LOOKING BEYOND THE QUESTION 'DO YOU FEEL SAFE AT HOME?': WHAT HEALTHCARE PROVIDERS NEED TO KNOW TO IDENTIFY, SUPPORT, AND APPROPRIATELY REFER FEMALE VICTIMS OF INTIMATE PARTNER VIOLENCE

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DOCTOR OF NURSING PRACTICE

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ABSTRACT

The purpose of this practice improvement project was to educate healthcare providers about Intimate Partner Violence (IPV). The World Health Organization (WHO) (2014) created a clinical handbook for healthcare providers. This handbook has guidelines on how to address IPV in a healthcare setting (World Health Organization, 2014). WHO used the guidelines to create educational seminars for healthcare providers.

This practice improvement project uses Pender's Health Promotion Model as a theoretical framework. The practice improvement project also uses the Iowa Model as a guide for design and implementation. The author held five educational seminars to educate 42 healthcare providers on the WHO's clinical guidelines. The author also provided an informational booth at a primary care conference with information about the guidelines listed above. The author created and distributed resource pamphlets to both educational seminar and conference attendees.

The attendees of the educational seminars demonstrated knowledge acquisition as a result of the educational seminar. This was determined through pre and posttests that were administered before and after each of the educational seminars, respectively. Knowledgeable healthcare providers are able to identify, support and refer victims of IPV to the appropriate care that they need. Also, as a result of the educational seminars, there was a behavioral change from how healthcare providers were currently practicing to how they intend to practice in the future. This intent to change practice could result in more case findings and referrals for victims of IPV.

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DEDICATION

To: Cora Hazel Thomas

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CHAPTER 1. BACKGROUND AND SIGNIFICANCE

Intimate partner violence (IPV) is a widespread public health concern in the United States. The term intimate partner violence has largely replaced the use of the term Domestic Violence (DV), although both are found in the literature. Both terms describe violence that can be physical, emotional, sexual, or psychological. An intimate partner is someone who is a current or former partner or spouse (Centers for Disease Control and Prevention, 2014a). IPV is extensive and encompasses acts such as rape, stalking, sexual coercion, physical force, threats, humiliation, or preventing an individual from accessing money, family or friends (Centers for Disease Control and Prevention, 2014a).

The World Health Organization (WHO) includes not only physical abuse in the definition of IPV, but also psychological and sexual abuse (Taft et al., 2013). The Centers for Disease Control and Prevention (CDC) (2014a) includes the act of threatening physical or sexual violence in its definition. Therefore, the most complete definition of IPV is classified in four different categories: physical violence, sexual violence, threatening physical or sexual violence, and psychological and/or emotional violence (Centers for Disease Control and Prevention, 2014a). Each of these categories is defined below.

The definition of physical violence by the CDC (2014a) is the "intentional use of physical force with the potential for causing death, disability, injury or harm (p. 1)". Pushing, punching, biting, choking, scratching, and shaking are just some examples of physical violence (Centers for Disease Control and Prevention, 2014a). Sexual violence includes physically forcing someone into sexual contact against his/her will, abusive sexual contact, or attempting or completing a sexual act with someone who is unable or unwilling to consent (Centers for Disease Control and Prevention, 2014a). The CDC (2014a) also states that threatening physical or sexual violence

includes the use of "words, gestures, or violence to communicate the intent to cause death, disability, injury, or physical harm (p. 1)". Finally, psychological and/or emotional violence is recognized as a form of IPV. Psychological and/or emotional violence "involves trauma to the victim caused by the acts, threats of acts, or coercive tactics (p. 1)." Examples of psychological or emotional violence include, but are not limited to, controlling what the victim can or cannot do, keeping the victim away from her/his friends and family, and controlling the victim's financial means (Centers for Disease Control and Prevention, 2014a).

Epidemiology

It is estimated that there are approximately 42 million women in the United States alone that have experienced IPV in their lifetime (Chang, 2014). That is more than one in three women in the United States (Chang, 2014). Approximately 7 million have experienced some form of IPV over the last 12 months (Chang, 2014). More than one in four women reports being raped in their lifetime, and almost 50% of all women in the United States report having experienced some form of psychological violence by an intimate partner in their lifetime (Black et al., 2011). IPV not only affects women, but their children, the communities that the victims live in, as well as society as a whole (Taft et al., 2013).

Men are also victims of IPV. One in 71 men in the United States reports having been raped (Black et al., 2011). Men are more likely than women to be raped by a stranger, although almost 50% of male victims of rape are raped by an acquaintance (Black et al., 2011). Men are also at a higher risk than women for facing an offender with a weapon (Catalano, 2006). IPV is often thought as a concern for only females, but males, especially boys, are at a high risk for becoming victims of IPV. Male victims of IPV can have either male or female perpetrators (Moyer, 2013). Sexual violence is most often committed by a male, regardless of whether the

victim is male or female (Black et al., 2011). As women are more likely to be victims of IPV, this paper will focus on women, with the understanding that men can be victims of IPV as well.

Regardless of race or cultural group, women of childbearing age are at the greatest risk for IPV. Although IPV may not be routinely screened for in pregnant women, it may be more common than several of the other diseases or conditions that pregnant women are screened for such as gestational diabetes, neural tube defects, and preeclampsia (Centers for Disease Control and Prevention, 2012). The CDC suggests that IPV may be associated with unintended pregnancies, delayed prenatal care, as well as smoking and alcohol abuse (2012). In many ways, the pregnant population provides an opportunity for providers to screen for violence, because this is a time that many women who would not seek care otherwise do so for prenatal visits (Centers for Disease Control and Prevention, 2012). The American College of Obstetricians and Gynecologists (ACOG) notes that although women of all ages may suffer from IPV, it is most prevalent among women of reproductive age, and therefore ACOG feels is it important to identify these women to avoid serious issues, including pregnancy complications and unintended pregnancy (American College of Obstetricians and Gynecologists, 2012).

Although awareness of IPV is becoming much more prevalent, only slightly more than half of all victims report the IPV to police (Catalano, 2006). African-American women have the highest level of reporting to police, at 66.4% (Catalano, 2006). Several reasons were given as to why women do not report IPV to police including: fear of retaliation, to protect the abuser, and the belief that the police would not do anything (Catalano, 2006).

Unfortunately, for too long there has been a culture of silence surrounding IPV. The community as a whole may serve as bystanders to IPV, never really addressing the topic. If a topic is not discussed, but rather silently accepted, the door is left open for a perpetrator to act

violently (Waltermaurer, 2012). Social justification of a behavior, such as IPV, can occur as a result of a lack of knowledge about the subject of IPV, or as a result of pressure from society to act in a certain manner, such as not advocating for victims of IPV. Through more open discussion and education about IPV a lower social justification could occur, making the environment more favorable for victims of IPV to come forward. The lower the social justification, the higher the likelihood that someone will act when IPV is seen or discussed (Waltermaurer, 2012).

Social/Cultural Context

The amount of IPV that is reported in the United States varies according to the race of an individual. According to the National Intimate Partner and Sexual Violence Survey done in 2010, women who identified as multiracial reported the highest incidence of rape in their lifetime, with American Indian (AI) or Alaska Natives reporting the next highest incidence, White and Black non-Hispanic women the next, and Hispanic women the least (Black et al., 2011). Stalking was reported with the same frequencies as rape for each of the races listed above (Black et al., 2011).

Two special populations of interest for this clinical improvement project are women who identify as either AI or Somali. These two populations are of interest because of the density of individuals who identify as either AI or Somali that live in the service areas of the clinic locations for this clinical improvement project. Specific research has been done on IPV within the AI population as well as within immigrants to the United States from Africa.

AI women experience more IPV than almost all other women, the only exception being those women who identify as multiracial (Black et al., 2011). There are several different risk factors for IPV that are prevalent in the AI populations, for example, “low income, low

educational attainment, unemployment, younger age, non-married status, childhood abuse, and alcohol use" (Sapra, Jubinski, Tanaka, & Gershon, 2014, p. 8). Some scholars believe that there is historical trauma among the AI community caused by displacement from their land by the U.S. government, as well as the relocation of AI children to boarding schools, which has caused an increase in violence among the AI community (Sapra, Jubinski, Tanaka, & Gershon, 2014). These scholars believe that in order to cope with this historical trauma, AIs have turned to alcohol or other substances to handle their emotions (Sapra, Jubinski, Tanaka, & Gershon, 2014). Alcohol use is a factor in many instances of IPV however in the AI community alcohol use is an even greater factor when it comes to violence. Alcohol and drug use are considered to be the single most prevalent health issue in today's Native American communities (Kunitz & Levy, 2000). Therefore, the AI population is at an even greater risk for violence.

AI women experience levels of abuse that are unique to being native. The National Center on Domestic and Sexual Violence (n.d.) outlines the specific cycle of violence within the AI population in a diagram (Appendix A). In addition to the typical concerns of isolation, intimidation, economic abuse, etc., AI women may also worry about both cultural abuse and ritual abuse (National Center on Domestic and Sexual Violence, n.d.).

Within cultural abuse there are two specific concepts that are not of concern to non-AI women. Competitions as to a woman's "Indian-ness" or her "blood quantum" are specific ways that AI men may abuse their partners (Spruhan, 2006). "Blood quantum" is a manner in which tribal benefits and membership to some tribes were determined based on the amount of AI someone has in his/her blood (Spruhan, 2006). For example, if a woman had only ¼ blood quantum (i.e. one grandparent who was full AI), and her partner had ½ blood quantum (i.e. one parent who was full AI), the male may use that against the woman that he is with as a form of

cultural abuse (National Center on Domestic and Sexual Violence, n.d.; Spruhan, 2006). Having a higher blood quantum is used as a status symbol in some AI tribes.

Somali women are of special concern because of the large number who have immigrated to the region where this clinical improvement project took place. Some studies done on immigrant men found that the stress caused by immigration together with looking for employment and transitioning to a new life may put those men at an increased risk of perpetrating IPV (Yick, 2000). Studies done on African women regarding IPV suggest that many African women consider IPV to be a normal part of being married (Ogunsiji, Wilkes, Jackson, & Peters, 2011). Interestingly enough, these women did not consider either verbal abuse or financial abuse as violence (Ogunsiji et al., 2011).

Also, individuals who work with immigrant victims of IPV regularly find that unlike victims of IPV in the United States—where the goal to prevent further violence is to separate the perpetrator and the victim—separation is not generally the goal in immigrant families (Uehling, Bouroncle, Roeber, Tashima, & Crain, 2011). Immigrant women often feel that separation is not in the best interest of the family, and therefore are more adamant in looking for ways to keep their family together rather than ways to necessarily keep her safe. Although advocates for victims of IPV may not agree with this decision, it is up to the woman to decide what she wants to do.

The number of studies done specifically on Somali women is small, but they find that IPV is prevalent both in Somalia as well as in Somali immigrants. The major difference in the violence between the two populations is that the violence is more openly displayed in their home country versus in the United States (Sullivan, Senturia, Negash, Shiu-Thornton, & Giday, 2005). Findings from the study done by Nilsson, Brown, Russell, and Khamphakdy-Brown (2008) show

that Somali women who had a higher proficiency in speaking English were actually more likely to experience IPV. The author concluded that the partner may feel threatened by the woman's English-speaking abilities and therefore may feel like he is losing control and be more likely to perpetrate IPV (Nilsson, Brown, Russell, & Khamphakdy-Brown, 2008).

Cycle of Violence/Power and Control Wheel

In 1979, Dr. Lenore Walker wrote a book titled "The Battered Woman". In this text, Dr. Walker coined the phrase "The Cycle of Violence" (Walker, 1979). The cycle of violence has three phases. The first phase is called the *tension building phase* (Walker, 1979). During this phase the victim and perpetrator have tension over day-to-day concerns, and verbal abuse will begin (Walker, 1979). The victim may try to evade a violent episode by doing what she can to make the abuser happy. Eventually, the tension reaches a state where the abuser begins physically abusing the victim (Walker, 1979).

The phase where physical violence occurs is known as the *acute battering episode* (Walker, 1979). When and why the battering episode occurs is not known. Typically the behavior of the victim is not what triggers the battering episode to begin, rather, outside circumstances trigger the battering episode (Walker, 1979). After the episode has occurred, the third phase of the cycle of violence begins.

The third phase is known as the *honeymoon phase* (Walker, 1979). In the honeymoon phase the abuse is ashamed and sorry about his behavior. During this time, which may last for days to months at a time, the abuser will try to make up for any wrongdoing by being overly helpful. He will try to convince the victim that his abusive behavior will not happen again (Walker, 1979). However, over time, tension starts to build between the abuser and the victim and the cycle continues.

A grassroots group of battered women in Duluth, MN felt that the honeymoon phase of Walker's (1979) theory did not fit with their personal experience. From the experiences that these women had, the Power and Control Wheel (Appendix B) was created (Domestic Abuse Intervention Programs, 2011b). The Domestic Abuse Intervention Programs (DAIP) (2011a) originally created the Power and Control Wheel (Domestic Abuse Intervention Programs, 2011b) in 1984. The Power and Control Wheel shows that perpetrators use multiple different tactics to control their victims, and that abuse is not always cyclical. The different tactics of violence include intimidation, coercion and threats, emotional abuse, isolation, using children, using male privilege, using economic abuse, or minimizing, denying or blaming the victim (Domestic Abuse Intervention Programs, 2011b). The outer ring of the wheel exemplifies the physical and sexual violence that occurs, but the inner portion of the wheel focuses on the more subtle ways that a perpetrator will keep a victim in a violent relationship (Domestic Abuse Intervention Programs, 2011b).

There have been several different versions of the Power and Control Wheel developed to target more specifically different populations who are victims of IPV. For example, there are wheels for the LGBT community, sex trafficking, teenagers, dating relationships, immigrants, and many more. The Power and Control wheels provide a potent visual representation of the myriad of components that are involved in IPV.

Children Who Witness IPV

One in every 15 children was exposed to IPV between their parents or between a parent and his/her partner in the past year (Hamby, Finkelhor, Turner, & Ormrod, 2011). There are two primary concerns with children who witness IPV. The first is the toll that witnessing the abuse has on the child at that time. The second is how witnessing abuse affects the child in the future,

and whether or not they will continue the cycle of violence by either entering into an abusive relationship or becoming a perpetrator themselves (Hamby et al., 2011; Godbout, Dutton, Lussier, & Sabourin, 2009).

The U.S. Preventive Services Task Force finds that children who witness IPV are "at risk for developmental delay, school failure, psychiatric disorders, and violence against others" (Nelson, Nygren, McInerney & Klein, 2014, p. 387). Both boys and girls who witness IPV may meet the diagnostic criteria for posttraumatic stress disorder (PTSD) (Moretti, Obsuth, Odgers, & Reebye, 2006). Moretti et al. (2006) also found that girls were at a much higher risk for depression than boys. Boys who witnessed IPV expressed their anger outwardly, by being aggressive with others (Moretti et al., 2006).

Children who were from homes where the parents reported IPV performed worse in school than those children whose parents did not report IPV. On average, children from the homes with IPV scored 12% worse than their peers from homes without IPV (Wood & Sommers, 2011). Also, boys who witnessed IPV were more aggressive toward friends and girls who witnessed IPV were more aggressive toward their romantic partners (Wood & Sommers, 2011).

Boys who witness IPV as children are twice as likely to perpetrate violence on their own families as adults (National Coalition Against Domestic Violence, 2014). Girls who witnessed IPV as children are four to six times more likely to experience IPV in their relationships as adults (Wood & Sommers, 2011). Interestingly, recent research finds that there may be a dose-response relationship to IPV meaning that the more violence that is seen, or the more severe the violence is, the more likely that a child may repeat the cycle of violence in a future generation (Wood & Sommers, 2011).

Mothers who are victims of IPV express concern over the effects that IPV has on their children. Through structured interviews with mothers who are victims of IPV, Insetta et al. (2015) found that mothers are hesitant to bring up the topic of violence with their children because they are unsure of how to answer questions about the abuse. However, some mothers want to educate their children about IPV and the personal experiences that the mother has experienced so that the children will hopefully not enter into a violent relationship themselves (Insetta et al., 2015).

Many mothers who are victims of IPV report that they feel responsible for exposing their children to violence. Although these mothers are victims, they still feel responsible for not shielding their children from the violence (Insetta et al., 2015). Some studies show that as victims of IPV, women have altered perceptions of what a healthy relationship is, and those altered views may affect how they bond with their children (Levendosky, Lannert, & Yalch, 2012). Unfortunately, when there is a poor bond between a mother and child, there is an increased chance that children will become part of a violent relationship (Levendosky et al., 2012).

Impact of IPV on Healthcare

Women who are victims of IPV are at a much higher risk of morbidity and mortality (Usta, Antoun, Ambuel, & Khawaja, 2012). The number of women who are killed each year by an intimate partner is not well known. The CDC has developed a National Violent Death Reporting System (NVDRS) that has been implemented in 32 states so far (Centers for Disease Control and Prevention, 2014b). The purpose of the NVDRS is to gain a better understanding of how and why violent deaths are occurring in the United States. For the year 2012, there were 386 females who were killed by their spouse or intimate partner (Centers for Disease Control and

Prevention, 2014b). Those results are only from 19 states that were using the NVDRS in 2012, therefore the actual number of victims is likely much higher (Centers for Disease Control and Prevention, 2014b).

Victims of IPV more frequently report suffering from anxiety, low self-esteem, gastrointestinal issues, sexually transmitted diseases, chronic pain, pregnancy concerns and suicide attempts (Black et al., 2011). Other chronic health concerns may include pelvic inflammatory disease, migraine headaches, neurologic disorders, injury or death (Moyer, 2013). For mental health concerns alone, IPV accounts for more than 18.5 million healthcare visits per year (National Coalition against Domestic Violence, 2007).

There is a significant cost associated with IPV. Victims of IPV are more likely to have a poorer quality of life and use health care services more often (Campbell, 2002). A large study of over 3,000 women found that on average, annual healthcare costs for a woman who is currently a victim of IPV were 42% higher compared to a woman not experiencing IPV (Bonomi, Anderson, Rivara, & Thompson, 2009). The study shows that women who are physically abused have the highest healthcare costs, especially if the abuse was recent or is ongoing (Bonomi, Anderson, Rivara, & Thompson, 2009). Regardless of when the IPV occurred, this population of women had a 19% increase in healthcare costs for the remainder of their lives (Rivara et al., 2007). This equates to a 19.3 million dollar healthcare expense every year for excess costs due to IPV (Rivara et al., 2007).

Proportionally, more female victims of IPV seek healthcare than the general population of women seeking healthcare (Ramsay et al., 2012). One study in the UK found that when looking at a group of women living in the community versus those who were a clinical population, the women that presented to the clinic were up to four times as likely to have

experienced IPV (Feder et al., 2009). However, women may seek treatment for the healthcare concerns related to IPV for years without disclosing that they are a victim of IPV, and that is why it is important to educate healthcare providers on identifying symptoms of IPV (Dienemann, Campbell, Wiederhorn, Laughon, & Jordan, 2002). Whether the physical manifestations of the abuse are overt or not does not necessarily indicate the severity of abuse that a victim is experiencing. Therefore the first challenge is identifying whether an individual is a victim of IPV.

Significance of Proposed Project/Intervention

The World Health Organization (2013) suggests that for providers to fulfill the important role of identifying victims, they must be adequately trained. However, for the training to be effective it needs to not only increase the number of victims who are identified, but also provide training on how to support and appropriately refer victims of IPV (World Health Organization, 2013). This recommendation from the WHO arises from the knowledge that without knowing how to support or refer victims of IPV, some providers feel unprepared to treat victims of IPV.

This clinical improvement project takes the current evidence-based practice recommendations regarding IPV and relays that information to healthcare providers. The focus is on identifying victims of IPV even if they say that they feel safe at home by assessing their current symptoms and asking appropriate questions. Once providers identify victims, the focus shifts to tailoring support specifically to each victim, and referring the victim to the services that are appropriate for that individual. By educating healthcare providers on the current evidence-based practices, the ultimate goal is to identify and provide assistance to victims of IPV that are ready for additional support.

This intervention is significant primarily because of the populations that will be served as a result of this project. The author selected five clinics within Essentia Health for this intervention because of the needs identified in those counties: the Essentia Health and Essentia Health St. Mary's clinics in Moorhead, Park Rapids, and Detroit Lakes, MN; as well as two Essentia Health clinics in Fargo, ND that serve the residents of Clay, Hubbard, and Becker counties in MN, and Cass County in ND respectively. It is known that low socioeconomic status, alcohol abuse, and lack of secondary education can be risk factors for intimate partner violence (Abramsky et al., 2011).

Socioeconomic Status

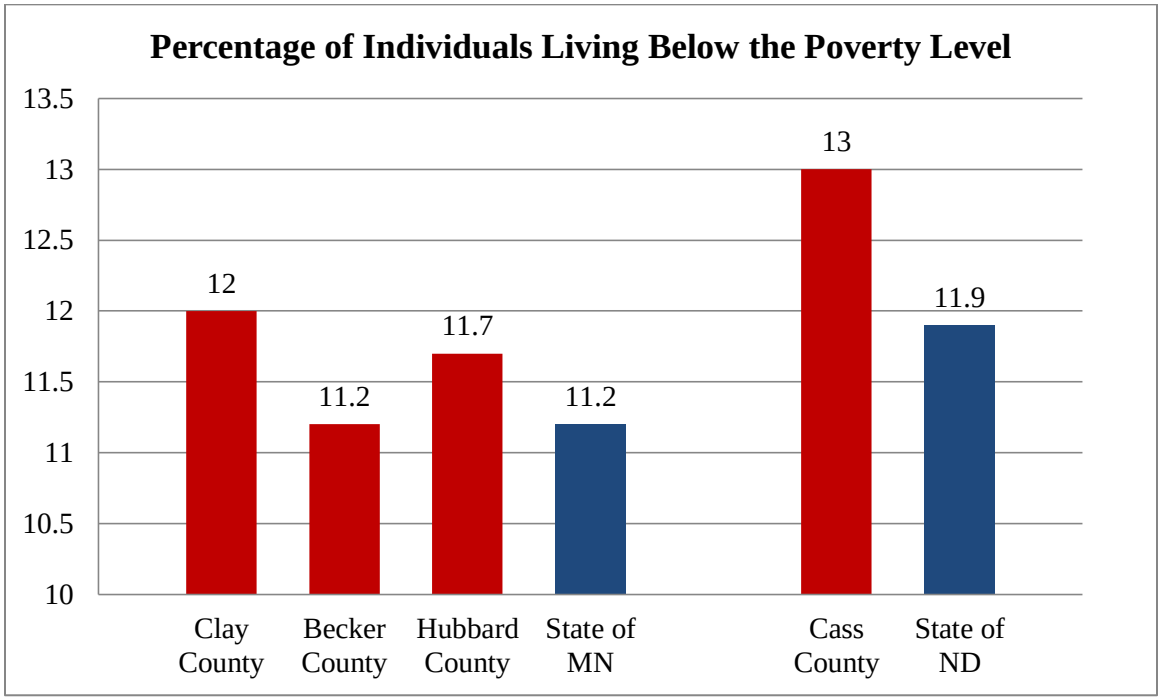


Figure 1: Socioeconomic Status

As you can see in the graph above, the selected counties of Becker, Hubbard, and Clay in MN and Cass County in ND are at or above the state percentage for persons in poverty.

Alcohol Abuse

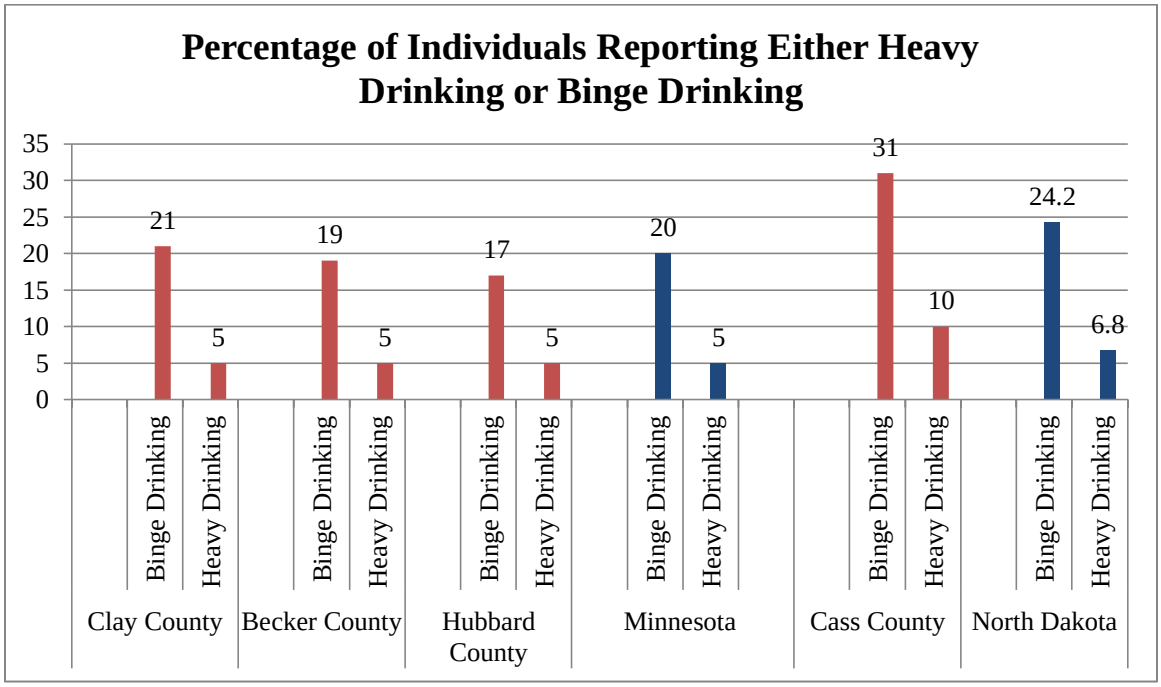


Figure 2: Alcohol Abuse

Twenty percent of Minnesotans report binge drinking, which is on the high side of the range of 17-20% that was reported for the selected counties (Minnesota Department of Human Services, 2009). Five percent of Minnesotans report heavy drinking, which is equal to what was reported in the selected counties as well (Minnesota Department of Human Services, 2009). For Cass County, ND, the percentage of individuals who either drink heavily or binge drink is higher than the rest of North Dakota (Institute for Health Metrics and Evaluation, 2015; Pickard, 2015). Of importance to note, Cass County contains a large university population.

Secondary Education

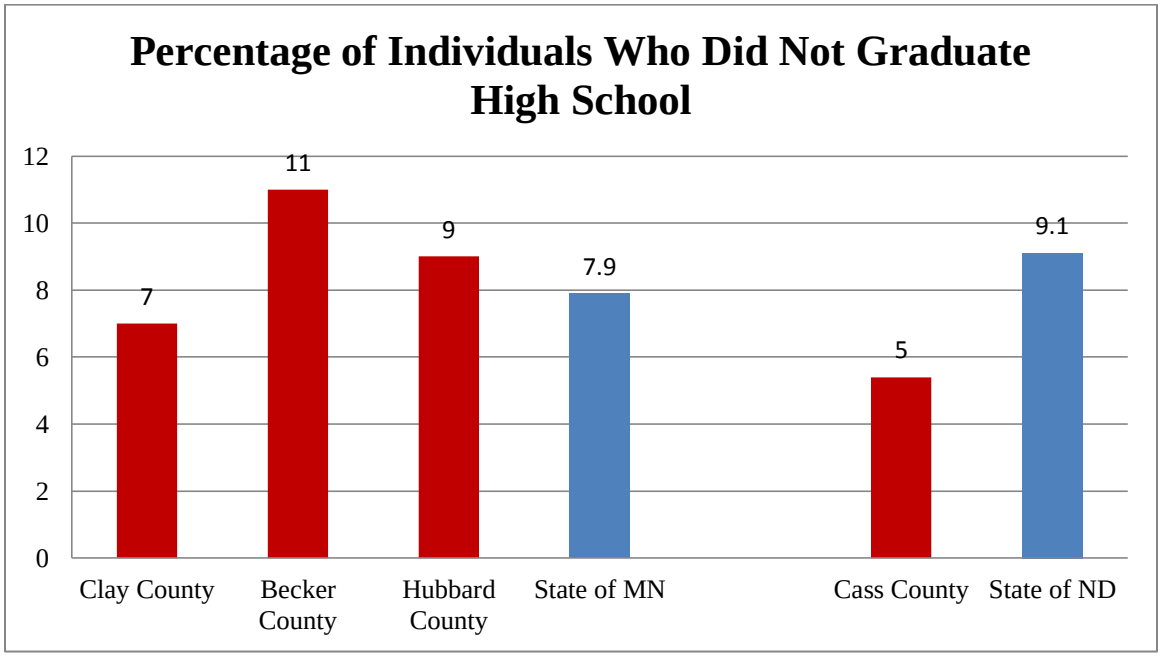


Figure 3: Secondary Education

The Minnesota state average of 7.9% of the population who did not graduate high school is relatively low within the 7-11% range of high school students who did not graduate within the selected counties (Stratis Health, 2012a; Stratis Health, 2012b; Stratis Health, 2012c; & U. S. Census Bureau, 2014). Cass County, ND is actually doing better than the remainder of the state of North Dakota on high school graduation rates (U. S. Census Bureau, 2015).

The results from the U.S. Census Bureau data for Clay, Hubbard, and Becker counties in MN, as well as Cass County in ND show that there is a substantial portion of the population in these counties that is at risk for IPV. Therefore, the author selected this population of individuals to study. The goal of educating healthcare providers on how to identify, support, and refer victims of IPV within Clay, Hubbard, and Becker counties in MN, and Cass County in ND was to connect the women who are suffering from IPV with resources that are available to help them within their communities.

The other facet of the clinical improvement project aims to increase awareness of IPV by providing clinical tools and resources to healthcare providers who attend the 2015 Spring Conference for Essentia Health. The author set up an informational booth to provide healthcare providers with information on the LIVES acronym (L for listen, I for inquire about needs and concerns, V for validate, E for enhance safety, and S for support), as well as algorithms for treatment that are outlined in the WHO Clinical Handbook for IPV (World Health Organization, 2014). Providing information on first-line support for victims of IPV to healthcare providers across the region allows for healthcare providers to have a point of reference when caring for victims of IPV.

CHAPTER 2. THEORETICAL FRAMEWORK

Health Promotion Model

There is one theoretical framework, and one model that best guides this clinical improvement project. The theoretical framework is the Health Promotion Model by Nola Pender. The Health Promotion Model is a model that was developed in an effort to provide a health care model that would complement the other models of health protection that were already being used in nursing (Pender, 2011). There are three primary components to the Health Promotion Model: individual characteristics and experiences, behavior specific cognitions and affect, and behavioral outcomes (Pender, 2011).

The first component, *individual characteristics and experiences*, includes any previous behaviors that are similar to the health behavior that a patient is presenting with at the present time (Pender, 2011). A healthcare provider who cares for a victim of IPV may have cared for other women in the past who have either disclosed violence or who have presented in a similar manner as his/her current patient is presenting. This component also includes all of the personal factors that make up that healthcare provider, such as their age, race, and socioeconomic status (Pender, 2011).

The second component of *behavior specific cognitions and affect* includes the perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, situational influences, commitment to a plan of action, and immediate competing demands and preferences (Pender, 2011). Examples of items in this component for healthcare providers include perceived benefits such as helping a woman to no longer have to live with violence. A perceived barrier for a healthcare provider may be not being able to help a woman help keep herself from a violent situation. Perceived self-efficacy is something that

healthcare providers need to have to address IPV. One physician stated "*We are in the ideal position to find out about it…It is easier because we have permission to ask questions without being criticized…That's the nature of our job. And we're in a very privileged position"* (Yeung, Chowdhury, Malpass, & Feder, 2012, p. 3).

Continuing within the second component of Pender's model, *behavior specific cognitions and affect*, activity-related affect could be something such as believing that by addressing IPV with a patient, as a healthcare provider you are making a difference in that individual's life. Interpersonal influences include support from colleagues, the organization you work for, family, and friends. Support from those entities will reinforce the importance of addressing IPV in primary care practice. Situational influences are complicated to assume on behalf of a healthcare provider. An example may be simply focusing on other health-promoting behaviors such as getting an annual mammogram and a flu shot, rather than focusing on the health-promoting behavior of addressing the violent relationship the patient is in. Commitment to a plan of action for a healthcare provider could mean screening every patient for IPV, or it could mean systematically addressing IPV every time a disclosure of violence is made.

Perhaps the biggest concern that healthcare providers have that relates to Pender's *behavior specific cognitions and affect* are those of immediate competing demands and preferences. The number one barrier that healthcare providers cite when explaining why they do not address IPV is lack of time (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). One nurse states that a barrier to asking about IPV is related to the time involved to care for that woman should she disclose IPV. The nurse states "*If you are going to ask, you have to have the time to listen to the response and deal with the issue"* (Beynon et al., 2012, p. 5). A study done on why physicians and nurses do not ask about IPV found that in addition to a lack of time, there

were eight other major barriers. These barriers included lack of training, a partner being present, lack of resources, lack of space or privacy, discomfort with the topic, lack of practitioner knowledge of resources, language/cultural practices, and behaviors attributed to women living with abuse (Beynon et al., 2012). Some of the behaviors that have been attributed to women living with abuse include women going back to their abuser after help was offered, women who defend their partner, or women who do not disclose violence although it is suspected (Beynon et al., 2012).

The final component of this model is that of a *behavioral outcome* (Pender, 2011). As a healthcare provider, the behavioral outcome that would be a health-promoting behavior would be addressing IPV with every patient that discloses violence. Another health-promoting behavior could be to offer a follow-up appointment to any patient where violence is not disclosed but there is concern for IPV (World Health Organization, 2014).

The Health Promotion Model as adapted for healthcare providers caring for victims of IPV can be seen in Figure 1. This model will be used to educate healthcare providers about IPV. Understanding how previous patient and personal experiences can shape an interaction with a victim of IPV is important. Also, taking into consideration all of the behavior specific cognitions and affect will allow a healthcare provider to see what the barriers and benefits could be to working with a victim of IPV. Finally, the goal of the Health Promotion Model as adapted for healthcare providers caring for victims of IPV is that healthcare providers can get to the point where they systematically address every disclosure of violence that occurs. The process of how to do this will be explained in depth in the literature review.

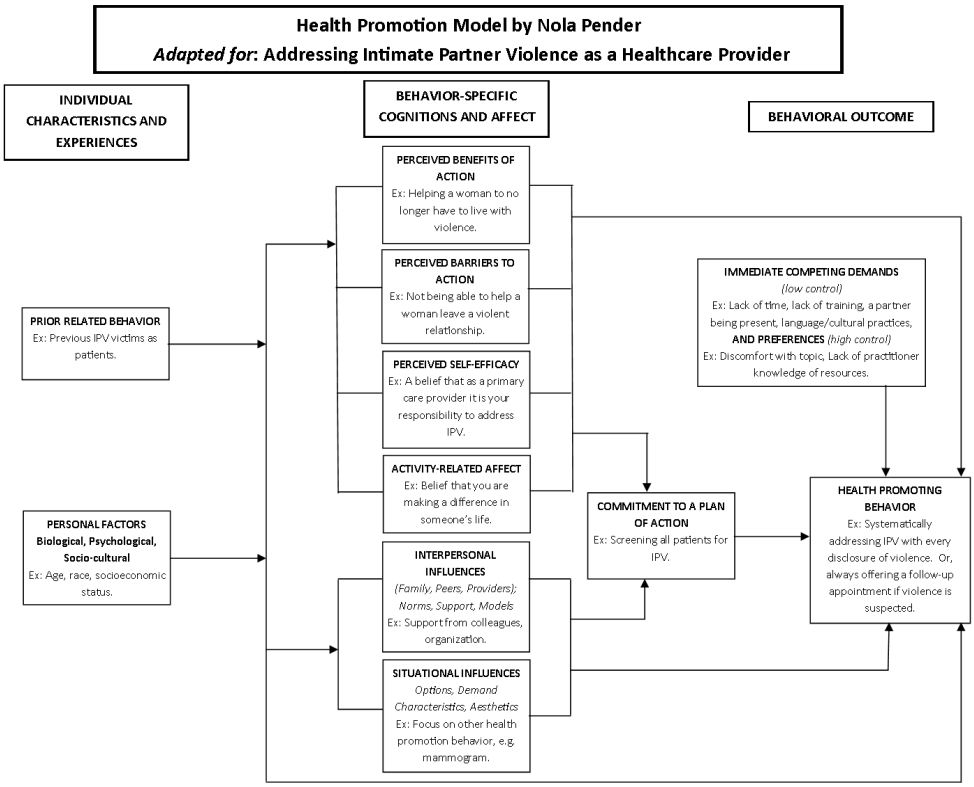


Figure 4: Health Promotion Model: Adapted for Addressing IPV as a Healthcare Provider

Iowa Model

The model that helps guide this clinical improvement project is the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001). The Iowa Model is a systematic model that helps facilitate the development and implementation of an evidence-based educational seminar on Intimate Partner Violence for healthcare providers in five primary care clinics within Essentia Health, as well as an educational booth on IPV at the Essentia Health Spring Conference, 2015. The model includes several feedback loops, reflecting analysis, evaluation, and modification which is based on the evaluative data of both process and outcome

indicators. Each category has individual steps, and by addressing each feedback loop, key elements of project development and implementation will not be missed (Appendix C). To recap, the purpose of this clinical improvement project is to educate healthcare providers on the 2014 World Health Organization guidelines for treating victims of IPV.

1. **Problem-focused triggers:** Both the educational seminar and the educational booth on IPV were prompted from problem-focused and knowledge-focused triggers.
    a. Identification of a clinical problem, IPV, by healthcare providers and by a Doctor of Nursing Practice student.
2. **Knowledge-focused triggers:**
    a. New clinical guidelines by the World Health Organization for caring for women who have been subjected to violence.
3. **Topic priority for organization:** Essentia Health desired to have educational seminars about IPV at five of their primary care clinics as well as a booth at the Spring Conference for two reasons:
    a. To provide healthcare providers with the most up-to-date evidence-based practice guidelines regarding caring for victims of IPV.
    b. To know that the facility is providing the highest quality of care to patients who are victims of IPV. Both of these goals are congruent with the overarching patient care goals of Essentia Health.
4. **Form a team:** The team included one Doctor of Nursing Practice (DNP) student from North Dakota State University (NDSU), the director of the Essentia Institute of Rural Health, the Chief of Primary Care for the West Region of Essentia Health, the CME Education Specialist within Essentia, as well as a physician or APRN lead at each of the

selected primary care clinics in Moorhead, Park Rapids, and Detroit Lakes, MN as well as Fargo, ND. The team and individual roles were:

Table 1:

Team for Iowa Model

Name	Affiliation	Contact Information	Role
Anna Thomas, RN, BSN	Doctor of Nursing Practice Student at North Dakota State University	anna.r.thomas@ndsu.edu	Project coordinator and educational seminar educator
Katherine Dean, MBA	Essentia Institute of Rural Health; Director	kdean@eirh.org	Approval for the project within Essentia Health
Richard Vetter, MD	Essentia Health, Chief of Primary Care, West Region	richard.vetter@essentiahealth.org	Approval for the project within the primary care clinics
Andrea Carlson	Essentia Health, CME Education Specialist, Brainerd, MN	andrea.carlson.2@essentiahealth.org	Facilitation of CME Credit, Spring Conference Booth, and the project within the two Fargo clinics
Lara Lunde, MD	Essentia Health Moorhead Clinic	lara.lunde@essentiahealth.org	Facilitation of the project within the Moorhead Clinic
Penni Weston, FNP	Essentia Health Fargo South University Clinic	penni.weston@essentiahealth.org	Facilitation of the project within the Fargo Clinics
Charlotte Rollie, CNM, CNP	Essentia Health Park Rapids Clinic	charlotte.rollie@essentiahealth.org	Facilitation of the project within the Park Rapids Clinic
Hope Mathern, DNP	Essentia Health St. Mary's Detroit Lakes Clinic	hope.mathern@essentiahealth.org	Facilitation of the project within the Detroit Lakes Clinic

5. **Assess relevant research:** The author completed a literature review and synthesis with the results indicating that there is a sufficient base of information to continue on to the step of piloting change in practice.
6. **Pilot change in practice:** Objectives were selected:

    Practice Improvement Project Objective: 1. Instruct clinicians about the LIVES acronym, as well as teach clinical algorithms to attendees of the 2015 Spring Conference for Essentia Health on April 24th, 2015.

    Practice Improvement Project Objective: 2. Equip healthcare providers to appropriately address and refer victims of intimate partner violence.

    Practice Improvement Project Objective: 3. Motivate healthcare providers to address intimate partner violence through evidence-based approaches.

    The author collected feedback from the initial discussions with key informants. The author utilized evidence-based guidelines from the World Health Organization's clinical handbook on healthcare for women subjected to IPV (2014). The evidence-based educational seminar served as a pilot for disseminating the most up-to-date information on IPV. Based on the initial pilot and survey feedback, the author provides suggestions in Chapter 6 for future educational seminars on the topic of IPV. As the World Health Organization comes out with updated practice guidelines, the resources created for the educational seminar can be updated and modified for use in new provider education.
7. **Monitor and analyze structure, process, and outcome data:** A pre-test and a post-test were completed before and after each educational seminar. The data was collected and evaluated to analyze the healthcare providers' knowledge development, confidence levels

on addressing IPV, and practice implications, both before and after the educational seminars. The author sought feedback regarding the educational seminar and areas for improvement in the future. The results from the feedback as well as the pre-tests and post-tests are discussed in the results chapter of this dissertation.

CHAPTER 3. LITERATURE REVIEW

Screening for IPV

Over the years the recommendations on whether to screen for IPV have changed although the sentiment behind the need to identify and treat victims of IPV has not changed. The prevalence of IPV is significant, and the consequences for the victims are severe. Educating healthcare providers on how best to identify, support, and refer victims of IPV is one way to help victims of IPV feel heard and supported.

With all of the known adverse outcomes for victims of IPV, it may seem as though universal screening is something that would be widely endorsed. In actuality, universal screening for IPV is something that is hotly debated. The current recommendation from the United States Preventive Services Task Force is to screen all women of childbearing age for IPV (Institute of Medicine, 2011). This is a grade B recommendation, which means that the net benefit is moderate (Moyer, 2013). The justification in favor of screening are that the number of individuals who are affected by IPV are high, and that women who are victims of IPV are generally in favor of screening (MacMillan et al., 2009). Also, screening techniques are feasible and they would offer the opportunity for healthcare providers to have the conversation with patients about IPV (MacMillan et al., 2009).

However, results from a review done by the Cochrane Collaboration found that there was insufficient evidence to suggest universal screening for IPV (Taft et al., 2013). The justification for not screening all women is that there has not been a long-term benefit shown to those women who are screened (Taft et al., 2013). As with all universal screenings, the benefits must outweigh the costs.

The World Health Organization (2014) also does not recommend universal screening for IPV. Rather, the WHO suggests that healthcare providers talk to women about IPV if they have injuries or conditions that may be related to violence (World Health Organization, 2014). As the recommendations regarding screening may change over time, it is important to teach healthcare providers different manners in which to identify victims of IPV. Also, not all women who are victims of IPV will report that they are victims on a screening tool, which further justifies the need for healthcare providers to be able to assess for signs and symptoms of IPV in lieu of a positive report.

Current Practices for Identifying IPV/Barriers to Addressing IPV

Currently there are several different screening instruments that healthcare providers use to identify IPV, and there is not one single definitive instrument. Examples of these scales include the Hurt, Insult, Threaten, Scream (HITS) instrument, the Partner Violence Screen (PVS), the Humiliation, Afraid, Rape, Kick (HARK), the Woman Abuse Screening Tool (WAST), and the Abuse Assessment Scale (AAS) to name a few (U.S. Department of Health and Human Services, 2012). Although one tool has not been identified as superior, there may be one screening tool that works better in a specific setting than another. For example, the HITS tool has been found to have higher specificity and sensitivity than the WAST in family practice clinics (U.S. Department of Health and Human Services, 2012).

Wathen and MacMillan (2012) suggest that a case-finding approach may be more beneficial to identifying victims of IPV than a traditional screening tool. The case-finding approach is one that allows for providers to examine a patient's presenting clinical signs and symptoms, and then ask appropriate questions regarding IPV if necessary (Wathen & MacMillan, 2012). Similar to case-finding is simply asking open-ended questions. Using open-

ended questions makes victims of IPV feel more supported and less isolated than closed-ended questions (Chang, 2014).

There are many different reasons that a provider may not address IPV. A study done by Gutmanis, Beynon, Tutty, Wathen, and MacMillan (2007) identifies several different barriers that a healthcare provider may have to not addressing IPV. Some of the barriers include; preparedness, self-confidence, practitioner lack of control, comfort following disclosure, professional supports, practice pressures, and practitioner consequences of asking (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007).

Desires of Victims of IPV

Victims of IPV want healthcare providers who listen, are concerned, compassionate, and non-judgmental (Feder, Hutson, Ramsay, & Taket, 2006). A study done by Richardson et al. (2002), found that approximately 42% of women said that they would find it easier to discuss issues of IPV with a female provider than a male provider. However, another study found that having the same healthcare provider at each visit made victims of IPV feel more comfortable disclosing the violence (Chang, 2014). Victims of IPV also want healthcare providers who are aware of services and referrals for victims (Feder, Hutson, Ramsay, & Taket, 2006).

Victims of IPV do not want to feel like they are being blamed, or like the healthcare provider is making excuses on behalf of the abuser (Chang, 2014). One study found that women who had been victims of IPV preferred that their healthcare provider address the IPV as a part of their medical history so that they did not feel like they were being interrogated (Chang, 2014). Victims also desire more community interventions, including media campaigns, to get information about IPV out into the community (Usta, Antoun, Ambuel & Khawaja, 2012).

How to Address IPV in Primary Care

The World Health Organization (2014) put together a clinical handbook that is meant to guide healthcare providers on how to work with victims of IPV. The acronym LIVES reminds healthcare providers what they need to do to offer first-line support to victims of IPV (World Health Organization, 2014). The acronym is L for *listen*, I for *inquire about needs and concerns*, V for *validate*, E for *enhance safety*, and S for *support* (World Health Organization, 2014).

Listening includes being compassionate, not judgmental. Listening also includes having empathy for the victim and being concerned. Inquiring about needs and concerns can include things such as asking about the safety of children, the victim's mental health, and/or asking about how she is feeling physically. Validation is one of the most important facets of working with victims of IPV. Ensuring that these individuals know that a healthcare provider believes what they are saying is crucial to establishing a positive rapport. Enhancing safety can include determining a plan for her and perhaps her children that will help keep her from experiencing more violence. Finally, supporting the victim of IPV can include connecting her to services in the community that can help her, such as a women's shelter or a mental health professional (World Health Organization, 2014).

This acronym is designed specifically as a model for first-line support. The LIVES acronym is important to remember with any instance where IPV is disclosed. It may be the only opportunity to intervene, and therefore this acronym can help to remind healthcare providers what they can do to help. Once the healthcare provider gives first-line support, the next step is to care for the conditions that brought her to seek care. From there it may be appropriate to refer to other healthcare providers and other individuals in the community who can help her (World Health Organization, 2014).

There are certain things that are not the responsibility of the healthcare provider. For example, the healthcare provider is not responsible for convincing a woman to leave her relationship, or making her report her abuse to authorities. The healthcare provider is not responsible for asking for detailed information of any of the violence that she experienced. Suggesting that she do any of these things may not only not help the victim, they may actually cause more pain (World Health Organization, 2014).

When IPV is disclosed, of upmost importance is to make sure that the conversation between the healthcare provider and the victim is private. That includes making sure that children who would be old enough to know what is being discussed are not present for the conversation either. Encourage the victim to talk, but do not pressure the conversation. Allowing time for silence and reflection is important. Also, let the victim know that all conversations between healthcare providers and victims will remain private, unless there is a situation where the healthcare provider is required to report the violence, in which case the healthcare provider will tell the victim that the report will be made (World Health Organization, 2014).

In the states of Minnesota and North Dakota there are mandatory reporting laws for violence against children and vulnerable adults (Appendix D). All healthcare providers are mandatory reporters. If there is known or suspected physical abuse, sexual abuse, or neglect to a child, a report must immediately be made to a local law enforcement agency or social services (North Dakota Department of Human Services, 2010a; Office of the Revisor of Statutes, 2014a). Children who view abuse are also reportable (North Dakota Department of Human Services, 2010a; Office of the Revisor of Statutes, 2014a). Vulnerable adults include residents or inpatients of a facility, an individual who receives home care, an individual who receives services at a facility for adults, or an individual who possesses a physical or mental disability that

causes that individual to not be able to care for themselves (North Dakota Department of Human Services, 2010b; Officer of the Revisor of Statutes, 2014b). If there is known or suspected maltreatment of individuals who qualify as vulnerable adults, a report must be made immediately to either law enforcement or social services (North Dakota Department of Human Services, 2010b; Officer of the Revisor of Statutes, 2014b).

CHAPTER 4. DESIGN AND IMPLEMENTATION

Project Site

Essentia Health is an integrated health care system with locations in North Dakota, Minnesota, Idaho and Wisconsin (Essentia Health, 2014a). Essentia Health currently has "17 hospitals, 66 clinics, 5 ambulance services, eight long-term care facilities, two assisted living facilities, four independent living facilities and one research institute" (Essentia Health, 2014a, p. 1). The mission of Essentia Health is: "We are called to make a healthy difference in people's lives" (Essentia Health, 2014a, p. 1). A project designed to educate providers on how to care for victims of IPV fits within Essentia Health's overall mission.

Congruence with Essentia Health's Goals

Essentia Health has a policy that outlines specifically what the goals of the organization are in regard to patient care (2014b). One of the goals states, "We strive to promote health and wellness in an effort to improve the human condition in our community. In our inpatient and outpatient care departments and clinics, we focus on providing safe and effective evidence-based patient care, effective patient and family education, and optimal patient care outcomes" (Essentia Health, 2014b, p. 2). Essentia Health's goal is closely aligned with this clinical improvement project, because by providing the 2014 WHO guidelines for treating victims of IPV to healthcare providers, it allows healthcare providers to practice with current evidence-based practice.

Another goal within the policy regarding patient care is to make sure that healthcare providers are educated (Essentia Health, 2014b). Educating healthcare providers on the latest evidence regarding caring for victims of IPV is a way to ensure that this goal is met. Clinical practice changes at a fast pace, which makes an educational seminar on evidence-based practice regarding care for victims of IPV a relatively simple way to make sure that these healthcare

providers are provided with the latest evidence. Similarly, for those healthcare providers who are unable to attend an educational seminar, but are able to gather resources at the Spring Conference, they will be able to reference those tools within their practice.

Project Design

Guided conversations with four primary care providers within Essentia Health, including one internal medicine physician, one family practice physician, one family practice/pediatrician and one family nurse practitioner took place in the fall of 2014. The selected healthcare providers identified a need for additional information and resources regarding how to identify, support, and refer victims of IPV within the community. Also, through personal experience and 360 clinical hours as a DNP student at a rural primary care clinic, an educational need was identified in regard to providing resources on how to identify, support, and refer victims of IPV from a healthcare provider perspective. Finally, communication with a member of the Essentia Health Institute of Rural Health indicated that during a recent disclosure training, a need for more education on IPV was identified as well.

The healthcare providers that provided their insight said that they would specifically like more information on how to identify victims if they don't have an affirmative answer on the screening question "Do you feel safe at home?". Healthcare providers would also like a pamphlet of resources that they could keep with them for their reference. Healthcare providers also indicated that knowing who to refer victims of IPV to is a challenge, and so more information in that area would be beneficial.

Project Objectives

Practice Improvement Project Objective: 1. Instruct clinicians about the LIVES acronym, as well as teach clinical algorithms to attendees of the 2015 Spring Conference for Essentia Health on April 24th, 2015.

Practice Improvement Project Objective: 2. Equip healthcare providers to appropriately address and refer victims of intimate partner violence.

Practice Improvement Project Objective: 3. Motivate healthcare providers to address intimate partner violence through evidence-based approaches.

Evidence-Based Intervention

A pre-test and post-test was completed at each of the five primary care clinics during each educational seminar. A pre-test was administered to all healthcare providers regarding their knowledge on the topic of IPV, their confidence to identify, support, and refer victims of IPV, and their current practices with victims of IPV (Appendix E). The pre-test was administered immediately prior to each educational seminar. The baseline information gathered from the pre-test was used for comparison with the post-test results. Collected surveys were compiled and the data was analyzed using statistics as recommended with consultation of the Statistical Counseling Center at North Dakota State University (NDSU).

Next, information regarding how to identify, provide first-line support, and take appropriate next steps for victims of IPV, were integrated into both a PowerPoint presentation and a resource pamphlet (Appendix F) based on the current evidence-based practice findings from the World Health Organization's (2014) *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Both the PowerPoint presentation and resource pamphlet were presented by this Doctor of Nursing Practice student from North Dakota

State University during a one hour lunch educational seminar. Additional information regarding specific resources in each of the local areas where the educational seminars was provided were added to the PowerPoint presentation and pamphlet as well (Appendices G, H, I). Due to the mandatory reporting laws surrounding abuse, information regarding the laws specific to Minnesota and North Dakota were also provided. Appendix D contains a handout from the Rape and Abuse Crisis Center (2009) that has a brief synopsis of the mandated reporting laws for both Minnesota and North Dakota. This handout was provided to all of the attendees of the educational seminar. Once the content was determined, the pamphlet was created through the NDSU Graphic Services and Copy Shop.

Finally, a post-test was distributed to all healthcare providers who attend the educational seminar (Appendix J). The post-test asked the same knowledge questions as the pre-test to gauge whether or not there was an increase in knowledge. The post-test also assessed whether or not a provider intended to change how they care for victims of IPV based on the information provided during the educational seminar. Finally, the post-test assessed whether or not the participant had an increased confidence in his/her ability to identify, support, and refer victims of IPV following the educational seminar. The post-test also asked for feedback on what participants liked and didn't like about the educational seminar. Collected post-tests were compiled and the data was analyzed using statistics as recommended with consultation of the Statistical Counseling Center at North Dakota State University.

In order to make sure that the educational seminar presentation met the rigorous criteria required for knowledge acquisition and practice improvement, CME credit was sought and received. CME credit through Essentia Health allows for both Nurse Practitioners and Physicians to obtain continuing education credits that are required for license renewal. Approval for CME

credit at Essentia Health went through an internal CME committee. The educational seminar was approved, and provided 1.00 AMA PRA Category 1 Credits to all educational seminar attendees.

The second component of the project was to provide an informational booth on the topic of IPV at the Essentia Health Spring Conference, 2015. The topic of the conference was *Safety, Value and Quality in Primary Care*, therefore educating providers on IPV fit well within the educational goal of the conference. The informational booth provided resources that are designed to educate providers on first-line support for victims of IPV. The booth also allowed for healthcare providers to receive suggestions of resources in the area that would be appropriate referrals for victims of IPV.

Prior to project initiation, training through the Collaborative Institutional Training Initiative (CITI) was completed (Appendix K). Also, internal review board (IRB) approval from North Dakota State University (NDSU) was obtained (Appendix L). Essentia Health accepts reciprocity for NDSU IRB approval, and does not require duplication of IRB. This clinical improvement project was considered exempt by the NDSU IRB. In addition, permission from the Essentia Institute for Rural Health to complete this clinical improvement project was obtained (Appendix M). Finally, permission from the World Health Organization (Appendix N) for the use of their clinical tools, the creator of the Iowa Model (Appendix O), and the author of the Power and Control Wheel (Appendix P) was obtained.

After all of the educational seminars were completed, the data from the pre and post-tests was entered into an Excel spreadsheet. Statistical analysis was completed on the information with the help of the Statistical Counseling Center at NDSU. Paired t-tests and McNemar's tests were done to generate p-values for each of the questions that were asked on the pre and post-tests. Descriptive statistics were obtained to aid in the evaluation of the project objectives.

Evaluation Plan

The Logic Model was used as an evaluation model for the practice improvement project (W. K. Kellogg Foundation, 2004).

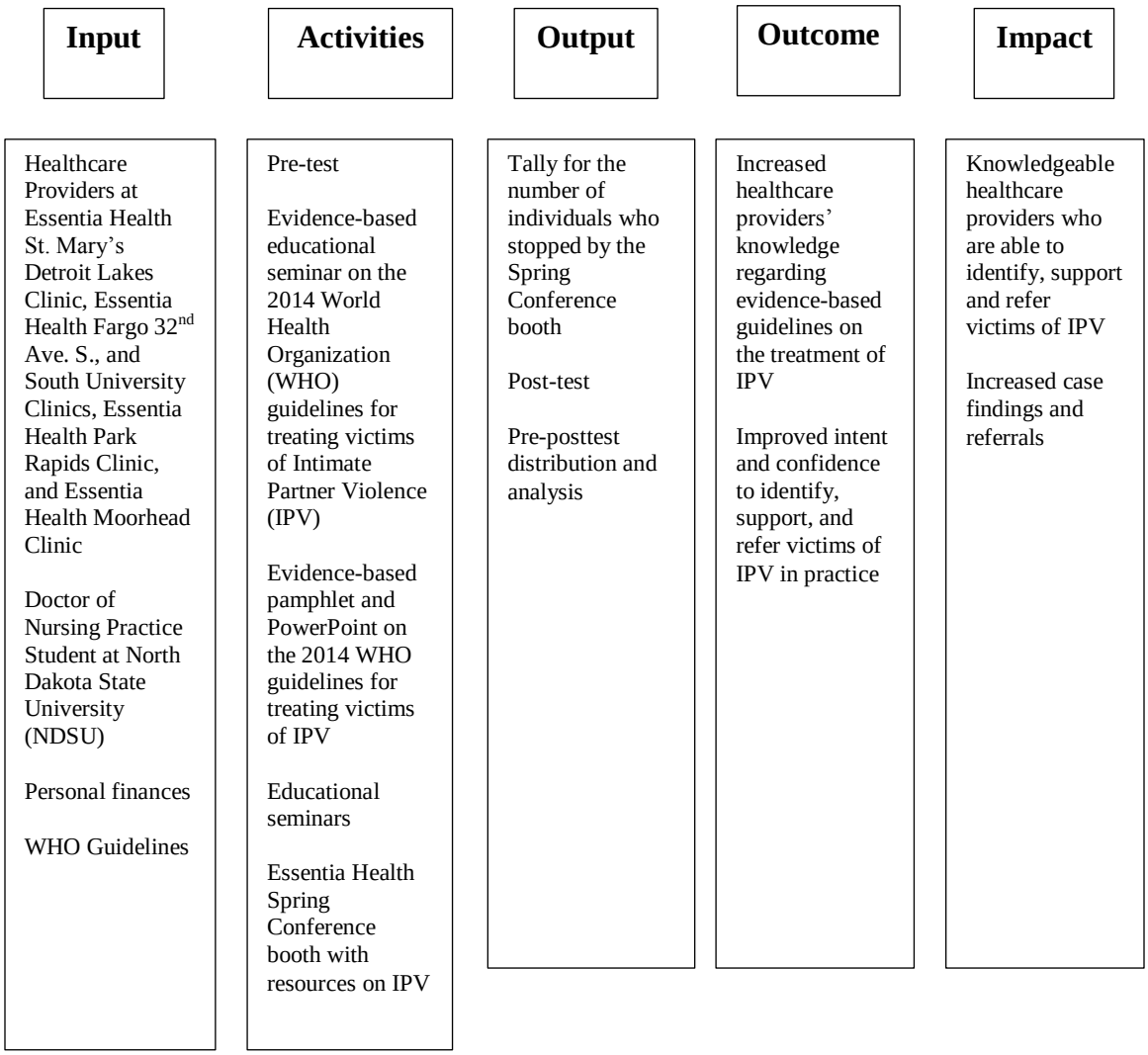


Figure 5: Logic Model

Practice Improvement Project Objective: 1. Instruct clinicians about the LIVES acronym, as well as teach clinical algorithms to attendees of the 2015 Spring Conference for Essentia Health on April 24th, 2015.

In order to evaluate the first objective, a tally of how many conference attendees stop by the IPV booth was collected. A log was also kept of comments and questions from conference attendees.

Practice Improvement Project Objective: 2. Equip healthcare providers to appropriately address and refer victims of intimate partner violence.

In order to evaluate the second objective, a pre-test and post-test were done prior to and following each educational seminar presentation. The pre-test tested the knowledge of healthcare providers before the educational seminar through ten true or false questions regarding IPV. The same knowledge questions that were on the pre-test were also on the post-test, which gauged whether or not there was knowledge acquisition throughout the educational seminar.

Another component of the pre-test was a five-point Likert scale ranging from Not Confident (1) to Very Confident (5) that assessed how confident a provider was in his/her ability to identify, support, and refer victims of IPV. The same Likert scale from the pre-test was on the post-test, only now the provider was asked how his/her confidence has changed in identifying, supporting, and referring victims of IPV.

Practice Improvement Project Objective: 3. Motivate healthcare providers to address intimate partner violence through evidence-based approaches.

In order to evaluate the third objective, a portion of the pre-test included a Likert scale ranging from Not Often (1) to Very Often (5) to assess how a healthcare provider currently practices in regard to caring for victims of IPV. The post-test asked the same questions as the pre-test, only now the scale changed to Not Likely (1) to Very Likely (5) to assess how likely a provider was to change their current practices regarding IPV as a result of the educational seminar.

Protection of Human Subjects

Healthcare providers at Essentia Health St. Mary's Detroit Lakes Clinic, Essentia Health Park Rapids Clinic, Moorhead Clinic, and Fargo 32nd Ave. S. and South University clinics were involved in this practice improvement project. Likewise, attendees of the Essentia Health Spring Conference were involved in this practice improvement project. There were no potential risks to the human subjects who were involved. An informed consent handout was provided. There was no risk to the participants, and therefore the risk did not need to be minimized.

The potential benefit of this project was that healthcare providers will have an increased awareness and understanding of the latest evidence-based clinical guidelines for treating victims of IPV. The attendees of the Spring Conference will have a snapshot of how to provide first-line support to victims of IPV, and will have clinical tools available to help them care for victims of IPV. Victims of IPV who present to one of the five primary care clinics where the educational seminar was presented could benefit from the knowledge that the healthcare providers learned because the healthcare providers will be able to identify, support, and refer these victims for appropriate services.

Knowledge of IPV is important because the literature review showed that there is a need for healthcare providers to be educated on IPV, and staying up-to-date on the latest evidence-based practice guidelines is important for any healthcare provider. All healthcare providers at the five primary care clinic sites were invited to participate in all aspects of this clinical improvement project, including women and minorities. Likewise, all attendees of the Spring Conference for Essentia Health were invited to visit the educational booth and gather resources to bring back to their clinical sites. Children were not included in this clinical improvement project as they are not old enough to be healthcare providers.

CHAPTER 5. RESULTS

Sample Population

The educational seminars were open to all healthcare professionals at the selected clinic sites in Moorhead, Park Rapids, and Detroit Lakes, MN, as well as two sites in Fargo, ND. Continuing Medical Education (CME) credit was obtained through Essentia Health's CME Committee. The educational seminar was worth 1.00 American Medical Association Physician Recognition Award Category 1 Credits. CME flyers and emails were sent to all employees at each of the selected clinics at least one week in advance. The educational seminar for Grand Rounds (Appendix Q) was available to all employees of Essentia Health.

Data Results

The educational seminar was open to all healthcare professionals and was presented both at family practice clinics in Moorhead, Park Rapids, and Detroit Lakes, MN, as well as Fargo, ND, and at Essentia Health Grand Rounds on May 14th, 2015. Throughout the five educational seminars there were 42 people who completed either all or part of the pre and post-tests. Of the 42 individuals who responded, ten were from clinic one, five from clinic two, 11 from clinic three, 11 from clinic four, and five from clinic five.

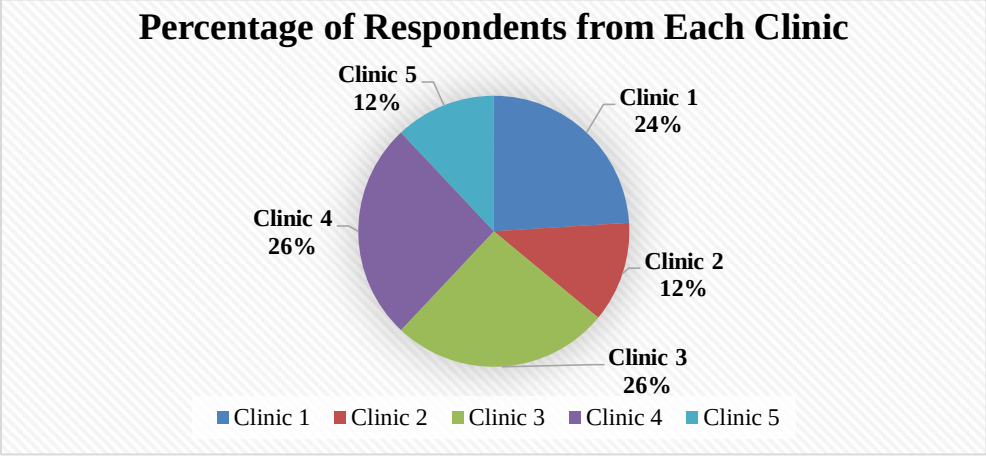


Figure 6: Clinic Participation

Demographic Data

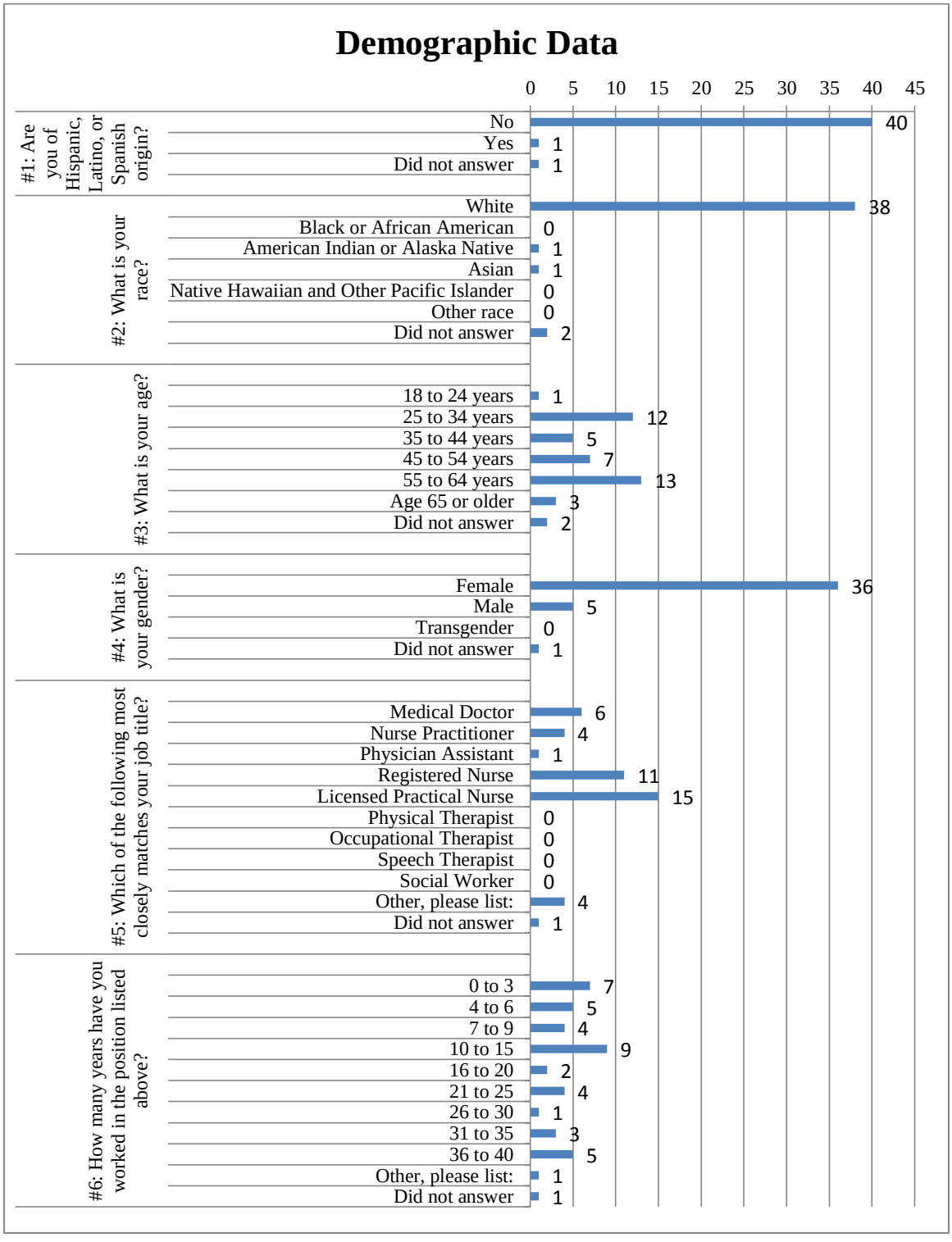


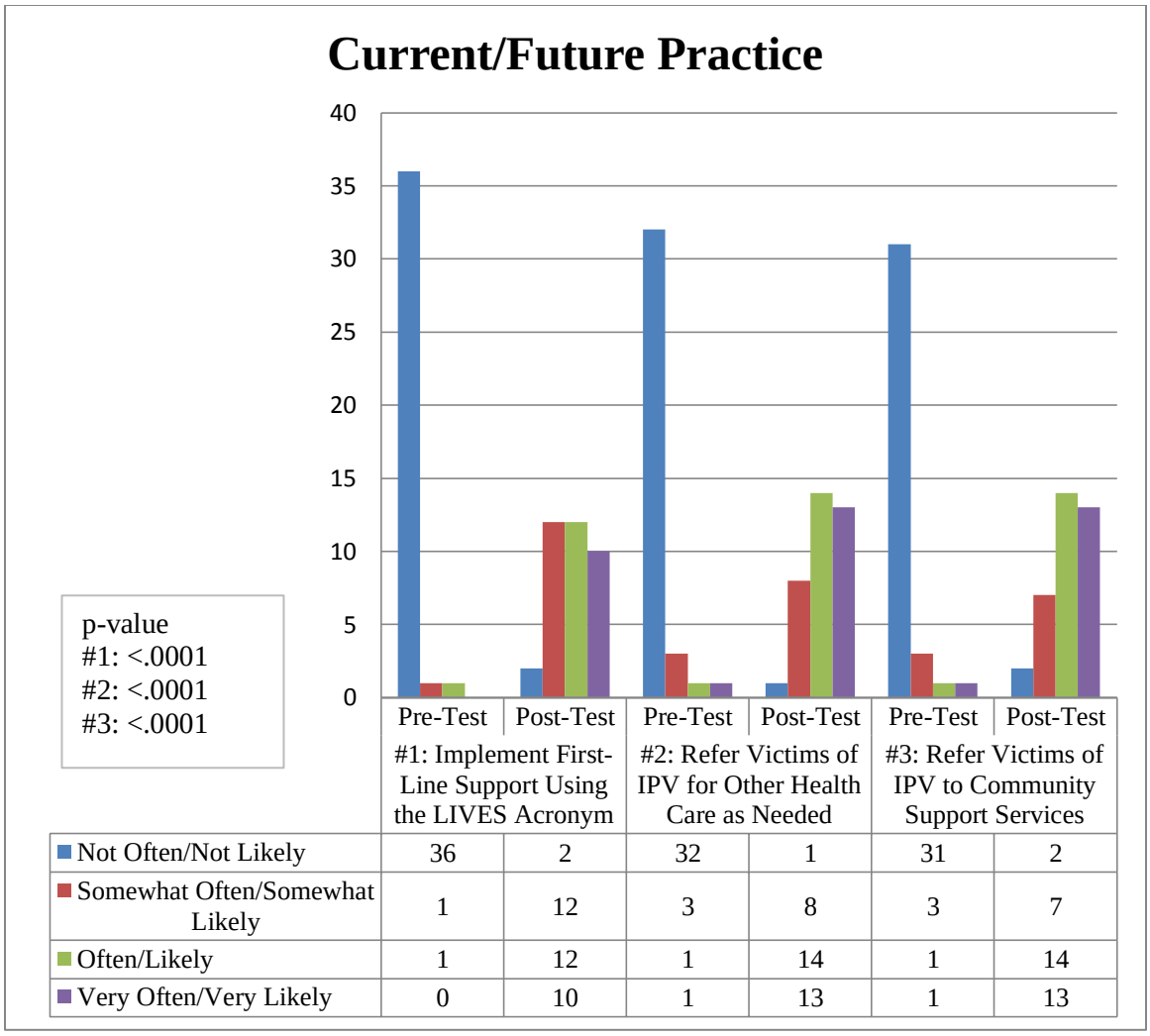
Figure 7: Demographic Data

There were 42 individuals who completed part of all or some of the pre and post-tests. Demographic data was gathered on the pre-test. The results are listed in the graph above. The last two demographic questions on the pre-test were focused on the individual's job role. For the question "Which of the following most closely matches your job title?", the four individuals who wrote in their job titles answered with "CMA", "Medical Lab Tech", "Radiologic Technologist" and "Chaplain". The next question was "How many years have you worked in the position listed above?" For this question, one answered "Other", for which the individual wrote in"47".

Current/Future Practice

There were paired questions on the pre and post-tests to determine how often providers do certain skills specific to working with victims of Intimate Partner Violence. The pre-test asked how often those skills were done currently, and the post-test asked how often they would be done in the future as a result of the information received in the educational seminar. On the pre-test, the answer choices were "Not Often, Somewhat Often, Often, and Very Often". Likewise, on the post-test, the answer choices were "Not Likely, Somewhat Likely, Likely, and Very Likely". For each question the number of people who increased a level, i.e. from "Not Likely" to "Somewhat Likely", will be provided. An example of a change in two categories could be going from "Somewhat Likely" on the pre-test to "Very Likely" on the post-test. Or, for an increase in three categories, that individual would have responded with "Not Likely" on the pre-test, and "Very Likely" on the post-test.

Also, for each of the questions, a paired t-test was done to determine statistical significance. The paired t-test was done to assess whether the mean change was equal to zero. If the null is rejected, then we can conclude that the mean change is different from zero. Each of the questions and responses has been implemented into the graph below.



	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test
	#1: Implement First-Line Support Using the LIVES Acronym		#2: Refer Victims of IPV for Other Health Care as Needed		#3: Refer Victims of IPV to Community Support Services	
Not Often/Not Likely	36	2	32	1	31	2
Somewhat Often/Somewhat Likely	1	12	3	8	3	7
Often/Likely	1	12	1	14	1	14
Very Often/Very Likely	0	10	1	13	1	13

Figure 8: Current/Future Practice

For each question in the Current/Future Practice section, the p-value was <.0001 which rejects the null hypothesis and concludes that the mean change is different from zero. In this case, that means that the post-test mean is statistically greater than the pre-test mean.

Testing Knowledge

On the pre and post-tests there were the same ten knowledge questions. The goal of these questions was to find out what the providers knew prior to the educational seminar and if there was any knowledge acquisition after the educational seminar. Each of the questions are analyzed

in the chart below. Frequencies of how many got the answer correct on the pre-test and post-test are also provided below.

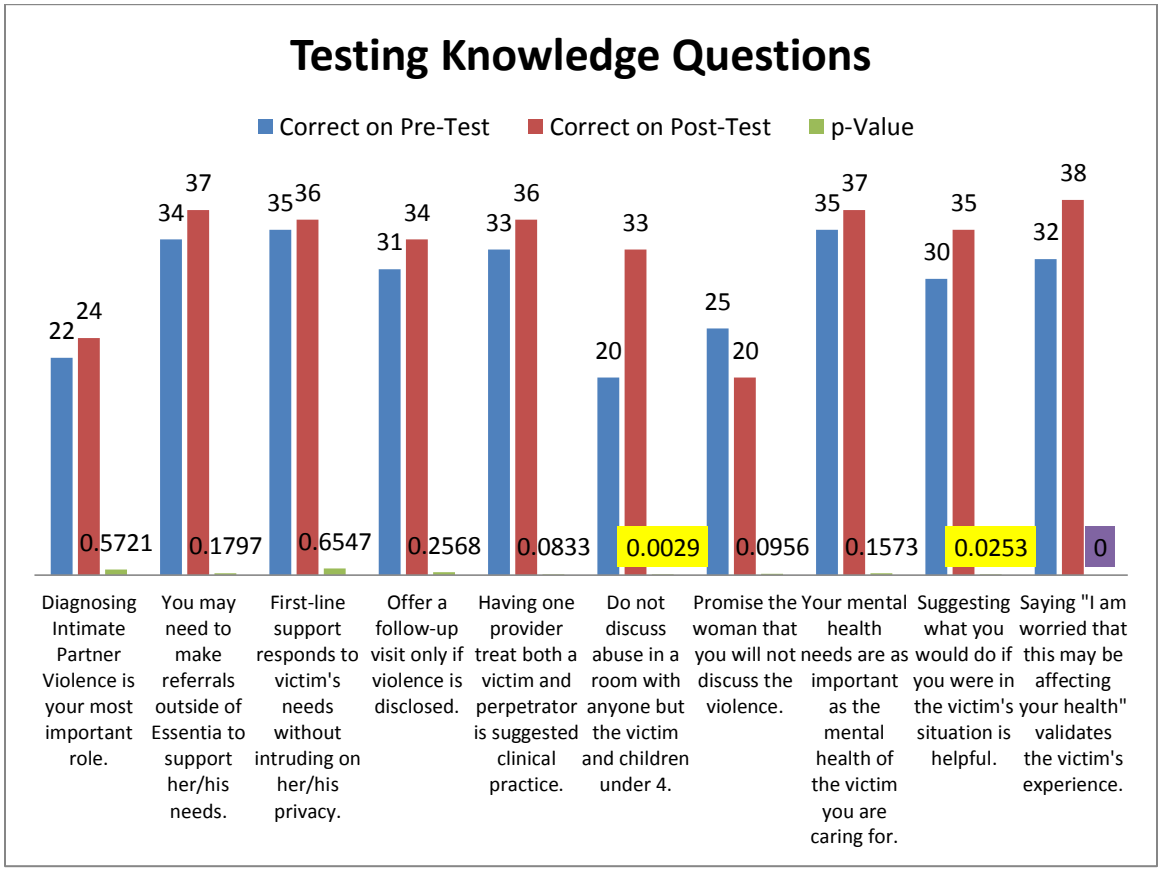


Figure 9: Testing Knowledge

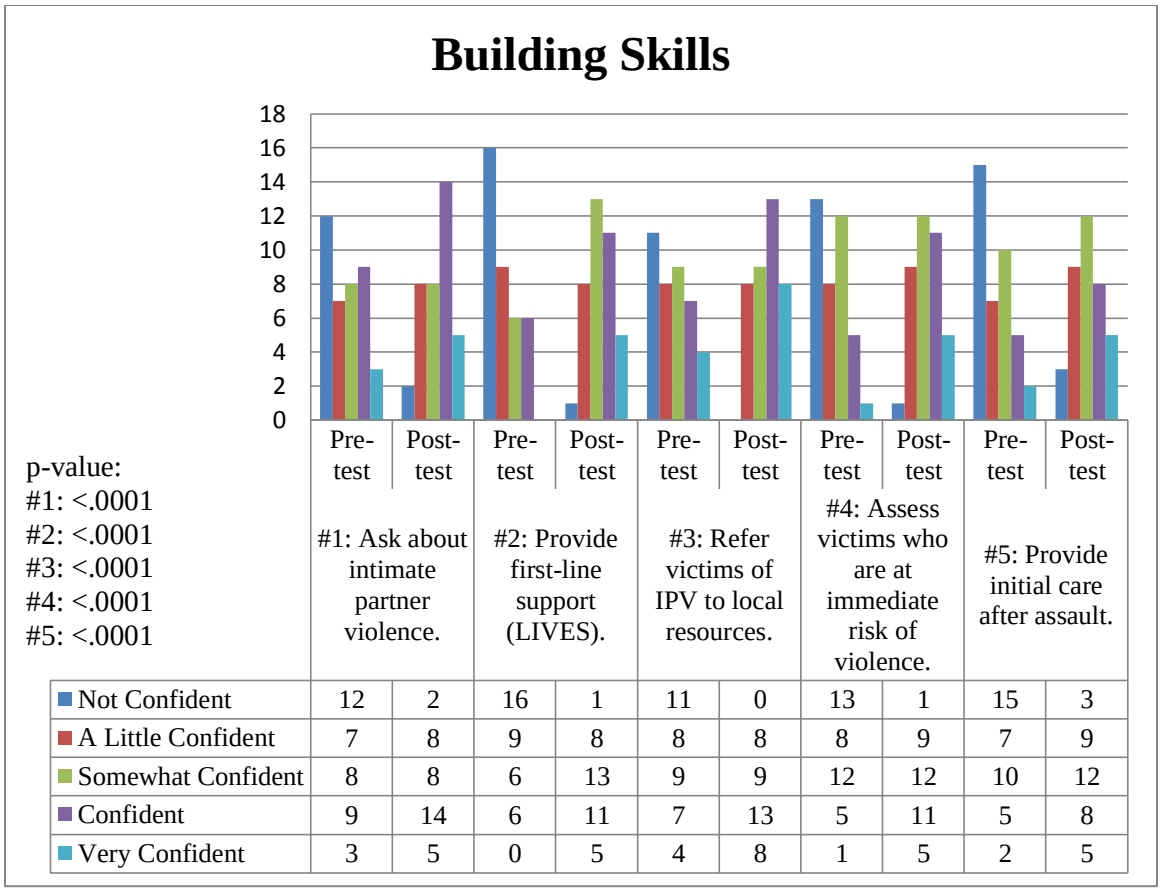
For the first nine questions in the testing knowledge section a McNemar's test was done. McNemar's test was used to test the null hypothesis that the percentages for the pre-tests are the same as the percentages for the post-test. There is no simple analog test for True/False questions, but a p-value of greater than .05 would mean that we do not reject the null hypothesis, so we can conclude that the rate of correct answers is statistically different. For questions one through five, as well as seven and eight the p-value was greater than .05 meaning that we do not reject the null hypothesis. For question six and question nine, we do reject the null hypothesis. The results from question six and question nine are statistically different from the pre-test to the post-test.

For question ten, a McNemar's test cannot easily be calculated since the 2nd row would only have zeros here. When looking at all ten of the true and false questions together, there was a mean change (improvement) of 0.8947 from the pre-test to the post-test. This is statistically significant using an alpha level of 0.05 since the p-value is much less than alpha. Further analysis will be completed in the next chapter.

Building Skills

There were paired questions on the pre and post-tests to determine the level of confidence that providers have in working with victims of IPV. The pre-test asked how confident providers were at doing those skills currently, and the post-test asked how their confidence has changed as a result of the educational seminar. The answer choices for both the pre and post-tests were "Not Confident, A Little Confident, Somewhat Confident, Confident, and Very Confident". For each question the number of people who increased a level, i.e. from "Not Confident" to "Somewhat Confident" will be provided. An example of a change in two categories could be going from "Somewhat Confident" on the pre-test to "Very Confident" on the post-test. Or, for an increase in three levels, that individual would have responded with "Not Confident" on the pre-test, and "Very Confident" on the post-test.

Also, for each of the questions, a paired t-test was done to determine statistical significance. The paired t-test was done to assess whether the mean change was equal to zero. If the null is rejected then we can conclude that the mean change is different from zero. Each of the questions and results will be illustrated in the graph below.



p-value:
#1: <.0001
#2: <.0001
#3: <.0001
#4: <.0001
#5: <.0001

	#1: Ask about intimate partner violence.		#2: Provide first-line support (LIVES).		#3: Refer victims of IPV to local resources.		#4: Assess victims who are at immediate risk of violence.		#5: Provide initial care after assault.	
	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Not Confident	12	2	16	1	11	0	13	1	15	3
A Little Confident	7	8	9	8	8	8	8	9	7	9
Somewhat Confident	8	8	6	13	9	9	12	12	10	12
Confident	9	14	6	11	7	13	5	11	5	8
Very Confident	3	5	0	5	4	8	1	5	2	5

Figure 10: Building Skills

For all five of the Building Skills questions the p-value was <.0001 which means that we would reject the null and conclude that the mean change is different from zero. In this case, we can conclude that the post-test mean is statistically greater than the pre-test mean.

Program Evaluation

The post-test had questions asking the attendees of the educational seminars to rate the instructor, material, and overall program by answering either, “Not Helpful”, “Somewhat Helpful”, “Helpful”, or “Very Helpful”. Five people rated both the instructor and the educational materials as “Helpful”, and 33 people rated the instructor and educational materials as “Very Helpful”. Four people did not answer those questions. Four people rated the overall program as

"Helpful" and 34 people rated the overall program as "Very Helpful". Four people did not answer the question.

The question "What did you like the most about this program?" had an open text space. The answers for this question are listed here:

- Good speaker
- Easy to follow and very informative
- Explaining how it grows from when abuse 1st started and how it increases
- Enhance awareness and provide help to the victim
- Clear presentation and thorough. Nice job.
- Anna's knowledge and the widespread abuse in this area.
- Very informative
- Interesting
- Handouts, suggestions on what to say/do
- Information
- Information/New ideas
- It was very informative. The presenter did a nice job of relaying it.
- Short and to the point
- Very informative, good public speaker
- I like that all were invited providers
- There is little education for this in medical school
- Education – stats. Prevalence of this.
- Pre & post-test evaluation
- Everything – just so upsetting!

- Great topic that is not discussed often.
- Learned the statistics in this area and was shocked.
- The statistics.
- Use of materials and referring to story/example for application.
- Resource info. I am doing what is recommended.

The question "How could this program be improved?" had an open text space. The answers for this question are listed here:

- None
- Phone numbers for victim or attendee on a small card
- ?
- Excellent program
- N/A
- N/A
- A lot of info for a short time
- None
- Nothing – thorough.
- N/A
- Offer it to other clinics. Important subject.
- Possibly use video to show example of how to talk to a pt about IPV

The question "Would you recommend this program to others?" had a yes/no answer. 35 people answered yes, none answered no, and six people did not answer this question. Although there was not a free text option here, two people did write in the answers of "4+!!!" and "ED Staff, Case Managers" to this question as well.

Essentia Health Spring Conference

There were 41 people who stopped at the educational booth at the Essentia Health Spring Conference. All employees of Essentia Health were invited to attend the conference. The comments and questions that the attendees had are listed below:

- Great info
- So important
- As a nurse, I feel like they [victims of IPV] don't like to say that they don't feel safe.
- Good topic
- This [IPV] is something that I wish was discussed more often
- Great! Thanks for presenting this topic
- Such a sad situation for those women
- Helpful handout
- Do you find that many patients listen to this advice?
- Awesome, thanks!
- Can I take a few of these handouts back to my clinic?
- Great, thanks.
- Appreciate it!
- What does "LIVES" mean?

CHAPTER 6. DISCUSSION AND CONCLUSION

Discussion and recommendations related to the practice improvement project will be discussed in this chapter. Interpretation of the result findings and how the result findings relate to the theoretical framework that guided the practice improvement project will be completed. Each objective will be discussed, as well as the limitations of the practice improvement project. Recommendations will be made based on the findings. Also, implications for practice and future research will be discussed.

Interpretation of Results

Practice Improvement Project Objective: 1. Instruct clinicians about the LIVES acronym, as well as teach clinical algorithms to attendees of the 2015 Spring Conference for Essentia Health on April 24th, 2015.

Achievement of this objective was based on providing information on the LIVES acronym and clinical algorithms to attendees of the 2015 Spring Conference for Essentia Health. The portion of Pender's Health Promotion Model that guided this objective is the *behavior specific cognitions and affect* (Pender, 2011). Specifically, as mentioned in Chapter 2, a barrier to addressing IPV in the primary care setting that was identified was a lack of resources. Therefore, by providing resources to the attendees of the Spring Conference this objective was achieved. There were 41 individuals who attended the booth, several of which asked questions and provided comments which are listed in Chapter 5. A pamphlet explaining how to implement the LIVES acronym into practice was provided to conference attendees. Likewise, a poster with the clinical algorithm on how to care for a victim of IPV was presented to the attendees of the conference.

Practice Improvement Project Objective: 2. Equip primary care providers to appropriately address and refer victims of intimate partner violence.

Achievement of this objective is based on whether or not there was knowledge acquisition as well as how healthcare providers' confidence has changed in identifying, supporting, and referring victims of IPV. Pender's Health Promotion model discusses that *behavior specific cognitions and affect* that determine whether or not a health promoting behavior is completed (Pender, 2011). The goal of this objective was to provide the educational background necessary to ameliorate as many of the perceived barriers to action as possible.

For the ten true and false questions that healthcare providers were asked in both the pretest, only one participant answered all ten questions correctly. However, on the posttest, there were 12 participants who answered all ten questions correctly. The knowledge acquisition from the educational seminar will help healthcare providers to appropriately address and refer victims of IPV. Also, for the true and false questions, the paired t-test shows a mean change (improvement) of a little less than one point (.8947). This is statistically significant using an alpha level of .05 since the p-value is much less than alpha level. Again, this shows that there was knowledge acquisition as a result of the educational seminar.

On the true and false test, the statement "Do not discuss abuse in a room with anyone but the victim and children under the age of 4" was one that initially almost half of the respondents answered incorrectly. 17 answered True, and 20 answered False. On the posttest, 33 answered correctly, and only 4 answered incorrectly. The WHO states that no one over the age of 2 should be in the room when violence is being discussed (World Health Organization, 2014). This was a point of discussion in all of the educational seminars that were provided.

In order to analyze this objective further, the pre and posttests asked questions on healthcare providers' confidence to ask about IPV, provide first-line support through the use of the LIVES acronym, refer victims of IPV to local resources, assess victims who are at immediate risk of violence, and provide initial care after assault. For all five of the questions that were asked in the Building Skills section of the pre and posttests, the null hypothesis that the mean change was equal to zero was rejected. Therefore, we can conclude that the posttest mean is statistically greater than the pretest mean. This shows that the healthcare providers' confidence to ask about IPV, provide first-line support to IPV victims, refer victims of IPV, assess victims who are at immediate risk of violence, and provide initial care after assault is increased as a result of the educational seminar.

Practice Improvement Project Objective: 3. Motivate primary care providers to address intimate partner violence through evidence-based approaches.

The final objective is related to the last component of Pender's Health Promotion Model. In this component, *behavioral outcomes* are achieved (Pender, 2011). In this case, the *behavioral outcome* was a change in practice that includes providing first-line support through the use of the LIVES acronym, referring victims of IPV to other healthcare services as needed, and referring to community support services as needed. As shown below, the participants in the educational seminar indicated that there would be a change in their future practice.

The pre and posttests asked questions regarding current and future practice. The questions asked were how often a healthcare provider currently used the LIVES acronym, how often he/she referred to other healthcare services as needed, and how often he/she referred to community support services. For all three of the questions regarding current and future practice that were asked in the pre and posttests, the null hypothesis that the mean change was equal to

zero was rejected. Therefore, we can conclude that the posttest mean is statistically greater than the pretest mean. This shows that healthcare providers' are more likely to implement first-line support using the LIVES acronym, refer to other healthcare services as needed, and refer to community support services as a result of the educational seminar.

The change in practice items showed that prior to the educational seminar, the overwhelming majority of healthcare providers who attended the educational seminar were not implementing first-line support via the LIVES acronym, were not referring victims of IPV for other healthcare, and were not referring victims of IPV to community support. Initially, 35/37 participants stated that they were either "Not Often" or "Somewhat Often" referring victims of IPV to other healthcare as needed. On the posttest, 27/36 participants stated that they would refer victims of IPV either "Often" or "Very Often".

Likewise, 34/36 participants stated initially that they had "Not Often" or "Somewhat Often" referred victims of IPV to community support. After the educational seminar, 27/36 participants stated that they would refer victims of IPV to community support services either "Often" or "Very Often". The education that was provided in addition to the resources that were handed out during the education seminar were both cited as reasons for this planned change in practice.

Limitations

Several limitations must be considered when evaluating this practice improvement project. A limitation of this practice improvement project was that not as many advanced practice providers attended the educational seminar as initially hoped for. This may be due to heavy clinic schedules, perceived knowledge of the topic, or any other number of variables. Throughout all five of the clinic sites, there were only 11 advanced practice providers. That

included six MDs, four NPs, and one PA. However, several other disciplines within the healthcare system attended the educational seminars and the evaluations that those individuals provided indicated that they appreciated the education as well. The exposure of this topic to a variety of members of the healthcare team turned out to be beneficial. In hindsight, nurses often ask the first questions about abuse, so educating this large population of individuals is imperative as well.

The pre and posttest that were created were also a limitation of this practice improvement project. All of the information on the pre and posttest came from the WHO's Clinical Handbook on IPV (World Health Organization, 2014). The pre and posttest were approved for use by the practice improvement project committee. However, the pre and posttests have not been tested for external validity and reliability. Ideally, the instrument that is used is both externally valid and reliable (Moran, Burson, & Conrad, 2014).

Finally, a limitation of the practice improvement project is that the data was obtained through a self-reported pre/posttest. It has been shown in previous research that when compared to observing an individual, when asking how a behavior will change via a self-report questionnaire, the participant may answer in a manner that is not consistent with their actions (Elliott, Nerney, Jones, & Friedmann, 2002). Participants may overstate their adherence to a behavior if they believe that it is socially desirable (Moran, Burson, & Conrad, 2014).

Recommendations

Recommendations include further development, implementation, and evaluation of the most recent literature on how to care for victims of IPV. In relationship to the Intimate Partner Violence module, new guidelines and literature are found frequently. Keeping the PowerPoint

presentation up-to-date with recent evidence, as well as the area resource sheets recent with current resources will be essential.

Another recommendation, based on feedback from the committee for this dissertation, is to take the next step in educating healthcare providers by not just telling them what is important to do, but rather by showing them what to do. For example, creating vignettes on a positive or negative interaction between a provider a victim of IPV, would be one way to expand this project. Another option would be to provide healthcare providers with exact phrases to say. This would empower healthcare providers to feel able to approach the subject and to know that they are being helpful and supportive. The comfort level would belong to providers, not patients, but ultimately would make the patient experience better.

Another recommendation, based on feedback from a participant, would be to expand the scope of where this educational seminar is offered. For this practice improvement project, the focus was on primary care. Feedback from an educational seminar participant specifically suggested offering this education to the Emergency Department staff, as well as Case Management. These two disciplines, as well as other disciplines are avenues that would be an option for future practice improvement projects.

Implications for Practice

The practice improvement project has shown that there is a need for increased healthcare provider knowledge and the subsequent increase in recognition, support, and referral of victims of IPV, which have major implications for practice. As discussed in Chapter 1, the prevalence of IPV is pervasive. Increased healthcare provider knowledge on how to care for victims of IPV may ultimately increase the number of victims who are identified and referred to services.

The materials created for this practice improvement project were reported as effective. To meet the educational needs of other healthcare providers, additional dissemination of this practice improvement project could be considered. The results of the project will be disseminated to the clinics that participated in the practice improvement project. Additionally, as other opportunities to disseminate the findings present themselves; this author plans to share the findings of the clinical improvement project in other avenues such as poster presentations at conferences or through submission to a journal.

Implications for Future Research

There is a need for continued education and support for healthcare providers who want to provide excellent care for victims of IPV. Arranging to complete the educational seminar during a medical staff meeting at each of the clinics may be one way to increase the number of advanced practice providers who are reached. There are many other healthcare providers who would benefit from an educational experience regarding caring for victims of IPV as well, and practice improvement projects could focus on improving awareness about evidence-based IPV care.

Another avenue for future research could be assessing intimate partner violence in the Lesbian, Gay, Bisexual, and Transgender (LGBT) communities. Currently, most of the research that has been completed on screening tools has been done on heterosexual women. Research on how intimate partner violence presents within the LGBT community, and what tools would be most helpful for supporting each of these populations is an opportunity for future research.

Another option for a future practice improvement project could be that of assessing patient education on IPV. Through collaboration with a local IPV center it may be possible to find out why victims of IPV are presenting to their center for help. From there, the researcher

could provide intentional passive patient education through the use of handouts, posters, business cards, etc. that could be displayed in restrooms, waiting areas, and exam rooms. Several national and local organizations provide resources that could be utilized for awareness. The researcher then could reassess at a later date whether or not the passive patient education efforts resulted in more victims of IPV seeking help at the collaborating IPV center.

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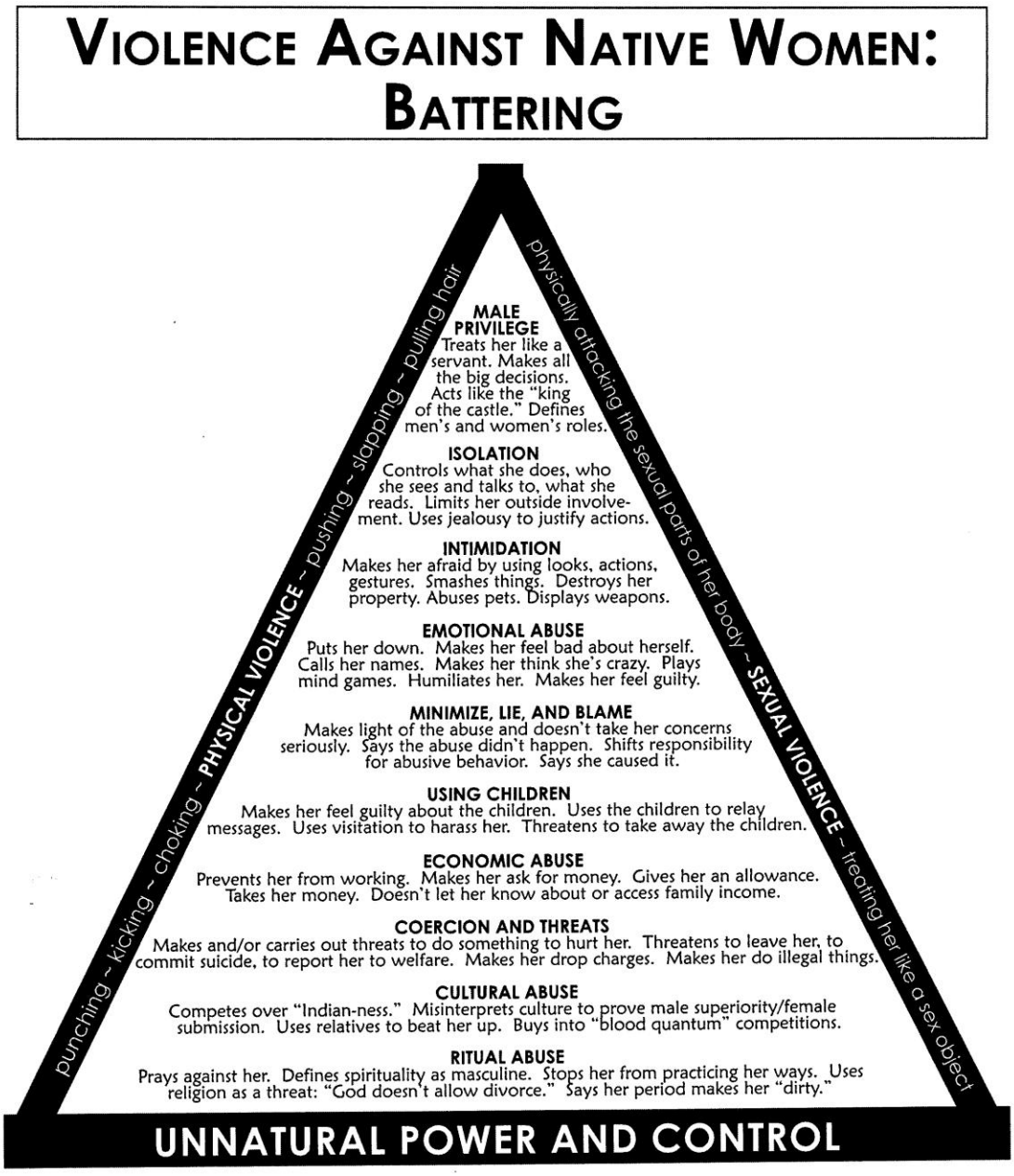
APPENDIX A. VIOLENCE AGAINST NATIVE WOMEN



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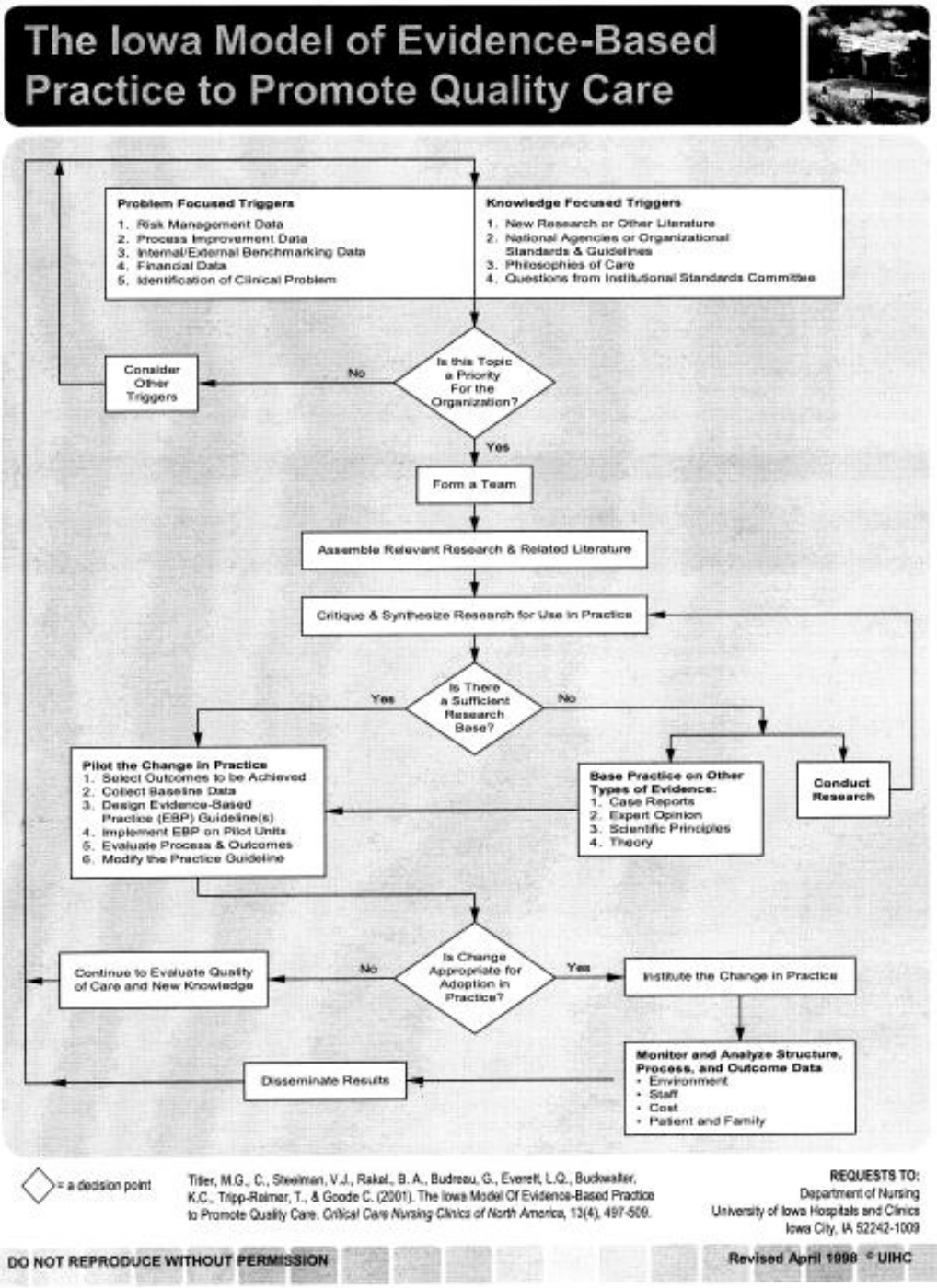
NATIONAL CENTER
on Domestic and Sexual Violence
training · consulting · advocacy
4612 Shoal Creek Blvd. · Austin, Texas 78756
512.407.9020 (phone and fax) · www.ncdsv.org

Developed by:
Sacred Circle - National Resource Center to End Violence Against Native Women

APPENDIX B. POWER AND CONTROL WHEEL

DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org

APPENDIX C. IOWA MODEL



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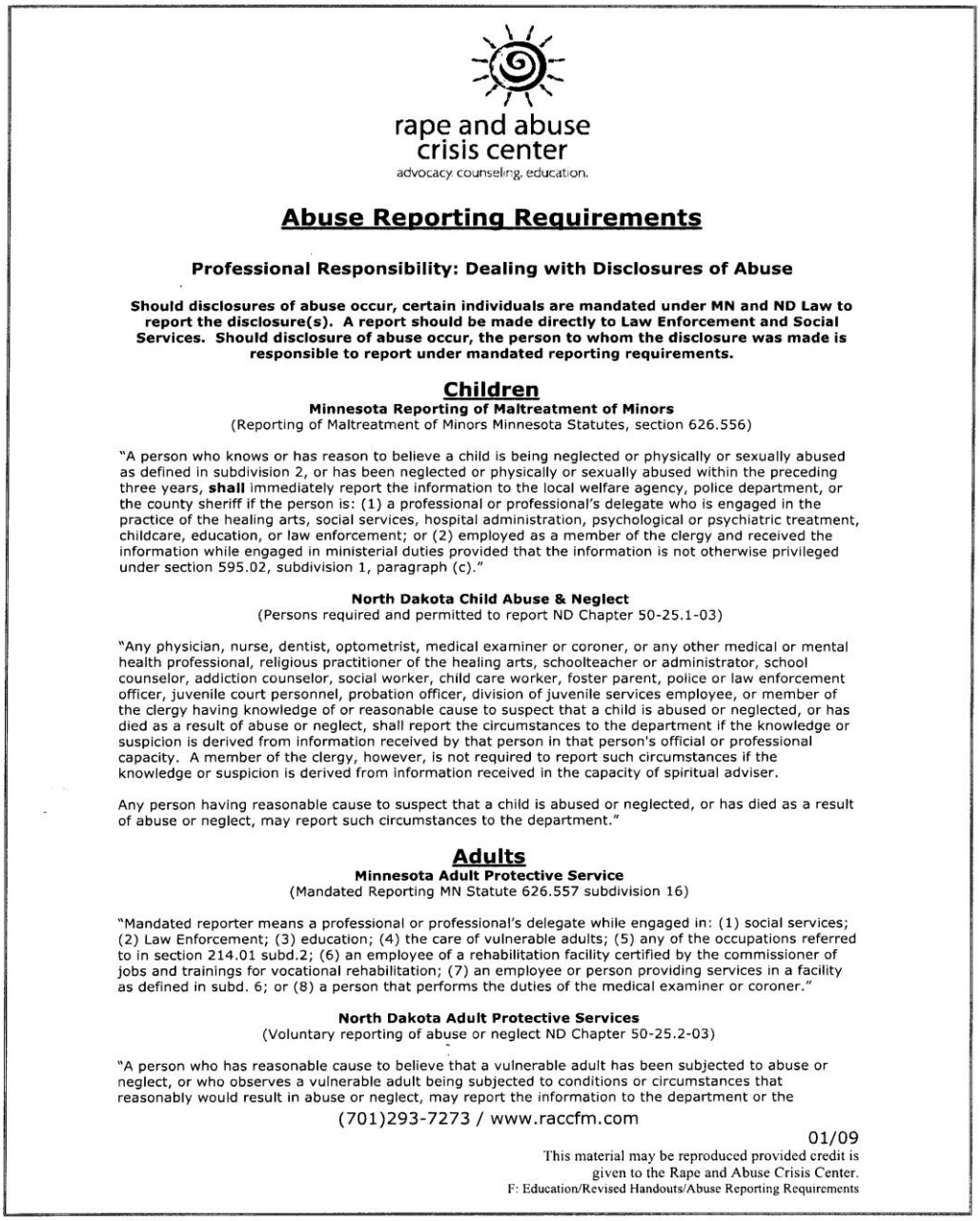
APPENDIX D. MANDATED REPORTING LAWS



rape and abuse
crisis center
advocacy counseling, education.

Abuse Reporting Requirements

Professional Responsibility: Dealing with Disclosures of Abuse

Should disclosures of abuse occur, certain individuals are mandated under MN and ND Law to report the disclosure(s). A report should be made directly to Law Enforcement and Social Services. Should disclosure of abuse occur, the person to whom the disclosure was made is responsible to report under mandated reporting requirements.

Children

Minnesota Reporting of Maltreatment of Minors
(Reporting of Maltreatment of Minors Minnesota Statutes, section 626.556)

"A person who knows or has reason to believe a child is being neglected or physically or sexually abused as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, **shall** immediately report the information to the local welfare agency, police department, or the county sheriff if the person is: (1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, childcare, education, or law enforcement; or (2) employed as a member of the clergy and received the information while engaged in ministerial duties provided that the information is not otherwise privileged under section 595.02, subdivision 1, paragraph (c)."

North Dakota Child Abuse & Neglect
(Persons required and permitted to report ND Chapter 50-25.1-03)

"Any physician, nurse, dentist, optometrist, medical examiner or coroner, or any other medical or mental health professional, religious practitioner of the healing arts, schoolteacher or administrator, school counselor, addiction counselor, social worker, child care worker, foster parent, police or law enforcement officer, juvenile court personnel, probation officer, division of juvenile services employee, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser.

Any person having reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, may report such circumstances to the department."

Adults

Minnesota Adult Protective Service
(Mandated Reporting MN Statute 626.557 subdivision 16)

"Mandated reporter means a professional or professional's delegate while engaged in: (1) social services; (2) Law Enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01 subd.2; (6) an employee of a rehabilitation facility certified by the commissioner of jobs and trainings for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subd. 6; or (8) a person that performs the duties of the medical examiner or coroner."

North Dakota Adult Protective Services
(Voluntary reporting of abuse or neglect ND Chapter 50-25.2-03)

"A person who has reasonable cause to believe that a vulnerable adult has been subjected to abuse or neglect, or who observes a vulnerable adult being subjected to conditions or circumstances that reasonably would result in abuse or neglect, may report the information to the department or the

(701)293-7273 / www.raccfm.com

01/09

F: Education/Revised Handouts/Abuse Reporting Requirements

department's designee or to an appropriate law enforcement agency. A law enforcement agency receiving a report under this section shall immediately notify the department or the department's designee of the report."

Who Must Report

Doctors, dentists, educators, daycare and group home staff, foster parents, pharmacists, nurses, employee assistance counselors, clergy, psychiatrists, psychologists, police, and social workers are among the people who MUST step in to help children. Failure to report may constitute a misdemeanor charge.

What You Must Report

You must report neglect, physical abuse, sexual abuse, emotional abuse, and exposure to domestic violence which has affected children or is currently endangering them; including incidents dating back as far as three years.

Who to Call

To report any case of abuse or neglect, you may call Child Protection at the County Social Service Office or local Law Enforcement. Any child who is abandoned or subject to real or imminent threats may be removed from the threatening environment by a peace officer.

What Child Protection Needs to Know

The following is essential information needed in a Child Protection Report

- The child's identity
- Any person believed to be responsible for the abuse or neglect of the child (if the person is known)
- The nature and extent of the abuse or neglect
- The name and address of the reporter
- The name and address of the victim and perpetrator
- The location of the child and their current level of risk

What Happens After You Call in a Report?

If you are a mandated reporter, you must follow your oral report with a written report within 72 hours (excluding weekends and holidays). Social Services and Law Enforcement are mandated to report to each other upon the receipt of a child maltreatment report.

Confidentiality of Reporter's Identity

The name of the reporter shall be confidential. Any person conducting the investigation/assessment who intentionally discloses the name of the reporter is guilty of a misdemeanor. To compel the disclosure of a reporter requires a court order.

What Can Child Protection Tell You About the Case?

You may be privy to the following information:

- the agency's determination as to whether maltreatment occurred
- the name of the child protection worker conducting the assessment
- the nature of the maltreatment, if it was determined to have occurred
- a description of the services being provided to the child

*Social services may deny the request of the reporting party if it is determined that disclosure of the information is detrimental to the child's best interest.

APPENDIX E. PRE-TEST

Pre-Test

Intimate Partner Violence
North Dakota State University

Are you of Hispanic, Latino, or Spanish origin?
___No
___Yes

What is your race?
___White
___Black or African American
___American Indian and Alaska Native
___Asian
___Native Hawaiian and Other Pacific Islander
___Other race

What is your age?
___18 to 24 years
___25 to 34 years
___35 to 44 years
___45 to 54 years
___55 to 64 years
___Age 65 or older

What is your gender?
___Female
___Male
___Transgender

Which of the following most closely matches your job title?
___Medical Doctor
___Nurse Practitioner
___Physican Assistant
___Registered Nurse
___Licensed Practical Nurse
___Physical Therapist
___Occupational Therapist
___Speech Therapist
___Social Worker
___Other, please list _____

How many years have you worked in the position listed above?
___0-3
___4-6
___7-9
___10-15
___16-20
___21-25
___26-30
___31-35
___36-40
___Other, please list _____

Please check the box that best describes your answer.

How often do you...	Not often	Somewhat often	Often	Very often
1. Implement first-line support using the LIVES acronym				
2. Refer victims of IPV for other health care as needed				
3. Refer victims of IPV to community support services				

Testing Knowledge

Please circle True or False as your answer to each of the following statements.

1. Diagnosing intimate partner violence is your most important role. True False
2. You may need to make referrals outside of Essentia to support her/his needs. True False
3. First-line support responds to a victim's needs without intruding on her/his privacy. True False
4. Offer a follow-up visit only if violence is disclosed. True False
5. Having one provider treat both a victim and perpetrator is suggested clinical practice. True False
6. Do not discuss abuse in a room with anyone but the victim and children under 4. True False
7. Promise the woman that you will not discuss the violence. True False
8. Your mental health needs are as important as the mental health of the victim you are caring for. True False
9. Suggesting what you would do if you were in the victim's situation is helpful. True False
10. Saying "I am worried that this may be affecting your health" validates the victim's experience. True False

Building Skills

Please circle the number that best describes your confidence to do the following:

Your confidence to:	Not Confident	A Little Confident	Somewhat Confident	Confident	Very Confident
1. Ask about intimate partner violence	1	2	3	4	5
2. Provide first-line support (LIVES)	1	2	3	4	5
3. Refer victims of IPV to local resources	1	2	3	4	5
4. Assess victims who are at immediate risk of violence	1	2	3	4	5
5. Provide initial care after assault	1	2	3	4	5

APPENDIX F. RESOURCE PAMPHLET

Intimate Partner Violence

Comments or Questions?

Contact:
Anna Thomas, BSN, RN, DNP Student

E-mail: anna.r.thomas@ndsu.edu

Please Remember

This may be your ***only opportunity*** to help this woman. Provide first-line support (LIVES) every time.

Information reprinted with permission from:

World Health Organization (2014). ***Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook***. Geneva, Switzerland: WHO Document Production Services.

IPV Intimate Partner Violence
RAPE hit push slap strangle shove choke kick bite
sexual assault
physical abuse
threats EMOTIONAL
stalking ABUSE financial
reproductive coercion abuse

What do I do if I suspect violence?

First-line support involves 5 simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word "LIVES" can remind you of these 5 tasks that save women's lives:

Listen	Listen to the woman closely, with empathy, and without judging
Inquire about needs and concerns	Assess and respond to her various needs and concerns — emotional, physical, social and practical (e.g. childcare)
Validate	Show her that you understand and believe her. Assure her that she is not to blame.
Enhance safety	Discuss a plan to protect herself from further harm if violence occurs again.
Support	Support her by helping her connect to information, services and social support.

So, how do I actually do that?

LISTEN:

Do:

- Be patient and calm.
- Acknowledge how she is feeling.
- Ask, "How can we help you?"
- Allow for silence.
- Give her time to think.

Don't:

- Pressure her to tell her story.
- Look at the computer or answer the telephone.
- Rush her.
- Try to finish her thoughts for her.
- Tell her someone else's story or talk about your own troubles.

INQUIRE:

- Phrase your questions as invitations to speak.
- Ask open-ended questions.
- Reflect on her feelings and explore as needed.

Examples include: "What would you like to talk about?" "How do you feel about that?" "It sounds as if you are feeling angry about that..." "Could you tell me more about that?"

- **Avoid** asking leading questions.
- **Avoid** asking "why" questions.

Examples include: "I would imagine that made you feel upset, didn't it?" "Why did you do that...?"

VALIDATE:

Important things you can say.

- "It's not your fault. You are not to blame."
- "What happened has no justification or excuse."
- "Everybody deserves to feel safe at home."
- "Help is available." [Say this only if it is true.]

ENHANCE SAFETY:

Questions to assess immediate risk of violence. Women who answer "yes" to at least 3 of the following questions may be at especially high immediate risk of violence.

- Has the physical violence happened more often or gotten worse over the past 6 months?
- Has he ever used a weapon or threatened you with a weapon?
- Has he ever tried to strangle you?
- Do you believe he could kill you?
- Has he ever beaten you when you were pregnant?
- Is he violently and constantly jealous of you?

** If it is **not safe for the woman to return home**, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place she can go to (such as a friend's home or church).**

SUPPORT:

How to help:

- Ask her what issues are most important to her right now. You can ask her, "What would help the most if we could do it right away?"
- Help her to identify and consider her options.
- Discuss her social support. Does she have a family member, friend, or trusted person in the community whom she could talk to? Does she have anyone who could help her with money?

Possible resources:

Helpline, support groups, crisis center, legal support, mental health counselor, social worker, psychologist.

APPENDIX G. AREA RESOURCES DETROIT LAKES, MN

Area Resources for Victims of Intimate Partner Violence – Detroit Lakes

Lakes Crisis and Resource Center 218-847-8572 PO Box 394 Detroit Lakes, MN 56502 (Office) http://lakescrisis.com/home **Services:** 24 hour Crisis Hotline # (877-754-9683) Mental Health Crisis Hotline #s: (877-380-3621) or (218-850-HELP) Mary's Place (Shelter)	**Becker County Human Services** 218-847-5628 712 Minnesota Ave Detroit Lakes, MN 56501 http://www.co.becker.mn.us/dept/human_services/default.aspx
Solutions Behavioral Healthcare Professionals (Mental Health Services) 1104 West River Road Detroit Lakes, MN 56501 (218) 844-6853	**Safe at Home** http://www.sos.state.mn.us/index.aspx?page=1473 Designed to help survivors of IPV, sexual assault, stalking, or others who fear for their safety maintain a confidential address.
Anishinabe Legal Services - White Earth Office P.O. Box 379 White Earth, MN 56591 **Phone:** (218) 983-4653 **Toll Free:** (877) 800-7295 Provides free legal assistance to low-income individuals living on or near the Leech Lake, Red Lake, & White Earth Reservations in Northwestern Minnesota.	**Lakeland Mental Health** (Mental Health Services) http://www.lmhc.org/detroit-lakes.html 928 8th St. SE Detroit Lakes, MN 56501 (218) 847-1676 Crisis Hotline # (800) 223-4512
White Earth Reservation Tribal DOVE Program (Down On Violence Everyday) White Earth Reservation Tribal Council Human Services Division PO Box 418 White Earth, MN 56591 1-218-983-4656	**Prairie St. John's** (Mental Health Services – Inpatient treatment) 510 4th St. S. Fargo, ND 58103 701-476-7200
National Dating Abuse Helpline 1-866-331-9474 www.loveisrespect.org	**National Domestic Violence Hotline** 1-800-799-SAFE (7233) www.ndvh.org
National Suicide Prevention Lifeline 1-800-273-TALK (8255) www.suicidepreventionlifeline.org	**National Sexual Assault Hotline** 1-800-656-HOPE (4673) www.rainn.org

APPENDIX H. AREA RESOURCES FARGO, ND & MOORHEAD, MN

Area Resources for Victims of Intimate Partner Violence – Fargo/Moorhead

Rape and Abuse Crisis Center (Advocacy, Counseling, Education) 701-293-7273 1-800-344-7273 www.raccfm.com	**YWCA** (Emergency Shelter) 3000 S. University Dr. Fargo, ND 58103 701-232-3449 www.ywcacassclay.org
Churches United for the Homeless (Emergency Shelter) 1901 1st Avenue North Moorhead, MN 56560 218-236-0372	**Village Family Service Center (Moorhead)** (Counseling Services) 1401 8th St. S. Moorhead, MN 56560 701-451-4811 (phone) 1-701-451-4840 (fax)
Village Family Service Center (Fargo) (Counseling Services) 1201 25th St. S. P.O. Box 9859 Fargo, ND 58106 701-451-4900 (phone) 1-800-627-8220 701-451-5057 (fax)	**Southeast Human Service Center** (Mental Health Services) 2624 9th Avenue South Fargo, N.D. 58103-2350 Phone: (701) 298-4500
Prairie St. John's (Mental Health Services) 510 4th St. S. Fargo, ND 58103 701-476-7200	**Solutions Behavioral Healthcare Professionals** (Mental Health Services) 866-455-6417 891 Belsly Blvd. Moorhead, MN 56560
Lakeland Mental Health (Mental Health Services) 1-800-223-4512 (Emergency Crisis Line) 1010 32nd Ave. S Moorhead, MN 56560-5001 (218) 233-7524	**Community Health Service, Inc.** **(Formerly Migrant Health Service, Inc.)** (Victim Advocacy Services) 810 4th Ave. S, Suite 101 Moorhead, MN 56560 218.236.6502 or 800.842.8693
National Dating Abuse Helpline 1-866-331-9474 www.loveisrespect.org	**National Domestic Violence Hotline** 1-800-799-SAFE (7233) www.ndvh.org
National Suicide Prevention Lifeline 1-800-273-TALK (8255) www.suicidepreventionlifeline.org	**National Sexual Assault Hotline** 1-800-656-HOPE (4673) www.rainn.org

APPENDIX I. AREA RESOURCES PARK RAPIDS, MN

Area Resources for Victims of Intimate Partner Violence

Park Rapids, MN

Headwaters Intervention Center 500 Main Ave S, Park Rapids, MN 56470 (218) 732-7413 24 Hour Crisis Line offering confidential support, referral, and counseling for victims of domestic violence.	**Minnesota Coalition for Battered Women** http://www.mcbw.org/ 24-Hour Phone Line: (866) 223-1111 24-hour hotline for victims of domestic abuse throughout Minnesota helps connect individuals to resources and services available to them.
Lake Country Associates 515 Bridge Street East Park Rapids, MN 56470 (218) 366-9229	**Safe at Home** http://www.sos.state.mn.us/index.aspx?page=1473 Designed to help survivors of IPV, sexual assault, stalking, or others who fear for their safety maintain a confidential address.
Battered Women Legal Advocacy Project http://www.bwlap.org/ 1-800-313-2666 or (612) 343-9842 Statewide program serving battered women, their advocates, attorneys and the general public in Minnesota.	**Lakeland Mental Health** (Mental Health Services) http://www.lmhc.org/detroit-lakes.html 928 8th St. SE Detroit Lakes, MN 56501 (218) 847-1676 Crisis Hotline # (800) 223-4512
Hubbard County Social Services http://www.co.hubbard.mn.us/socialservices.htm (218) 732-1451 or 1-877-450-1451 301 Court Ave., Park Rapids, MN 56470	**Family Advocacy Center of Northern MN** http://www.facnm.net/ (218) 333-6011 800 Bemidji Ave. N., Suite 4 Bemidji, MN 56601 One of the only centers in America to serve the needs of child sexual and physical abuse, adult sexual assault and domestic violence under one roof.
National Dating Abuse Helpline 1-866-331-9474 www.loveisrespect.org	**National Domestic Violence Hotline** 1-800-799-SAFE (7233) www.ndvh.org
National Suicide Prevention Lifeline 1-800-273-TALK (8255) www.suicidepreventionlifeline.org	**National Sexual Assault Hotline** 1-800-656-HOPE (4673) www.rainn.org

APPENDIX J. POST-TEST

Post-Test

Intimate Partner Violence
North Dakota State University

Please rate the instructor, material, and the overall program by circling the appropriate number.

	Not helpful	Somewhat helpful	Helpful	Very helpful
Instructor	1	2	3	4
Educational Materials	1	2	3	4
Overall Program	1	2	3	4

Testing Knowledge

Please circle True or False as your answer to each of the following statements.

1. Diagnosing intimate partner violence is your most important role. True False
2. You may need to make referrals outside of Essentia to support her/his needs. True False
3. First-line support responds to a victim's needs without intruding on her/his privacy. True False
4. Offer a follow-up visit only if violence is disclosed. True False
5. Having one provider treat both a victim and perpetrator is suggested clinical practice. True False
6. Do not discuss abuse in a room with anyone but the victim and children under 4. True False
7. Promise the woman that you will not discuss the violence. True False
8. Your mental health needs are as important as the mental health of the victim you are caring for. True False
9. Suggesting what you would do if you were in the victim's situation is helpful. True False
10. Saying "I am worried that this may be affecting your health" validates the victim's experience. True False

Continued on back page

Building Skills

Please circle the number that best describes how your confidence to do the following ***has changed***:

Your confidence to:	Not Confident	A Little Confident	Somewhat Confident	Confident	Very Confident
1. Ask about intimate partner violence	1	2	3	4	5
2. Provide first-line support (LIVES)	1	2	3	4	5
3. Refer victims of IPV to local resources	1	2	3	4	5
4. Assess victims who are at immediate risk of violence	1	2	3	4	5
5. Provide initial care after assault	1	2	3	4	5

Please check the box that best describes your answer.

As a result of this program, how likely are you to:	Not likely	Somewhat likely	Likely	Very likely
1. Implement first-line support using the LIVES acronym				
2. Refer for other health care as needed				
3. Refer to community support services				

What did you like the most about this program?

How could this program be improved?

Would you recommend this program to others?

____ Yes _____ No

Comments and suggestions about the program:

Thank you for completing this evaluation.

APPENDIX K. CITI TRAINING

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Anna Thomas (ID: 4405484)
- **Email:** anna.r.thomas@ndsu.edu
- **Institution Affiliation:** North Dakota State University (ID: 907)
- **Phone:** 7013181265

- **Curriculum Group:** Human Research
- **Course Learner Group:** Human Subjects: Social/Behavioral Research Course
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 14091070
- **Completion Date:** 09/18/2014
- **Expiration Date:** 09/17/2017
- **Minimum Passing:** 80
- **Reported Score*:** 100

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Belmont Report and CITI Course Introduction (ID: 1127)	09/18/14
History and Ethical Principles - SBE (ID: 490)	09/18/14
Defining Research with Human Subjects - SBE (ID: 491)	09/18/14
The Federal Regulations - SBE (ID: 502)	09/18/14
Assessing Risk - SBE (ID: 503)	09/18/14
Informed Consent - SBE (ID: 504)	09/18/14
Privacy and Confidentiality - SBE (ID: 505)	09/18/14
Records-Based Research (ID: 5)	09/18/14
Research with Children - SBE (ID: 507)	09/18/14
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	09/18/14
Internet-Based Research - SBE (ID: 510)	09/18/14
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	09/18/14
North Dakota State University (ID: 12090)	09/18/14

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

APPENDIX L. INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

NDSU NORTH DAKOTA STATE UNIVERSITY

April 2, 2015

Mykell Barnacle
Nursing
Sudro 131

Re: IRB Certification of Exempt Human Subjects Research:
Protocol #PH15225 , "LOOKING BEYOND THE QUESTION 'DO YOU FEEL SAFE AT HOME?': WHAT PROVIDERS NEED TO KNOW TO RECOGNIZE, SUPPORT, AND APPROPRIATELY REFER FEMALE VICTIMS OF INTIMATE PARTNER VIOLENCE"

Co-investigator(s) and research team: Anna Thomas

Certification Date: 4/2/15 Expiration Date: 4/1/18
Study site(s): Essentia Health clinics and spring conference
Sponsor: n/a

The above referenced human subjects research project has been certified as exempt (category # 2) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, Protection of Human Subjects). This determination is based on the original protocol submission (received 3/30/15).

Please also note the following:
- If you wish to continue the research after the expiration, submit a request for recertification several weeks prior to the expiration.
- The study must be conducted as described in the approved protocol. Changes to this protocol must be approved prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
- Notify the IRB promptly of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Report any significant new findings that may affect the risks and benefits to the participants and the IRB.

Research records may be subject to a random or directed audit at any time to verify compliance with IRB standard operating procedures.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.
Sincerely,

Kristy Shirley Digitally signed by Kristy Shirley DN: cn=Kristy Shirley, o=NDSU, ou=Institutional Review Board, email=kristy.shirley@ndsu.edu, c=US Date: 2015.04.02 13:12:04 -05'00'

Kristy Shirley, CIP, Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult www.ndsu.edu/irb. This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

INSTITUTIONAL REVIEW BOARD
NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | ndsu.edu/irb

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

APPENDIX M. ESSENTIA INSTITUTE OF RURAL HEALTH APPROVAL LETTER

Essentia Institute
of Rural Health

April 28, 2015

Dear Ms. Thomas:

I reviewed your project and CME proposal on educating health care providers on the care of patients who are survivors of intimate partner violence or sexual assault. Per Essentia Health's Student Learner Policy this project is a quality improvement project. As such, a submission to Essentia Health's Internal Review Board is not necessary. You may proceed with your project under the direction of Essentia Health physician Laura Lunde, MD.

This project, which you are working on to complete your DNP program, is meaningful to our community, patients, and the Essentia Health providers and staff you will be working with. Thank you for sharing the results of your work through the multiple CME presentations you have planned.

If you have any further questions, please feel free to contact me at 218.786.3008 or kdean@eirh.org. If you have a final presentation document you can share with me, I would appreciate having it for our files.

Sincerely,

Kate Dean

Kate Dean, MBA
Director Health Science and Graduate Medical Education
Essentia Institute of Rural Health

Ph: 218-786-3008
Email: kdean@eirh.org

APPENDIX N. PERMISSION TO USE WHO COPYRIGHTED MATERIAL

Gmail by Google

Anna Thomas <anna.rae.thomas@gmail.com>

ID: 155901 - Form to request permission to reproduce or reprint WHO copyrighted material

1 message

permissions <permissions@who.int> Mon, Mar 23, 2015 at 5:52 AM
To: "anna.r.thomas@ndsu.edu" <anna.r.thomas@ndsu.edu>

Dear Anna,

Thank you for completing the online form and for your interest in WHO health information products.

On behalf of the World Health Organization, we are pleased to authorize your request to reproduce the WHO material as detailed in the form below.

This permission is subject to the following conditions:

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We thank you for your interest in WHO and our published information.

Kind regards,

Joelle Jacquier
WHO PRESS

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Sent: vendredi 27 février 2015 21:40
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---
* Title
* Mrs
---
* First name
* Anna
---
* Family name
* Thomas
---
* Organization/affiliation
* North Dakota State University
---
* Web site address
*
---
* Type of organization/affiliation
* Academic
---
* If other, please specify
*
---
* Position
*
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* Telephone
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* Subject of interest
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APPENDIX O. PERMISSION TO USE IOWA MODEL

Gmail by Google

Anna Thomas <anna.rae.thomas@gmail.com>

Permission to Use and/or Reproduce The Iowa Model

1 message

Kimberly Jordan - University of Iowa Hospitals and Clinics <noreply@qemailserver.com> Mon, Feb 2, 2015 at 11:47 AM
Reply-To: Kimberly Jordan - University of Iowa Hospitals and Clinics <kimberly-jordan@uiowa.edu>
To: anna.rae.thomas@gmail.com

You have permission, as requested today, to review/use *The Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001).* Click the link below to open the model.

Copyright of the Iowa Model of Evidence-Based Practice to Promote Quality Care will be retained by The University of Iowa Hospitals and Clinics.

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The Iowa Model

In written material, please add the following statement:

- *Used/Reprinted with permission from the University of Iowa Hospitals and Clinics and Marita G. Titler, PhD, RN, FAAN. Copyright 1998. For permission to use or reproduce the model, please contact the University of Iowa Hospitals and Clinics at (319)384-9098 Cε.*

If you have questions, please contact Kimberly Jordan at 319-384-9098 Cε or kimberly-jordan@uiowa.edu.

APPENDIX P. PERMISSION TO USE POWER AND CONTROL WHEEL

Gmail by Google

Anna Thomas <anna.rae.thomas@gmail.com>

Re: Use of Power and Control Wheel
3 messages

Melissa Scaia <executivedirector@theduluthmodel.org> Thu, Aug 20, 2015 at 12:17 PM
To: Anna Thomas <anna.r.thomas@ndsu.edu>

Dear Anna,

Yes, I would need to see the paragraphs(s) that describe the Power and Control Wheel first please. Thanks.

Sincerely,

Melissa

On Aug 12, 2015, at 11:33 AM, Anna Thomas <anna.r.thomas@ndsu.edu> wrote:

Good Morning-
My name is Anna Thomas, and I am a Doctor of Nursing Practice student at North Dakota State University. I am completing my clinical improvement project for my dissertation on educating primary care providers on Intimate Partner Violence. I am wondering if it would be possible to reference and reproduce the Power and Control Wheel within my dissertation. There would be no revenue generating activity.
Please let me know if this would be possible. Thank you!
Anna Thomas

Melissa Scaia <executivedirector@theduluthmodel.org> Fri, Aug 21, 2015 at 11:11 AM
To: Anna Thomas <anna.r.thomas@ndsu.edu>
Cc: Karin Sollom <ksollom@theduluthmodel.org>

Dear Anna,

Thank you for sending this. Here are a few thoughts.

- While advocates of IPV do use this as a tool, please know that the Power and Control Wheel was developed to represent the experience of battered women - battering being one type of domestic violence.
- One piece of the reason why the Power and Control Wheel was created was because battered women in Duluth said that the "honeymoon phase" of Lenore Walker's Cycle of Violence did not resonate with their experience.
- Also, all of the spokes represent different tactics of abuse and violence - not different types of power and control.
- The outer ring of the wheel exemplifies physical and sexual violence.

Sincerely,

Melissa

On Aug 21, 2015, at 10:47 AM, Anna Thomas <anna.r.thomas@ndsu.edu> wrote:

Good Morning Melissa-
Here is the paragraph that references the Power and Control Wheel. I am open to any and all adaptations.
Thank you.
Anna Thomas

More recently, advocates for victims of IPV have utilized a tool called the Power and Control Wheel (APPENDIX F) (Domestic Abuse Intervention Programs, 2011b). The Domestic Abuse Intervention Programs (DAIP) (2011a) originally created the Power and Control Wheel (Domestic Abuse Intervention Programs, 2011b) in 1984. The Power

and Control Wheel shows that perpetrators use multiple different tactics to control their victims, and that abuse is not always cyclical. The different types of power and control include intimidation, coercion and threats, emotional abuse, isolation, using children, using male privilege, using economic abuse, or minimizing, denying or blaming the victim (Domestic Abuse Intervention Programs, 2011b). The outer ring of the wheel exemplifies the physical violence that occurs, but the inner portion of the wheel focuses on the more subtle ways that a perpetrator will keep a victim in a violent relationship (Domestic Abuse Intervention Programs, 2011b).

From: Melissa Scaia <executivedirector@theduluthmodel.org>
Sent: Thursday, August 20, 2015 12:17 PM
To: Anna Thomas
Subject: Re: Use of Power and Control Wheel

[Quoted text hidden]

Melissa Scaia <executivedirector@theduluthmodel.org> Fri, Aug 21, 2015 at 11:59 AM
To: Anna Thomas <anna.r.thomas@ndsu.edu>
Cc: Karin Sollom <ksollom@theduluthmodel.org>

Dear Anna,

I recently wrote this for a shelter's Facebook page for a more thorough explanation:

The "cycle of violence theory" is linked to battered women's syndrome (BWS). A 1996 DOJ report states that BWS is no longer "useful or appropriate" in explaining the experiences of women who are battered. In addition, our theories about what we believe is the cause of domestic violence will lead us to a particular intervention. In the case of the "Cycle of Violence" the intervention that was most widely used was "anger management" to end the tension phase so that a violent/explosion phase did not occur.

The history of the Power and Control Wheel here in Duluth is based on the creation of our curriculum for working with men who batter to change and too many women in our support groups stating that the "Cycle of Violence Theory" by Lenore Walker was something they could not relate to - especially the "honeymoon stage." Ellen, Coral and Shirley, original advocates in Duluth, then said after too many women said that they couldn't relate to it that they were not going to use it and were going to spend an extensive amount of time just listening to the stories of battered women and not insert their theories or any other textbook theories or models from other fields of study (including chemical dependency). After about a year or two of talking with battered women around the country themes kept emerging. Those themes were then graphically put into the wheel of "The Power and Control Wheel" - with physical and sexual violence on the outer ring. We also don't talk about the wheel as a theory but a representation of the experiences of many battered women - that has been translated into over 22 different languages worldwide and over 30 different cultural contexts. "The Duluth Model" recently received the international award from World Future Council and UN Women for the world's best policy to end violence against women and girls.

The infö above is only if you want to use it. Otherwise it looks great. Thanks for the inquiry.

Sincerely,

Melissa

On Aug 21, 2015, at 11:38 AM, Anna Thomas <anna.r.thomas@ndsu.edu> wrote:

Hello Melissa-
Thank you so much for the feedback. I have talked about Dr. Walker's theory in the previous paragraph, so this flows nicely together. Please let me know if you think that these changes are ok. I appreciate your assistance.
Anna Thomas

Battered women in Duluth, MN felt that the honeymoon phase of Walker's (1979) theory did not fit with their

personal experience. From the experiences that these women had, the Power and Control Wheel (APPENDIX F) was created (Domestic Abuse Intervention Programs, 2011b). The Domestic Abuse Intervention Programs (DAIP) (2011a) originally created the Power and Control Wheel (Domestic Abuse Intervention Programs, 2011b) in 1984. The Power and Control Wheel shows that perpetrators use multiple different tactics to control their victims, and that abuse is not always cyclical. The different tactics of violence include intimidation, coercion and threats, emotional abuse, isolation, using children, using male privilege, using economic abuse, or minimizing, denying or blaming the victim (Domestic Abuse Intervention Programs, 2011b). The outer ring of the wheel exemplifies the physical and sexual violence that occurs, but the inner portion of the wheel focuses on the more subtle ways that a perpetrator will keep a victim in a violent relationship (Domestic Abuse Intervention Programs, 2011b).

From: Melissa Scaia <executivedirector@theduluthmodel.org>
Sent: Friday, August 21, 2015 11:11 AM
To: Anna Thomas
Cc: Karin Sollom
[Quoted text hidden]

[Quoted text hidden]

APPENDIX Q. GRAND ROUNDS FLYER

Thursday Grand Rounds
Intimate Partner Violence

Date/Time: **May 14, 2015 12:15 — 1:15 pm**
Location: Essentia Health - South University Auditorium
1702 S. University Dr., Fargo, ND
Videoconference to Solutions at 32nd Ave.;
Other sites can join via MOVI by dialing 14003
Click here for attendance sheet & evaluation
Presenter: **Anna Thomas, RN, BSN**

Learning Objectives

1. Implement first-line support measures via the LIVES acronym to all victims of Intimate Partner Violence.
2. Demonstrate an understanding of Intimate Partner Violence and the role of a primary care provider in caring for these patients.
3. Reference resources provided on how to care for victims of Intimate Partner Violence.
4. Provide resources and referrals within the community to victims of Intimate Partner Violence.

Target Audience

All members of the health care team

Faculty Disclosure

To comply with ACCME Standards for Commercial Support, Essentia Health requires faculty members to disclose the existence of any relevant financial interest or other relationship with companies whose products or services are related to the subject matter of the presentation.

All planners and faculty have submitted signed disclosure forms indicating that they do not have actual or potential conflicts of interest that might have a direct bearing on the subject matter of this CME activity.

Accreditation

Essentia Health is accredited by the Minnesota Medical Association (MMA) to provide continuing medical education for physicians.

Essentia Health designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This program offers 1.0 contact hours for continuing education. Most medical professional organizations accept *AMA PRA Category 1 Credits™*. Go to your respective organization's website for more detailed information regarding credit requirements.

NOTE: If you have any special mobility, vision, or hearing needs, please contact Andrea Carlson, CME Education Specialist at Andrea.Carlson2@essentiahealth.org or 218-855-5264.

Essentia Health

Continuing Medical Education

APPENDIX R. EXECUTIVE SUMMARY

Background

Intimate partner violence (IPV) is a widespread public health concern in the United States. IPV can be physical, emotional, sexual, or psychological. An intimate partner is someone who is a current or former partner or spouse (Centers for Disease Control and Prevention, 2014a). IPV is extensive and encompasses acts such as rape, stalking, sexual coercion, physical force, threats, humiliation, or preventing an individual from accessing money, family or friends (Centers for Disease Control and Prevention, 2014a).

Women who are victims of IPV are at a much higher risk of morbidity and mortality (Usta, Antoun, Ambuel, & Khawaja, 2012). Victims of IPV more frequently report suffering from anxiety, low self-esteem, gastrointestinal issues, sexually transmitted diseases, chronic pain, pregnancy concerns and suicide attempts (Black et al., 2011). Other chronic health concerns may include pelvic inflammatory disease, migraine headaches, neurologic disorders, injury or death (Moyer, 2013). For mental health concerns alone, IPV accounts for more than 18.5 million healthcare visits per year (National Coalition against Domestic Violence, 2007). Women may seek treatment for the healthcare concerns related to IPV for years without disclosing that they are a victim of IPV, and that is why it is important to educate healthcare providers on identifying symptoms of IPV (Dienemann, Campbell, Wiederhorn, Laughon, & Jordan, 2002).

The World Health Organization (2013) suggests that for providers to fulfill the important role of identifying victims, they must be adequately trained. However, for the training to be effective it needs to not only increase the number of victims who are identified, but also provide training on how to support and appropriately refer victims of IPV (World Health Organization,

2013). This recommendation from the WHO arises from the knowledge that without knowing how to support or refer victims of IPV, some providers feel unprepared to treat victims of IPV.

Project Summary

This clinical improvement project takes the current evidence-based practice recommendations regarding IPV and relays that information to healthcare providers. The focus is on identifying victims of IPV even if they say that they feel safe at home by assessing their current symptoms and asking appropriate questions. Once providers identify victims, the focus shifts to tailoring support specifically to each victim, and referring the victim to the services that are appropriate for that individual. By educating healthcare providers on the current evidence-based practices, the ultimate goal is to identify and provide assistance to victims of IPV that are ready for additional support.

A pre-test and post-test was completed at each of the five primary care clinics during each educational seminar. A pre-test was administered to all healthcare providers regarding their knowledge on the topic of IPV, their confidence to identify, support, and refer victims of IPV, and their current practices with victims of IPV (Appendix E). The pre-test was administered immediately prior to each educational seminar. The baseline information gathered from the pre-test was used for comparison with the post-test results. Collected surveys were compiled and the data was analyzed using statistics as recommended with consultation of the Statistical Counseling Center at North Dakota State University (NDSU).

Next, information regarding how to identify, provide first-line support, and take appropriate next steps for victims of IPV, were integrated into both a PowerPoint presentation and a resource pamphlet (Appendix F). The materials were built upon the current evidence-based practice findings from the World Health Organization's (2014) *Health care for women subjected*

to intimate partner violence or sexual violence: A clinical handbook. Both the PowerPoint presentation and resource pamphlet were presented by this Doctor of Nursing Practice student from North Dakota State University during a one hour lunch educational seminar. Additional information regarding specific resources in each of the local areas where the educational seminars was provided were added to the PowerPoint presentation and pamphlet as well (Appendices G, H, I). Due to the mandatory reporting laws surrounding abuse, information regarding the laws specific to Minnesota and North Dakota were also provided. Appendix D contains a handout from the Rape and Abuse Crisis Center (2009) that has a brief synopsis of the mandated reporting laws for both Minnesota and North Dakota. This handout was provided to all of the attendees of the educational seminar. Once the content was determined, the pamphlet was created through the NDSU Graphic Services and Copy Shop.

Finally, a post-test was distributed to all healthcare providers who attend the educational seminar (Appendix J). The post-test asked the same knowledge questions as the pre-test to gauge whether or not there was an increase in knowledge. The post-test also assessed whether or not a provider intended to change how they care for victims of IPV based on the information provided during the educational seminar. Finally, the post-test assessed whether or not the participant had an increased confidence in his/her ability to identify, support, and refer victims of IPV following the educational seminar. The post-test also solicited feedback about strengths and weaknesses of the educational seminar. Collected post-tests were compiled and the data was analyzed using statistics as recommended with consultation of the Statistical Counseling Center at North Dakota State University.

Results

The attendees of the educational seminars demonstrated knowledge acquisition as a result of the educational seminar. This was determined through pre and posttests that were administered before and after each of the educational seminars, respectively. Knowledgeable healthcare providers are able to identify, support and refer victims of IPV to the appropriate care that they need. Also, as a result of the educational seminars, there was a behavioral change from how healthcare providers were currently practicing to how they intend to practice in the future. This intent to change practice could result in more case findings and referrals for victims of IPV.

Recommendations

Recommendations include further development, implementation, and evaluation of the most recent literature on how to care for victims of IPV. In relationship to the Intimate Partner Violence module, new guidelines and literature are found frequently. Keeping the PowerPoint presentation up-to-date with recent evidence, as well as the area resource sheets recent with current resources will be essential.

Another recommendation, based on feedback from the committee for this dissertation, is to take the next step in educating healthcare providers by not just telling them what is important to do, but rather by showing them what to do. For example, creating vignettes on a positive or negative interaction between a provider and a victim of IPV would be one way to expand this project. Another option would be to provide healthcare providers with exact phrases to say. This would empower healthcare providers to feel able to approach the subject and to know that they are being helpful and supportive. The comfort level would belong to providers, not patients, but ultimately would make the patient experience better.

Another recommendation, based on feedback from a participant, would be to expand the scope of where this educational seminar is offered. For this practice improvement project, the focus was on primary care. Feedback from an educational seminar participant specifically suggested offering this education to the Emergency Department staff, as well as Case Management. These two disciplines, as well as other disciplines are avenues that would be an option for future practice improvement projects.

Implications for Practice

The practice improvement project has shown that there is a need for increased healthcare provider knowledge and the subsequent increase in recognition, support, and referral of victims of IPV, which have major implications for practice. As discussed in Chapter 1, the prevalence of IPV is pervasive. Increased healthcare provider knowledge on how to care for victims of IPV may ultimately increase the number of victims who are identified and referred to services.