

Evaluation of a Public Health Department Project: Effectiveness of Expanded Access to
Care for Women Survivors of Intimate Partner Violence

Alfreda J. Rhodes-King, MSN, BSN, RN, BS

Northern Kentucky University

College of Health Professions

Nunn Drive, Highland Heights, KY

Rhodeskina1@nku.edu

(224) 637-7356(Cell)

Abstract

Aims and objectives: To evaluate the effectiveness of expanded access to care for women survivors of Intimate Partner Violence (IPV). The project consisted of three phases: 1) Administration of the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) of healthcare practitioners, 2) chart audits of healthcare practitioners' (HCP) documentation of follow-up care for women survivors of intimate partner violence, and 3) review of literature for best practices to enhance follow-up care and evidence-based nursing practices.

Background: A Sexual Assault Follow-Up Examination (SAFE) pilot program was implemented to provide appropriate and timely health assessments and follow-up care for women survivors two to four weeks after their IPV experience. I am not sure that this is evidence in the paper.

Design: Descriptive Quantitative Design and literature review of best practices.

Methods: The PREMIS was utilized as a knowledge assessment to identify healthcare practitioners' IPV background, actual knowledge, opinions and practice issues. Data were collected from six PREMIS results and evidence-based best practices to make recommendations for follow-up care.

Results: Effectiveness of expanded access to care at the SAFE clinic for women survivors of IPV may be enhanced through additional staff education, partnerships with sexual assault advocates and community coalitions, strengthening program development and expanding community outreach to IPV specific- populations.

Conclusion: The inclusion of clinic-based IPV advocates and principles of trauma-informed care empowers survivors to advocate for their own care. The effectiveness of a program relies on many variables, specifically, leadership, education, and experienced personnel who possess IPV background, knowledge, opinions and the ability to inform practice changes. Recommendations to improve program effectiveness and follow up care are provided.

Relevance to clinical practice: Nurses are influential in guiding current programs and healthcare policy. Community awareness of the epidemic portions of IPV/domestic violence (DV) is vital to expanding access to care for women survivors of IPV.

Keywords: PREMIS (Physician Readiness to Manage Intimate Partner Violence) Intimate Partner Violence (IPV), Healthcare Practitioners (HCPs), Sexual Assault Follow-Up Examinations (SAFE), Women Survivors, Education, "Health Care Can Change from Within", Interventions

Intimate Partner Violence (IPV) is a major public health concern. Research indicates the incidence of intimate partner violence is underreported (CDC, 2015; Messing, Mohr, & Durfee, 2012; Iverson, Wiltsey-Stirman, Vaughn, & Gerber, 2013; NISVS, 2010). Research reveals that women avoid seeking help due to various barriers such as poor communication with health care professionals, lack of awareness of resources and fear of harm or death to self or family (CDC, 2015; Eubanks & Resick, 2016; Messing, Mohr & Durfee, 2012). Therefore, this practice change project was conducted to evaluate the effectiveness of expanded access to care for women survivors of IPV, particularly women who sought sexual assault follow-up examinations performed by healthcare practitioners (HCP) working at the project site. The sexual assault follow-up examinations (SAFE) were conducted in a recently implemented clinic, which was specifically designed to address the needs of sexual assault women survivors of IPV. The SAFE clinic shared space with HCPs and administrative personnel aligned with the Reproductive Health and Sexually Transmitted Infections (STIs) clinics.

Background and Significance

IPV involves four subtypes of violence which include: sexual violence, physical violence, psychological aggression, and stalking (Breiding, Basile, Smith, Black, and Mahendra, 2015). Perpetrators of IPV may be former or current spouses, dating partners, girlfriends/boyfriends, and sexual partners (CDC, 2015). Crimes associated with IPV also include robbery, aggravated assault, and simple assault committed by a perpetrator who is the victim's current or former spouse, boyfriend, or girlfriend (Catalano, 2015). Women and men encounter IPV. In a 2010 summary report of The National Intimate Partner and Sexual Violence Survey (NISVS), more

than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States will be exposed to IPV during their lifetime (Black et al., 2011).

The prevalence of severe physical violence by an intimate partner impacts approximately 29 million women and 16 million men in the United States annually (Breiding et al., 2015). The National Crime Victimization Survey (NCVS, 2010) reveals females are at greatest risk for intimate partner violence between the ages of 18-34 years of age with risks declining in women 50 years of age or older.

Exposure to violence by an intimate partner can result in physical and psychological injuries leading to disabilities, chronic health problems and death. Furthermore, a history of child abuse can be a precursor to re-victimization by an intimate partner (Black et al.). Health related concerns include, but are not limited to depression, anxiety disorders such as post-traumatic stress syndrome(PTSD), substance use disorders, isolation, fear, embarrassment and shame (NISVS, 2010).

Advance practice nurses have an obligation to provide trauma-based nursing care for women exposed to intimate partner violence through coaching, mentoring and role modeling trauma-informed care principles (TICP) (Cleary and Hungerford, 2015) . Various ways for mental health nurses to embrace sexual-assault women survivors include implementing the TICP such as promoting safety, educating sexual assault women survivors about recovery principles, strengthening self-awareness of cultural diversity, instilling hope, and promoting empowerment by helping the sexual assault women survivors to identify specialized services and become their own advocate for health care (2015).

Review of the Literature

The literature emphasizes the importance of promoting recovery for women survivors of IPV. Allen, Larsen, Trotter, & Sullivan (2013) describe the meaning of strength-based and survivor-based interventions for women survivors of IPV. Although an advocate can make referrals or provide information, ultimately women survivors choose which interventions they need based on their priorities and what is important to them. In addition, advocates may rely on a sexual assault women survivor's instinct or capacity to support her own self-identified goals.

Ciancone, Wilson, Collette, & Gerson (2000) concluded that Sexual Assault Nurse Examiners (SANE) programs consistently offered follow-up care for women survivors, however the programs did not consistently document legal proceedings and outcomes. Although SANE programs were reportedly similar in relation to training, screening for sexually transmitted diseases (STD), pregnancy prophylaxis, staffing and documentation, the authors reported SANE programs showed inconsistencies during collection of information on STD cultures, Human Immunodeficiency Virus (HIV), as well as drug and alcohol screening. The authors reported limited SANE programs provided data regarding medical follow-up, adding that this information is vital for evaluating program effectiveness and performance (Ciancone et al., 2000).

Boykins and Mynatt (2007) findings revealed difficulty contacting sexual assault survivors after the forensic examination. Therefore, they recommend providing information about the importance of follow-up care to the woman survivor or someone accompanying her.

Coker, Smith, Whitaker, Le, Crawford and Flerx (2012) conducted a quasi-experimental study investigating efficacy of clinic-based advocacy of IPV and to increase help-seeking, reduce violence, and improve women's well-being. Of the 429 women who agreed to participate in the study, 76% (327) completed the first interview and 70.6 % (231) completed at least one follow-up interview. Coker et al. (2012) hypothesized having an in-clinic based advocate would increase

help seeking behaviors and reduce IPV over time. In addition, these researchers hypothesized that women in the advocate intervention clinics would have a decrease in depression, suicidal tendencies and medical care visits, and an improved self-perceived mental and physical health over time. Results revealed staffing clinics with a trained IPV advocate reduces violence and depressive symptoms, lending to the possibility of improving safety and women's well-being.

Hamberger, Ambuel, Guse, Phelan, Melzer-Lange, and Kistner (2014) supported interventions based on "Healthcare Can Change from Within" model across individual and system levels. Changes in clinical staff attitudes and knowledge as well as refining changes in the system's policies, procedures, and cultural practices in the environment may promote expansion of access to care. Hamberger et al. identified sustained changes in clinical staff who self-reported an increase in knowledge of regulatory and legal requirements and community resources for IPV victims. In addition, the authors credit the changes to: 1) intensive clinical staff training on legal and regulatory requirements and community resources, 2) placement of an expert within the clinic setting to answer staff questions, 3) engagement of clinic and emergency department clinical staff to develop and implement new policies and procedures related to IPV, thus increasing individual staff understanding, 4) collaboration with an IPV non-profit to raise awareness of community support, and 5) implementation of team work including the front desk, nursing, physician, and ancillary staff to minimize the possibility of individual practitioners bearing the burden alone.

Darnell, Peterson, Berliner, Stewart, Russo, Whiteside... Zatrack (2015) conducted a logistic regression study on a population 521 English speaking, non-prisoner, females (476) and males (45) ages 15 and older, with a mean age of 31. The study revealed the IPV survivors who identified linkages to social support, self-reported a mental health condition, and completed a

SANE examination were more likely to demonstrate follow-up attendance for medical and counseling services. In contrast, Darnell et al. (2015) reported poor follow-up attendance was often linked to whether the IPV survivor was homeless, sexually assaulted in public, did not receive services by a SANE, lived potentially chaotic lifestyles, and experienced greater psychosocial stress. Gaps in the evidence included: 1) missing documentation by the SANE, which included inconsistent service delivery linkages for post assault follow-up, 2) missing data evaluating whether victims attended follow-up one to two weeks after the emergency department visit, and 3) missing data on whether the victims had a current mental health illness, prior mental health condition, and prior trauma history.

DeGue et al. (2014) conducted 140 systematic studies examining the effectiveness of primary care interventions with IPV populations. The majority of the studies reviewed (108, 77.1%) lacked sufficient evidence to adequately evaluate the effectiveness of primary care interventions for preventing sexual violence. However, the study demonstrated three different programs that have shown positive outcomes while working with the sexual violence population: 1) Teen Dates, 2) funding for the 1994 United States Violence against Women Act, and 3) Shifting Boundaries. Therefore, DeGue et al. concluded there is justification to conduct ongoing rigorous research efforts to identify strategies and interventions linked to prevention of sexual violence.

Health Care Can Change from Within Model

The *Healthcare Can Change from Within* (HCCW) intervention model was used to guide this project. The goal of the model is to achieve sustainable system change at the provider level, the clinic system level, and the clinic culture level in intimate partner violence programs (Ambuel, Phelan, Hamberger, & Wolff, 2009).

The HCCW model seeks to: 1) change knowledge, attitudes, clinical skills, and clinical behavior of the provider; 2) enhance support for providers by changing clinical policies, procedures, workflows, as well as incorporate patient education; and 3) establish professional norms, values, roles, and expectations. These strategies result in creating self-sustaining improvement in the health system's ability to identify, intervene, and prevent IPV, thereby improving the health of women.

According to Ambuel et al. (2009) the HCCW model has four critical components that must be addressed to ensure system change that improves IPV screening and intervention in the clinic or ED setting. Ambuel et al. emphasized the importance of developing internal, on-site IPV expertise. Research has shown that quick access to an IPV advocate increases the likelihood of identification and referral for services. Selected clinic staff members should receive over 20 hours of training on: 1) definitions and dynamics of IPV, 2) healthcare prevalence statistics, 3) the health impact of IPV, 4) knowledge of and collaboration with local advocacy programs, 5) legal and ethical issues in working with IPV survivors, and 6) skills training for asking about and responding to reports of IPV from patients, including assessing danger; and helping to develop safety plans.

These specially trained in-clinic advocates play a key role in maintaining and advancing the clinic or system's initiatives to address IPV. The advocates take the lead in developing policies and procedures, provide or direct staff and provider in-service training, develop patient-education resources, and lead continuous quality-improvement projects (Ambuel et al., 2009).

The second component to the systems-change model is the development of clinic or unit-based policies and procedures, which are critical to a successful systems-based response to IPV. Policies and procedures provide concrete strategies which demonstrate the organization's

commitment to address the issue. However, because each setting is different in its orientation to patient care, policies and procedures should reflect such uniqueness (Ambuel et al., 2009).

The third component is collaboration with local advocacy agencies and IPV experts. Advocacy programs can be invited to support ongoing in-service efforts and can function as consultants to support the in-clinic advocates or the broader system initiative. A sustainable systems-level intervention also incorporates continuous quality-improvement strategies such as chart audits and/or aggregate feedback (Ambuel et al., 2009).

Primary prevention strategies are the underpinnings of the fourth component of Ambuel et al. HCCW model. Posted signage and pamphlets providing information on healthy relationships and conflict-resolution strategies should be provided to all patients, whether they are at risk patients or not. Due to individual differences in health literacy, patient engagement involves clinicians facilitating patients' understanding of the information in patient education resources (Ambuel et al., 2009, Veterans Health Education and Information, 2010).

As a result of the individual and organizational investment, work, and ongoing commitment required to achieve HCCW components 1 through 4, Ambuel et al. (2009) seek to influence an evolution of a new clinic culture. The development of new roles, norms, values and expectations influence sustaining system changes and improvement overtime. The HCCW model is a perfect fit to inform the practice changes for this project because of the IPV population -specific interventions and strategies that are addressed for mobilizing effective program evaluation, prevention strategies, and changes at the system level, cultural level and HCPs practice level.

Methods

Purpose and Design

The aim of this practice change project was to explore the following questions:

- 1) What is the effectiveness of the SAFE Clinic on women survivors of IPV?
- 2) What are the best practices for sexual assault follow-up examinations for women survivors of IPV in community based settings?

To answer the questions, a descriptive quantitative survey of health care providers was employed along with a chart audit and a review of the literature to inform best practice recommendations.

Participants and Recruitment

The participants were healthcare practitioners, all registered nurses and advance practice nurses, who were employed by the project site. The participants' median age was 53. The first part of the project involved a tool used as a knowledge assessment of the healthcare practitioners IPV background, knowledge, opinions and practice. The name of the tool used for this project was "Physicians Readiness to Manage Intimate Partner Violence Survey (PREMIS)".

The Investigational Review Board (IRB) from the project site and the student's University approved the project. Participants were recruited with posters and flyers to advertise the practice change project which detailed the risks and benefits, the participants' ability to voluntarily withdraw from the project, timelines for data collection, process for data collection and storage, and measures to protect participants' privacy and anonymity. All participants signed the informed consent. To minimize a risk of tampering and ensure confidentiality, a secured box was placed behind double locks accessible by keycard entry.

Data collection

PREMIS Instrument. Dr. Lynn Short and her colleagues are credited with promoting and expanding utilization of the PREMIS in over ten countries and translating the PREMIS into numerous languages such as Greek and Spanish. Although the PREMIS was originally developed for use with physicians, it has been tested with healthcare providers and other student populations. The tool has been psychometrically tested for validity and reliability. Reliability of

the PREMIS using the Cronbach's alpha ranged from 0.74-0.96 for different PREMIS scales. Another advantage of the PREMIS tool is the ability to identify training issues and other on-site interventions (Short, 2006). The PREMIS tool contains 67 individual and takes approximately 15 minutes to complete. Section 1 contains the respondent profile. The last four numbers of the social security number were omitted to protect privacy.

The author reviewed evidence-based literature for best practices to enhance follow-up care for women survivors of IPV, completed a randomly selected chart audit to identify the number of women who follow up after the initial assessment, and performed a knowledge assessment to determine the healthcare practitioners' IPV background, actual knowledge, opinions and practice issues. Data were collected from February 15, 2017 through April 18, 2017.

Section II measures the IPV Background which includes items that identify HCPs perceived preparation and perceived knowledge. Section III measures IPV Knowledge with eight multiple choice, and true/false, and don't know items. Section IV measures IPV Opinions containing 32 statements using a response scale from Strongly Disagree (1) to Strongly Agree (7). Section V identifies IPV Practice Issues using 13 items using a Likert-type, multiple choice, yes, no, unsure, not applicable, and I am not currently in a clinical practice response scales. Sample questions include: 1) Please circle the number which best describes how prepared you feel to perform the following: a) Help an IPV victim create a safety plan, and b) Make appropriate referrals for IPV, 2) How much do you now feel you know about: a) IPV? b) Child abuse? c) Elder abuse? 3) Which of the following are warning signs that a patient may have been abused by his/her partner? (Check all that apply) Chronic unexplained pain, Anxiety, Substance abuse, Frequent injuries, and Depression, and 4) Circle T for "true", F for "false", or DK if you

“don’t know” the answer to the following: a) Alcohol consumption is the greatest single predictor of the likelihood of IPV, and b) There are no good reasons for not leaving an abusive relationship.

Chart audits were identified as a crucial method for evaluating the documentation of expanded access to care for women survivors of IPV. The author aimed to randomly select 25 medical charts of women who sought sexual assault follow-up examinations and were between 18-49 years of age based on a 2016 report that 100 women survivors of IPV sought healthcare in 2015 at the project site. Six weeks after the data collection began, only one chart was available to audit due to the lack of appropriate referrals. Therefore, data gleaned from the sole chart audit was not included in the results for the practice change project.

Data Analysis and Results

Data were analyzed from six HCPs who completed the PREMIS knowledge assessment. Due to the small sample size, data were analyzed by adding the total number of each item or response option and calculating the percentages of the response options. Opportunities for practice changes or educational interventions were identified based on ranking and percentages of response options for the PREMIS items.

Demographics. Respondents were all female, bachelor or master prepared registered nurses, practicing in a Midwestern state. Their ages ranged from 34-59, with the median age of 53 years old. Respondents listed their primary field of practice as public health (83.3%). The average time in practice was 10.5 years, with missing data for two respondents. Graduation rates ranged from 1984-2015. No physicians practiced at the project site. Respondents reported anywhere from 3-33 nurses or nurse practitioners worked at the project site. The range of patients cared for in a week was less than 20 to greater than 60.

Practitioner Preparation and Background

The amount of healthcare practitioners' previous training about Intimate Partner Violence/Domestic Violence (IPV/DV) varied. Fifty percent of HCPs completed an estimated 12, 14 and 20 hours of IPV respectively. Healthcare practitioners responded they were well prepared to help an IPV victim assess his/her danger of lethality (50.0%). Fifty percent of HCPs responded they were either well prepared or fairly well prepared to ask appropriate questions about IPV respectively. However, one third of the HCPs felt they knew very little about how to document in a patient's chart.

The majority of HCPs responded they were well prepared or fairly well prepared to make appropriate IPV referrals (66.6%). Over one third of the HCPs responded having minimal preparation to make a safety assessment for the victim's children. Fifty percent of the HCPs responded they are well prepared or quite well prepared to help an IPV victim create a safety plan. One half of HCPs responded they knew the legal reporting requirements for IPV.

Practitioner IPV Knowledge

The majority of HCPs positively linked IPV risk factors to family history of abuse (66.6%). On the other hand, over one third of the HCPs linked IPV risk factors to being female. All HCPs responded that batterers have trouble controlling their anger. The majority (66.6%) of HCPs reported it is appropriate to ask "Has your partner ever hurt or threatened you?" Two thirds of HCPs reported chronic unexplained pain, anxiety, substance abuse, and depression were symptoms associated with the possibility an individual had been abused by his or her partner. All HCPs responded injuries in different stages of recovery may indicate abuse. Over 83.3% of HCPs responded false to the statement "Reasons for concern about IPV should not be included in a patient's chart if s/he does not want to disclose violence".

Reasons an IPV victim may not be able to leave a violent relationship were identified by the majority of HCPs (e.g. child beliefs, fear, love, financial dependence, religious beliefs and isolation). In addition, over one third of the HCPs responded there are no good reasons for not leaving an abusive relationship.

Practitioner IPV Opinions

Healthcare practitioners' opinions concerning interaction with IPV patients, patterns of substance use, and causes of victimization varied. For example, over 66.6 % of HCPs either disagreed or strongly disagreed that patients who abuse alcohol or other drugs are likely to have a history of IPV. Fifty percent of HCPs disagreed or strongly disagreed victims of abuse have a right to make their own decisions about whether hospital staff should intervene. Sixty six percent of HCPs disagreed with the statement "If a patient refuses to discuss the abuse, staff can only treat the patient's injuries".

Relative to staff opinions, 50.0% of HCPs reported they do not have the necessary skills to discuss abuse with an IPV victim who is from a different cultural/ethnic background. The majority of HCPs (83.3%) responded false to the statement "Reasons for concern about IPV should not be included in a patient's chart if s/he does not disclose violence". In addition, 66.6% of HCPs responded false to the statement "Victims of IPV are able to make appropriate choices about how to handle their situation".

The majority (66.6%) of HCPs either disagreed or strongly disagreed that alcohol abuse is a leading cause of IPV. Furthermore, half of the HCPs disagreed that victims of abuse often have valid reasons for remaining in the abusive relationship. Fifty percent of HCPs disagreed that they can match therapeutic interventions to an IPV patient's readiness to change. One HCP

agreed that women who choose to step out of traditional roles are a major cause of IPV. One HCP agreed with the statement “I can recognize victims of IPV by the way they behave”.

Practitioner IPV Practice Issues

Over sixty percent of the HCPs reported making one to five new diagnoses of IPV in the last 6 months prior to completing the PREMIS knowledge assessment, although 50.0% of the HCPs reported that they did not screen patients for IPV. One third of the HCPs reported screening all pregnant patients at specific times of their pregnancy. Only one HCP reported screening all patients with abuse indicators on history or exam. Although all HCPs reported being familiar with policies regarding screening and management of IPV victims, only 50.0% of the HCPs reported they used a protocol to some extent when dealing with adult IPV.

Fifty percent of the HCPs asked about the possibility of IPV when seeing patients with depression and/or anxiety. However, 50.0% of the HCPs reported eating disorders and irritable bowel syndrome were unrelated to IPV. In addition, over a third of the HCPs did not link headaches to IPV. When seeing patients with chronic pelvic pain, 33.3% of the HCPs responded asking about IPV was not appropriate.

When IPV was identified, the majority (66.6%) of HCPs reported providing information such as phone numbers, pamphlets, or other information to the patient. However, 50.0% of the HCPs responded IPV patient education or resource materials were available, but not well displayed. All HCPs reported having adequate knowledge of referral resources for patients in the community (including shelters or support groups), although 33.3% of HCPs responded they did not have adequate adult IPV referral resources for patients.

Discussion

Based on the results of this practice change project, numerous opportunities for educational interventions are indicated. For example, raising awareness about IPV risk factors and therapeutic communication techniques is indicated. Education about legal reporting requirements for child abuse may be beneficial because over a third of the HCPs reported not being as knowledgeable of legal reporting requirements for child abuse.

Additional findings suggested the HCPs may possess a traditional medical philosophy of healthcare versus the philosophy of patient-centered care where shared decision-making and partnerships are part of self-managing one's own healthcare. In addition, the HCPs philosophy of IPV may generate paternalistic feelings that place the HCPs in a position of becoming frustrated while trying to "fix" the situation (Veterans Health Education & Information, 2010). Therefore, education of the HCPs about the principles of trauma-informed care may promote the ability of the women survivors to self-manage their care and build a sense of well-being.

Activities related to cultural competency for healthcare practitioners who provide care for women survivors of IPV should be integrated into an annual education plan because the majority of the HCPs reported a lack of knowledge about how to respond to IPV victims from different cultural backgrounds. Additional areas identified for improvement in the quality of care for women survivors of IPV is related to an affirmative response that healthcare providers do not have time to assist patients with addressing IPV. Education in the use of interpersonal skills and sensitivity training would be a positive addition to a staff education program.

Results from the PREMIS Practice Issues revealed opportunities to improve healthcare practitioners' practices with nursing assessment, screening, patient education and safety planning for women survivors of IPV. Darnell et al. (2015) study revealed missing data relative to the Sexual Assault Nurse Examiner (SANE) forensic examinations. Consistencies in data

collection and documentation of this critical information in the patients' medical record can positively influence patient outcomes relative to medical care and legal proceedings. In addition, service delivery linkages such as referrals to mental health services are reported to positively impact follow-up care among sexual assault victims.

The expansion of community partnerships and establishment of a referral system with community partners may be an area for improving access to care for women survivors of IPV. Expansion of referral resources for the IPV patients at the project site may be a strategy for influencing the effectiveness of the SAFE clinic access to care. Building a stronger alliance with the HCPs from the Family Nurse Partnership Program may complement referral resources for the SAFE clinic.

Strengths and Limitations

Strengths included in this practice change project were: 1) interventions recommended in the HCCW model which are relevant to working with systems changes and intimate partner violence, therefore making the framework easily integrated with the aims and objectives of the project, 2) utilization of a reliable and valid instrument with reliability at alpha Cronbach ($\alpha = 0.74$), which is designed to determine healthcare practitioners IPV background, knowledge, opinions and practice issues, 3) an existing Memorandum of Understanding between a women's shelter for IPV victims and the project site, therefore providing an avenue for expanding access to care and building community partnerships, 4) placement of Advance Practice Nurse, certified in Family Practice within the SAFE clinic, and 5) opportunities to collaborate with community agencies through regular meetings with the county Sexual Assault Response Team (SART).

Limitations associated with the project included: 1) a lack of actual referrals of women survivors of IPV to the SAFE clinic for sexual assault follow-up examinations, 2) a small sample

size, 3) difficulty attracting women survivors of IPV for healthcare at the SAFE clinic through community outreach efforts, 5) fifty percent of sexual assault cases evaluated by the Sexual Assault Nurse Examiner(SANE)/Forensic Nurse Examiner(FNE) involve minors and as such, cases are referred to the local children's agency, 6) limited patient and staff IPV education resources for the SAFE clinic, 7) limited data showing documentation practices of healthcare practitioners who provide healthcare for women survivors of IPV in the SAFE clinic, 8) a lack of clarity involving response items with numerous rating scales for selection, and 9) difficulty with interpreting the differences between the responses in the rating scales used for the PREMIS which may impact the HCPs interpretations of questions and statements.

Recommendations and Implications for Future Practice

Based on the PREMIS IPV results and best findings from the literature, several recommendations are warranted. Healthcare practitioners' effectiveness in the referral process is based on their jurisdiction's legal requirements and warrants additional research. Use of a standardized IPV screening tool which complements the demographic population for the project site is recommended. Safety planning can mean the difference between life and death. Therefore, education about safety planning and a safety assessment with IPV victims and their children may improve the quality of care by emphasizing the importance of safety. Healthcare practitioners working with the IPV population should receive education on how to document injuries relative to IPV and sexual assault. Expansion of the referral resources for patients at the project site may be a strategy for improving the effectiveness of the SAFE clinic's ability to expand access to care for women survivors of IPV. In addition, collaboration with HCPs from the Family Nurse Partnership Program, a home visit program for first time mothers, may complement these referral resources.

Evidence from Darnell et al. (2015) suggested 1) ensuring available social support to help IPV survivors cope with the trauma of sexual assault, 2) explaining to survivors who opted not to have a forensic examination what possible delayed reactions may occur in response to the sexual assault, 3) informing survivors how follow-up care may facilitate coping with mental health, legal, and medical issues which may surface post assault, 4) providing continuity of care by ensuring the same provider who examined the survivor during the acute phase, is also the same provider for follow-up care, and 5) exploring the option of SANEs scheduling follow-up appointments due to the rapport established during the emergency department visit. Darnell et al. (2015) also revealed follow-up care was improved significantly when the IPV survivor had prior service linkages for mental health care. In addition, establishing and disseminating public health bulletins to enhance community awareness of the epidemic portions of IPV/DV is fundamental to expanding access to follow-up care.

Ciancone et al. (2000) recommended consistency in data collection of forensic evidence and medical follow-up as a means of measuring program effectiveness and appropriate outcome data. Education of the healthcare practitioners about IPV identification and treatment measures reduces barriers to accessing follow-up care.

Education of IPV survivors promotes self-confidence and self-esteem through economic and safety planning. In an effort to protect victims and mitigate actions from repeat offenders of IPV/DV, it is necessary to strengthen legislation. Promotion of positive relationships also builds trust, thus improving capacity building between community agencies and women survivors of IPV (Jack et. al., 2012; Nolan, et al., 2017).

Conclusion

An advantage of integrating trauma- informed care into practice may be linked to IPV risk reduction, evolution of higher standards of IPV preventative care, and expansion of access to care. Interprofessional collaboration and team work may strengthen global efforts to cultivate emotional support and positive relationships that empowers women survivors of IPV. In addition, the integration of IPV awareness education may build a stronger platform for identification of effective interventions while improving healthcare practitioners' IPV knowledge, opinions and practices (Cleary & Hungerford, 2015).

References

- AHRQ Health Care Innovations Exchange (2017). *Innovations and tools to improve quality and reduce health disparities*. Retrieved from <https://innovations.ahrq.gov/qualitytools/pdo-study-act-pdsa-cycle>
- Allen, N.E., Larsen, S., Trotter, J., & Sullivan, C.M. (2013). Exploring the core delivery service processes of an evidence-based community advocacy program for women with abusive partners. *Journal of Community Psychology*, 41, 1-18. doi:10.1002/jcop.21502
- American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. p. 1-29. Washington, DC: Author.
- Ambuel, B. L., Hamberger, L.K., Clare E. Guse, C.E., Melzer-Lange, M., Phelan, M.B., & Kistner, A. (2013). Healthcare can change from within: Sustained improvement in the healthcare response to Intimate Partner Violence. *Journal of Family Violence*, 28, 833-847. doi: 10.1007/s10896-013-9550-9
- Ambuel, B., Phelan, M. B., Hamberger, L. K., & Wolff, D. (2009). Healthcare can change from within: A sustainable model for intimate partner violence prevention and intervention. In V. Banyard, V. Edwards, & K. Kendall-Tackett (Eds.), *Trauma and physical health: Understanding the effects of extreme stress and psychological harm*, p. 202-237. New York, NY: Routledge.
- Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The national intimate partner and sexual violence survey (NISVS): 2010 summary report. *National Center for Injury Prevention and Control*,

- Centers for Disease Control and Prevention*. Atlanta: GA. Retrieved from www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf
- Boykins, A.D. & Mynatt, S. (2007). Assault history and follow-up contact of women survivors of recent sexual assault. *Issues in Mental Health Nursing*, 28, 867-881. doi: 10.1080/01612840701493394
- Breiding, M. J., Basile, K.C., Smith, S.G., Black, M.C., & Mahendra, R.R. (2015). Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 2.0. Atlanta, GA: *National Center for Injury Prevention and Control, Centers for Disease Control and Prevention*, 1-156.
- Breiding, M.J., Smith, S. G., Basile, K.C., Walters, M.L., Chen, J. & Merrick, M.T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization: National intimate partner and sexual violence survey, United States, 2011. *Mortality and Morbidity Weekly Report (MMWR, 9/5/14)*, 63, 1-18. Division of Violence Prevention, National Center for Injury Prevention and Control, CDC. Retrieved from www.cdc.gov/mmwr
- Catalano, S. (2012). Intimate partner violence: *Bureau of Justice Statistics, National Crime Victimization Survey, 1993–2010*. Washington, D.C.
- Chandrasekara, W. S. (2016). Help seeking attitudes and willingness to seek psychological help: Application of the theory of planned behavior. *International Journal of Management, Accounting and Economics*, 3, p.233-245.
- Ciancone, A.C., Wilson, C., Collette, R., Gerson, L.W. (2000). Sexual assault nurse examiner programs in the United States. *Annals of Emergency Medicine*, 35, p.353-357.

- Cleary, M., & Hungerford, C. (2015). Trauma-informed care and the research literature: How can the mental health nurse take the lead to support women who have survived sexual assault? *Issues in Mental Health Nursing*, 36, 370-378. doi: 10.3109/01612840.2015.1009661
- Coker, A.L., Smith, P.H., Whitaker, D.J., Le, B., Crawford, T.N., & Flerx, V.C. (2012). Effect of an in-clinic IPV advocate intervention to increase help seeking, reduce violence, and improve well-being. *Violence against Women*, 18, p.118-131. doi: 10.1177/1077801212437908
- Connor, P.D., Nouer, S.S., Mackey, S.T., Tipton, N.G., Lloyd, A.K. (2011). Psychometric properties of an intimate partner violence tool for health care students. *Journal of Interpersonal Violence*. 26, 1012-1035. doi: 10.1177/0886260510365872
- Darnell, D., Peterson, R., Berliner, L., Stewart, T., Russo, J., Whiteside, L., & Zatrack, D. (2015). Factors associated with follow-up attendance among rape victims seen in acute medical care. *Psychiatry*, 76, p.89-101. doi: 10.1080/00332747.2015.1015901
- DeGue, S., Valle, L. A., Holt, M. K., Massetti, G.M., Matjasko, J.L., Tharp, A.T. (2014). A systematic review of primary prevention strategies for sexual violence perpetration. *Aggression and Violent Behavior*, 19, p. 346-362.
- Eubanks Fleming, C.J., & Resick, P.A. (2016). Professional versus personal resource utilization in survivors of intimate partner violence. *Psychological Trauma: Theory, Research, Practice, and Policy*, 8, 319–324. American Psychological Association Retrieved from <http://dx.doi.org/10.1037/tra0000074>
- Hamberger, L.K., Ambuel, B., Guse, C.E., Phelan, M.B., Melzer-Lange, M. & Kistner, A. (2014). Effects of a systems change model to respond to patients experiencing partner

- violence in primary care medical settings. *Journal of Family Violence*, 29, 581–594. doi: 10.1007/s10896-014-9616-3
- Iverson, K. Wells, S., Wiltsey-Stirman, S., Vaughn, R., Gerber, M. (2013). VHA primary care providers' perspectives on screening female veterans for intimate partner violence: A preliminary assessment. *Journal of Family Violence*. 28, 823-831. doi: 10.1007/s10896
- Jack, S.M., Ford-Gilboe, M., Wathen, C.N., Davidov, D.M., McNaughton, D.B., Coben, J.H., Olds, D.L., & MacMillan, H.L. (2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research*, 12, 1-14. Hamilton ON: Canada.
- Journal of Clinical Nursing Author's Guidelines (2017). Retrieved from <http://onlinelibrary.wiley.com/journal/10.1111/> (ISSN) 1365-2702
- Messing, J.T., Mohr, R. & Durfee, A. (2012). Intimate partner violence and women's experiences of grief. *Child and Family Social Work*, 20, 30-39. doi: 10.1111/cfs.12051
- Nolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing Intimate Partner Violence across the Lifespan: A Technical Package of Programs, Policies, and Practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- Short, L. M., Alpert, E., Harris Jr., J.M., Surprenant, Z.J. (2006). A tool for measuring Physician readiness to manage intimate partner violence *American Journal of Preventive Medicine*, 30, p. 173-216. doi:10.1016/j.ampre.2005.10.009
- State of Illinois Attorney General Office & A Safe Place (September, 2015). *Domestic Violence Curriculum*. Symposium conducted at the meeting of A Safe Place of Waukegan, IL.

Veterans Health Education and Information. (2010). *Patient Education: TEACH for Success Manual*. Durham: NC