: SAH-C DV: Prevention relationship conflict & IPV among military couples & Vets.	Efficacy of SAH-C	2 Psychological IPV measures	Greater reduction in psychological	Level of Evidence-II Strength, EB Rec trmt at the VA for EB/IPV Weakness: access Contribution Strong. EB TRMT for IPV

Table B4

First Author	Conceptual Framework	Design/Method	Sample/Setting	Major Var & Def	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Iverson, et al. J Gen Intern Med 2019: 34(1): 2435-24342	i-PHARIS	Qualitative Purpose: Find successful Barriers to facilitators of IPV screening programs. Implement in VHA. 11 VAMCs	N = 32 VHA administrators & clinicians	IPV: find successful clinical practices & barriers of IPV. DV: 1 hr. semi structured phone interviews	Phone transcripts	Mixed method	5 successful clinical practices were found	Level-4 Strength randomized non control. Study assessing Veterans Effectiveness of screening programs Qual & Quan data collected

Table B5

First Author	Conceptual Framework	Design/Method	Sample/Setting	Major Var & Def	Measurement	Data AnalysiS	Findings	Appraisal: Worth to Practice
(Adjognon, et al., 2021)	i-PHARIS	Qualitative Purpose: IPV implementation strategies present the first examination of clinical IPV screening responses recorded for female VHA patients. Align and extend current literature	32 admins and clinical staff 11 VHA facilities nationwide Data collection 2012-2018	IV; Extract IPV data from EMRs DV: # of pos IPV screenings		Rapid content analysis the code	Considerable proportion of female VHA patients disclosed IPV.	Level- 5 Strong contributor Alignment with current research and addressing barriers. Highlighted 8 strategies. Weakness ongoing training on IPV needed

Table B6

First Author	Conceptual Framework	Design/Method	Sample/ Setting	Major Var & Def	Measurement	Data AnalysiS	Findings	Appraisal: Worth to Practice
Portnoy, et al.,2021	Quality improvement	QI implementation strategies of differing intensities & investigate the clinical effectiveness of IPV screening programs	CWHCs Multisite Balanced randomization 16-20 Setting: VAMC PC	IV: evaluate the clinical effectiveness of IPV screening programs. DV: Compare the clinical effectiveness of 2 IPV screening tools	Baseline recruitment materials	Univariate analysis	VA based PCC are ideal settings to implement EB IPV screening programs	Level VII Contribution - STR-EVB IPV screening practices Recommend s PCC screenings

Appendix C

Appendix D

Statement of Mutual Agreement

Appendix D1

Eastern Kentucky University
Doctor of Nursing Practice (DNP) Program
Statement of Mutual Agreement

The purpose of this document is describe the nature of the agreement for the Doctor of Nursing Practice (DNP) Project between:

Student Name: Stephanie Ralston
Partnering Organization Name: Robley Rex VA Medical Center

This statement of mutual agreement is completed in the DNP Project planning phase as a precursor to the Institutional Review Board (IRB) and to show general organizational support for the DNP Project.

General Information:

DNP Project Title:	"Among VA health providers (P) what interventions (I) improve the rate of Intimate Partner Violence (IPV) screenings (O)?"
Partnering Organization:	Name of Organization: VA Name of Organizational Contact: Melinda Collett, LCSW National Intimate Partner Violence Assistance Program Coordinator Phone: 502-287-4929 Email: Melinda.Collett@va.gov

Brief Description of the Project: Quality Improvement (QI) Initiative for increasing IPV screening and interventions in the PCP outpatient setting.

Identified Problem/Gap:	Relationship Health and Safety Assessment (RHS) screening not been completed across the board Screen all Veterans annually IPV screening being part of routine preventive services Primary Care Providers (PCPs) integrating IPV into their practices Substantial barriers in Knowledge, attitudes, beliefs, and behaviors
Proposed Intervention(s):	Identify barriers or challenges to spreading screening in the outpatient setting/Primary Care setting. PCPs have plans for positive screens to offer education, resources referrals. Acknowledge strengths in disclosing. Follow through with referrals Raise Awareness

Appendix D2

	Develop and Implement IPV pocket Cards Create and Implement outreach events; provide training and education Build internal collaborations across all the CBOCs
Proposed Evaluation of: • Outcomes • Process	To screen all women of childbearing age consistent with the Directive 1198 and U.S. Preventive Services Task Force (USPTF) recommendations. Screen all Veterans annually
Description of On-Site Activities: • Student's Role • Meetings • Access to Data	Review healthcare factor reports, bimonthly Continue to participate with Tiger Team and the IPV stakeholder committee Meet with IPV manager as needed IPV Champion Review de-identified IPV data Review IPVAP consults of applicable # Of screens and # of referrals, # post referrals and the # of referrals to IPVAP Program Manager • IPVAP Manager and I, decided the first focus clinics will Newburg, New Albany and the more rural areas, FT, and Grayson • Pulling data from VSSC database July 2020 comparing to know • 6-month intervals comparing data • Opinion poll survey for the providers – knowledge checks etc. • End of Sept plan pre-Domestic Violence Awareness month - pop up awareness fair at Newburg • Oct for Domestic Violence (DV) awareness month pop up, polling and awareness at the Facility and out in the CBOCs • Possible interventions; Training tool RADAR, Clinical Reminders, Safety Flag • Process eval for end of project • KABB- Knowledge, Attitudes, beliefs, and behaviors • IPV Champions
Intellectual Property: • Ownership	

Appendix D3

• Plans for Dissemination • Non-disclosure expectations • Publication Plans	*** All EKU DNP Projects will require at minimum a de-identified abstract to be uploaded into the digital repository as a marker of academic work.

Institutional Review Board:

EKU is the IRB of Record	The organization agrees to let EKU be the IRB of Record. ☑ Yes ☐ No ☐ Other: (Explain) ❑
Organization is the IRB of Record	The organization prefers to be the IRB of Record. ☐ Yes ☑ No ☐ Other: (Explain)

Other elements for clarification prior to implementation of the DNP Project. Describe.

DNP Student Signature: Stephanie White Ralston
Date: 04/26/2022

Partnering Organization's Signature: Gerald Dryden
Date:

Digitally signed by Gerald Dryden
Date: 2022.04.27 22:52:08 +09'00'

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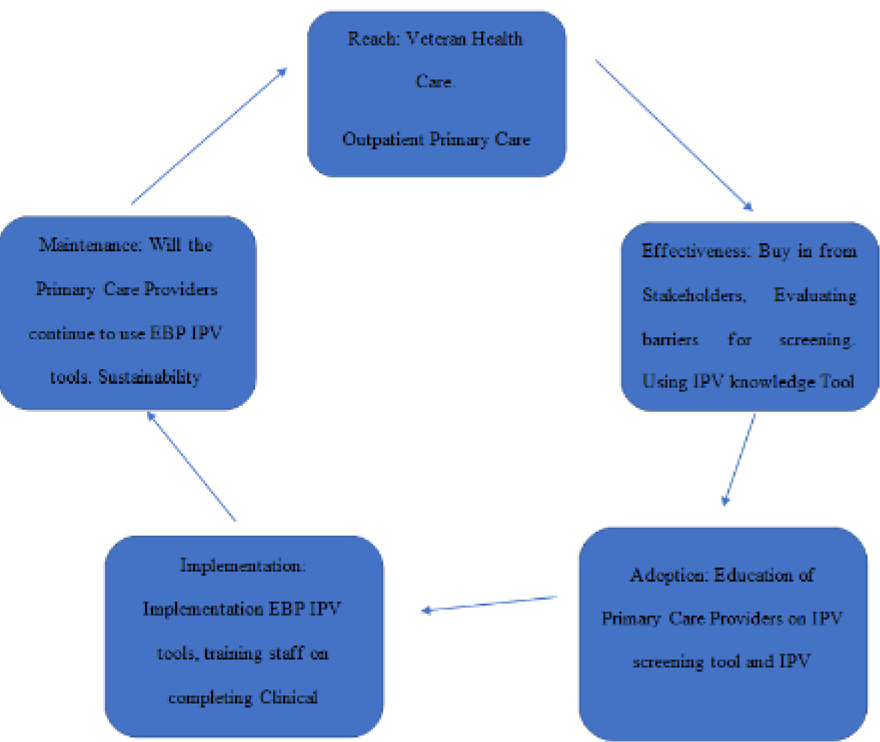
Appendix E

Re-Aim Theoretical Model



Appendix F

Staff Training

Department of Veterans Affairs Intimate Partner Violence (IPV) Assistance Program

Mission

Our mission is to implement a comprehensive person-centered, recovery oriented assistance program for Veterans, their families and Caregivers and VHA employees who use or experience intimate partner violence.

#ENDDOMESTICVIOLENCENOW

VA IPV Resources

- IPV Coordinators
- Link to community-based support groups
- Link to community-based advocacy and Legal services
- Referral to and coordination with other VA treatment providers
- Connection to domestic violence shelters
- Homeless services: HUD-VASH and GPD
- Interventions for Veterans who use violence

Nat'l Domestic Violence Hotline
800-799-7233
KY Coalition Against Domestic Violence
1-502-209-5382
IN Coalition Against Domestic Violence
1-317-917-3685

National Center for PTSD

- Call 802-296-6300
- Visit ptsd.va.gov

Veteran's Crisis Line

800-273-8255, Press 1

Women's Health

- Call 855-VA-WOMEN
- Visit womenshealth.va.gov

IPVAP Coordinator
Melinda Collett, LCSW, BCD,CHWC
502-709-2942 Phone
502-287-1931 Fax

VA Can Help Build Healthy Relationships!

The VA recognizes that strong healthy relationships are vital to the health and well-being of Veterans and their partners, caregivers and families. Many programs are available to help build or strengthen current relationships, or assist in address relationship conflict or distress in healthy ways. If you would like to improve your current relationship, or have concerns that you may be in an unhealthy or unsafe relationship, please talk to us. Your VA providers have many resources that can help!

QUICK REFERENCE RESOURCES

CAREGIVER SUPPORT PROGRAM 1.855.260.3274 • www.caregiver.va.gov

CHAPLAIN SERVICES
https://www.patientcare.va.gov/chaplain/index.asp

CRISIS LINE 1.800.273.8255 Press 1 • www.veteranscrisisline.net

INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM
https://www.socialwork.va.gov/IPV/index.asp

LGBTQ www.patientcare.va.gov/LGBT/index.asp

MILITARY SEXUAL TRAUMA
https://www.mentalhealth.va.gov/msthome.asp

NAT'L DOMESTIC VIOLENCE HOTLINE 1.800.799.SAFE (7233)

VET CENTER 1.877.WAR.VETS www.vetcenter.va.gov

For more information or assistance, please contact the VA Intimate Partner Violence Assistance Program Coordinator

Melinda S. Collett, LCSW, BCD, CHWC
Robley Rex IPVAP Coordinator
Strength at Home Regional Trainer
Robley Rex VAMC Louisville, KY

VA helps build healthy & safe relationships
Visit us at: www.socialwork.va.gov/IPV

Appendix G

Recruitment Flyer

Attention: Attend the IPV Awareness and Safety Virtual Fair

Intimate Partner Violence

Veteran Affairs Health Care System's mission is to implement a comprehensive person-centered, recovery-oriented aid program for Veterans, their families, and Caregivers and VA employees who use or experience intimate partner violence.

Commonly Asked Questions about IPV

What interventions are in place to aid with IPV?
What role do Primary Care Providers play in assessing IPV?
Who is at risk of experiencing IPV?
Why is IPV screening important?
What are barriers to screening for intimate partner violence?

What - IPV HEALTH AND SAFETY AWARENESS FAIR

To better understand the importance of IPV screenings and Interventions, there will be an ***Awareness IPV Health, and Safety Fair*** *held in the main conference room at the Greenwood CBOC. This IPV Health and Safety Fair will supply educational tools on IPV screenings and interventions. There will also be opportunities for Primary Care Providers to ask one on one questions with an IPV Champion.*

Target Audience – Ambulatory Care Outpatient Health Care Staff

When – February 13th, 2023

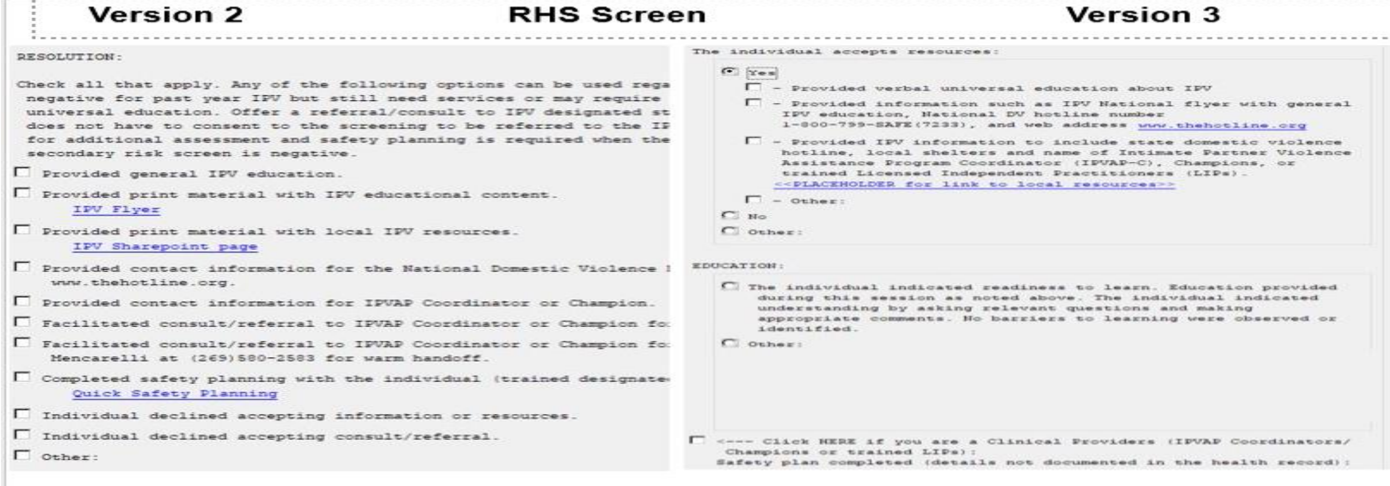
Where – Microsoft Teams

Contact Stephanie Ralston @ Stephanie.Ralston@va.gov for more information.

#ENDINTIMATEPARTNERVIOLENCE

Appendix H

E-HITS/RHSS



Version 2 | RHS Screen | Version 3

Version 2

RESOLUTION:

Check all that apply. Any of the following options can be used rega
negative for past year IPV but still need services or may require
universal education. Offer a referral/consult to IPV designated st
does not have to consent to the screening to be referred to the IP
for additional assessment and safety planning is required when the
secondary risk screen is negative.

- ☐ Provided general IPV education.
- ☐ Provided print material with IPV educational content.
  IPV Flyer
- ☐ Provided print material with local IPV resources.
  IPV Sharepoint page
- ☐ Provided contact information for the National Domestic Violence I
  www.thehotline.org.
- ☐ Provided contact information for IPVAP Coordinator or Champion.
- ☐ Facilitated consult/referral to IPVAP Coordinator or Champion fo
- ☐ Facilitated consult/referral to IPVAP Coordinator or Champion fo
  Mencarelli at (269)580-2583 for warm handoff.
- ☐ Completed safety planning with the individual (trained designate
  Quick Safety Planning
- ☐ Individual declined accepting information or resources.
- ☐ Individual declined accepting consult/referral.
- ☐ Other:

Version 3

The individual accepts resources:

- (•) Yes
  - ☐ - Provided verbal universal education about IPV
  - ☐ - Provided information such as IPV National flyer with general IPV education, National DV hotline number 1-800-799-SAFE(7233), and web address www.thehotline.org
  - ☐ - Provided IPV information to include state domestic violence hotline, local shelters and name of Intimate Partner Violence Assistance Program Coordinator (IPVAP-C), Champions, or trained Licensed Independent Practitioners (LIPs).
    <<PLACEHOLDER for link to local resources>>
  - ☐ - Other:
- ( ) No
- ( ) Other:

EDUCATION:

- ( ) The individual indicated readiness to learn. Education provided during this session as noted above. The individual indicated understanding by asking relevant questions and making appropriate comments. No barriers to learning were observed or identified.
- ( ) Other:

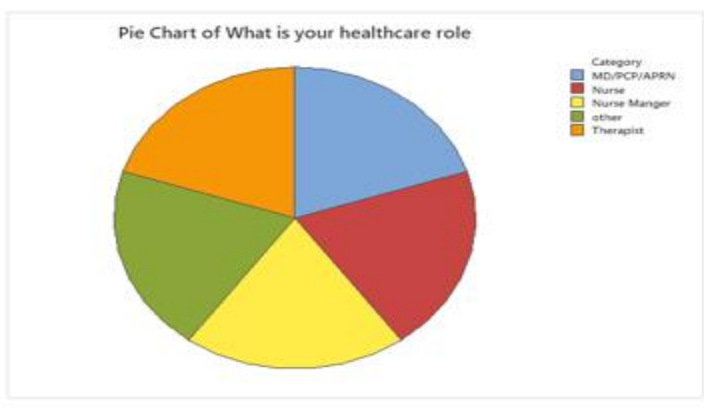
☐ <--- Click HERE if you are a Clinical Providers (IPVAP Coordinators/ Champions or trained LIPs):
Safety plan completed (details not documented in the health record):

V3 resource section is condensed from V2 and allows for sites to still build in local resources. Education section was added related to the Joint Commission standard and an optional box to document if a safety plan was completed for LIP staff only.

6

Appendix I

Demographic Survey



WORKSHEET 7

Pie Chart of What is your healthcare role