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Improving intimate partner violence screening in a women's health practice through implementation of an evidence-based screening tool

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Abstract

The purpose of this quality improvement project was to implement intimate partner violence screening in an outpatient women's health clinic with no prior screening process in place. Current recommendations are to screen all reproductive age women for intimate partner violence [6]. During a three-month period 170 patients out of 260 eligible patients were screened using the HARK screening tool, 7 of those patients screened positive and were offered referrals to social work. While universal IPV screening was not achieved, a screening rate of 64% is a remarkable improvement from an apparent absence of screening prior to project implementation.

Key words: Intimate Partner Violence, HARK Screening tool, Intimate Partner Violence Screening

Background

Approximately 20 people per minute or more than 10 million individuals are physically abused by an intimate partner each year in the United States[1]. Intimate partner violence (IPV) is defined as abuse or aggression that occurs in a romantic relationship by either a current or former spouse or dating partner [1]. 85% of people who have experienced IPV are women, and those of reproductive age are at the highest at risk [1]. Not only does IPV affect women's mental health, but it has also been shown to contribute to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections [2, 3]. Because of the affect IPV plays in a women's OB/GYN health, Obstetric and Gynecologic (OBGYN) providers are in an important and convenient position to assess and provide support for women who experience IPV. There are many opportunities for screening and intervention to occur during pregnancy, family planning, annual examinations, and other women's health visits [2.]

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support, and reviewing available prevention and referral options [2]. Health care providers are often the first professionals to offer care to women who are abused, however, less than 10% of health care providers currently screen for IPV [2]. This in part is due to barriers such as lack of training, lack of physician-patient relationship, fear of legal involvement, a focus on the patient's primary reason for the visit, organizational barriers, a lack of standardized process, and a lack of policy [4]. The U.S. Preventive service task force (USPSTF) currently recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services [5] and an objective of reducing IPV is in the developmental stage for healthy people 2030 goals [6].

Purpose

The purpose of this project is to observe whether the implementation of a validated standardized IPV screening tool increases IPV screening rates as well as referrals to social work. Screening for IPV can also foster a provider-patient relationship, allowing for more open communication, and comfort in discussing topics of sensitive nature. Therefore, the clinical question posed is: In reproductive age women can a standardized IPV screening tool given during annual well women exams increase the number of women screened for IPV and lead to an increased number of women referred on for help over a 3-month period of use?

Setting and Population

This project was implemented in a Midwestern, outpatient women's health clinic that is part of a large health system. There are three OB/GYN providers that work at the project site (2 MDs and 1 WHNP). The group of subjects selected for this project were women 18 years and older presenting to the clinic for their annual well women exam. Over 1,000 women 18 years of age and older are seen by this clinic for annual well women exams each year.

Intervention

The HARK tool is a validated screening tool used to screen for domestic violence, or IPV [7]. The HARK tool was created due to the idea that short questions that reliably identify women experiencing IPV who present in clinical settings are a pre-requisite for developing an appropriate response from health services to this substantial public health problem [7]. The HARK screening tool asks the following four questions:

H	HUMILIATION Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

A	AFRAID Within the last year, have you been afraid of your partner or ex-partner?
R	RAPE Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
K	KICK Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

Patients respond to each of these questions with a “yes” or a “no”. Otherwise, the question is marked as “patient refused”. A score greater than 1 suggests domestic violence and prompts a best practice advisory (BPA) to release alerting the provider of the recommendation to refer the patient to social work. This screening was implemented for three months among all women 18 years of age and older presenting for their annual well women exam. Providers involved in the implementation were educated on the tool prior to implementation.

Methods

Prior to implementation of the HARK screening tool, the following information was pulled from the three participating provider’s charting done in the same months as this project in 2022 by the EMR (Electronic Medical Record) specialists: a) number of charts where IPV was screened or discussed and b) number of referrals to social work for IPV. This data was compared to data from the three months of implementation of the tool among the three providers. The HARK screening tool was sent to the patients as part of their e-check in for their upcoming appointment. However, hard copies were provided if they did not complete it electronically. During their visit the patient and provider examined and discussed the results of the survey. This gave the patient a second chance to confirm their answers to the HARK screening tool and have an open discussion on IPV. Data on the following was collected monthly during implementation:

the number of people screened for IPV, and the number of women referred on to social work. The data was kept secured on a protected drive at the clinic of implementation.

Outcome and Results

A total of three providers implemented the HARK screening tool over the course of three months with the goal of screening 95% of women who presented for their well women exam. The chart review revealed that a total of 267 annuals were seen throughout the project's duration. Of these eligible visits, 170 IPV screenings were performed for an overall screening rate of 64%. Screening results showed that 7 of the 170 patients disclosed IPV within the past 12 months. These 7 patients were all offered a social work referral due to screening positive for intimate partner violence.

This data was compared to April 17, 2022 through July 14, 2022. During this time frame in 2022 a total of 318 annuals were seen with no screening for IPV or referrals to social work offered for intimate partner violence concerns.

Discussion

Initially a 4% IPV prevalence appears low when comparing this to much higher rates reported in the literature. One must differentiate between lifetime IPV and past-year IPV as well as recognizing that IPV often goes unreported. There are many reasons why patients may choose not to report past-year IPV. For example, women may have other concerns to address with their medical provider, find it unnecessary to discuss such matters, or be less likely to share if they know it must be reported and they are not ready for that [9]. However, after being exposed to such questions they may start to think about disclosing this information at the next visit now knowing it is a safe space, or after having time to plan [8].

Current recommendations are to screen all women including those who present for OB visits due to women of reproductive age being at the highest risk for IPV [5]. As mentioned previously, IPV contributes to numerous gynecologic and pregnancy complications therefore, screening only women presenting for their well women exam cut out a large portion of the recommended screening population, limiting the results. Another limiting factor was that the three providers that took part in this study were all at the same location. This limits the ability to compare demographic differences.

This study's results confirm that the clinic of interest can manage broader implementation of IPV. While universal IPV screening was not achieved, a screening rate of 64% is a remarkable improvement from an apparent absence of screening prior to project implementation. The act of screening communicated to clients that the clinic is a safe space to talk about IPV. In addition to promising results for clients, the project generated value for PCPs, including greater awareness of how IPV impacts health, willingness in screening for IPV, and enhanced trauma-informed services in the clinic of interest.

Recommendations for advancing this preventative health service are keeping the incorporation of a screening form within the EMR. There should be further training to include all providers, and expansion of screening procedures across multiple locations. The project included a trauma-informed approach to care by cultivating awareness of how trauma impacts health, improving identification of IPV, increasing delivery of interventions to reduce trauma perpetuation, and empowering survivors in their pursuit of safety [8]. Greater institutional support and improved partnership with local IPV agencies are warranted. Additional interventions and resources besides social work referral should be readily available for patients.

Further recommendations could include creating an interdisciplinary medical-law partnership which allows health care professionals to make immediate referrals where patients can receive integrated care from a team comprised of advocates, attorneys, and specialty-trained medical and mental health providers [9]. Another recommendation is to consider ensuring patients receive evidence-based mental health care when they disclose IPV. An important aspect of care involves assessing immediate safety as well as future provider communications, including who can access the patient's electronic medical record [9].

Conclusion

Intimate partner violence is a form of interpersonal trauma that affects individuals with behavioral health disorders at alarming rates. Prominent risk factors for IPV include female sex, childhood trauma, mental illness, substance use, and socioeconomic hardship. IPV has serious adverse health and financial consequences, particularly for women who are at greater risk for partner violence. A quality improvement project was developed to address IPV in women's health outpatient clinic with no prior screening. The project aimed to implement universal IPV screenings for a limited number of female-identified clients. The screening rate for 270 eligible visits was 64%. The rate of positive screenings was 4%, and intervention was offered for each positive case.

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