Facilitating Follow Up Services for Survivors of Intimate Partner Violence Presenting to Emergency Departments

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Abstract

Background: Patients who suffer from intimate partner violence (IPV) have many chronic health concerns. Lack of access to health care services is one contributing factor to poor health outcomes in this group. Survivors of IPV seek care from many community services. The Emergency Department (ED) is a common location for patients to present for care immediately following a violent event. After discharge, there is often no formal follow up care. This interaction with the healthcare system is a potential access point for continuity of care.

Purpose: This project aimed to improve access to follow up care as well as primary care services for patients presenting to the ED with complaints of IPV. PICOT Question: In patients with complaints of intimate partner violence presenting to the ED, does a follow up phone call with a registered nurse address barriers to accessing primary and follow up healthcare services?

Method: The IOWA model was used for project design. The project was designed with input from members of the forensic team at the project site based on noted concerns of patients lost to follow up and literature review findings supporting this same concern.

Procedures: All patients who presented to the ED with complaints of IPV were called for follow up over a 3 month time frame. The telephone intervention included a reminder of scheduled appointments, offer to establish care with a primary care provider (PCP), education of community resources, and safety planning.

Nursing Implications: Registered nurses can help this population improve access to services by assessing individual needs and facilitating contact with appropriate healthcare services.

Keywords: domestic violence, intimate partner violence, primary care, barrier or barriers

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Facilitating Follow Up Services for Survivors of Intimate Partner Violence Presenting to Emergency Departments

Intimate Partner Violence (IPV) is a crime that impacts millions of Americans each year. Until surveillance data in 2011 began reporting on incidence levels in the United States, statistics were difficult to find on how vast this problem is. According to research by the National Intimate Partner and Sexual Violence Survey (NISVS) 1 in 4 women and 1 in 10 men are victims of sexual violence, physical violence, or stalking by a current or former intimate partner over the course of their lifetime (Smith, et al. 2015). Since the original survey, researchers have identified a number of social and practical variants that make it difficult to report on data which may indicate even higher incidences of violence. Some of these factors include the intimate nature of this crime, repeat incidents, lack of access to health care and law enforcement, lack of training by healthcare workers and law enforcement staff to track such incidents, and more (Smith, et al. 2015).

Survivors of assault who seek healthcare often sustain physical injuries such as strangulation, musculoskeletal trauma, and head or brain injuries. Research has suggested that survivors are more likely to participate in high risk behaviors that affect long-term health such as smoking, substance abuse, and high-risk sexual behavior (Breiding, et al. 2015). These injuries and high-risk behaviors can have lasting effects on survivors and can lead to a sequela of symptoms and occasionally even death. Not much research has been done on the lasting effects of domestic violence injuries although there is evidence that survivors of IPV are more likely to experience poor health outcomes (WHO, 2005). Research efforts have also started to measure long-term health impacts on survivors including the relationship of IPV with chronic illnesses, risky health behaviors, mental health, and utilization of healthcare services (Poleshuck, et, al,

2018; Kazmerski, et. al., 2015). There is emerging evidence to support an increased mental health burden on survivors of IPV (Dichter, et al., 2017; Van Deinse, et. al, 2019). Additionally, a recent study of Missouri women survivors of IPV found it was significantly more likely for survivors to be overweight or obese, current cigarette users, excessive alcohol drinkers, and to have poorer mental health by report (Bosch, et al., 2017). The authors of this study reported a correlation with IPV and high cholesterol and high blood pressure as well as an even higher increased risk in those who were unable to work due to IPV. There is also evidence that women who are victims of domestic violence are at increased risk for homicide resulting from their abuser and leaving or attempting to leave a violent relationship can increase this risk even further (Campbell et al., 2003).

Another challenge facing this population is access to health care services. Researchers have begun to investigate challenges facing IPV survivors and accessing mental health services, community resources, and access to primary health care services (Anyikwa, 2015; Velonis, et. al, 2017, Nichols, et. al, 2018, Mastrocinque, et. al, 2017, Calton, et. al, 2016). A number of barriers have been identified but more research is needed in this area. One particularly disturbing barrier seems to be the health care provider's attitude towards survivors of IPV. Emerging evidence shows that a poor experience with a provider regarding IPV disclosure leads to lack of follow up care. (Mackenzie et. al, 2019).

Health care providers should understand this population is a high risk and vulnerable group. Better understanding of the socioeconomic challenges experienced by this group may also increase compassion and understanding during health visits. Through learning to identify IPV survivors as a vulnerable group, providers can better manage and treat identified injuries. They can also help survivors access follow up care by referring them to local resources (social work

services, primary care, mental health services, etc). Patients often present to the Emergency Department immediately following an assault which provides an opportunity for health providers to intervene. Adequate training through screening mechanisms as well as trauma informed education should help providers be more sensitive to specific needs of this population. More data regarding barriers to routine and chronic disease management is needed as well as effective interventions to help providers work with this population.

The PICOT question addressed in this review aimed to examine access to acute and chronic healthcare services by investigating current identified barriers to healthcare for survivors of IPV. The PICOT question for this project is: In patients with complaints of intimate partner violence presenting to the ED, does a follow up phone call with a registered nurse address barriers to accessing primary and follow up healthcare services?

Review of Literature

A systematic review of four databases was conducted to explore the topic of IPV and access to primary health care services. The databases used for the literature review were: PubMed, Web of Science, PsycINFO, and Cochrane. Search terms include "domestic violence" with the Boolean operator OR, "intimate partner violence", "primary care" and "barrier" with the Boolean operator OR "barriers". Results were limited to the past 5 years. PubMed resulted 117 sources, Web of Science resulted 76, PsycINFO resulted 33, and Cochrane resulted 13. This left 239 total sources. After reading titles and abstracts for relevance to the topic and removing duplicate articles, 28 remained for analysis (see Figure 1). Due to lack of data on the specific question regarding barriers in access to primary care services in patients suffering from IPV, sources were retained for their relevance to the topic of access to health care services,

implementation of IPV services in the primary care setting, and experiences with help seeking in general.

To address the possibility of publication bias, a review of the gray literature was performed by searching: Intimate Partner Violence or Domestic Violence barriers to access primary care in Google's search engine and looking at the first 20 results. There was no evidence of a publication bias based in the gray literature, and findings were consistent with findings in this investigator's systematic review. Several themes in the gray literature included: the use of primary care to screen for intimate partner violence, barriers to screening for intimate partner violence in primary care, and integrating healthcare providers and social/community services. A similar lack of research specifically relating to barriers in accessing primary care services for sufferers of intimate partner violence was found.

Summary of Data and Analysis

Articles were reviewed for level of evidence and quality of research using the Johns Hopkins Nursing Evidence-Based Practice Model method which was used with permission (Dang & Dearhold, 2017, Appendix A). Figure 2.1 and figure 2.2 outline steps for evaluating research using this model. Four level one studies were reviewed including three randomized control trials, one of which is currently active with preliminary results published and one that included a mixed methods qualitative review. The third level one study was a systematic review without meta-analysis. All four studies were high (A) quality research.

Four level two studies were analyzed and found to be high (A) quality research. Sixteen studies were level three and either high (A) or (A/B) for qualitative studies reviewed. Four level four studies were reviewed with either high (A) or good (B) quality research. One level five study was analyzed and found to be of good (B) quality.

A thematic approach was taken for review of literature due to the heavy reliance on qualitative sources. Themes expressed throughout the literature included integration of primary care with social and allied services for better outcomes, feeling of trust and understanding during disclosure, and a general lack of data on barriers to accessing primary care. Findings were consistent across cultures in this analysis.

Integration of primary care with social and allied services

Many sources reported recognition of the importance of utilizing primary care services. Primary care provides long-term health care over the lifetime and is helpful for developing relationships with providers over time. Primary care providers (PCP) occasionally offer services for IPV survivors and most utilize referral programs that include mental health services, safety planning, and parental support (Hegarty et al., 2016). No available evidence exists to support the efficacy of these interventions offered. More research is needed to assess helpfulness of these resources but it is clear that primary care has a role to play in supporting IPV survivors who disclose their abuse.

Having a long-term relationship with a provider through primary care may make services more readily available when patients decide they would like interventive services. Not all survivors of IPV are ready to disclose at the time they seek health services so the timing of supportive interventions is important (Ford-Gilboe et al., 2015).

Access to health care is especially difficult for vulnerable populations and many studies suggest integrating primary care services with police, community advocacy groups, and social services is helpful for positive long-term results (Briones-Vozmediano et al., 2019; Lewis et al., 2019). Not all IPV survivors will seek help through their primary care and often will seek out legal or community resources first (Evans & Feder, 2016; Mantler et al., 2018; Vives-Cases et

al., 2017; Sawyer, et al, 2015). A common theme among sources was the reported need for better education and communication between legal, advocacy, social, and health services. An example of this includes results from a trial of integrating primary care services into shelter services (Mantler, et. al., 2018). The study findings illustrated that the visibility of health providers while at the shelter increased follow up with primary care after leaving the shelter. This finding suggests the importance of developing a trusting relationship with providers.

Feeling of Trust and Understanding During Disclosure

It is helpful for patients to develop a rapport with providers as this may influence their willingness to disclose abuse and continue to seek health services (Mackenzie, et al. 2019). A common theme found in the literature was that survivors of IPV were often afraid to disclose violence due to social and cultural stigma and fear of retaliation or misunderstanding from providers or loved ones (Hill et al., 2016; Huntley et al., 2019). By approaching patients with a positive regard and knowledge of IPV issues, providers can help develop a sense of trust and influence future attempts to access health services (Mackenzie et al., 2019). In a study of Lesbian, Gay, and Bisexual (LGB) patients, who are historically vulnerable to intimate abuse, establishing trust with providers and community support networks was critical in improving access to care (Floyd et al., 2016).

A trusting relationship with providers may also make counseling and interventions more successful (Weaver et al. 2015; O'Doherty et al. 2016). In order to build a positive rapport, providers must first be educated on the various barriers to health services that IPV survivors may experience. It is important for providers to validate patient fears and to help survivors navigate the many barriers they may encounter while seeking lifestyle changes and escalation of care.

Barriers to Accessing Health Services

Almost all qualitative studies analyzed identified one of the biggest barriers to disclosing IPV is social and cultural stigma faced by survivors. A lack of community or cultural knowledge leads to a fear of reporting. This finding was consistent across cultures and especially among vulnerable populations (Dhunna et al., 2018; Taherkhani et al., 2019; Finfgeld-Connett, 2017; Sabri et al., 2015) suggesting future interventions may be targeted at challenging social and cultural norms regarding violence in the home. Improving provider, law enforcement, and social services knowledge may also be prudent to challenge current practices (MacCormac & Romo, 2018).

Future interventions should be targeted at improving resources and public perception of available services (Huntley et al., 2019) as well as increasing funding for resources and changes at the policy level (Stark et al., 2016).

Potentially Useful Interventions

There were some quantitative studies found in the literature. A common limitation in these studies was short duration and small sample size. Although the sample size of these few studies would limit generalizability, the barriers for seeking help and health services in this population appear to be similar across cultural groups. This is promising for future interventions in long-term trials.

One randomized control trial reported on the effectiveness of community health worker follow up after identification of current IPV (Rodgers, et al, 2017) against routine care which included a family advocate during presentation to a community health center. The study found that outcomes were similar among groups although the follow up group was less likely to be lost to follow up and more satisfied with their care. The results of this study suggest that personalized

care is helpful to keep survivors in touch with resources although the intervention only lasted for 3 months identifying opportunity for further study.

In this increasingly digital age, online interventions are promising sources of information and safety planning. The flexibility of online access and ability to tailor interventions supports this hypothesis (Tarzia et al., 2016). Through a coordinated effort between the United States, Canada, New Zealand, and Australia, investigators developed several online tools for use (Ford-Gilboe et al., 2017). Results of this study showed positive perception of the intervention with no identified harms to participants. The study report also demonstrated benefits on depressive symptoms, PTSD symptoms, experience of coercion by partners, helpfulness of safety planning, confidence in planning for self and children, mastery of educational material, and improvement in social support (Ford-Gilboe et al., 2020).

Barriers to Implementation of Interventions

Although potential interventions are being developed to address IPV, there are barriers to implementing them. As described throughout this review, social and cultural norms prevent survivors from accessing care. This stigma may also impact implementation of services and funding for supportive interventions at the national and regional level. Government and community resources need more funding for cultural education and implementation of services (Garcia-Moreno et al, 2015) and national policy efforts should be involved to address this problem (Colombini et al, 2017; Colombini et al, 2019). Funds should be targeted at communities with lower resources as lack of funding significantly impacts ability to implement effective interventions (Schwab-Reese & Renner, 2018) and communities with low levels of resources are likely to be more vulnerable to IPV.

Limitations

Limitations in this review include English language, full text or completed studies, lack of randomized control trials, and the use of mostly qualitative sources. Lack of randomized controlled trials (RCT) was expressed as a limitation in many of the articles and many sources expressed a need for intervention and implementation studies. The intervention studies that were found (including the four RCTs) cited short intervention time as a limitation and suggested longitudinal follow up.

Evaluation and Recommendations

The few RCTs completed were short term studies that identified potentially useful interventions. These interventions centered around patient education, safety, and follow up care. Most of the remaining literature revealed qualitative data regarding patient experiences of the healthcare system following IPV or providers' perception of barriers to screening and treating patients with IPV complaints. The reviewed qualitative studies supported the need to design more intervention studies with long-term follow up. The literature supports the general conclusion that significant barriers to addressing IPV include barriers to services from personal, social, and systemic factors; the need to build trusting relationships with survivors to encourage disclosure; and the need for primary care practices to engage with survivors to support positive long-term health outcomes.

Methods

Project Setting

The project site was a level one trauma center emergency department (ED) that has a team of forensics registered nurses (RN) who are trained to care for survivors of sexual and physical violence. At the start of the project, there were 9 nurses on the team, 3 of whom are

nurse practitioners (NP). One of these providers leads the team and performs follow up examinations to track injuries identified during the initial examination. Each team member takes call for 12 hour shifts and responds to pages from providers in the ED. When a patient presents to the hospital with complaint of sexual assault, intimate partner violence, strangulation, non-accidental trauma (child abuse), or concern for elder abuse, healthcare providers in the hospital alert the forensic team using a paging system embedded in the electronic documentation system.

The forensic nurses are trained to document injuries and collect evidence to be used in a court of law if charges are filed for the assault. The examination varies in length depending upon complaint. Sexual assault examinations can take up to 3 hours to gather evidence and document injuries using photography and charting in the medical records. The examination is a systematic exam that starts with taking a history, opening a physical evidence recovery kit (PERK), collecting clothing and potential evidence, and looking over the patient for injuries. The forensic examiner uses a blue light to highlight body fluid for collection, photographs and measures injuries, and uses a substance called toluidine dye to highlight sensitive injuries that may not be visible to the naked eye (typically used to highlight micro tears on genitalia). They also can perform a pelvic exam to identify injuries on the cervix and hymen or an anorectal examination to identify injuries to the mucosal lining of the rectum if indicated.

Because the examination is so meticulous, forensic nurses are able to help healthcare providers identify and treat injuries that may cause long-term health consequences (such as strangulation and head injuries) which require close follow up to prevent sequela. They also help with safety planning by working with social work and other local community services to help patients identify options for seeking help in the event they decide to leave their abusive situation.

Follow Up Healthcare Services for Survivors of IPV

This is an important part of the forensic nurses' job as a survivor of IPV is at higher risk for death when they decide or attempt to leave an abusive situation (Campbell et al, 2003).

Often, patients will remain in the ED for further management after the forensics examination has been completed. Most patients are discharged home although occasionally they will need to be admitted to the hospital for care. At the time of discharge, patients are scheduled for follow up with the nurse practitioner on the team if there are injuries that may continue to worsen over the next few days and require further documentation. Not all IPV patients require a follow up appointment with the forensics team depending on the nature of their assault.

Occasionally patients will be scheduled for an appointment with their PCP if they have one. This is dependent upon the ED attending provider's preference as there is currently no defined protocol for follow up. Given the nature of the ED and its focus on acute care, follow up is not generally a priority for providers who are working on more urgent or immediate patient needs. This is a problem that could more easily be addressed by the forensic team given the structural constraints of the ED and the specialized training of this group.

It is not uncommon for patients to miss their follow up appointments although the number of missed appointments is not currently tracked due to the variance in patients who need further care. There are a variety of potential reasons why these patients do not return for appointments or seek out primary care services but the literature has not identified any particularly effective interventions to address this. There has been some promising research noted by Rogers et al (2017) which concluded that patients who were followed by a case manager were less likely to be lost to follow up care and more satisfied with services.

The purpose of this project was an evidence based practice project to address the gap in follow up care for these patients. All patients who presented to the ED for complaints of IPV

were called for follow up during the 3 month time frame of implementation. The rationale for the phone intervention is based on preliminary findings of better satisfaction and engagement in care found in Rogers et al (2017) as well as encouragement of a trusting relationship with health care services which was identified as a common theme throughout the review of literature. Questions to be addressed were based on the literature citing gaps in access to primary healthcare services, mental health services, and need for safety planning. The telephone intervention from the NP student investigator helped patients navigate perceived or actual barriers to accessing primary care. The NP student investigator educated on available services and answered questions regarding the examination or process for reporting to law enforcement.

IOWA Model

The Iowa model was used with permission to design the project (Iowa Model Collaborative, 2017, Appendix B). The Iowa model is a conceptual framework tool designed to aid clinicians in identifying and addressing clinical concerns. The framework uses a team-based approach to identify relevant practice issues, gather evidence surrounding the clinical question, design a practice change, and evaluate results. Advantages of the model include the use of a team approach, ability to change practice as evidence dictates, and continuity of practice guidance over time as new evidence emerges. This was helpful as the NP student investigator utilized input from the forensics team nurses to design the goals of the project.

Protection of Human Subjects and Permissions

Implementation occurred after proposal acceptance and Institutional Review Board (IRB) determination. The IRB was consulted and it was determined that the project did not fall under IRB review as it was an Evidence Based Practice Project (Appendix C). The project moved forward after the approval of the forensics team lead.

Procedures

The forensics team was educated on the purpose of the project in order to facilitate timely notification of IPV patient presentations and to let patients know they will be receiving follow up calls. This allowed patients to give an appropriate phone number for follow up or to decline if they did not wish to have continuation of care. All patients who presented to the ED with complaints of IPV at the University of Virginia were offered a follow up call. The follow up call was done by the NP student investigator using Doximity which is a telephone application that allowed the NP student investigator to call patients anonymously. The phone calls were conducted within 72 business hours of their initial exam to facilitate safety planning and needed follow up services. The calls also answered questions regarding forensics services, the legal process, or community resources. Voicemails were not left to protect the patient in the event of surveillance of phone messages and another call was attempted if the patient was unreachable.

Patients were reminded of any follow up appointments scheduled for them during their initial exam and were offered an appointment with a PCP if they did not already have one. Any other immediate safety needs were addressed to help patients navigate the health and community service system and medical questions were deferred to a primary care or specialty provider.

Questions explored in the telephone appointment included: Do you have a PCP? Do you plan to see your PCP as a result of your injuries and if not, why? Are you aware of your options if you decide to leave your current situation? Are you aware of counseling resources available to you? Do you plan to follow up with the forensic team as a result of your injuries?

The intent of these questions was to facilitate establishing care with primary care and mental health services when applicable. The questions were also intended to promote a trusting relationship with the health care system and to encourage attendance of scheduled follow up

appointments. Those who expressed a need for mental health services were directed towards local resources (Sexual Assault Resource Agency if applicable, Community Service Board, Region 10, etc) depending on their locality and situation. Follow up phone calls were two months after initial encounter to assess continuity of treatment and effectiveness of telephone intervention however, there were barriers to this process. These are discussed further in the results section below.

Results

The project ran from August 1, 2020 through October 31, 2020. During this time 14 patients were seen by the Forensics Department for complaints of IPV. Of those 14, one was a minor. This person was contacted as part of routine care for follow up but was not included in the results.

Of the 13 adult patients, five were unable to be reached for various reasons. Of those five patients, two were admitted to the hospital during the follow up time period. Three of the five patients were lost to follow up due to inability to contact them via phone.

The remaining seven patients were contacted via telephone to follow up on their initial forensic appointment. Out of these seven patients, one of them had declined a forensic examination but requested a follow up call for assistance in community service access. Out of the remaining six patients, two had a follow up appointment with the nurse practitioner. Four of the seven patients were scheduled for follow up appointments with a PCP or an obstetrics provider either during their initial exam in the Emergency Department or during their follow up call. All four of these patients attended their appointments as planned.

Although a scripted follow up was initially used during the first follow up call (and was adhered to as best as possible) several needs emerged indicating the need for more personalized

education and care coordination. The differences between each patient situation identified the need for follow up to be tailored to the patient's current priorities.

Case Descriptions

Case 1

This patient was contacted to discuss follow up care. It was immediately evident that a follow up appointment was not a priority for them given they were homeless and had not eaten since discharge from the hospital two days prior. The NP student investigator immediately shifted focus of the phone call and was able to help the patient access an open food bank and remind them of a follow up with local Region 10 services. A follow up appointment was also scheduled for an establishment of care with a PCP and the patient was reminded of this. The patient was scheduled for a follow up appointment with the forensic lead NP and this appointment was done while they were admitted a second time to the hospital.

Case 2

This patient was contacted via telephone and the topic of safety planning was addressed. The NP student investigator was able to discuss the importance of yearly appointments with a PCP (they had one but had not been in several years). Community resources were discussed for counseling and safety planning in the future. This patient was contacted a second time for follow up. The patient expressed the phone calls were somewhat helpful and stated that they still felt “shocked” by their experience.

Case 3

This patient was contacted via telephone and safety planning was addressed as well as follow up for specialty services. Questions regarding the legal process and protective orders were addressed. The patient had suffered an injury requiring specialty care as a result of their assault

and was having difficulty accessing timely follow up. This patient had a designated PCP who was involved in the case and was able to help with this process. This patient was contacted through a second phone call and further questions regarding the legal process were addressed as well as counseling services available. The patient found this follow up especially helpful and stated they felt very supported because of the follow through by the forensic team.

Case 4

This patient was contacted via phone call and follow up appointment was rearranged to help facilitate transport to the appointment. The patient did not show for their follow up appointment and was unable to be reached a second time.

Case 5

This patient was contacted for a follow up call and safety planning (including emergency safety community resources), financial planning for purposes of leaving their abuser, primary care, and local social services were addressed. This patient found the follow up helpful.

Case 6

This patient did not want an examination or to follow up for clinic appointment but did express interest in safety planning discussion. They stated appreciation for the follow up call service.

Case 7

This patient reviewed the events of the assault with NP student investigator and asked questions regarding access to follow up care and available counseling services. This patient found the follow up call helpful for navigating the immediate time frame after assault.

Discussion

Overall, the project demonstrated a need for better follow up care for survivors of IPV. In keeping with the literature regarding feelings of fear regarding disclosure, forensic nurses who are trained in responding to trauma can be particularly helpful. All of the patients who were contacted expressed appreciation for the service and several stated they were thankful to have someone check in. By initiating a welcoming encounter with the health system, forensic nurses have the ability to promote a better sense of trust in health care providers and hopefully encourage patients to seek care for other health concerns.

More research is needed to identify long term impact of follow up care on health outcomes but the findings from this project align with the findings in similar studies (Rogers, 2017, Mackenzie et al, 2019). Patients who are followed individually appreciate the service and are less likely to be lost to follow up when cared for by a provider who understands the complexities of IPV.

Impact of Coronavirus

It is worth noting the effect of the coronavirus global pandemic on the impact of this pilot project. Overall, the forensic team saw a reduction in volume from August 2020-November 2020 in comparison to the same months in 2019. Already, experts have begun studying the effects of this epidemic on IPV and violence within the home (Evans et al., 2020) citing the reduced access in services due to safety concerns, the lack of visibility within the community, and increased burden of the economic impacts (job loss, child care loss) on financial security of survivors of IPV.

It is not known how the global pandemic will impact this population in the long term but early results indicate that it will not be in a positive way. Healthcare communities can act now to

mitigate the poor health outcomes that may arise from worsening violence in the home by becoming more educated in the unique needs of this population. Providers can be educated in trauma informed care which has been shown to be helpful for improving survivors' trust in health care providers (Mackenzie et al, 2019). Providers can also learn about community resources in their locality which may be beneficial for patients who present in safety crisis.

Health systems can work towards mitigating violence in the home by improving access to services. Finding the most cost effective and realistic way to interact with patients for follow up is important. While the ED may not be the appropriate service line to focus on initiating follow up protocols, forensic nurses who often work within the ED are more likely to have the capacity to perform this service. Forensic nurses are already trained in trauma informed care and have the knowledge to adapt to patient needs based on their immediate and long term priorities. Nurses are able to educate patients on the health benefits of establishing care with primary care services while also assessing a patient's level of understanding or ability to access these services.

Nursing Practice Change

The results of the project were discussed at the monthly forensics team staff meeting and members of the team were engaged in the project. The team discussed the implications of the project and agreed to implement follow up calls on patients seen for sexual assault and IPV. To keep up with the volume of patients, each team member will now contact the patients they see while on call. By keeping the provider constant, it is felt that this will encourage more trust in seeking health care services. Since not all team members have access to Doximity and the team does not have a designated office phone, it was discussed that team members should obtain their own google or other anonymous telephone number for contact methods (for patient and nurse privacy).

System Improvement Recommendations

This project clearly documented the need for improved follow up services for patients. This patient population has its inherent challenges and more frequent contact with the health system would be beneficial for this group for long term health and safety. The forensic team plans to propose a full time RN position as it grows in patient size to aid in care coordination.

Strengths and Limitations of Project

The adaptability of the EBP design is a strength to support this model over a research model because it allows for flexibility based on individual needs. This was especially helpful for follow up calls when the patient was not interested in primary care services or long term follow up but had other immediate health needs (Case 1). The EBP model provides an opportunity to identify trends in useful interventions for more robust research projects in the future. By identifying common themes in the follow up phone calls, more robust research studies can focus on determining long term effectiveness. Potential weaknesses include difficulty contacting patients for follow up given the current literature citing lack of follow up care in this population and lack of robust current research supporting the effectiveness of this type of intervention.

Products of Scholarly Project

The project results will be submitted to the University of Virginia School of Nursing for completion of the Doctorate of Nursing Practice. A presentation will be given to UVA DNP advisors and interested community members and a submission of the manuscript will be sent to Libra (UVA's scholarly repository). An abstract has been submitted to the International Association of Forensics Nurses for review and potential presentation at the annual conference in September 2021.

References

Anyikwa, V. A. (2015). The Intersections of Race and Gender in Help-Seeking Strategies Among a Battered Sample of Low-Income African American Women. Journal of Human Behavior in the Social Environment, 25(8), 948–959. https://doi.org/10.1080/10911359.2015.1047075

Bosch, J., Weaver, T. L., Arnold, L. D., & Clark, E. M. (2017). The Impact of Intimate Partner Violence on Women's Physical Health: Findings From the Missouri Behavioral Risk Factor Surveillance System. Journal of Interpersonal Violence, 32(22), 3402–3419. https://doi.org/10.1177/0886260515599162

Breiding, M. J., Basile, K. C., Smith, S. G., & C, B. M. (2015). Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements. Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf

Briones-Vozmediano, E., Castellanos-Torres, E., Goicolea, I., & Vives-Cases, C. (2019). Challenges to Detecting and Addressing Intimate Partner Violence Among Roma Women in Spain: Perspectives of Primary Care Providers. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260519872299

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. Trauma, Violence & Abuse, 17(5), 585–600. https://doi.org/10.1177/1524838015585318

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study. *American Journal of Public Health*, *93*(7), 1089–1097.

Colombini, M., Alkaiyat, A., Shaheen, A., Garcia Moreno, C., Feder, G., & Bacchus, L. (2019). Exploring health system readiness for adopting interventions to address intimate partner violence: A case study from the occupied Palestinian Territory. *Health Policy and Planning*. MEDLINE®. https://doi.org/10.1093/heapol/czz151

Colombini, M., Dockerty, C., & Mayhew, S. H. (2017). Barriers and Facilitators to Integrating Health Service Responses to Intimate Partner Violence in Low- and Middle-Income Countries: A Comparative Health Systems and Service Analysis. *Studies in Family Planning*, *48*(2), 179–200. https://doi.org/10.1111/sifp.12021

Dang, D., & Dearholt, S. (2017). Johns Hopkins nursing evidence-based practice: model and guidelines. 3rd ed. Indianapolis, IN: Sigma Theta Tau International

Dhunna, S., Lawton, B., & Cram, F. (2018). An Affront to Her Mana: Young Māori Mothers' Experiences of Intimate Partner Violence. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260518815712

Dichter, M. E., Sorrentino, A., Bellamy, S., Medvedeva, E., Roberts, C. B., & Iverson, K. M. (2017). Disproportionate Mental Health Burden Associated With Past-Year Intimate Partner Violence Among Women Receiving Care in the Veterans Health Administration. *Journal of Traumatic Stress*, *30*(6), 555–563. c8h. https://doi.org/10.1002/jts.22241

Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy*, *19*(1), 62–73. https://doi.org/10.1111/hex.12330

Evans, M. L., Lindauer, M., & Farrell, M. (2020). A Pandemic within a Pandemic—Intimate Partner Violence during Covid-19. *New England Journal of Medicine*, *2020*(383), 2302–2304. https://doi.org/10.1056/NEJMp2024046

Finfgeld-Connett, D. (2017). Intimate Partner Violence and its Resolution among Mexican Americans. *Issues in Mental Health Nursing*, *38*(6), 464–472. https://doi.org/10.1080/01612840.2017.1284968

Floyd, S. R., Pierce, D. M., & Geraci, S. A. (2016). Preventive and Primary Care for Lesbian, Gay and Bisexual Patients. *American Journal of the Medical Sciences*, *352*(6), 637–643. https://doi.org/10.1016/j.amjms.2016.05.008

Ford-Gilboe, Marilyn, Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and Predictors of Service Use Among Women Who Have Separated from an Abusive Partner. *Journal of Family Violence*, *30*(4), 419–431. https://doi.org/10.1007/s10896-015-9688-8

Ford-Gilboe, M, Varcoe, C., Scott-Storey, K., Wuest, J., Case, J., Currie, L., Glass, N., Hodgins, M., MacMillan, H., Perrin, N., & et al. (2017). A tailored online safety and health intervention for women experiencing intimate partner violence: The iCAN Plan 4 Safety randomized controlled trial protocol. *BMC Public Health*, *17*(1), 273. https://doi.org/10.1186/s12889-017-4143-9

Ford-Gilboe, Marilyn, Varcoe, C., Scott-Storey, K., Perrin, N., Wuest, J., Wathen, C. N., Case, J., & Glass, N. (2020). Longitudinal impacts of an online safety and health intervention for women experiencing intimate partner violence: Randomized controlled trial. *BMC Public Health*, *20*(1), 260. MEDLINE®. https://doi.org/10.1186/s12889-020-8152-8

Garcia-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *Lancet*, *385*(9977), 1567–1579. https://doi.org/10.1016/S0140-6736(14)61837-7

Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. *BMC Family Practice*, *17*(1), 115. https://doi.org/10.1186/s12875-016-0508-x

Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry*, *28*(5), 519–532. https://doi.org/10.1080/09540261.2016.1210103

Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors Influencing Mental Health Screening and Treatment Among Women in a Rural South Central Appalachian Primary Care Clinic. *Journal of Rural Health*, *32*(1), 82–91. https://doi.org/10.1111/jrh.12134

Huntley, A. L., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. *BMJ Open*, *9*(6), e021960. https://doi.org/10.1136/bmjopen-2018-021960

Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. Worldviews on Evidence-Based Nursing, 14(3), 175-182. doi:10.1111/wvn.12223.

Johns Hopkins Nursing Evidence Level and Quality Guide, levels I-III. Dang, D., & Dearholt, S. (2017). Johns Hopkins nursing evidence-based practice: model and guidelines. 3rd ed. Indianapolis, IN: Sigma Theta Tau International.

Kazmerski, T., McCauley, H., Jones, K., Borrero, S., Silverman, J., Decker, M., Tancredi, D., & Miller, E. (2015). Use of Reproductive and Sexual Health Services Among Female Family

Planning Clinic Clients Exposed to Partner Violence and Reproductive Coercion. Maternal & Child Health Journal, 19(7), 1490–1496. https://doi.org/10.1007/s10995-014-1653-2

Lewis, N. V., Dowrick, A., Sohal, A., Feder, G., & Griffiths, C. (2019). Implementation of the Identification and Referral to Improve Safety programme for patients with experience of domestic violence and abuse: A theory-based mixed-method process evaluation. *Health & Social Care in the Community*, *27*(4), E298–E312. https://doi.org/10.1111/hsc.12733

MacCormac, O. J., & Romo, T. (2018). Challenges facing a woman wishing to report intimate partner violence in Belize. *BMJ Case Reports*, *2018*. https://doi.org/10.1136/bcr-2018-226048

Mackenzie, M., Gannon, M., Stanley, N., Cosgrove, K., & Feder, G. (2019). "You certainly don't go back to the doctor once you've been told, 'I'll never understand women like you.'" Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. *Sociology of Health & Illness*, *41*(6), 1159–1174. https://doi.org/10.1111/1467-9566.12893

Mantler, T., Jackson, K. T., & Walsh, E. J. (2020). Integration of Primary Health-Care Services in Women's Shelters: A Scoping Review. Trauma, Violence, & Abuse, 21(3), 610–623. https://doi.org/10.1177/1524838018781105

Mastrocinque, J. M., Thew, D., Cerulli, C., Raimondi, C., Pollard, R. Q., & Chin, N. P. (2017). Deaf Victims' Experiences With Intimate Partner Violence: The Need for Integration and Innovation. Journal of Interpersonal Violence, 32(24), 3753–3777. https://doi.org/10.1177/0886260515602896

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & for the PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ*, *339*(jul21 1), b2535–b2535. https://doi.org/10.1136/bmj.b2535

Nichols, E. M., Bonomi, A., Kammes, R., & Miller, E. (2018). Service seeking experiences of college-aged sexual and intimate partner violence victims with a mental health and/or behavioral disability. Journal of American College Health, 66(6), 487–495. https://doi.org/10.1080/07448481.2018.1440572

O'Doherty, L., Taket, A., Valpied, J., & Hegarty, K. (2016). Receiving care for intimate partner violence in primary care: Barriers and enablers for women participating in the weave randomised controlled trial. *Social Science & Medicine (1982)*, *160*, 35-42. https://doi.org/10.1016/j.socscimed.2016.05.017

Poleshuck, E., Mazzotta, C., Resch, K., Rogachefsky, A., Bellenger, K., Raimondi, C., Thompson Stone, J., & Cerulli, C. (2018). Development of an Innovative Treatment Paradigm for Intimate Partner Violence Victims With Depression and Pain Using Community-Based Participatory Research. *Journal of Interpersonal Violence*, *33*(17), 2704–2724. c8h. https://doi.org/10.1177/0886260516628810

Rodgers, M. A., Grisso, J. A., Crits-Christoph, P., & Rhodes, K. V. (2017). No Quick Fixes: A Mixed Methods Feasibility Study of an Urban Community Health Worker Outreach Program for Intimate Partner Violence. *Violence Against Women*, *23*(3), 287–308. https://doi.org/10.1177/1077801216640383

Sabri, B., Huerta, J., Alexander, K. A., St Vil, N. M., Campbell, J. C., & Callwood, G. B. (2015). Multiple Intimate Partner Violence Experiences: Knowledge, Access, Utilization and Barriers to Utilization of Resources by Women of the African Diaspora. *Journal of Health Care for the Poor and Underserved*, *26*(4), 1286–1303. https://doi.org/10.1353/hpu.2015.0135

Sawyer, S., Coles, J., Williams, A., & Williams, B. (2015). Preventing and reducing the impacts of intimate partner violence: Opportunities for Australian ambulance services. *Emergency Medicine Australasia: EMA*, *27*(4), 307–311. https://doi.org/10.1111/1742-6723.12406

Schwab-Reese, L. M., & Renner, L. M. (2018). Screening, management, and treatment of intimate partner violence among women in low-resource settings. *Women's Health (London, England)*, *14*, 1745506518766709. https://doi.org/10.1177/1745506518766709

Smith S. J., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2015). National Intimate Partner and Sexual Violence Survey: 2015 Data Brief-Updated Release. Retrieved from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Stark, L., Landis, D., Thomson, B., & Potts, A. (2016). Navigating Support, Resilience, and Care: Exploring the Impact of Informal Social Networks on the Rehabilitation and Care of Young Female Survivors of Sexual Violence in Northern Uganda. *Peace and Conflict-Journal of Peace Psychology*, *22*(3), 217–225. https://doi.org/10.1037/pac0000162

Taherkhani, S., Negarandeh, R., & Farshadpour, F. (2020). Barriers to Leaving a Relationship From the Perspective of Married Abused Iranian Women: Secondary Analysis of the Interviews With Abused Women. Journal of Interpersonal Violence, 35(19–20), 4162–4184. https://doi.org/10.1177/0886260519844777

Tarzia, L., Murray, E., Humphreys, C., Glass, N., Taft, A., Valpied, J., & Hegarty, K. (2016). I-DECIDE: An online intervention drawing on the psychosocial readiness model for women experiencing domestic violence. *Women's Health Issues*, *26*(2), 208–216. https://doi.org/10.1016/j.whi.2015.07.011

Van Deinse, T. B., Wilson, A. B., Macy, R. J., & Cuddeback, G. S. (2019). Intimate Partner Violence and Women with Severe Mental Illnesses: Needs and Challenges from the Perspectives of

Behavioral Health and Domestic Violence Service Providers. *Journal of Behavioral Health Services & Research*, *46*(2), 283–293. c8h. https://doi.org/10.1007/s11414-018-9624-9

Vives-Cases, C., Goicolea, I., Hernandez, A., Sanz-Barbero, B., Davo-Blanes, Mc., & La Parra-Casado, D. (2017). Priorities and strategies for improving Roma women's access to primary health care services in cases on intimate partner violence: A concept mapping study. *International Journal for Equity in Health*, *16*, 96. https://doi.org/10.1186/s12939-017-0594-y

Velonis, A. J., Daoud, N., Matheson, F., Woodhall-Melnik, J., Hamilton-Wright, S., & O'Campo, P. (2017). Strategizing Safety: Theoretical Frameworks to Understand Women's Decision Making in the Face of Partner Violence and Social Inequities. Journal of Interpersonal Violence, 32(21), 3321–3345. https://doi.org/10.1177/0886260515598953

Weaver, T. L., Gilbert, L., El-Bassel, N., Resnick, H. S., & Noursi, S. (2015). Identifying and Intervening with Substance-Using Women Exposed to Intimate Partner Violence: Phenomenology, Comorbidities, and Integrated Approaches Within Primary Care and Other Agency Settings. *Journal of Womens Health*, *24*(1), 51–56. https://doi.org/10.1089/jwh.2014.4866

WHO | WHO multi-country study on women's health and domestic violence against women. (n.d.). WHO; World Health Organization. Retrieved March 27, 2020, from https://www.who.int/reproductivehealth/publications/violence/24159358X/en/

Tables and Figures

Table 1

Evidence sort for Intimate Partner Violence

Citation	Year	Study Purpose	Study Design	Sample	N	Independent (Predictor) Variable(s)	Dependent (Outcome) Variable(s)	Findings	Level of Evidence	Quality
Ford-Gilboe, M., Varcoe, C., Scott-Storey, K., Wuest, J., Case, J., Currie, L., Glass, N., Hodgins, M., MacMillan, H., Perrin, N., & et al. (2017). A tailored online safety and health intervention for women experiencing intimate partner violence: The iCAN Plan 4 Safety randomized controlled trial protocol. BMC Public Health, 17(1), 273. https://doi.org/10.1186/s12889-017-4143-9	2017	Test online IPV intervention. Reduce access to barriers, improve intervention, & maximize effect	RCT	Women who have experienced IPV in the past 6 months in Canada	450	Tailored, interactive online safety and health intervention vs. usual treatment (general online safety information)	Primary: depressive and PTSD symptoms Secondary: helpful safety actions, safety planning self-efficacy, mastery, and decisional conflict	Not yet available, trial currently active	I	A
Colombini, M., Dockerty, C., & Mayhew, S. H. (2017). Barriers and Facilitators to Integrating Health Service Responses to Intimate Partner Violence in Low- and Middle-Income Countries: A Comparative Health Systems and Service Analysis. Studies in Family Planning, 48(2), 179–200. https://doi.org/10.1111/sifp.12021	2017	Identify and analyze barriers & facilitators to integrated health sector response to IPV in low and middle income countries. Looks at various points of access to services.	Systematic Review w/o meta-analysis	Full text articles, all designs	11	Measures relating to integrated health sectors response to IPV. Entry points and level of comprehensiveness enabled factors and barriers to integration	Effectiveness of health sector response to IPV	The following traits are important: availability of guidelines, management support, intersectoral coordination with clear & accessible referral options. Trained staff with continued education for health workers & supervised environment to enact new IPV	I	A

		Tracks benefits vs. challenges at each point.						protocols. Connected system level response and coordination between entry points of service emerged as a crucial trait for success		
Ford-Gilboe, M., Varcoe, C., Scott-Storey, K., Perrin, N., Wuest, J., Wathen, C. N., Case, J., & Glass, N. (2020). Longitudinal impacts of an online safety and health intervention for women experiencing intimate partner violence: Randomized controlled trial. BMC Public Health, 20(1), 260. MEDLINE®. https://doi.org/10.1186/s12889-020-8152-8	2020	Can online IPV interventions reduce barriers to support and improve outcomes?	RCT	Canadian adult women survivors of IPV	462	iCAN Plan 4 Safety intervention (tailored to pt) vs. non-tailored version of the tool	Primary: depressive and PTSD symptoms Secondary: helpful safety actions, safety planning self-efficacy, mastery, and decisional conflict	Both groups improved over time on primary and secondary outcomes. Changes did not differ over time but women in tailored group reported more positive fit and helpfulness.	I	A
Rodgers, M. A., Grisso, J. A., Crits-Christoph, P., & Rhodes, K. V. (2017). No Quick Fixes: A Mixed Methods Feasibility Study of an Urban Community Health Worker Outreach Program for Intimate Partner Violence. Violence Against Women, 23(3), 287–308. https://doi.org/10.1177/1077801216640383	2017	Identify the feasibility, acceptability & safety of providing follow up care with a community based IPV advocate with currently abused women	Mixed Methods; RCT	Multilevel project conducted in 4 Philadelphia community health centers	58	Community Health Worker combined with Family Health Advocate vs. Family Health Advocate alone	Satisfaction with intervention and impact of participation on perceived safety and motivation t change	Participants were satisfied with both. Those assigned to case worker were less often lost to follow up, and more engaged. Few were able to safely leave their environment during the study which was only 3 months	I	A
Lewis, N. V., Dowrick, A., Sohal, A., Feder, G., & Griffiths, C. (2019). Implementation of the	2019	Identify variation in referral	Mixed methods; case	5 London boroughs that had	Case study- 1; Survey	Extent of normalization of IRIS protocol	Descriptive data on implementati	IRIS linked healthcare and DV advocacy	II	A

Identification and Referral to Improve Safety programme for patients with experience of domestic violence and abuse: A theory-based mixed-method process evaluation. Health & Social Care in the Community, 27(4), E298–E312. https://doi.org/10.1111/hsc.12733		practices across the UK. This study was a follow up analysis of the Identification and Referral to Improve Safety (IRIS) implementation	study, Quantitative cross sectional survey data; qualitative data, document review	implemented the IRIS study	118; 27 qualitative interviews, 44 documents	by NHS staff, how is IRIS normalized by staff from NHS and 3rd sector orgs, what factors affect normalization of IRIS, how do these factors affect normalization of IRIS	on of IRIS study and the extent to which providers had integrated it into their practice.	groups. All third sector participants and most NHS staff showed high individual specification of DVA work, although the latter demonstrated varied legitimization of the DVA work. The collective specification between NHS and third sector teams was less strong due to the differences in organisations' ethos and culture.		
Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. International Review of Psychiatry, 28(5), 519–532. https://doi.org/10.1080/09540261.2016.1210103	2016	Understand barriers to screening & implementation of IPV response in primary care & to identify promising interventions in the literature	Systematic Review	Systematic reviews identified through literature search Included interventions relevant to recovery between 2013-2015	16	Interventions for IPV in primary care	Efficacy of intervention	Little evidence to support interventions. Most common interventions in primary care: response/referral, psychological treatment, safety planning, and parenting support. More research needed to identify	II	A

								effective treatments.		
Ford-Gilboe, M., Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and Predictors of Service Use Among Women Who Have Separated from an Abusive Partner. Journal of Family Violence, 30(4), 419–431. https://doi.org/10.1007/s10896-015-9688-8	2015	Analyze patterns of access to health, social, violence, and legal services in Canadian women who had separated from an abusive partner	Quas-experimental; Case control	Baseline data from Women's Health Effects Study	309	Abuse history, social and health variables	Access to health, social, legal, and violence services	Associations between types of abuse histories, social location, health, and use of services exist. Long-term studies need to be done to identify if service use changes over time after women leave an abuse relationship and to identify why these changes might exist.	II	A
Garcia-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. Lancet, 385(9977), 1567–1579. https://doi.org/10.1016/S0140-6736(14)61837-7	2015	Explore potential interventions health systems can implement to prevent and reduce the sequela of domestic violence	Systematic Review	5 countries-South Africa, Brazil, Spain, India, Lebanon as well as literature search	5	Government, community, and health system funding and response to violence	Insight for improved health care access for survivors of domestic violence	Government and community resources need to put more funding into addressing sexual and domestic violence. Survivors seek healthcare from various points in the system and more providers need to be trained to recognize and respond to violence.	II	A
Mantler, T., Jackson, K. T., & Walsh, E. J. (2018). Integration of Primary Health-Care Services	2018	Examine research pertaining	Scoping review	4 electronic databases;	19	Integration of primary health care and	Efficacy of primary health-care	Three themes: increased access & acceptability	III	A

in Women's Shelters: A Scoping Review. Trauma, Violence & Abuse, 1524838018781105. MEDLINE®. https://doi.org/10.1177/1524838018781105		to IPV and primary health-care/ women's shelter integration. Identify research related to integrating the two		all sources		women's shelter services	received and integration of services	of services, bridge back to health care, decreasing future health care burden by integrating access to health care		
Schwab-Reese, L. M., & Renner, L. M. (2018). Screening, management, and treatment of intimate partner violence among women in low-resource settings. Women's Health (London, England), 14, 1745506518766709. https://doi.org/10.1177/1745506518766709	2018	Identify evidence-based interventions to support low-resource areas affected by IPV	Scoping review	All studies	34	Barriers to implementation of IPV interventions	Implications for providers and researchers	Researchers must consider local contexts when implementing IPV programs in low-resource areas; additional research is needed to establish effective protocol for this underserved group.	III	A
Sabri, B., Huerta, J., Alexander, K. A., St Vil, N. M., Campbell, J. C., & Callwood, G. B. (2015). Multiple Intimate Partner Violence Experiences: Knowledge, Access, Utilization and Barriers to Utilization of Resources by Women of the African Diaspora. Journal of Health Care for the Poor and Underserved, 26(4), 1286–1303. https://doi.org/10.1353/hpu.2015.0135	2015	Analyze data from a large multisite comparative case-control research project that involves African American and African	Mixed methods; non-experimental quantitative and qualitative	Women in Baltimore, MD, St. Croix and St. Thomas. English or Spanish speaking women of African descent 18-55 who were	163 women experienced multiple types of IPV (from quantitative)11 of those women consented to follow up interviews.	Experiencing multiple types of IPV	Barriers or perceived barriers to help seeking, access to resources, utilization of resources	Quantitative data: determine if Black women in Baltimore who experienced multiple IPV were significantly different from Black women in US Virgin Islands who experienced multiple IPV	III	A; A/H

		Caribbean women		in an intimate relationship in the past 2 years				with respect to demographic, mental health, risk for lethality and knowledge/access/and utilization of resources. Qualitative themes: barriers at all levels; fear of violence or loneliness; lack of awareness; mental health; financial dependence on abuser; attachment to abuser; barriers that prevented having no contact with the abuser; obstacles involving the criminal justice system/perceived ineffectiveness of the system		
Huntley, A. L., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. BMJ Open, 9(6), e021960. https://doi.org/10.1136/bmjopen-2018-021960	2019	To understand help-seeking by male victims of domestic violence and abuse and their experience	Systematic review and qualitative evidence synthesis	12 databases	12	Experience of domestic violence or abuse by males	Help seeking or barriers to help seeking in this population	9 themes: barriers to help seeking, fear of disclosure, challenge to masculinity, commitment to relationship, diminished confidence/despondency, and	III	A; A/I

		s of support						invisibility/perception of services; experiences of interventions of support: initial contact, confidentiality, appropriate professional approaches and inappropriate professional approaches		
Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. Health Expectations: An International Journal of Public Participation in Health Care & Health Policy, 19(1), 62–73. https://doi.org/10.1111/hex.12330	2016	Explore different paths to accessing support and experience of barriers vs. facilitators to disclosure and help-seeking	Qualitative	Women seeking help from specialist domestic violence and abuse agencies in the UK interviewed twice over 5 months	31	Experience of domestic violence or abuse and seeking help at a health agency	facilitators or barriers to accessing help	Access to support usually came through police/ housing agencies. Rarely from a GP. Informal disclosure only led to help if the family member or friend had experience with domestic abuse	III	A; A/B
Dhunna, S., Lawton, B., & Cram, F. (2018). An Affront to Her Mana: Young Māori Mothers' Experiences of Intimate Partner Violence. Journal of Interpersonal Violence, 886260518815712.	2018	Understand the lived reality of young Maori mothers who experience IPV & examine if responsiveness has been	Qualitative	Maori women aged 14-19 from E Hine longitudinal maternal health care study	6 participants out of 43 from the original study	Experience of IPV among young Maori mothers vs. no abuse	Extended family support, autonomy, and hospitality or nurturing supportive influences	Extended family is both a violence perpetuating and protective factor. Structural and institutional barriers prevent safe service responses for this population Exposure to violence as a young child also	III	A/B

		culturally safe.						put young women at risk		
Taherkhani, S., Negarandeh, R., & Farshadpour, F. (2019). Barriers to Leaving a Relationship From the Perspective of Married Abused Iranian Women: Secondary Analysis of the Interviews With Abused Women. Journal of Interpersonal Violence, 886260519844777. https://doi.org/10.1177/0886260519844777	2019	Identify barriers to leaving a relationship from perspective of a married abused Iranian woman	Secondary analysis of qualitative study	Married abused Iranian women selected using a purposive sampling method	24	Abused Iranian married women	Fear, Lack of resources, Beliefs and attitudes, and Dependence	Contextual factors were reasons for not leaving relationship. Interventions should focus on enriching resources, education about domestic violence, and modification of existing attitudes and beliefs	III	A/B
Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. BMC Family Practice, 17(1), 115. https://doi.org/10.1186/s12875-016-0508-x	2016	Interviews designed to identify development and implementation barriers to addressing family violence in the primary care setting	Qualitative	2 sources: primary health care sites; network meeting of primary care professionals	4 primary care sites; 35 delegates at network meeting	Primary care site addressing IPV	Enablers and barriers	Four themes emerged: getting started, building effective relationships, source funding, and shaping the national approach to family violence. Results suggest need for more research and prioritizing at the national level is needed	III	A/B
Colombini, M., Alkaiyat, A., Shaheen, A., Garcia Moreno, C., Feder, G., & Bacchus, L. (2019). Exploring health system readiness for adopting interventions to address intimate partner violence: A case study	2019	To identify how ready the Palestinian territory is to adopt new	Case study with qualitative methods	Public health care providers, key informants, 19	1	Current services for domestic violence survivors	readiness of health systems and services to adopt new interventions	Major gaps in care include: governance, financial resources, information systems,	III	A/B

from the occupied Palestinian Territory. Health Policy and Planning. MEDLINE®. https://doi.org/10.1093/heapol/czz151		practices regarding domestic violence services		stakeholders, health facility observations, and document review of legal and policy materials				coordination between services, and values regarding domestic violence.		
Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors Influencing Mental Health Screening and Treatment Among Women in a Rural South Central Appalachian Primary Care Clinic. Journal of Rural Health, 32(1), 82–91. https://doi.org/10.1111/jrh.12134	2016	To explore barriers and facilitators to accessing mental health services in primary care population of Rural Appalachia	Qualitative study	Patients and Providers at a rural primary care clinic in Appalachia; Study stems from a larger research project in which females over 18 wee sample	22 18 female patients and 4 providers	4 primary care concerns: Depression, anxiety substance abuse, and IPV	Barriers or facilitators to seeking mental health services in primary care	Stigma, lack of support and lack of education; integrated care and positive experiences with providers were identified as barriers and facilitators by patients. Operational, mental health competence, predicted patient reaction & attitudes; clinic characteristics, provider characteristics, and patient/provider education were identified as barriers/facilitators	III	A/B
Tarzia, L., Murray, E., Humphreys, C., Glass, N., Taft, A., Valpied, J., & Hegarty, K. (2016). I-DECIDE: An online	2016	Outlines theoretical and conceptual	Non-experimental, theoretica	Women experiencing intimate	n/a	Use of an online decision aid to seek help and safety	Potential outcomes include internal	Argues that a theoretical model should be used in intervention	III	A/B

intervention drawing on the psychosocial readiness model for women experiencing domestic violence. Women's Health Issues, 26(2), 208–216. https://doi.org/10.1016/j.whi.2015.07.011		development of an online health relationship tool and decision aid. Explores the use of psychosocial readiness model as a framework for the intervention	l article proposing a planned intervention	partner violence			factors: awareness, self-efficacy, and perceived support; may also impact mood such as depression	development and evaluation		
Weaver, T. L., Gilbert, L., El-Bassel, N., Resnick, H. S., & Noursi, S. (2015). Identifying and Intervening with Substance-Using Women Exposed to Intimate Partner Violence: Phenomenology, Comorbidities, and Integrated Approaches Within Primary Care and Other Agency Settings. Journal of Womens Health, 24(1), 51–56. https://doi.org/10.1089/jwh.2014.4866	2019	Part of another study, this article analyzed associations between women's and doctor's baseline characteristics and uptake of intervention. Authors analyzed individual and contextual factors in decisions	Qualitative	Participants in the weave study (a study of intervention by family doctors in primary care on IPV women) Original study included consenting women who were afraid of their partner in	20	Women who took up counseling sessions (either one or all 6 sessions) vs. those who did not	Characteristics of providers, readiness to change,	Women who attended counseling sessions were less likely to be in a current relationship and rated doctors' communication skills more favorably. Nonintervention were less likely to be open to receiving help and were less likely to regard their trial doctor as their primary doctor. Findings suggest a trusting relationship with	III	A/B

		to attend/not attend counseling with family doctors		the last 12 months (Sample of 20,000 women surveyed)				PCP benefit willingness to change and interest in intervention.		
Finfgeld-Connett, D. (2017). Intimate Partner Violence and its Resolution among Mexican Americans. Issues in Mental Health Nursing, 38(6), 464–472. https://doi.org/10.1080/01612840.2017.1284968	2017	To find information in the primary literature relating to Mexican American women and their experience with IPV to generate new knowledge and find generalizable knowledge	Systematic Review	All studies	19	Mexican American Women who experience IPV	Themes among studies	Various themes emerged: IPV is fueled by culture; Barriers to IPV include normalization, fear, taboo relating to disclosure, lack of knowledge and support, and self-nurturance; Resolution of IPV involves judicious disclosure to those perceived to be able to help, awareness and availability of help,	III	A/B
Stark, L., Landis, D., Thomson, B., & Potts, A. (2016). Navigating Support, Resilience, and Care: Exploring the Impact of Informal Social Networks on the Rehabilitation and Care of Young Female Survivors of Sexual Violence in Northern Uganda. Peace and Conflict-Journal of Peace Psychology, 22(3), 217–225. https://doi.org/10.1037/pac0000162	2016	To understand girls' perception of quality of care and barriers or facilitators to reintegration into society after sexual	Qualitative	Girls 13-17 from 4 camps for displaced persons. Survivors of sexual violence & girls from general camp	12	Experience of sexual violence	Access to formal services, disclosure of abuse, experience of social stigmatization; perpetrator identity	Themes identified have implications for policy measures. Family friends were often close support networks for recovery and helped access formal care. Stigma and social norms directly	III	A/B

		violence in Uganda.		population				impacted girls' recovery.		
O'Doherty, L., Taket, A., Valpied, J., & Hegarty, K. (2016). Receiving care for intimate partner violence in primary care: Barriers and enablers for women participating in the weave randomised controlled trial. Social Science & Medicine (1982), 160, 35-42. https://doi.org/10.1016/j.socscimed.2016.05.017	2016	Identify factors involved in women's uptake of a counseling intervention delivered by family doctors in the WEAVE primary care trial	Qualitative study	Random selection of participants from the intervention arm of the weave trial	20	Intervention group of WEAVE trial	Factors that impacted decisions to participate and response to intervention	Attenders were less likely to be in a current relationship & more likely to view their doctors' communication skills highly. Perceived value of the intervention, awareness of safety, participation as a path toward support, viewing primary care as a mental health and physical health home; readiness for change; viewing GP as a safe place or interpreting them as a busy provider were all factors influencing uptake	III	A/B
Mackenzie, M., Gannon, M., Stanley, N., Cosgrove, K., & Feder, G. (2019). "You certainly don't go back to the doctor once you've been told, 'I'll never understand women like you.'" Seeking candidacy and structural competency in the dynamics of	2019	To explore women's experience with family doctors and discussion of	Qualitative	Women who experience abuse. Sample obtained from Scottish	20	Experienced abuse and no longer viewed to be at risk	Lived experiences of interactions with general practitioners	GP encounters with women who have experienced abuse influence future help-seeking depending on	III	A/B

domestic abuse disclosure. Sociology of Health & Illness, 41(6), 1159–1174. https://doi.org/10.1111/1467-9566.12893		Domestic Abuse		Women's Aid and ASSIST (advocacy support group)				provider response		
Briones-Vozmediano, E., Castellanos-Torres, E., Goicolea, I., & Vives-Cases, C. (2019). Challenges to Detecting and Addressing Intimate Partner Violence Among Roma Women in Spain: Perspectives of Primary Care Providers. Journal of Interpersonal Violence, 886260519872299. https://doi.org/10.1177/0886260519872299	2019	To identify barriers for access to care among Romani women survivors of IPV and to gather ideas for interventions across different services	Concept mapping study	Roma civil society groups, primary health care professionals and other stakeholders (social work, etc) across Spain	12	Barriers to help seeking for Romani women	Actions to improve primary health care services' and professionals' responses to Romani women seeking help due to IPV	8 themes: Relationship with provider; practices to promote respect & improve detection; strengthen collaboration with Romani associations; enhance resources for follow up; facilitate participation in care; enhance cultural knowledge for staff; strengthen awareness in Romani community; & develop community led action for prevention	IV	A
Sawyer, S., Coles, J., Williams, A., & Williams, B. (2015). Preventing and reducing the impacts of intimate partner violence: Opportunities for Australian ambulance services. Emergency Medicine	2015	Propose actions for Australian ambulance services to undertake to reduce	Opinion of nationally recognized expert committees;	Australian government's National Plan to reduce violence	1	Ambulance services and interactions with IPV patients and other health services	Interventions ambulance services can take to support IPV work	Immediate actions that ambulance services can implement: collaboration with external	IV	A

Australasia: EMA, 27(4), 307–311. https://doi.org/10.1111/1742-6723.12406		the impacts of intimate partner violence in line with national strategies.	practice guidelines; review of National Plan (n=1)	towards women and supporting literature				agencies, education, data collection, and promoting zero tolerance of violence towards women		
Vives-Cases, C., Goicolea, I., Hernandez, A., Sanz-Barbero, B., Davo-Blanes, Mc., & La Parra-Casado, D. (2017). Priorities and strategies for improving Roma women's access to primary health care services in cases on intimate partner violence: A concept mapping study. International Journal for Equity in Health, 16, 96. https://doi.org/10.1186/s12939-017-0594-y	2017	Integrate key stakeholder opinions about interventions needed to improve access to primary health services and professional responses to Roma women in an IPV situation. Define top 10 priority interventions across services	Concept mapping study	Stakeholders in Spain who work with Roma women experiencing IPV	50	Stakeholders opinions on Romani women exposed to IPV and treatment/intervention options	Priority actions to improve primary health care response to Romani women in IPV situation	Efforts should be integrated across service lines to reinforce primary health care response to IPV. Improve detection, strengthen coordination among services, enhance resources, facilitate participation, increase knowledge & cultural sensitivity, strengthen awareness in community, develop community approach	IV	A

Floyd, S. R., Pierce, D. M., & Geraci, S. A. (2016). Preventive and Primary Care for Lesbian, Gay and Bisexual Patients. American Journal of the Medical Sciences, 352(6), 637–643.https://doi.org/10.1016/j.amjms.2016.05.008	2016	To discuss preventative care for LGB patients in the United States	Review of literature	LGB persons in the United States	n/a	LGB vs. heterosexual individual	Accessibility to primary care services	Establish trusting relationship & assistance in dealing with complexities of LGB care is critical to improving access.	IV	B

Figure 1

Database Results

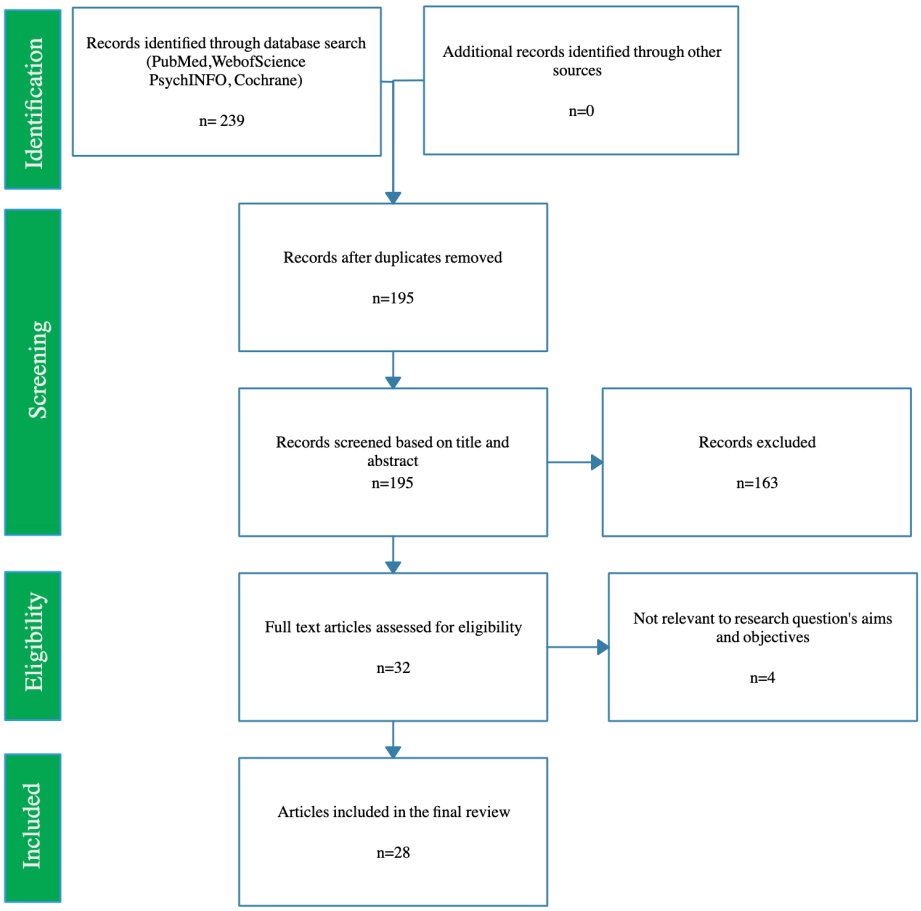


Figure 1. Adapted "Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement." (Moher et al., 2009)

Figure 2.1

Johns Hopkins Nursing Evidence-Based Practice Level and Quality Guide

Johns Hopkins Nursing Evidence-Based Practice

Appendix D

Evidence Level and Quality Guide

Evidence Levels	Quality Ratings
Level I Experimental study, randomized controlled trial (RCT) Explanatory mixed method design that includes only a level I quaNtitative study Systematic review of RCTs, with or without meta-analysis	**QuaNtitative Studies** **A High quality**: Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence. **B Good quality**: Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence. **C Low quality or major flaws**: Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.
Level II Quasi-experimental study Explanatory mixed method design that includes only a level II quaNtitative study Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	**QuaLitative Studies** No commonly agreed-on principles exist for judging the quality of quaLitative studies. It is a subjective process based on the extent to which study data contributes to synthesis and how much information is known about the researchers' efforts to meet the appraisal criteria. *For meta-synthesis, there is preliminary agreement that quality assessments of individual studies should be made before synthesis to screen out poor-quality studies*[1]. **A/B High/Good quality** is used for single studies and meta-syntheses[2]. The report discusses efforts to enhance or evaluate the quality of the data and the overall inquiry in sufficient detail; and it describes the specific techniques used to enhance the quality of the inquiry. Evidence of some or all of the following is found in the report: • Transparency: Describes how information was documented to justify decisions, how data were reviewed by others, and how themes and categories were formulated. • Diligence: Reads and rereads data to check interpretations; seeks opportunity to find multiple sources to corroborate evidence. • Verification: The process of checking, confirming, and ensuring methodologic coherence. • Self-reflection and scrutiny: Being continuously aware of how a researcher's experiences, background, or prejudices might shape and bias analysis and interpretations. • Participant-driven inquiry: Participants shape the scope and breadth of questions; analysis and interpretation give voice to those who participated. • Insightful interpretation: Data and knowledge are linked in meaningful ways to relevant literature. **C Low quality** studies contribute little to the overall review of findings and have few, if any, of the features listed for high/good quality.
Level III Nonexperimental study Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta-analysis Exploratory, convergent, or multiphasic mixed methods studies Explanatory mixed method design that includes only a level III quaNtitative study QuaLitative study Meta-synthesis	

Figure 2.1. Johns Hopkins Nursing Evidence Level and Quality Guide, levels I-III. Dang, D., & Dearholt, S. (2017). Johns Hopkins nursing evidence-based practice: model and guidelines. 3rd ed. Indianapolis, IN: Sigma Theta Tau International. Reprinted with permission

Figure 2.2

Johns Hopkins Nursing Evidence-Based Practice Level and Quality Guide

Johns Hopkins Nursing Evidence-Based Practice

Appendix D

Evidence Level and Quality Guide

Evidence Levels	Quality Ratings
Level IV Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels/position statements	A **High quality:** Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years B **Good quality:** Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years C **Low quality or major flaws:** Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the past five years
Level V Based on experiential and nonresearch evidence Includes: • Integrative reviews • Literature reviews • Quality improvement, program, or financial evaluation • Case reports • Opinion of nationally recognized expert(s) based on experiential evidence	**Organizational Experience (quality improvement, program or financial evaluation)** A **High quality**: Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial, or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence B **Good quality**: Clear aims and objectives; consistent results in a single setting; formal quality improvement, financial, or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence C **Low quality or major flaws**: Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial, or program evaluation methods; recommendations cannot be made **Integrative Review, Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference** A **High quality**: Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field B **Good quality**: Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions C **Low quality or major flaws**: Expertise is not discernable or is dubious; conclusions cannot be drawn

1 https://www.york.ac.uk/crd/SysRev/!SSLI/WebHelp/6_4_ASSESSMENT_OF_QUALITATIVE_RESEARCH.htm
2 Adapted from Polit & Beck (2017).

Figure 2.2. Johns Hopkins Nursing Evidence Level and Quality Guide, levels IV and V. Dang, D., & Dearholt, S. (2017). Johns Hopkins nursing evidence-based practice: model and guidelines. 3rd ed. Indianapolis, IN: Sigma Theta Tau International. Reprinted with permission.

Figure 3

The Iowa Model Revised: Evidence Based Practice to Promote Excellence in Health Care

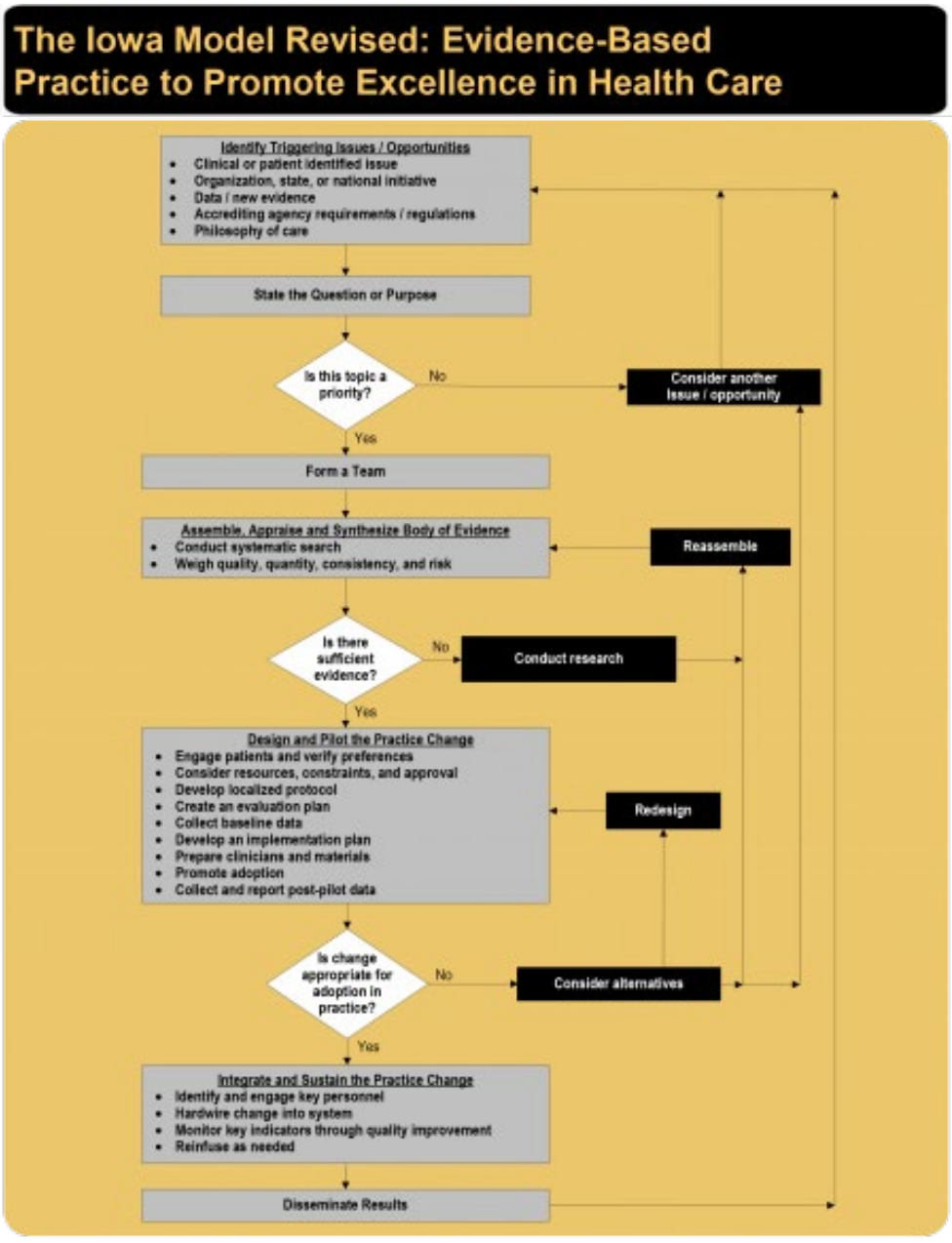
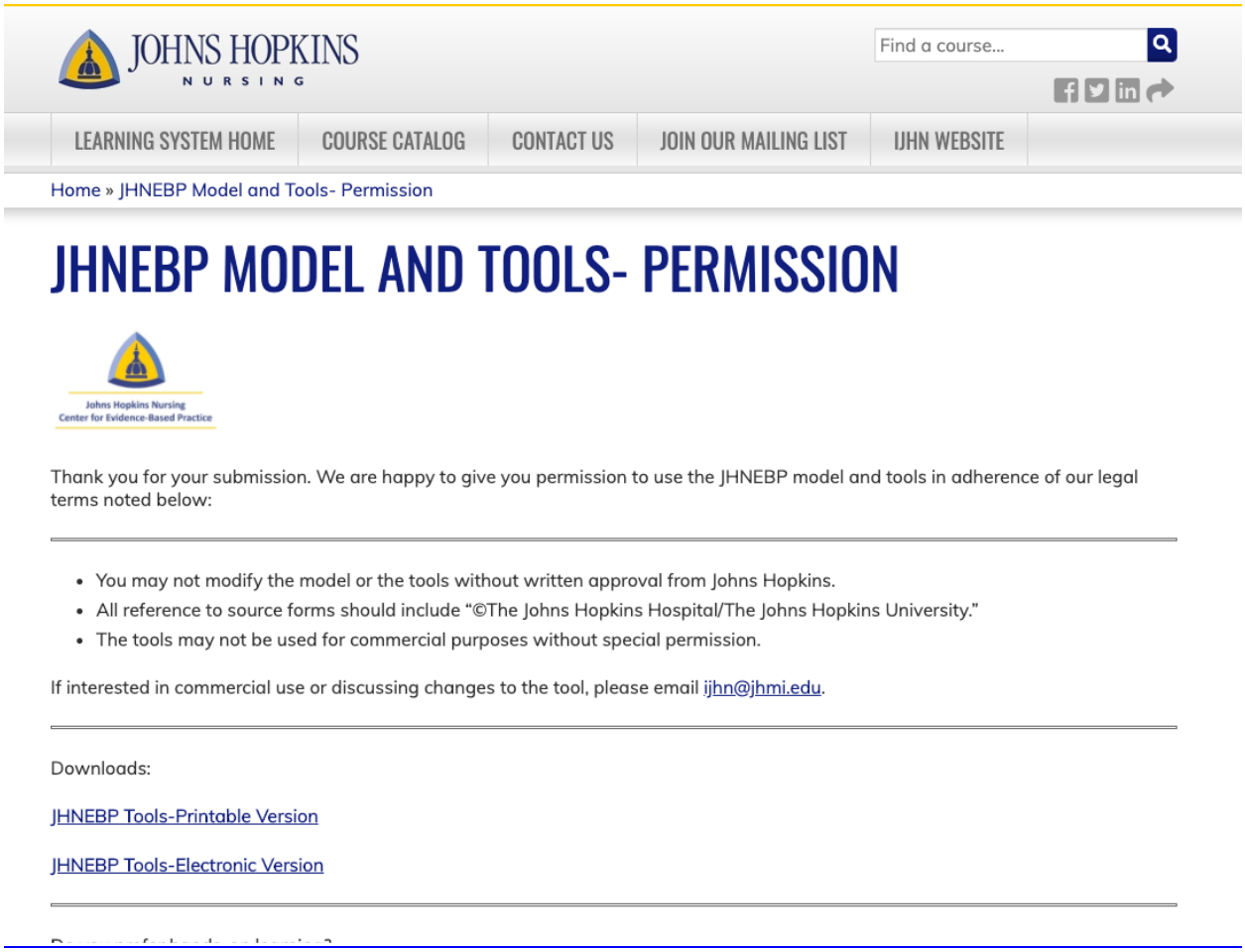


Figure 3. The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care. Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. Worldviews on Evidence-Based Nursing, 14(3), 175-182. doi:10.1111/wvn.12223. Reprinted with permission.

Appendix A



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Johns Hopkins Nursing
Center for Evidence-Based Practice

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JHNEBP Tools-Printable Version

JHNEBP Tools-Electronic Version

Appendix B

Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care

Inbox ×

Kimberly Jordan - University of Iowa Hospitals and Clinics <noreply@qemailserver.com> 9:58 AM (0 minutes ago)

to me

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Appendix C

IS ☒ **Program Evaulation**

Program evaluation is a systematic method for collecting, analyzing, and using information to answer questions about programs that are in place, particularly about their effectiveness and efficiency.

Program evaluation may include:

- feasibility evaluations to ensure that a program or portion of the program is feasible, appropriate, and acceptable before it is fully implemented.
- formative evaluations that occur during the program implementation or process and may lead to changes in the program before the program is completed.
- summative evaluations that occur at the end of the program implementation.

- program process evaluation, program impact evaluation and program outcome evaluations that focus on how a program was implemented and how it operated; evaluates outcomes and impact.

The methodology employed to collect and analyze data may resemble research; however, the purpose of the project is not to create generalizable knowledge. The information gleaned from program evaluation efforts is generally used to improve a particular program, and not to generate generalizable knowledge, even though results are sometimes shared outside of the institution.

Any activity, meeting one of the above categories, is determined by the IRB-HSR to NOT represent human subject research and therefore no submission to the IRB-HSR is required. However, it is recommended that investigators document their determination by placing a copy of this completed application in your files to address any future queries about the project.

If you checked an item under question # 1 YOU ARE DONE. DO NOT ANSWER ANY ADDITIONAL QUESTIONS.
If you did not check an item under #1 proceed to #2.

RE: Determination Form for Evidence Based Practice Project irbhsr 22547 DNP program ×

Mills, Karen Coleman (kcm6t) kcm6t@virginia.edu via myuva.onmicrosoft.com Aug 4, 2020, 9:38 AM
to me, caa3sv@virginia.edu_

Good morning ,

In the future please communicate with the IRB using your UVA email. It is more secure than your non UVA email. .

Apologies for the delay. I was waiting on response from the IRBHSR QI COMMITTEE. The IRBHSR QI Committee reviewed this project and determined that this project as described does not meet the criteria for Human Subject Research. They determined this project was QI and Program evaluation. Your submission was updated to reflect this determination. No additional IRB submission/review is necessary for you to proceed with this project. Please refer to the attached IRB signed Determination (see PDF) for additional information.

Your project was assigned IRB Tracking Id # 22547 . This tracking ID has been added to the project documents attached.

This project was determined to be non human subject research. The results may only be published as non human subject research and not as human subject research.

Please keep this email and all attached documents with the project files.

Contact the IRB if anything with this project changes OR if you have questions or concerns.

Thanks,
Karen

Karen Coleman (Mimms) Mills, RN
Compliance Coordinator
IRB-HSR Board Member
Institutional Review Board-Health Sciences Research
434-964-7666
This number is Not a UVA number – dial full 7 digits OR if outside the 434 area code dial all 10 digits
OFFICE HOURS: M--F 08:00 - 12:00

Appendix D
Abstract Accepted for Presentation at the International Conference on Forensic Nursing Science and Practice September 22, 2021

Abstract

Background: Patients who suffer from intimate partner violence (IPV) have many chronic health concerns. Lack of access to health care services is one contributing factor to poor health outcomes in this group. Survivors of IPV seek care from many community services. The Emergency Department (ED) is a common location for patients to present for care immediately following a violent event. After discharge, there is often no formal follow up care. This interaction with the healthcare system is a potential access point for continuity of care.

Purpose: This project aimed to improve access to follow up care as well as primary care services for patients presenting to the ED with complaints of IPV. PICOT Question: In patients with complaints of intimate partner violence presenting to the ED, does a follow up phone call with a registered nurse address barriers to accessing primary and follow up healthcare services?

Method: The IOWA model was used for project design. The project was designed with input from members of the forensic team at the project site based on noted concerns of patients lost to follow up and literature review findings supporting this same concern.

Procedures: All patients who presented to the ED with complaints of IPV were called for follow up over a 3 month time frame. The telephone intervention included a reminder of scheduled appointments, offer to establish care with a primary care provider (PCP), education of community resources, and safety planning.

Nursing Implications: Registered nurses can help this population improve access to services by assessing individual needs and facilitating contact with appropriate healthcare services.

Keywords: domestic violence, intimate partner violence, primary care, barrier or barriers

Appendix E

Manuscript Submission to Journal of Forensic Nursing

Facilitating Follow Up Services for Survivors of Intimate Partner Violence Presenting to Emergency Departments

Christine Arcidicono DNP, RN, FNP-C

Abstract

Background: Patients who suffer from intimate partner violence (IPV) have many chronic health concerns. Lack of access to health care is one contributing factor to poor health outcomes in this group. The Emergency Department (ED) is a common location for patients to access care but follow up is often lost. There is potential for better continuity of care through this access point.

Purpose: This project aimed to improve access to follow up and primary care services for patients presenting to the ED with complaints of IPV. PICOT Question: In patients with complaints of intimate partner violence presenting to the ED, does a follow up phone call with a registered nurse address barriers to accessing primary and follow up healthcare services?

Method: The IOWA model was used for project design and was designed with input from members of the forensic team on site.

Procedures: All patients who presented to the ED with complaints of IPV were called for follow up over a 3 month time frame. The telephone intervention included a reminder of scheduled appointments, offer to establish care with a primary care provider (PCP), education of community resources, and safety planning.

Nursing Implications: Registered nurses can help this population improve access to services by assessing individual needs and facilitating contact with appropriate healthcare services.

Keywords: domestic violence, intimate partner violence, primary care, barrier or barriers

Facilitating Follow Up Services for Survivors of Intimate Partner Violence Presenting to Emergency Departments

Intimate Partner Violence (IPV) is a crime that impacts millions of Americans each year. One in 4 women and 1 in 10 men are victims of violence or stalking by a current or former intimate partner over the course of their lifetime (Smith, et al. 2015). Researchers have identified multiple variants that make it difficult to report data suggesting higher incidences of violence.

Survivors often sustain physical injuries such as strangulation, musculoskeletal trauma, and head or brain injuries and are more likely to participate in high risk behaviors that affect long-term health (Weaver et al. 2015). There is evidence that survivors of IPV are more likely to experience poorer health and have an increased mental health burden (Weaver et al. 2015). Women who are victims of domestic violence are at increased risk for homicide from their abuser and attempting to leave a relationship can increase this risk further (Campbell et al., 2003).

Another challenge facing this population is access to mental health, community, and primary care services. One particularly disturbing barrier seems to be the health care provider's attitude towards survivors of IPV. A poor experience with a provider regarding IPV disclosure can lead to lack of follow up care (Mackenzie et. al, 2019).

The PICOT question addressed in this review aimed to examine access to acute and chronic healthcare services by investigating current identified barriers to healthcare for survivors of IPV. The PICOT question for this project is: In patients with complaints of intimate partner violence presenting to the ED, does a follow up phone call with a registered nurse address barriers to accessing primary and follow up healthcare services?

Review of Literature

A systematic review of four databases was conducted to explore the topic of IPV and access to primary health care services. The databases used for the literature review were: PubMed, Web of Science, PsycINFO, and Cochrane. Search terms include "domestic violence" with the Boolean operator OR, "intimate partner violence", "primary care" and "barrier" with the Boolean operator OR "barriers". Results were limited to the past 5 years. After reading titles and abstracts for relevance to the topic and removing duplicate articles, 28 remained (see Figure 1). Due to lack of data regarding barriers in access to primary care services, sources were retained for their relevance to the topic of access to health care services, implementation of IPV services in the primary care setting, and experiences with help seeking in general.

To address the possibility of bias, a review of gray literature was performed. There was no evidence of publication bias and findings were consistent with systematic review. A similar lack of research relating to barriers in accessing primary care for survivors of intimate partner violence was found.

Summary of Data and Analysis

Articles were reviewed for level of evidence and quality using the Johns Hopkins Nursing Evidence-Based Practice Model method which was used with permission (Dang & Dearhold, 2017). A thematic approach was taken for review of literature due to the heavy reliance on qualitative sources.

Integration of primary care with social and allied services. Many sources reported the importance of utilizing primary care. Primary care providers (PCP) occasionally offer services for survivors and most utilize referral programs that include mental health services, safety planning, and parental support (Hegarty et al., 2016). More research is needed to assess

helpfulness of these resources but it is clear that primary care has a role in supporting IPV survivors.

Access is especially difficult for vulnerable populations and studies suggest integrating primary care with community services is helpful for positive long-term results (Briones-Vozmediano et al., 2019; Lewis et al., 2019). Not all survivors will seek help through primary care and often will seek out legal or community resources first (Evans & Feder, 2016; Mantler et al., 2018; Vives-Cases et al., 2017; Sawyer, et al, 2015). A common theme was the reported need for better education and communication between legal, advocacy, social, and health services. An example of this includes results from a trial of integrating primary care services into shelter services (Mantler, et. al., 2018). The study found the visibility of health providers while at the shelter increased follow up with primary care after leaving. This suggests the importance of developing a trusting relationship with providers.

Feeling of Trust and Understanding During Disclosure. A common theme in the literature was fear of disclosure due to social or cultural stigma and fear of retaliation or misunderstanding from providers or loved ones (Hill et al., 2016; Huntley et al., 2019). By approaching patients with a positive regard and knowledge of IPV issues, providers can help develop a sense of trust and influence future attempts to access health services (Mackenzie et al., 2019). Not all survivors are ready to disclose at the time they seek health services so the timing of supportive interventions is important (Ford-Gilboe et al., 2015). In a study of Lesbian, Gay, and Bisexual (LGB) patients, who are historically vulnerable to intimate abuse, establishing trust with providers and community support networks was critical in improving access to care (Floyd et al., 2016).

A trusting relationship with providers may also make interventions more successful (Weaver et al. 2015; O'Doherty et al. 2016). In order to build a positive rapport, providers must first be educated on the various barriers to health services that IPV survivors may experience. This may help survivors navigate the barriers they will encounter while seeking lifestyle changes and escalation of care.

Barriers to Accessing Health Services. Almost all qualitative studies analyzed identified social and cultural stigma as one of the biggest barriers to disclosing IPV and a fear of reporting. This finding was consistent across cultures and especially among vulnerable populations (Dhunna et al., 2018; Taherkhani et al., 2019; Finfgeld-Connett, 2017; Sabri et al., 2015) suggesting future interventions may be targeted at challenging social and cultural norms regarding violence in the home. Improving provider, law enforcement, and social services knowledge may also be prudent to challenge current practices.

Future interventions should be targeted at improving resources and public perception of available services (Huntley et al., 2019) as well as increasing funding for resources and changes at the policy level (Gear et al., 2016, Stark et al., 2016).

Potentially Useful Interventions. A common limitation in the quantitative studies found was short duration and small sample size. Although the sample size of these studies would limit generalizability, the barriers for seeking help and health services in this population appear to be similar across cultural groups.

One randomized control trial reported on the effectiveness of community health worker follow up after identification of current IPV (Rodgers, et al, 2017) against routine care which included an advocate only during presentation to a community health center. The study results suggest that personalized care is helpful to keep survivors in touch with resources.

In this increasingly digital age, online interventions are promising sources of information and safety planning. The flexibility of online access and ability to tailor interventions supports this hypothesis (Tarzia et al., 2016). An international study developed several online safety tools (Ford-Gilboe et al., 2017) and showed positive perception of the intervention with no identified harms to participants. The intervention also demonstrated benefits on mental health, coercion by partners, safety planning, confidence in planning for self and children, mastery of educational material, and improvement in social support (Ford-Gilboe et al., 2020).

Barriers to Implementation of Interventions. Although interventions are being developed to address IPV, there are barriers to implementation. Government and community resources need more funding for education and implementation of services (Garcia-Moreno et al, 2015) and national policy efforts should be involved (Colombini et al, 2017; Colombini et al, 2019). Funds should be targeted at communities with lower resources as lack of funding significantly impacts ability to implement effective interventions (Schwab-Reese & Renner, 2018) and communities with low levels of resources are likely to be more vulnerable to IPV.

Limitations

Limitations in this review include English language, full text or completed studies, lack of randomized control trials, and the use of mostly qualitative sources. This was expressed as a limitation in many of the articles. The intervention studies cited short intervention time as a limitation and suggested longitudinal follow up.

Methods

Project Setting

The project took place at a level one trauma center. The hospital employs a team of forensics registered nurses who are trained to care for survivors of sexual and physical violence.

The team lead is a nurse practitioner (NP) who performs follow up examinations to track injuries identified.

Most patients are discharged home following their presentation to the ED but occasionally they will need to be admitted to the hospital. At the time of discharge, patients are scheduled for follow up with the forensic NP if there are injuries that may continue to worsen over the next few days and require further documentation or treatment. Not all IPV patients require a follow up appointment with the forensics team depending on the nature of their assault. Occasionally patients are scheduled for an appointment with their PCP. It was not uncommon for patients to miss these appointments and not all patients have a PCP. The number of missed appointments has historically not been tracked due to the variance in patients who need follow up. Given the structural constraints of the ED, the forensic team is better positioned to facilitate follow up care.

The purpose of this project was an evidence based practice project to address the gap in follow up care for these patients. All patients who presented to the ED for complaints of IPV were called for follow up during the 3 month time frame of implementation. The telephone intervention educated on available services, answered patient questions and helped patients navigate perceived or actual barriers to accessing care.

Procedures

The Iowa model was used with permission (Iowa Model Collaborative, 2017). Implementation occurred after the Institutional Review Board determined the project did not require review as it was an Evidence Based Practice Project.

The forensics team was educated on the project's purpose to facilitate timely follow up and to let patients know about the follow up calls. This allowed patients to give a phone number

for follow up or to decline if they wished. All patients were offered a follow up call. The follow up call used an anonymous phone application and were conducted within 72 business hours of their initial exam. Questions regarding forensics services, the legal process, or community resources were answered. The calls also addressed safety planning and care coordination. Voicemails were not left to protect the patient in the event of surveillance of phone messages and another call was attempted if the patient was unreachable.

Patients were reminded of appointments scheduled for them during their initial exam and were offered an appointment with a PCP if they did not already have one. Any other immediate needs were addressed to help patients navigate the health and community service system and medical questions were deferred to a medical provider.

Questions explored in the telephone appointment included: Do you have a PCP? Do you plan to see your PCP as a result of your injuries and if not, why? Are you aware of your options if you decide to leave your current situation? Are you aware of counseling resources available to you? Do you plan to follow up with the forensic team as a result of your injuries?

Those who expressed a need for mental health services were directed toward applicable resources. Follow up phone calls were conducted two months after initial encounter to assess continuity of treatment and effectiveness of telephone intervention. There were barriers to this process which are discussed below.

Results

The project ran from August 1, 2020 through October 31, 2020. During this time 14 patients were seen by the Forensics Department for complaints of IPV. Of those 14, one was a minor. This person was contacted as part of routine care for follow up but was not included in the results.

Of the 13 adult patients, five were unable to be reached. Of those five patients, two were admitted to the hospital during the follow up time period and three were lost to follow up due to inability to contact them.

The remaining seven patients were contacted via telephone to follow up on their initial forensic exam. Out of these seven patients, one of them had declined a forensic examination but requested a follow up call for assistance in community service access. From the remaining six patients, two had a follow up appointment with the NP. Four of the seven patients were scheduled for follow up appointments with a PCP or an obstetrics provider either during their initial exam in the Emergency Department or during their follow up call. All four of these patients attended their appointments as planned.

Although a scripted follow up was initially used during the first follow up call several needs emerged indicating the need for more personalized education and care coordination. The differences between each patient situation identified the need for follow up to be tailored to the patient's current priorities.

Case Descriptions

Case 1. During the follow up call, it was immediately evident that an appointment was not a priority for them. This patient was homeless and had not eaten since discharge from the hospital two days prior. The NP student investigator immediately shifted focus of the phone call and was able to help the patient access an open food bank and remind them of a follow up with local community services. A follow up appointment was also scheduled for an establishment of care with a PCP and the patient was reminded of this. The patient was scheduled for a follow up appointment with the forensic lead NP. This appointment was done while they were admitted to the hospital for an unrelated illness.

Case 2. The topic of safety planning was addressed during this call. The NP student investigator was able to discuss the importance of preventative care. Community resources were discussed for counseling and safety planning. This patient was contacted a second time for follow up. The patient expressed the phone calls were somewhat helpful and stated that they still felt "shocked" by their experience.

Case 3. Safety planning was addressed as well as follow up for specialty services during their follow up call. Questions regarding the legal process and protective orders were addressed. The patient had suffered an injury requiring specialty care as a result of their assault and was having difficulty accessing timely follow up. This patient had a designated PCP who was involved in the case and was able to help with this process. This patient was contacted through a second phone call and further questions regarding the legal process were addressed as well as counseling services available. The patient found this follow up especially helpful and stated they felt very supported because of the follow through by the forensic team.

Case 4. This patient was contacted and follow up appointment was rearranged to help facilitate transport to the appointment. The patient did not show for their follow up appointment and was unable to be reached a second time.

Case 5. This patient was contacted for a follow up call and safety planning (including emergency safety community resources), financial planning for purposes of leaving their abuser, primary care, and local social services were addressed. This patient found the follow up helpful.

Case 6. This patient did not want an examination or to follow up for clinic appointment but did express interest in safety planning discussion. They stated appreciation for the follow up call service.

Case 7. This patient reviewed the events of the assault with NP student investigator and

asked questions regarding access to follow up care and available counseling services. This patient found the follow up call helpful for navigating the immediate time frame after assault.

Discussion

Overall, the project demonstrated a need for better follow up care for survivors of IPV. In keeping with the literature regarding feelings of fear regarding disclosure, forensic nurses who are trained in responding to trauma can be particularly helpful. All of the patients who were contacted expressed appreciation for the service and several stated they were thankful to have someone check in. By initiating a welcoming encounter with the health system, forensic nurses have the ability to promote a better sense of trust in health care providers and encourage patients to seek care for other health concerns.

More research is needed to identify long term impact of follow up care on health outcomes but the findings from this project align with the findings in similar studies (Rogers, 2017, Mackenzie et al, 2019). Patients who are followed individually appreciate the service and are less likely to be lost to follow up when cared for by a provider who understands the complexities of IPV.

Impact of Coronavirus

It is worth noting the effect of the coronavirus global pandemic on the impact of this project. Overall, the forensic team saw a reduction in volume from August 2020-November 2020 in comparison to the same months in 2019. Already, experts have begun studying the effects of this epidemic on IPV and violence within the home (Evans et al., 2020) citing the reduced access in services due to safety concerns, the lack of visibility within the community, and increased burden of the economic impacts (job loss, child care loss) on financial security of survivors of IPV.

It is not known how the global pandemic will impact this population in the long term but early results indicate that it will not be in a positive way. Healthcare communities can act now to mitigate the poor health outcomes that may arise from worsening violence in the home by becoming more educated in the unique needs of this population. Providers can be educated in trauma informed care which has been shown to be helpful for improving survivors' trust in health care providers (Mackenzie et al, 2019). Providers can also learn about community resources in their locality which may be beneficial for patients who present in safety crisis.

Health systems can work towards mitigating violence in the home by improving access to services. Finding the most cost effective and realistic way to interact with patients for follow up is important. While the ED may not be the appropriate service line to focus on initiating follow up protocols, forensic nurses who often work within the ED are more likely to have the capacity to perform this service. Forensic nurses are already trained in trauma informed care and have the knowledge to adapt to patient needs based on their immediate and long term priorities. Nurses are able to educate patients on the health benefits of primary care services while also assessing a patient's level of understanding or ability to access these services.

Nursing Practice Change

The results of the project were discussed at the monthly forensics team staff meeting and members were engaged in the results. The team discussed the implications of the project and agreed to implement follow up calls on patients seen for sexual assault and IPV. To keep up with the volume of patients, each team member contacts the patients they see for initial exam. By keeping the provider constant, it is felt that this will encourage more trust in seeking health care services.

System Improvement Recommendations

This project clearly documented the need for improved follow up services. This population has its inherent challenges and more frequent contact with the health system would be beneficial for this group for long term health and safety. The forensic team plans to propose a full time position as it grows in patient size to aid in care coordination.

Strengths and Limitations of Project

The adaptability of the IOWA model is a strength to support this project because it allowed for flexibility based on individual needs. This was helpful for follow up calls when the patient was not interested in primary care services or long term follow up but had other immediate health needs (Case 1). By identifying common themes in the follow up calls, more robust research studies can focus on determining long term effectiveness. Potential weaknesses include lack of robust research supporting the effectiveness of this type of intervention.

Products of Scholarly Project

The project results were submitted to the University of Virginia School of Nursing for completion of the Doctorate of Nursing Practice. An abstract has been submitted to the International Association of Forensics Nurses for review and accepted for presentation at the annual conference in September 2021.

References

Briones-Vozmediano, E., Castellanos-Torres, E., Goicolea, I., & Vives-Cases, C. (2019). Challenges to Detecting and Addressing Intimate Partner Violence Among Roma Women in Spain: Perspectives of Primary Care Providers. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260519872299

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X.,

Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study. *American Journal of Public Health*, *93*(7), 1089–1097.

Colombini, M., Alkaiyat, A., Shaheen, A., Garcia Moreno, C., Feder, G., & Bacchus, L. (2019). Exploring health system readiness for adopting interventions to address intimate partner violence: A case study from the occupied Palestinian Territory. *Health Policy and Planning*. MEDLINE®. https://doi.org/10.1093/heapol/czz151

Colombini, M., Dockerty, C., & Mayhew, S. H. (2017). Barriers and Facilitators to Integrating Health Service Responses to Intimate Partner Violence in Low- and Middle-Income Countries: A Comparative Health Systems and Service Analysis. *Studies in Family Planning*, *48*(2), 179–200. https://doi.org/10.1111/sifp.12021

Dang, D., & Dearholt, S. (2017). Johns Hopkins nursing evidence-based practice: model and guidelines. 3rd ed. Indianapolis, IN: Sigma Theta Tau International

Dhunna, S., Lawton, B., & Cram, F. (2018). An Affront to Her Mana: Young Māori Mothers' Experiences of Intimate Partner Violence. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260518815712

Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy*, *19*(1), 62–73. https://doi.org/10.1111/hex.12330

Evans, M. L., Lindauer, M., & Farrell, M. (2020). A Pandemic within a Pandemic—Intimate Partner Violence during Covid-19. *New England Journal of Medicine*, *2020*(383), 2302–2304. https://doi.org/10.1056/NEJMp2024046

Finfgeld-Connett, D. (2017). Intimate Partner Violence and its Resolution among Mexican Americans. *Issues in Mental Health Nursing*, *38*(6), 464–472. https://doi.org/10.1080/01612840.2017.1284968

Floyd, S. R., Pierce, D. M., & Geraci, S. A. (2016). Preventive and Primary Care for Lesbian, Gay and Bisexual Patients. *American Journal of the Medical Sciences*, *352*(6), 637–643. https://doi.org/10.1016/j.amjms.2016.05.008

Ford-Gilboe, Marilyn, Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and Predictors of Service Use Among Women Who Have Separated from an Abusive Partner. *Journal of Family Violence*, *30*(4), 419–431. https://doi.org/10.1007/s10896-015-9688-8

Ford-Gilboe, M, Varcoe, C., Scott-Storey, K., Wuest, J., Case, J., Currie, L., Glass, N., Hodgins, M., MacMillan, H., Perrin, N., & et al. (2017). A tailored online safety and health intervention for women experiencing intimate partner violence: The iCAN Plan 4 Safety randomized controlled trial protocol. *BMC Public Health*, *17*(1), 273. https://doi.org/10.1186/s12889-017-4143-9

Ford-Gilboe, Marilyn, Varcoe, C., Scott-Storey, K., Perrin, N., Wuest, J., Wathen, C. N., Case, J., & Glass, N. (2020). Longitudinal impacts of an online safety and health intervention for women experiencing intimate partner violence: Randomized controlled trial. *BMC Public Health*, *20*(1), 260. MEDLINE®. https://doi.org/10.1186/s12889-020-8152-8

Garcia-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *Lancet*, *385*(9977), 1567–1579. https://doi.org/10.1016/S0140-6736(14)61837-7

Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. *BMC Family Practice*, *17*(1), 115. https://doi.org/10.1186/s12875-016-0508-x

Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry*, *28*(5), 519–532. https://doi.org/10.1080/09540261.2016.1210103

Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors Influencing Mental Health Screening and Treatment Among Women in a Rural South Central Appalachian Primary Care Clinic. *Journal of Rural Health*, *32*(1), 82–91. https://doi.org/10.1111/jrh.12134

Huntley, A. L., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. *BMJ Open*, *9*(6), e021960. https://doi.org/10.1136/bmjopen-2018-021960

Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. Worldviews on Evidence-Based Nursing, 14(3), 175-182. doi:10.1111/wvn.12223.

Lewis, N. V., Dowrick, A., Sohal, A., Feder, G., & Griffiths, C. (2019). Implementation of the Identification and Referral to Improve Safety programme for patients with experience of domestic violence and abuse: A theory-based mixed-method process evaluation. *Health & Social Care in the Community*, *27*(4), E298–E312. https://doi.org/10.1111/hsc.12733

Mackenzie, M., Gannon, M., Stanley, N., Cosgrove, K., & Feder, G. (2019). "You certainly don't go back to the doctor once you've been told, 'I'll never understand women like you.'" Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. *Sociology of Health & Illness*, *41*(6), 1159–1174. https://doi.org/10.1111/1467-9566.12893

Mantler, T., Jackson, K. T., & Walsh, E. J. (2020). Integration of Primary Health-Care Services in Women's Shelters: A Scoping Review. Trauma, Violence, & Abuse, 21(3), 610–623. https://doi.org/10.1177/1524838018781105

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & for the PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ*, *339*(jul21 1), b2535–b2535. https://doi.org/10.1136/bmj.b2535

O'Doherty, L., Taket, A., Valpied, J., & Hegarty, K. (2016). Receiving care for intimate partner violence in primary care: Barriers and enablers for women participating in the weave randomised controlled trial. *Social Science & Medicine (1982)*, *160*, 35-42. https://doi.org/10.1016/j.socscimed.2016.05.017

Rodgers, M. A., Grisso, J. A., Crits-Christoph, P., & Rhodes, K. V. (2017). No Quick Fixes: A Mixed Methods Feasibility Study of an Urban Community Health Worker Outreach Program for Intimate Partner Violence. *Violence Against Women*, *23*(3), 287–308. https://doi.org/10.1177/1077801216640383

Sabri, B., Huerta, J., Alexander, K. A., St Vil, N. M., Campbell, J. C., & Callwood, G. B. (2015). Multiple Intimate Partner Violence Experiences: Knowledge, Access, Utilization and Barriers to Utilization of Resources by Women of the African Diaspora. *Journal of Health Care for the Poor and Underserved*, *26*(4), 1286–1303. https://doi.org/10.1353/hpu.2015.0135

Sawyer, S., Coles, J., Williams, A., & Williams, B. (2015). Preventing and reducing the impacts of intimate partner violence: Opportunities for Australian ambulance services. *Emergency Medicine Australasia: EMA*, *27*(4), 307–311. https://doi.org/10.1111/1742-6723.12406

Schwab-Reese, L. M., & Renner, L. M. (2018). Screening, management, and treatment of intimate partner violence among women in low-resource settings. Women's Health. https://doi.org/10.1177/1745506518766709

Smith S. J., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2015). National Intimate Partner and Sexual Violence Survey: 2015 Data Brief-Updated Release. Retrieved from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Stark, L., Landis, D., Thomson, B., & Potts, A. (2016). Navigating Support, Resilience, and Care: Exploring the Impact of Informal Social Networks on the Rehabilitation and Care of Young Female Survivors of Sexual Violence in Northern Uganda. *Peace and Conflict-Journal of Peace Psychology*, *22*(3), 217–225. https://doi.org/10.1037/pac0000162

Taherkhani, S., Negarandeh, R., & Farshadpour, F. (2020). Barriers to Leaving a Relationship From the Perspective of Married Abused Iranian Women: Secondary Analysis of the Interviews With Abused Women. Journal of Interpersonal Violence, 35(19–20), 4162–4184. https://doi.org/10.1177/0886260519844777

Tarzia, L., Murray, E., Humphreys, C., Glass, N., Taft, A., Valpied, J., & Hegarty, K. (2016). I-DECIDE: An online intervention drawing on the psychosocial readiness model for women experiencing domestic violence. *Women's Health Issues*, *26*(2), 208–216. https://doi.org/10.1016/j.whi.2015.07.011

Vives-Cases, C., Goicolea, I., Hernandez, A., Sanz-Barbero, B., Davo-Blanes, Mc., & La Parra-Casado, D. (2017). Priorities and strategies for improving Roma women's access to primary health care services in cases on intimate partner violence: A concept mapping study. *International Journal for Equity in Health*, *16*, 96. https://doi.org/10.1186/s12939-017-0594-y

Weaver, T. L., Gilbert, L., El-Bassel, N., Resnick, H. S., & Noursi, S. (2015). Identifying and Intervening with Substance-Using Women Exposed to Intimate Partner Violence: Phenomenology, Comorbidities, and Integrated Approaches Within Primary Care and Other Agency Settings. *Journal of Womens Health*, *24*(1), 51–56. https://doi.org/10.1089/jwh.2014.4866

Figure 1

Database Results

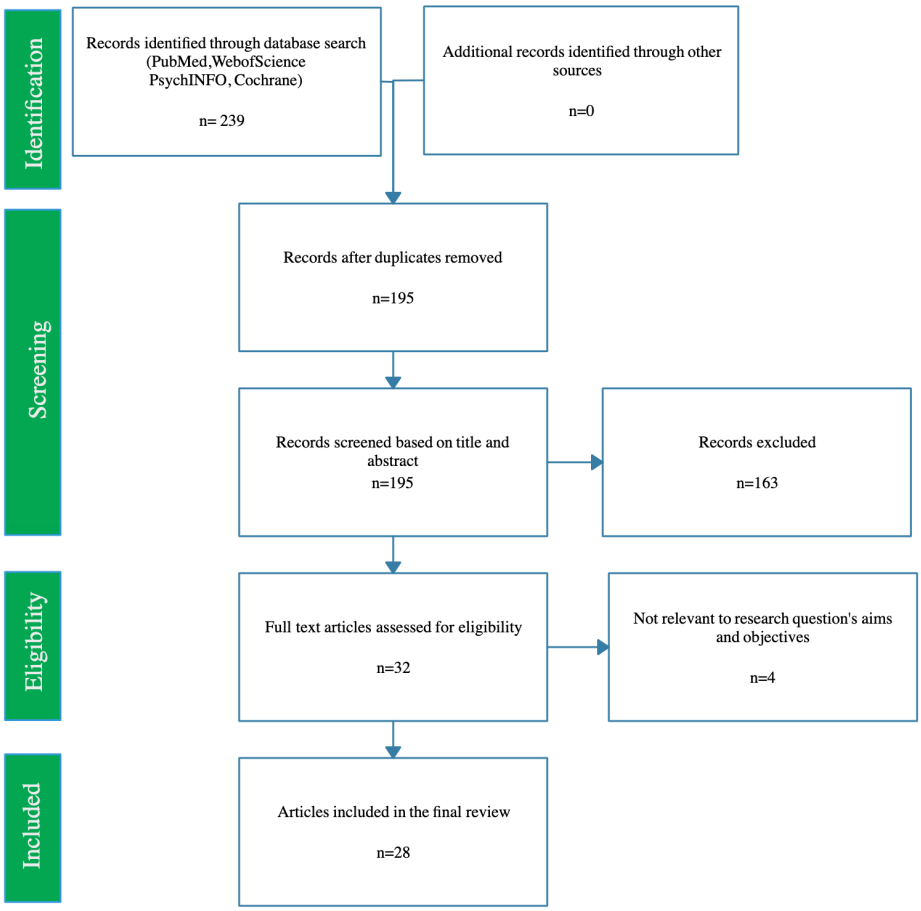

Figure 1. Adapted "Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement." (Moher et al., 2009)