Improving Screening and Referral for Violence Against Women: Interpersonal Violence and Adverse Childhood Experiences

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Executive Summary

This project has an overall goal of improving screening and referral for violence against women, and specifically targets intimate partner violence (IPV) and adverse childhood experiences (ACE). In 1995, the CDC and Kaiser Permanente discovered an exposure that dramatically increased the risk for seven out of ten of the leading causes of death in the United States. That exposure is toxic stress caused by various ACEs. Those who are exposed have triple the lifetime risk of heart disease and lung cancer, increased rates of obesity, diabetes, preterm labor, low birth weight, unplanned pregnancy, chronic pelvic pain, vaginismus, vaginitis, depression, PTSD, impaired sexual function, and increased perception of pain in labor. However, many Utah midwives and nurse practitioners are not trained in appropriate assessment or management of ACE survivors. This is problematic, as over half of Utahans have experienced at least one ACE. In addition to ACEs affecting the health of women, IPV leads to worsened health outcomes and increased healthcare costs. Furthermore, one in three women in Utah will be victims of rape, physical violence, or stalking by an intimate partner at least once in their lifetime.

Despite the prevalence of IPV and ACEs, midwives at a national and local level are not following ACOG guidelines for IPV screening, which state to screen at the new obstetrical visit, every trimester, and postpartum, nor are they assessing ACE scores or resiliency. Helping an individual develop resiliency traits is the hallmark of ACE intervention, and local mental health providers in Utah are trained to do so. However, healthcare providers are mostly unaware of such interventions. Therefore, the objectives of this project include obtaining knowledge of IPV, ACEs, screening tools, questionnaires, and recommendations for positive screens; implementing an IPV screening tool into new obstetrical and postpartum visits within a large midwifery practice in Utah; implementing an ACE assessment in this same practice; and providing midwives and nurse practitioners with resources for responding to a positive or negative screen. The HARK screening tool was used to screen for IPV. To assess ACEs and resiliency, the Health-Resiliency-Stress-Questionnaire (HRSQ) was built into and distributed via mEVAL, a patient-reported outcome email system for all seven clinics within this practice. Over 30 trauma-informed counselors were identified, and healthcare providers were given this information in addition to other resources for referral and follow-up for positive screens.

Overall, the goal for IPV screening was to implement a validated IPV screening tool to allow prevention strategies to take place and to provide the woman with resources to improve her health and safety. For ACE assessment, the goal was to increase provider awareness of patients' ACE score as it relates to their medical history and resiliency traits, provide appropriate referral resources to promote treatment for positive scores, and identify local resources that can help with toxic stress.

Content experts for this project include Susan Chasson, MSN, JD, FNP, CNM, SANE coordinator and Kathy Franchek, MD as they both serve on various IPV committees and have directly influenced IPV prevention, screening, and treatment in Utah. Further, Dr. Franchek is a pediatrician and is well versed in the ACE study, and Susan Chasson currently practices with adult populations. Committee experts include project chairs Amanda Al-Khudairi, DNP, WHNP-C and Diane Chapman, DNP, FNP-C, program sponsor and specialty track director Gwen Latendresse, PhD, CNM, FACNM, and assistant dean for MS & DNP programs Pam Hardin, PhD, RN.

Table of Contents

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Violence against women occurs in various ways and at various times in a woman's life, often through interpersonal relationships or during childhood through adverse experiences. Both interpersonal violence and adverse childhood experiences are highly prevalent among American women and both contribute significantly to health outcomes, healthcare costs, and overall functioning. One in three women in the United States have been victims of rape, physical violence, or stalking by an intimate partner at least once in their life time (ACOG, 2012), and more than half (63.1%) of Utah adults report being ACE survivors. Despite the prevalence of IPV and ACEs, midwives at a national and local level are not following ACOG guidelines for IPV screening, nor are they implementing ACE assessments even with ample evidence about its importance and the availability of effective interventions. The same issue applies to a nurse-midwifery practice in Salt Lake City, UT, where providers are not assessing for ACEs or resiliency, and there is no standardized and consistent use of an IPV screening tool. Furthermore, IPV is only screened at the new obstetrical visit at this clinic.

This project aims to improve screening, provide women's health providers at Birthcare Healthcare, a local nurse-midwifery practice, with resources for positive screens, and enhance the health and safety of women in Utah. By incorporating an ACE assessment tool into new obstetrical and annual visits, integrating a validated IPV screening tool into the EMR, and developing a web resource page for providers, midwives have an incredible opportunity to identify patients who would benefit from counseling, interventions for an unsafe environment, education on the effects of IPV or ACEs, and improved health outcomes.

Clinical Significance and Policy Implications

Clinical Significance

If midwives do not assess for IPV and ACEs appropriately, women may go without the help they need. IPV has been linked to poor pregnancy weight gain, infection, anemia, stillbirth, fetal injury, and preterm delivery, and ACEs are associated with negative health behaviors and adverse birth experiences (ACOG, 2012). Conversely, if appropriate and more frequent screening does occur, more women may disclose IPV or ACE history than they would if only asked once or not at all (ACOG, 2012). Research has shown that interpersonal violence is more prevalent in women who are assessed in all three trimesters when compared to only once during the first prenatal appointment as is current practice at Birthcare Healthcare (Alhusen, Ray, Sharps, & Bullock, 2015). In addition to increasing identification of those at risk, screening also provides an opportunity to halt the cycle of abuse, offer ongoing support, and provide referral to appropriate resources. It is known that pelvic examinations may be associated with terror and pain for survivors, and they may re-experience powerlessness, violation, and fear. If a woman has a history of abuse or adverse childhood experience, providers may follow recommendations more closely for explaining procedures in advance, adhere to new guidelines on when to perform a bimanual examination, and provide techniques to lessen anxiety and fear around obstetrical exams and procedures if they identify a positive screen ahead of time (ACOG, 2015). Finally, LoGiudice & Beck (2016) discuss the need for initiation of trauma-informed care, and they recommend the first step to implementing this type of care is to ask women if they are survivors or victims of past or current interpersonal violence and adverse childhood experiences.

Stakeholders

Stakeholders in this project include midwives, pregnant women, families and children of pregnant women, the unborn child, labor and delivery staff, postpartum staff, obstetricians, and mental-health professionals. Midwives are in a unique position to assess and give support to those who experience abuse, past or present, due to the nature of obstetrical care with several opportunities to screen and intervene over the course of a pregnancy (ACOG, 2012). Abuse survivors may seek out midwives, such as those employed with Birthcare HealthCare, in Salt Lake City, Utah, so they can have more control over their birth experience (LoGiudice & Beck, 2016).

Pregnant women are key stakeholders in this change project. According to Friedrichs (2015), more than half of Utah's population reported experiencing ACEs, and the severity of interpersonal violence may escalate during pregnancy or the postpartum period (ACOG, 2012). Also, homicide is a leading cause of maternal mortality with the majority of homicides being perpetrated by a current partner (ACOG, 2012). Up to 40% of children in the United States experience some form of childhood sexual abuse, and many do not disclose their experience until later in life (ACOG, 2015). However, ACOG (2015) reports that women support a universal inquiry about sexual assault, because they may have reluctance to initiate the discussion.

Lastly, the family unit is affected due to the destructive effects on family members and children with adverse pregnancy outcomes related to sexual abuse (past or present), the loss of financial or emotional stability with intimate partner violence, or toxic stress from childhood trauma (ACOG, 2012). These detrimental effects can lead to increased populations of homeless women and children (ACOG, 2012). Mental health professionals are primary stakeholders, as

they will receive referrals from obstetric providers who identify women in need of IPV and ACE counseling (ACOG, 2015).

Purpose and Objectives

The purpose of this project is to improve screening of intimate partner violence (IPV) and assessment of adverse childhood experiences (ACE) and resiliency within a midwifery practice in Salt Lake City, Utah. Furthermore, this project aims to educate providers on how and why to assess for these experiences, provide referral options to women who screen positive, and offer providers resources for a positive screen for IPV or poor resiliency with a history of childhood trauma. The following objectives serve to meet this purpose:

1. Obtain knowledge regarding significance of IPV, ACEs, existing screening tools and assessments, and recommendations for positive screens
2. Identify sponsor to "pitch" project to midwifery practice
3. Implement evidence-based IPV screening tool and ACE questionnaire into practice
4. Provide practitioners with resources on how to respond to positive IPV and ACE assessments
5. Disseminate results.

Literature Review

Studies demonstrating the correlation between poor health outcomes and IPV and ACEs highlight the need to screen or assess women for *both* IPV and ACEs to better improve women's health and newborn outcomes (ACOG, 2015). Specifically, providers should be looking at both present and past abuse. Nationally and locally in Utah, women have a high prevalence of IPV and ACEs, and midwives have an incredible opportunity to intervene when screening women for both types of adversity due to the nature and the frequency of prenatal visits. Furthermore,

providers need more education on how to screen for IPV and ACEs, what to do with a positive screen, and what screening tool to utilize (Eustace, Baird, Salto, & Creedy, 2016). If midwives can improve their ability to detect women who have experienced ACEs or IPV, midwives can greatly improve health and pregnancy outcomes.

Search Methods

A search about interpersonal violence, adverse childhood experiences, resiliency, and methods of intervention for those affected was done using PubMed, CINAHL, and the Cochrane Library Database. Keywords included *ACEs, adverse childhood experiences, resiliency, resiliency traits, trauma-informed care, interpersonal violence, domestic violence, past abuse, childhood abuse, childhood adversity, promoting resiliency, IPV, IPV screening, IPV screening tools, ACE questionnaire, ACE screening tool, violence against women, and pregnancy*. Research studies were limited to those published in the English language with full-text, human subjects, and the last 17 years from 2000-2017 to reflect the most comprehensive review of literature on violence against women. Committee opinions from national, professional organizations were included to reflect the most current practices and stances on interpersonal violence and childhood trauma. Additional information was garnered from the CDC's Brief Surveillance Report.

Background

Defining Abuse and Resiliency

Interpersonal violence has been defined as behavior within a relationship that either causes physical, sexual, or psychological harm, and this can be perpetrated by either a former or current partner (Eustace, Baird, Salto, & Creedy, 2016). The United States Preventative Services Task Force (USPSTF) describes IPV as above, but adds that this can occur among both

heterosexual or same-sex couples, all races and genders, and it does not require intimacy (Moyer, 2013).

Adverse childhood experiences were the center of a study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente that focused on the outcomes of trauma on the developing brain and health across the life span. Dr. Felitti, key researcher in the ACE study, included over 17,000 patients, who were mostly white, educated, middle-class, and insured. Over the past few decades, researchers have discovered three areas of the brain that are negatively affected by trauma as a child due to the overstimulation of the hypothalamic-pituitary-adrenal axis (HPA). The areas affected include the nucleus accumbens which is the brain's pleasure and reward center, the prefrontal cortex that is necessary for impulse control and executive functioning, and the brain's fear center, the amygdala (Burke, 2014). Damage to these areas may be directly linked to increases in substance abuse, multiple sex partners, obesity, and increased pain and fear in labor (Burke, 2014). Adverse childhood experiences include any childhood verbal, physical, and sexual abuse, parental neglect, parental substance abuse, divorced or separated parents, domestic violence of a parent, mentally ill family member, family member in prison, or a family member who attempted suicide (Redding, 2016).

One simply cannot discuss adverse childhood experiences without discussing the idea of resiliency, as helping an individual develop resiliency traits is the hallmark of improving lives of ACE survivors. Resiliency is considered to be the individual's ability to successfully adapt to life tasks in the face of social disadvantage or adverse events, and a resilient person is able to create an acceptance of reality, believe life is meaningful, manage adversity, and push through hardships (Luthar, 2000). Further, unrecognized and unresolved ACEs can continue to impact neurobiological changes that influence health, but when a person becomes resilient, it helps them

stop the cycle of the HPA overstimulation. Halting this maladaptive cycle can result in increased life success, higher academic achievement, less health problems, and utilization of less medication (APA, 2014). Resiliency is not developed overnight, but it involves behaviors, thoughts, and actions that can be learned by anyone. Trauma-informed counselors are trained in methods such as eye movement desensitization and reprocessing (EMDR) and trauma-based cognitive therapy that have been shown to improve a person's resiliency traits and lead to better health (APA, 2014).

Prevalence and Cost

More than half (63.1%) of Utah's adult residents are ACE survivors (Friedrichs, 2015). In the 2013 Utah Behavioral Risk Factor Surveillance System (BRFSS), researchers indicated that both direct (physical, sexual, or verbal) and environmental sources (exposure to mental illness, substance abuse, divorce, incarceration, or witnessing abuse) were associated with risky behaviors and poor health outcomes (Friedrichs, 2015). Nationally, it is estimated that 12-40% of children experience a form of childhood abuse, yet shame prevents many from reporting so the actual prevalence may be higher (ACOG, 2015). Approximately 1 in 5 women have experienced childhood sexual abuse, which is one of the most significant ACEs in terms of healthcare outcomes (ACOG, 2015). It is known that adult ACE survivors disproportionately utilize health care services, resulting in higher health care costs when compared to adults who have not had such experiences (ACOG, 2015).

Moyer (2013) noted that almost 31% of women report having experienced IPV in their lifetime, yet these rates are most likely lower than the actual rate due to underreporting. The World Health Organization reported that one in three women globally have been physically or sexually abused by a partner (WHO, 2013). Due to the amount of women affected by IPV,

Kottenstette & Stulberg (2013) note this prevalence results in almost two million injuries to women and over four billion dollars in medical and mental health costs. Also, there is a reported incidence of IPV of one in six pregnancies for adult women and one in five pregnancies for teens (Anderson, Marshak, & Hebbeler, 2002).

Outcomes

Physical and Psychological

The health outcomes of IPV and ACEs are significant and both can result in a number of negative effects later in life. The authors of the ACE study discuss extensively the pathophysiology behind the altered stress response when a child experiences an ACE. When this occurs, it can alter the life of the child leading to physical effects such as chronic pain, abdominal and pelvic pain, lower pain threshold, and increased rates of obesity, eating disorders, substance abuse, stroke, and diabetes (ACOG, 2015). Adults who have experienced ACEs or IPV can have sexual disturbances related to impaired desire, arousal, and orgasm, and they may be more likely to have multiple sexual partners and sexually transmitted infections. Other gynecologic outcomes include unintended pregnancy, chronic pelvic pain, dyspareunia, vaginismus, nonspecific vaginitis, and less likelihood of complying with recommendations for cervical cancer screening and prenatal care (ACOG, 2015). Women who have experienced IPV can experience more neurologic disorders and migraines, and they are more likely to be re-victimized by others. Psychological effects on victims of ACEs or IPV include depression, posttraumatic stress disorder, anxiety, substance abuse, suicidal behavior, and poor self-esteem (Moyer, 2013). Even with the knowledge of the varied impacts of IPV and ACEs, identifying the underlying cause of the wide array of symptoms with which women present can be challenging for providers. Because of this challenge, obstetrician-gynecologists and midwives

should routinely screen for childhood sexual abuse and IPV, be able to recognize disease processes that are a potentially a result of violence or adversity, and provide referral and support as appropriate (ACOG, 2015).

Pregnancy Outcomes

In addition to the physical and psychological effects listed above, pregnant women who have experienced ACEs or IPV, are more likely to experience preterm birth (up to 20% more), low birth weight, depression, anxiety, teen pregnancy, unintended pregnancy, and suicidal ideation in pregnancy (ACOG, 2015). Not only are these outcomes more likely to occur, but the prenatal visit and birth themselves can trigger symptoms of fear, shame, humiliation, guilt, self-blame, and recurring thoughts of the past abuse. Pregnant women also experience an increased perception of pain in labor if they have a high ACE score. Also, victims may begin to believe they caused or deserved the abuse (ACOG, 2015).

Screening

There is a universal understanding among professional organizations that it is important for women's health providers to screen for IPV. The USPSTF conducted a systematic review on IPV screening that examined the accuracy of screening tools for identifying IPV as well as the benefits and harms. Their conclusion is that clinicians should screen women of childbearing age for IPV, and provide or refer women who screen positive to intervention services (Moyer, 2013). They rank this as a B recommendation, and advise these recommendations be applied to asymptomatic and symptomatic women of reproductive age (14-46 years old) (Moyer, 2013). A B recommendation is given when there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial (USPSTF, 2012). The Institute of Medicine (IOM) and American Congress of Obstetricians & Gynecologists (ACOG) also supports this recommendation, but ACOG specifically recommends screening routinely at preconception, family planning, and gynecology visits as well as every trimester and postpartum visit (Anderson, Marshak, & Hebbeler, 2002). Further support for routine screening for IPV in healthcare settings was also identified in a recent Cochrane review which concluded that routine screening increased the identification of IPV, but rates were still below prevalence estimates of IPV in all women seeking healthcare (Eustace, Baird, Salto, & Creedy, 2016).

Anderson, Marshak, & Hebbeler (2002) suggest that using a validated tool for IPV screening is the only way to assess accurately for interpersonal violence. The USPSTF's systematic review of IPV screening concluded that there is adequate evidence to support that validated instruments help identify individuals with current and past abuse or increased risk for abuse (Moyer, 2013). They also report that several screening tools can be used, but those with the highest levels of sensitivity and specificity for IPV include Humiliation, Afraid, Rape, and

Kick (HARK), Hurt, Insult, Threatened with Harm, and Screamed (HITS), Ongoing Abuse Screen (OAS), Ongoing Violence Assessment Tool (OVAT), and Women Abuse Screening Tool (WAST) (Moyer, 2013). While ACOG recommends every trimester for IPV screening, the USPSTF found no evidence on appropriate intervals for screening once a tool is selected (Moyer, 2013).

While guidelines and recommendations for ACE screening are evolving, Corwin et. al, (2015) explain that assessing for ACEs is intended to uncover past experiences and major stressors so providers can intervene and give support that may have been overlooked. Also, the authors highlight that data from the Kaiser ACE study suggest that an important way to help providers gain a holistic view of an individual's health is to screen for ACEs and understand their exposure (Corwin et. al, 2015).

In addition to adequate research on the physiological effects, cost, and prevalence of ACEs, there are other benefits for the actual screening process of both IPV and ACEs. The USPSTF found that effective interventions for a positive screen can reduce violence, abuse, physical harm, or mental harm for women of reproductive age (Moyer, 2013). Kottenstette & Stulberg (2013) report that prenatal behavioral counseling by psychologists or social workers led to decreased IPV and improved birth outcomes such as reduced preterm birth, increased mean gestational age, and decreased rates of low birth weight. The authors also note screening and referral for counseling when compared to usual care lead to decreased pregnancy coercion, which is described as being physically threatened with pregnancy or prevented from contraception (Kottenstette & Stulberg, 2013).

There are few, if any, adverse effects for IPV or ACE screening, and the USPSTF found adequate evidence that the risk for harm to the individual from screening or interventions is no

greater than the risk of violence (Moyer, 2013). Reported consequences of screening may include loss of privacy, emotional distress, and concerns about further abuse, but women report feeling valued when asked about violence (Kottenstette & Stulberg, 2013). ACOG (2015) advises that not asking about violence may give additional support to the victim's belief that abuse does not matter and does not have medical relevance.

Resources and Best Care

Appropriate screening must be completed before providers can consider the need for referral or interventions. Prior to screening, the provider should make sure the patient is alone and make sure they are aware of what has to be reported by law. When screening, providers should make the questions seem natural, normalize the experience by giving facts about the commonality of violence, give the patient control over what and when she discloses information, ask if she has disclosed it before or sought help, listen attentively, and know that the physical exam can be postponed to address violence (ACOG, 2015).

There are various interventions for women who screen positive such as counseling, home visits, information cards, referrals to community services, and mentoring support, and these interventions may be provided by providers, nurses, social workers, or community workers (Moyer, 2013). Furthermore, providers should not screen for IPV or adverse childhood experiences until reliable procedures and resources for follow-up or intervention for positive screens have been identified (Kottenstette & Stulberg, 2013). ACOG (2015) recommends that providers compile a list of experts with experience in abuse and have crisis hotline numbers for IPV readily available. ACOG (2015) highlights the need to normalize interventions and suggests that appropriate scripting might include something like, "I would like Dr. X to assess you to determine if your past abuse is contributing to your current health problems." In addition to

having resources for referrals, providers should be aware of state and local reporting laws, as these vary from one jurisdiction to another (Moyer, 2013). In order to remain efficient, providers need easy access to available tools, specific guidelines, and other related materials to help them develop a clinical environment dedicated to the safety of their patients (Moyer, 2013).

While the USPSTF recommends the women's health care provider's role is simply to identify, report if needed, and refer to appropriate resources, there are other interventions or best practices providers can follow to provide trauma-informed care. ACOG (2015) reports that pelvic examinations may be associated with terror and pain, and feelings of vulnerability arise in the lithotomy position leading the survivor to re-experience past feelings of powerlessness, violation, and fear. Therefore, guidelines for when to provide physical exams and procedures should be adhered to and performed when medically necessary, providers should be equipped to provide compassionate and patient-centered care, and patients should receive anticipatory guidance for the possibility of the previously mentioned feelings and fears arising (ACOG, 2015). Lastly, the patient may want family or friends present, and she should know that she has the right to stop any time. The patient may also desire eye contact, a mirror to see the pelvic exam, and slower examinations (ACOG, 2015).

Common Barriers to IPV and ACE screening

Even when screening and intervention is agreed upon among providers in a particular practice, there are always barriers to change. Some studies highlight barriers to screening include inability to incorporate tools into practice, lack of education and training on screening and treatment or referral, feeling inadequately prepared to deal with positive screens, inability to develop rapport on initial visit and fear that asking sensitive questions will impair the relationship, and the lack of a multidisciplinary team to address violence (Eustace, Baird, Salto,

& Creedy, 2016). Despite these potential barriers, Anderson, Marshak, & Hebbeler (2002) report many women will talk openly if given a chance, women want health care providers to ask about violence although they reported the desire for confidentiality and support, and patients favor inquiry as they report a reluctance to initiate a discussion of the subject. Furthermore, research suggests pregnant women are comfortable disclosing sensitive personal information with midwives, as they believe their relationship with their midwife to be safe, supportive, and professional, but many midwives do not feel comfortable asking about or managing women who disclose IPV (Eustace, Baird, Salto, & Creedy, 2016). In regards to inability to screen due to logistics of clinic layout and time, there was a feasibility study published in 2016 that involved nurses administering an ACE questionnaire to patients in a family practice clinic, and they noted there were high rates of ACEs, only a couple minute increase to the visit, new insight for the patient into their overall health, a high success rate, and 100% of the staff felt it did not interfere with the visit (Glowa, Olson, & Johnson, 2016). Also, 98% of the staff felt it was acceptable to the patient from the staff member's perspective (Glowa, Olson, & Johnson, 2016).

A multidisciplinary approach is necessary to effectively implement ACE and IPV screening. Provider training, access to resources, technological advancements, and patient education are all facilitators to the process (Eustace, Baird, Salto, & Creedy, 2016). Eustace et. al (2016) further state that asking the screening questions alone is not enough, and midwives need to feel knowledgeable and confident in their abilities to respond to women who disclose current or past abuse.

Theoretical Framework

The ACE Star Model of Knowledge Transformation is applicable for this project as it guides the implementation of existing research into clinical practice (Stevens, 2012). The major stages of the model include discovery or research, evidence summary, translation to guidelines, practice integration, and outcome evaluation. Traversing these stages of the model will enable a practitioner to utilize a framework for systematically putting evidence-based practice into operation.

The first stage of discovery or research is where new knowledge is discovered through traditional research methods and inquiry (Stevens, 2012). The first stage of the interpersonal violence (IPV) and adverse childhood experiences (ACE) screening project involved a comprehensive search among databases to determine the prevalence of IPV and ACEs, as well as the clinical significance, recommendations, and health outcomes. Secondly, an evidence summary, or a literature review, was completed in order to synthesize the vast amount of knowledge that exists on the topic of ACEs and IPV. The advantages of producing such a literature review before implementation include reducing large quantities of information into a manageable medium, assessing consistencies and inconsistencies in the literature, and reviewing future research implications (Stevens, 2012).

Next, this DNP project incorporated the third stage of the ACE Star Model, translation to guidelines, by reviewing current professional organizations, such as the American College of Obstetricians & Gynecologists (ACOG), to have a guide in implementing the evidence into practice. After guidelines were reviewed, a process of practice integration was developed. This included working with key stakeholders at Birthcare Healthcare to build an existing screening

tool into an electronic system, discuss a pilot of the screening method, and determine usability within the electronic medical record.

Finally, there was an evaluation of the assessment interventions by conducting chart reviews in order to determine if the screening was occurring. By using this model, the goal of this project was carried out by transforming knowledge into an evidence-based quality improvement project.

Objectives, Implementation, and Evaluation

Before any of this project could be carried out, knowledge needed to be obtained regarding the significance and prevalence of interpersonal violence (IPV) and adverse childhood experiences (ACE) for women, which screening tools are evidence-based or validated, and what therapies or referrals are recommended for women who have a positive screen. To achieve this objective, a thorough literature review was completed that summarized national guidelines on screening, prevalence and significance of IPV and ACEs, barriers and facilitators to screening, and the health outcomes that are affected by IPV and ACE. The literature review was submitted to the project chair and content experts for review, and feedback was given to identify gaps in knowledge and recommendations for further exploration.

To accomplish the objective of improving IPV screening and implementation of ACE and resiliency screening, a sponsor for the practice site was identified for implementation. This sponsor helped facilitate discussion of this project at a provider meeting, recruited inside support for the project, and provided feedback on implementation strategies. The practice sponsor was Gwen Latendresse, who is also the program director of the certified nurse-midwifery program at the University of Utah. An IRB application was submitted, but it was ultimately exempt from IRB oversight..

Initially the primary goal for IPV screening was to implement an evidence-based tool, such as the two-question screening tool into existing EPIC notes or "smart text"; however, this was ultimately changed to the current University of Utah-approved IPV screening tool, the HARK tool, as it is hospital policy and already existed in the charting system used by the practice. Further, designing a unique smart text can take several months for the EPIC department to create, and the midwifery practice has additional changes to incorporate into this new EPIC smart text that were not yet decided upon at the time of implementation of this project. Nonetheless, despite the tool's existence in the system and current policy, the HARK tool was not being used. Therefore, an overview of the tool, how to access it, and the suggested frequency of screenings was presented to the practice at a monthly provider staff meeting. The midwife and medical assistant's daily workflows were taken into consideration, and screenshots of exactly how one should access the tool were presented in the PowerPoint presentation.

After meeting with Kristan Warnick, LPC and Susie Wiet, MD, local psychiatrists and founders of the trauma resiliency collaborative in Utah, I decided to use Dr. Wiet's HRSQ tool rather than the simple ACE questionnaire, as the latter does not include resiliency assessment. It should be noted that the decades of research of association between toxic stress and adverse health outcomes have come from Dr. Felitti's original ACE questionnaire, which has not been validated given the length of time and amount of variables involved in determining improvement in chronic health status. Therefore, Dr. Wiet's innovative HRSQ tool, that is currently in the final stages of a validation study, paved the way for midwifery providers to begin discussing ACEs, toxic stress, and developing resiliency. Dr. Wiet's tool includes four parts, two of which are validated screening tools. The first section (Part A) includes two parts. Part A-1 of the HRSQ is the Brief Resilience Scale (BRS), a validated resiliency tool that was originally studied

among mostly young to middle-aged females in the United States that was shown to have good internal consistency and test-retest reliability (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). Further, the BRS is the only tool to evaluate resiliency as the ability to bounce back or recover from stress. Part A-2 includes eight questions, put together by Dr. Wiet, to assess attachment and other protective factors that are not currently asked on other resiliency assessments. Part B includes a basic health assessment in order to gain an understanding of how the patient perceives his or her mental and physical health. Part C includes the validated PC-PTSD post-traumatic stress disorder screening tool. Lastly, Part D is the original ACE questionnaire from the Kaiser study with a few additional questions about ACEs that were added by Dr. Wiet. The HRSQ was designed to give primary care providers a quick overview of a person's ability to tolerate and cope with stress in relationship to their health and past traumatic experiences. Further, it is designed to stratify the ratio of resiliency traits to the expanded ACE score to produce an HRSQ risk-category that will be able to drive targeted intervention. It is an efficient, self-administered tool that takes approximately 2-5 minutes to complete. The validation study population includes 132 patients, mostly young to middle-aged females, who were screened in mostly primary care clinics. Other practices included in the validation study included pediatrics (mothers at the four-month well-child visit), internal medicine, addiction residential treatment center, outpatient psychiatry, and outpatient therapy.

In order to distribute the tool, the Health-Resiliency-Stress-Questionnaire (HRSQ) was built by university IT personnel and placed in the mEVAL electronic email system, so that the tool could be emailed to all new patients and updated yearly. Parts A-C will be asked annually, and Part D is asked once in a lifetime. This development took a handful of meetings and phone calls to discuss details of frequency of screening, how scoring should be displayed, who will be

responding to the results. IT met with their medical expert to verify its utility in the medical setting. mEVAL was chosen as providers at Birthcare Healthcare were already using this system for other screening tools for their patients. To evaluate this objective, I initially desired a two-month pilot period in order to do chart reviews to show how many patients were doing the screening and to determine barriers. However, this was when we were anticipating paper screening for ACEs. When it was discovered that having the HRSQ placed in the mEVAL system was very tangible after previously thinking it would take over a year and require all OB providers to sign off on its use, I knew this was an extremely beneficial change to make. However, this change to use mEVAL caused some delay in getting a two-month period of chart reviews, so only the first week of implementation was assessed. The bigger goal that was accomplished with this electronic system was providing sustainability in the practice even after this project is over, as the tool is a permanent adaptation to Birthcare Healthcare's mEVAL use.

Screening alone will not improve the health of women, as providers need to know how to respond to positive screens. Therefore, a key objective of this project was providing the midwives and practitioners adequate resources to respond to positive IPV and ACE screenings. Originally, I planned to create an algorithm for responding to IPV, but this was already designed by Dr. Kathy Franchek (content expert) and her domestic violence committee at the University of Utah. This includes a 100-page document detailing IPV reporting laws, ICD-10 codes, appropriate algorithms for response to vulnerable adult abuse, child abuse, sex trafficking, and interpersonal violence, as well as local resources for victims. This document was placed on the "PULSE" website for the midwifery practice to access at all times in a Birthcare Healthcare "Childhood Abuse and IPV" specific folder. Further, the one-page IPV algorithm was laminated and placed in all clinics.

Commented [DC1]: IUPV or IPV?

In order to help providers respond to the HRSQ screen, I met with several mental health professionals in the area and emailed over 50 providers to see who would be willing to see the midwives' patients for high scores. I created a document with over 30 trauma-informed mental health professionals and clinics that are either trained in EMDR or other trauma-focused therapies. Insurance information, wait times, languages spoken, and other therapies offered were included in the document, and this was placed on PULSE with the IPV resources. This was done due to feedback from University of Utah College of Nursing faculty about having enough resources for uninsured patients. Lastly, helpful links, HRSQ scoring, and suggested responses to various HRSQ risk levels were included on PULSE and discussed at the provider meeting.

A summary of the literature review and pilot screening period with results was included in an abstract for dissemination. It was accepted for a poster presentation at a local American College of Nurse-Midwives (ACNM) meeting, submitted for a poster presentation at the National Nurse Practitioner Symposium in Colorado, and discussed at the Trauma-Resiliency Collaborative monthly meeting. These venues and methods of dissemination were chosen, as a poster presentation to other midwives and practitioners is vital to spread awareness on the importance of screening appropriately for IPV and implementing ACE assessment, in order to facilitate a discussion about how to implement screening in other practices.

Results

In terms of results, the biggest accomplishments were achieving access to mEVAL, building the tool for Birthcare Healthcare after its acceptance among the practice, receiving positive feedback from the provider meeting about ACEs and IPV, discovering a preexisting electronic version of the HARK tool, educating providers about the already existing IPV

algorithms and policies, and developing a solid list of trauma-informed counselors who are willing and able to see this population for high HRSQ scores.

Further, chart reviews were conducted in the first week of implementation to gain understanding of how often providers were using the HARK tool and how often patients were filling out the HRSQ. I conducted chart reviews from all new obstetrical, annual, and six-week postpartum visits from all Birthcare Healthcare clinics, and I excluded problem visits or prenatal visits as these are not deemed appropriate for IPV screening. Approximately 50% of visits involved a provider using the HARK screening tool. However, providers were not utilizing the smart phrase in the note to input cores into the visit documentation. The mEVAL team provided me with data from all clinics for HRSQ screening. Madsen clinic had the highest completion rate, with 82.22% of patients completing the HRSQ, and this involved 37 completed assessments from a total of 45 visits. All other clinics had completion rates of approximately 33.33%-36.84%.

Barriers encountered throughout the implementation of this project included a general lack of knowledge about ACEs among IT personnel who were developing the tool, a misunderstanding of midwives' roles in obstetric clinics, lack of electronic access to the screening tool in some clinics, language barrier among non-English speaking patients, and provider inconsistency in inputting results into EPIC templates and utilization of the HARK screen.

Recommendations

In order for this project to have continued utility within the chosen midwifery practice, it was important for it to be sustainable and accepted by the midwives and their patients. Despite the challenges and delays that resulted from use of mEVAL for this project, it will ultimately

prove beneficial for the practice as it has created permanent change by embedding the tool within the EMR so providers can continue to easily use it in the future. However, some barriers still exist for mEVAL and IPV screening. When analyzing the completion rates for the HRSQ, it is important to note that the higher completion scores came from clinics that have an iPad in the waiting room to catch patients who did not complete the tool at home. Given that mEVAL is utilized by various providers and clinic types, there are key stakeholders actively involved in getting iPads at the lower completion rate clinics by end of May. This should help improve completion rates among patients. Secondly, some medical assistants are trained to put the results in the note, but this is not consistent at all clinics. Therefore, the mEVAL team will be doing further education to clinic staff on iPad use and how to access mEVAL results. I also developed a screening frequency reminder card that will be given to all midwives to improve consistency across all clinics and providers. Another recommendation is to have the appropriate smart texts include a hard stop for the providers to implement results, and this was discussed with a midwife fellow who will be working on smart texts in the near future. This same intervention will be done for HARK screening, by adding a hard stop to new obstetrical, annual, and postpartum visit smart texts. In order to improve completion among non-English speaking patients, Dr. Wiet will have the HRSQ in Spanish by mid-summer, and this may help completion rates at the primarily Spanish-speaking clinics within Birthcare Healthcare. Dr. Wiet has open communication with the mEVAL team to update this tool in various languages as needed. Another barrier faced in the implementation phase included lack of knowledge of midwife workflow and patient population, and education was provided to the mEVAL department. Further, two of the midwives involved in this project are actively involved with the mEVAL team to address these barriers and improve the utility of mEVAL.

Future goals are to have this project expanded to other clinics in the University of Utah, as family practice and other obstetric clinics use mEVAL, so this tool could be shared with all clinics if providers desire its use. The Trauma-Resiliency Collaborative serves as a meeting place for primary care providers, mental health counselors, and other trauma-informed individuals, and having Dr. Wiet involved in this project will allow for more providers to take on this HRSQ tool, especially if within the University system where it already exists.

There are numerous opportunities for future research that could stem from this project. Such opportunities include research on patient-reported outcome systems such as mEVAL, incidence of certain scores, how many patients follow suggested interventions, and how scores change from year to year. Further, it would be interesting to see if the rates of IPV change with the updated HARK tool.

While decades of research has been conducted on childhood trauma and IPV, a gap still exists in getting patients to talk about such experiences and referring to the appropriate service providers for intervention. This project successfully started to fill in that gap in a large midwifery practice in Utah, which I believe will serve as a launching ground for others to follow suit and help Utah become a trauma-informed community. That being said, the ultimate goal one day would be to have an entire mental wellness workforce or team member in the practice specifically in place for patients to discuss these types of violence.

DNP Essentials

This project addresses the DNP Essentials in many ways, but it most closely relates to Essential VII. Essential VII is the clinical prevention and population health for improving the nation's health. By screening pregnant women for intimate partner violence (IPV) and adverse childhood events (ACEs), the health of women, children, and families will be improved.

Literature supports the fact that ACEs and IPV experiences negatively affect many health outcomes of all adults, and detecting women with a history or current state of such experiences allows midwives to improve the health status of the United States population.

My project requires an analysis of scientific data related to individual, aggregate, and population health as it relates to violence against women and adverse childhood experiences. Once this analysis is performed, it is imperative to screen for women who have these experiences to allow for clinical prevention of adverse outcomes.

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Appendix A
Health-Resiliency-Stress-Questionnaire (HRSQ)

Health-Resiliency-Stress Questionnaire (HRSQ)

Name:_____ **Age:** _____ **Gender:** Female Male Other
Clinic or Provider: _____ **Date:** _____ **Zip Code:** _____

PART A

We each have our own ways to cope in life and get through difficult times.					
PLEASE CIRCLE THE ANSWER THAT SHOWS HOW TRUE EACH STATEMENT IS FOR YOU:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1) I tend to bounce back quickly after hard times.	1	2	3	4	5
2) I have a hard time making it through stressful events.	5	4	3	2	1
3) It does not take me long to recover from a stressful event.	1	2	3	4	5
4) It is hard for me to snap back when something bad happens.	5	4	3	2	1
5) I usually come through difficult times with little trouble.	1	2	3	4	5
6) I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

PLEASE CIRCLE THE ANSWER THAT SHOWS HOW TRUE EACH STATEMENT IS FOR YOU:	**Not true at all**	**Rarely true**	**Sometimes true**	**Often true**	**True nearly all the time**
1) I stay hopeful, even during stressful times.	1	2	3	4	5
2) I feel loved and supported.	1	2	3	4	5
3) I ask for help when I need it.	1	2	3	4	5
4) I have healthy, trusting relationship(s).	1	2	3	4	5
5) I choose healthy activities to decrease stress.	1	2	3	4	5
6) I can find positive solutions to life's problems.	1	2	3	4	5
7) I like who I am.	1	2	3	4	5
8) I feel optimistic about my future.	1	2	3	4	5

PART B

Some **physical health problems** can make it difficult to function or feel well.					
PLEASE CIRCLE THE ANSWER THAT FITS BEST:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
1) My overall physical health is...	1	2	3	4	5
2) My physical ability to do the tasks of everyday life is...	1	2	3	4	5
3) My ability to function when I have physical pain is...	1	2	3	4	5
4) My overall mental health is...	1	2	3	4	5
5) My ability to stay positive when I am not feeling well is...	1	2	3	4	5
6) My ability to function when I am feeling sad or blue is...	1	2	3	4	5

PART C

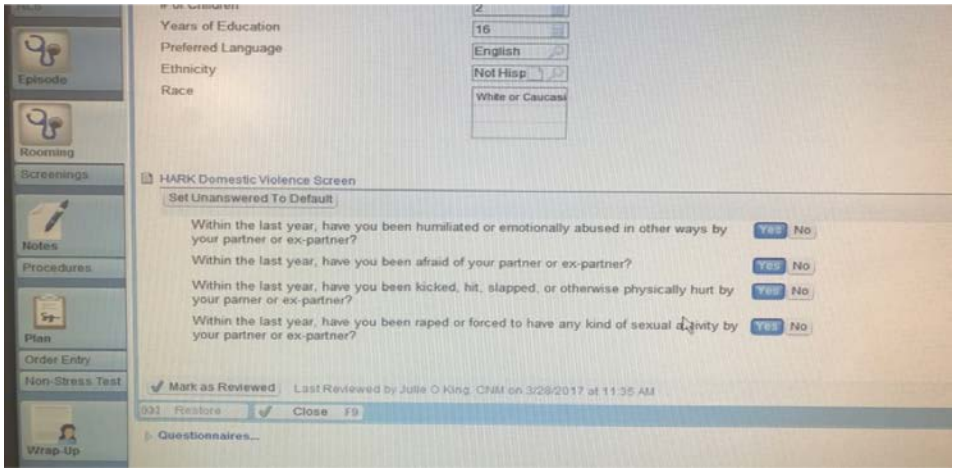
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you:			
1) Had nightmares or thought about it when you did not want to?	**Yes**	**No**	**Don't Know**
2) Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	**Yes**	**No**	**Don't Know**
3) Were constantly on guard, watchful, or easily startled?	**Yes**	**No**	**Don't Know**
4) Felt numb from your feelings or detached from others, activities or your surroundings?	**Yes**	**No**	**Don't Know**

Name: Date:

PART D

The following questions are about childhood experiences that may have happened before you were 18 years old.			
PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES YOUR EXPERIENCES (OR write in your total score if you prefer:)			
1) Did you live with anyone who was depressed, mentally ill, or suicidal?	Yes	No	Don't Know
2) Did you live with anyone who was a problem drinker or alcoholic?	Yes	No	Don't Know
3) Did you live with anyone who used illegal drugs or who abused prescription medications?	Yes	No	Don't Know
4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	Yes	No	Don't Know
5) Were your parents separated, divorced, one parent never involved OR lose a parent to death or abandonment?	Yes	No	Don't Know
6) Did you often feel that you did not have enough to eat, had to wear dirty clothes, had no one to protect you OR that your parents were not able to care for you due to their own struggles?	Yes	No	Don't Know
7) Did you often feel that no one in your family loved you, thought that you were important or special OR that your family didn't look out for each other, feel close or support each other?	Yes	No	Don't Know
8) In your home, did you ever see or hear domestic abuse (such as physical assaults or verbal threats) or were afraid to go home?	Yes	No	Don't Know
9) In your home, were you ever physically hurt, injured or threatened by anyone? (Do not include light spanking)	Yes	No	Don't Know
10) In your home, did anyone swear at you, insult you, or put you down?	Yes	No	Don't Know
11) Did anyone ever touch you inappropriately (sexually) OR watch you bathe/undress that made you feel uncomfortable, embarrassed, or ashamed?	Yes	No	Don't Know
12) Did anyone ever make you watch sexual acts (including pornography) OR try to make you touch them sexually?	Yes	No	Don't Know
13) Did anyone ever coerce or force you into having sex?	Yes	No	Don't Know
14) Were you bullied at school and felt unprotected?	Yes	No	Don't Know
15) Were you or your family ever homeless?	Yes	No	Don't Know
16) Were you often afraid to be outside because of violence in your community?	Yes	No	Don't Know

Appendix B
HARK tool for Interpersonal Violence screening in EPIC



Appendix C
Defense PowerPoint

Improving Screening and Referral for Violence Against Women: Interpersonal Violence and Adverse Childhood Experiences

Emily Miller, RN, SWHNP, SNM

In partial fulfillment of the requirements for the Doctor of Nursing Practice degree
October 20, 2016

Background

- Adverse Childhood Experiences – "Single greatest unaddressed public health threat facing our nation today" (Peters, 2015, para 2)
  - ACE-physical, emotional, sexual abuse or neglect, mental illness, substance dependence, incarceration, divorce, domestic violence
- Interpersonal Violence – Behavior in a relationship that either causes physical, sexual, or psychological harm (Eustace, Baird, Salto, & Creedy, 2016)
- More than half of Utahans have experienced an ACE (63.1%) (Friedrichs, 2015)
- 1 in 3 women have been victims of IPV (WHO, 2013)
- Increased healthcare costs (ACOG, 2015)
- Worse health outcomes (ACOG, 2015)

Problem Statement

- Midwives at a national and local level are not following ACOG guidelines, nor are they implementing ACE screening given extensive supportive literature
- A key barrier to provider screening is fear of a positive result (Eustace, Baird, Salto, & Creedy, 2016)
- **Purpose**: Implement ACE screening at NOB and annual visits, improve IPV screening tool at NOB, annual, and postpartum visits, and assist providers with how to refer or handle a positive screen.

Significance + Policy Implications

- Both providers and patients will benefit from screening and appropriate intervention (Moyer, 2013)
- Don't screen → Don't know → Don't intervene
- Don't intervene → Don't improve health

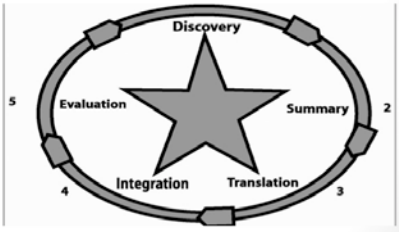
Implications
- Physical, emotional, mental (Moyer, 2013) and (Kottenstette & Stulberg, 2013)
- Financial (ACOG, 2015)

Objectives

- Obtain knowledge of IPV, ACEs, existing screening tools, and recommendations for positive screens
- Improve IPV screening with an evidence-based screening tool
- Implement ACE assessment in a large midwifery practice
- Provide midwifery practice with resources for responding to positive or negative screens, and identify local providers for appropriate referral
- Disseminate results

Theoretical Framework

ACE Star Model of Knowledge Transformation



Literature Review

- IPV and ACEs lead to significant, poor health outcomes (Felitti, 1998) (ACOG, 2015) (Moyer, 2013)

Chronic pain	Obesity	Eating disorder	Substance abuse	Stroke	Diabetes
Multiple sexual partners	**STIs**	**Unintended pregnancy**	**Chronic pelvic pain**	**Dyspareunia**	**Vaginismus**
Nonspecific vaginismus	**Decreased prenatal care**	Migraines	**Sexual Dissatisfaction**	Depression	PTSD
Impaired sexual desire	**Impaired arousal and orgasm**	Anxiety	Suicidal behavior	Poor self-esteem	**Preterm birth**
Low birth weight	**Teen pregnancy**	**Increased pain in labor**	Guilt	**Shame**	**Fear**
Autoimmune disorder	Prescription use	Premature Mortality	**Domestic Violence**	**Smoking**	**Stress**

Literature Review

- Duty to Respond
  - ACOG, USPSTF, IOM, COCHRANE (Moyer, 2013)
  - Screen, diagnose, refer (ACOG, 2015)
- Screening tool must be used (Anderson, Marshak, & Hebbeler, 2002)
  - Provider preference (Moyer, 2013)
- Family practice feasibility study (Glowa, Olson, & Johnson, 2016)
- Provider barriers and facilitators (Eustace, Saito, & Creedy, 2016)
- Screening leads to improved health (Moyer, 2013), (Kottenstette & Stulberg, 2013)

Implementation + Evaluation

Objectives	Implementation	Evaluation
1. Obtain knowledge	A literature review will be performed and submitted to project chair for review.	Project chair will approve and provide feedback.
2. Improve IPV screening and Implement ACE screening	Sponsor, Two question screening tool, EPIC templates, ACE questionnaire	Chart reviews, two-month pilot and documentation
3. Provide resources, Identify referral sites	Webpage, algorithm, patient + provider page, referral list	BCHC, DNP project chair feedback

Implementation + Evaluation

Objectives	Implementation	Evaluation
4. Evaluate feasibility of IPV and ACE screening	Survey, feedback, continuation	Project chair, BCHC sponsor, director feedback
5. Disseminate results	An abstract for a poster presentation will be created and submitted to the National Nurse Practitioner Symposium in CO	Abstract will be provided to content expert and project chair for feedback prior to submission.

Summary

- IPV and ACEs are highly prevalent and highly associated with worsened health outcomes, cost, and emotional well-being
- Midwives have a unique ability to intervene
- Screening and referral is a part of holistic care that leads to improved health outcomes

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- Gwen Latendresse, PhD, CNM, FACNM [BCHC Sponsor and Specialty Track Director]
- Pam Hardin, PhD, RN, Assistant Dean for MS & DNP program

Content Experts

- Susan Chasson, MSN, JD, FNP, SANE coordinator
- Kathy Franchek, MD

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Appendix D
Birthcare Healthcare Provider Meeting Presentation

mEVAL Update:
Adverse Childhood Experiences & HRSQ tool

Domestic Violence **Screening Tool** Update

Emily Miller
RN, BSN, DNP student

Objectives

- Describe ACE study, results and implications, role of the provider
- Discuss resiliency and how to respond to those with traumatic childhoods
- Introduce HRSQ tool & mEVAL update
- Demonstration of IPV/DV screening tool
- Update of U of U IPV algorithm and policy

Adverse Childhood Experiences (ACE) study

- Landmark study [CDC & Kaiser Permanente]
- ACE: any emotional, physical, sexual abuse; emotional & physical neglect; witnessing DV, mentally ill or substance abusing household members, loss of a parent, or having a family member incarcerated
  - "Single greatest unaddressed public health threat facing our nation today" (Peters, 2015, para 2)
- Large sample size [n=17,500]
- Dose response relationship
- Ongoing studies

Health Outcomes

Chronic pain	Obesity	Eating disorder	Substance abuse	Stroke	Diabetes
Multiple sexual partners	**STIs**	**Unintended pregnancy**	**Chronic pelvic pain**	**Dyspareunia**	**Vaginismus**
Nonspecific vaginismus	**Decreased prenatal care**	Migraines	**Sexual Dissatisfaction**	Depression	PTSD
Impaired sexual desire	**Impaired arousal and orgasm**	Anxiety	Suicidal behavior	Poor self-esteem	**Preterm birth**
Low birth weight	**Teen pregnancy**	**Increased pain in labor**	Guilt	**Shame**	**Fear**
Autoimmune disorder	Prescription use	Premature Mortality	**Domestic Violence**	**Smoking**	**Stress**

Pathophysiology of Trauma

- Neurobiology
  - **Nucleus accumbens** – substance abuse, multiple sex partners, obesity, eating disorders
  - **Prefrontal cortex** – anger/stress management, depression, inability to learn new skills
  - **Amygdala** – increased guilt, fear, shame, and increased pain in labor
- Hypothalamic pituitary adrenal axis
  - Protective → maladaptive

Resiliency

- Individual's ability to successfully adapt to life tasks in the face of social disadvantage or adverse events. Empowerment to move forward in life with sense of hope, capability, mastery, and expectation.
- Resiliency creates acceptance of reality, believing life is meaningful and worth living, manage adversity, and push through hardships
- Not done overnight, but there are tools
- Trauma-informed counselors are trained to help develop this (APA, 2014)
- Improves outcomes

HRSQ Tool

- Designed for primary care providers to give a quick overview of a person's ability to cope with stress in relationship to their health.
- 2-5 minutes
- Utility is to provide ratio of resiliency to ACEs in order to drive targeted intervention
- Goal is to go University-wide following completion of DNP project
- Mental health community prepared [TRC]

HRSQ Tool (cont.)

- Four-part tool
  - Part A – Resiliency traits
  - Part B – Mind-body connection, Physical Health
  - Part C – Psychological distress (PTSD)
  - Part D – Adverse childhood experiences survey
- Scoring
  - **Overall HRSQ score MOST important**
    - 7-10 extreme, 5-6 high, 3-4 moderate, 1-2 low
    - Scoring available on PULSE
  - ACE – 1-2 moderate, 4+ extreme
  - PTSD – 0 normal, 1 low, 2 high

meVal
PERSONAL HEALTH ASSESSMENT

- APRIL 5 – GO LIVE
  - Live personnel
  - MA reminder
  - Smartphrase "BCHCMEVAL"
- Frequency of screening
  - Parts A, B, & C asked yearly via email
  - Part D is asked ONCE IN A LIFETIME

How to Respond

- No magic pill – See the whole picture
- Goal
  - Explore level of risk and impact
  - Encourage patient to build on strengths
  - Take initial steps to connect trauma and health outcomes
  - Discuss resiliency builders [exercise, trusting relationship, mindfulness, yoga]
  - Refer to mental health [EMDR, trauma-trained, CBT]
- DOCUMENT
  - ICD-10 code "personal history of psychological abuse in childhood" [Z62.811]
    - Overview/Notes: HRSQ=8

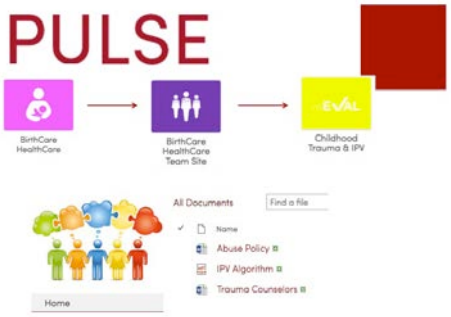
HRSQ Interventions

- Low (1-2)
  - Praise for having effective coping skills
  - Routine care/Resiliency Builders
- Moderate (3-4)
  - Has coping skills, but perhaps more stressors or past adversity
  - Watch closely for ACE related illnesses
  - Routine care/Resiliency builders
- High (5-6)
  - Review PHQ-9, suicidal score
  - Monitor ACE related illnesses closely
  - Referral to mental health services
  - Follow-up 1-2 weeks
- Extreme (7-10)
  - Screen for suicide and addiction, DV [safety plan agreement]
  - Refer to mental health, social services as appropriate
  - Follow-up 1-2 weeks

PULSE

- How to get there

PULSE



PULSE

- What you will find
  - List of trauma-trained counselors
    - Psychologytoday.com
  - Handout/Resiliency Builders
  - ACE info, helpful links
  - Targeted interventions
  - HRSQ tool and scoring system

Why BCHC?

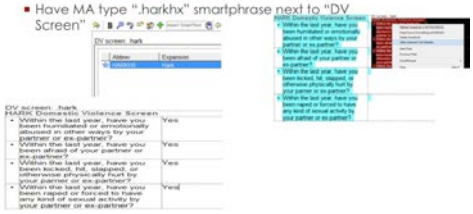
- Prevalence in Utah [60% had 1, 12% had atleast 4]
- Unique visits - next generation
- Midwives are sought out, the "in between"
- University of Utah is committed to trauma-informed care
  - "What's wrong with you" → "What happened to you?"
- Harms of not asking

Domestic Violence (DV) Interpersonal Violence (IPV)

- QUICK UPDATE
  - ACOG guidelines, U of U policy → NO8, annual, postpartum visits
  - USE A TOOL! [HARK Screening tool ALREADY exists]
    - Provider, NOT MEDICAL ASSISTANT

HARK → NOTE

- Have MA type ".harkhx" smartphrase next to "DV Screen"



HARK → NOTE (option 2)

IPV/DV added resources

- PULSE WEBSITE
  - Algorithm (laminated in clinics, on PULSE)
  - 50 pages U of U policy for IPV
    - ICD-10s, algorithms (IPV, SA, vulnerable adult)
    - Many, many resources and phone numbers
  - ".resource" smart phrase added

HIGHLIGHTS

- Review objective for mEVAL results
- Take time to look over PULSE IPV/trauma page
- ECHO presentations (5-part series)
- Call/email with questions!!!
  - (615) 598-7396
  - u0911521@utah.edu

Appendix E
Trauma-Informed Provider List

Trauma-Informed Counseling Services

NAME	CONTACT	INSURANCE ACCEPTED	LOCATION	SERVICES	MISC
Nicole Korman, LCSW, SUDC	801-739-3754	Medicaid, Private	Cottonwood Heights, UT	EMDR, addiction, psychotherapist	
Michelle Greene *Synergism Counseling*	801-350-1671	Medicaid	Heber City, Sandy, SLC	EMDR, depression/anxiety, trauma-focused, grief	
Cassidy Duhadway, LCSW *Peak Performance and Counseling Services*	435-709-3060	Medicaid, BCBS, Regence, SS (75-120)	Heber City, UT	EMDR, trauma, parenting	
Alicia Power, Med, LMFT, MAC *Power Counseling Services*	435-710-9056	Medicaid, Private	Heber, UT	EMDR, trauma	
Healing Group	801-305-3171	$25 individual, $50 couples	Midvale	Sex therapy, couples, trauma, depression, PPD	Free 15 min consult
Melinda Stonecliffe, LCSW, MSW	385-202-0071	Medicaid, Private	Millcreek	Trauma trained	
Pam Mitchell, LCSW	801-688-4515	Medicaid, Private	Millcreek	EMDR, trauma-trained w/ children & adults	
Polizzi Clinic	801-277-7740	Uninsured, scholarship	Millcreek	NO primary substance abuse or personality disorder	Must meet verified low income and uninsured
Family Counseling Center	801-261-3500	Sliding scale starting at $5	Murray	Medication management, depression, trauma, parenting	
Kristin Jones	801-380-3846	Medicaid, Private, SS (starts at $65)	Murray, SLC	EMDR	
TJ Grow, CMHC, MP *Holistic Elements*	801-784-3047	Medicaid, Private	Murray, UT	EMDR, trauma	
Janelle Nimer, Ph.D., LCSW *Utah Healing Center*	801-266-4643	Medicaid, Private, Discounted rate for student session	Murray, UT	Trauma trained	
The Peace House	435-731-8413	FREE	Park City, Kamas, Heber	Domestic violence shelter, past child abuse and resurfacing of symptoms	Children, families, hx of abuse or DV

Trauma-Informed Counseling Services

Kristen Warnick, CMHC *Healing Pathways Therapy Center*	435-248-2089	Sliding scale, scholarship option, some insurances	SLC	Trauma, EMDR, adults/teens/children, resiliency	
Emily Hawkins *Salt City Wellness*	801-960-2550	BCBS, EMI	SLC		Individual, mindfulness groups, EMDR somatic, trauma sensitive yoga
Jewish Family Services	801-746-4334	$25 or lower, insurance accepted, sliding scale	SLC	Parenting classes, counseling, family improvement, community assistance	
Simple Modern Therapy	435-730-2973	$75-$100	SLC	Individual, couples, LGBT	
Health Clinics of Utah	801-715-3500	$80 for primary—then referred to mental health *Uninsured only*	SLC	Full mental health services, Department of Health	Must have initial primary care visit and referred to mental health, then $5 LCSW session or APRN
Jill St. James	801-809-7985	BCBS, Molina, PEHP, UNI, Medicaid, Aetna	SLC	CBT, mindfulness, EMDR, energy balancing, massage	Booked 3 months out
Heather Holmgren	435-730-2973	BCBS, private pay w/ reimbursement	SLC	Trauma-trained, EMDR	
Elaine Winter, LCSW	801-829-9069	Medicaid, Private	SLC	EMDR, trauma focused	20+ yrs experience
Florie W. Jackson, LCSW *Salt Lake Counseling Service*	801-455-7985	Medicaid, Private	SLC	Trauma	
Child and Family Empowerment Services	801-972-2711	Medicaid, sliding scale, private	SLC	Trauma, EMDR	English, Spanish, Tongan
Amy-Rose White	541-337-4960	Self pay	SLC	PPD, trauma, reproductive mental health (infertility, loss, pregnancy anxiety)	1 month waitlist

Trauma-Informed Counseling Services

Stefanie Minen, CMHC	801-918-4432	Self pay	SLC	Complex trauma, family, parenting, grief	
Meg Martinez *Namaste Advice*	801-272-3500	Self pay, some help with OON insurance reimbursement	SLC	Complex trauma, intimacy, resiliency work	
University of Phoenix Counseling Skills Center	801-506-4142	Uninsured-Pro Bono	SLC campus	Trauma, CBT, Depression/anxiety	Run by masters students Strict no show policy
Kathleen Kaloudis, CMHC, RPT	801-201-7050	Medicaid, Private (no Select, Cigna, or PEHP)	SLC, Clearfield	Postpartum depression, EMDR	
Valley Behavioral Health	888-949-4864	Sliding scale for uninsured	SLC, Tooele, SLC	Full services	Must complete intake assessment to qualify
Midtown Community Health Center	801-486-0911	Sliding scale, Medicaid, Medicare	South SLC	Primary care and mental health	
Ascent Counseling	801-891-6123	Medicaid, Private	Sugarhouse	Complex trauma	
The Family Support Center	801-955-9110	$15-$100	Taylorsville	Individual/family therapy Parenting classes, adult survivors of childhood abuse	Spanish & English
University of Utah Educational Assessment and Student Support Clinic	801-581-6068 (ext 2)	$10	U of U Campus, SLC	Counseling	Masters students
****For more options visit *PsychologyToday.com* [Allows filtering by location, insurance, services, gender preference, sexuality, faith, etc.]**					

__Accepts Medicaid
__Low cost or free
__Private pay/Private insurance
__Spanish Speaking

Appendix F
HRSQ Scoring

Health-Resiliency-Stress Questionnaire (HRSQ): *Scoring*

Susie Wet, MD & Colleagues of TRC 10/2016 ©

SCORING

- add the three Risk-Values together to get the composite HRSQ score
- The HRSQ score determines the level of risk
- The level of risk determines a recommended level of care and/or other follow-up

HRSQ Score	Risk Category
7 – 10	Extreme
5 – 6	High
3 – 4	Moderate
1 – 2	Low

PARTS A + B TOTAL POINTS	RISK TYPE	RISK VALUE
20-35	Extreme	4
36-50	High	3
51-70	Moderate	2
71-80	Mild	1
81-100	Normative	0

+

PART C TOTAL POINTS	RISK TYPE	RISK VALUE
3 - 4	High	2
2	Low	1
0 or 1	Normative	0

+

PART D TOTAL POINTS	RISK TYPE	RISK VALUE
> 6	Extreme	4
5 - 6	High	3
3 - 4	Moderate	2
1 - 2	Mild	1
0	Normative	0

SCORING EXAMPLES

Mr. Adversity	Risk Value
Part A + B Total points = 22	4
Part C Total points = 4	2
Part D Total Points = 6	3
HRSQ Score	9
Risk Category	Extreme

Ms. Sadness	Risk Value
Part A + B Total points = 22	4
Part C Total points = 1	0
Part D Total Points = 1	1
HRSQ Score	5
Risk Category	High

Mr. Dysthymia	Risk Value
Part A + B Total points = 60	2
Part C Total points = 0	0
Part D Total Points = 3	2
HRSQ Score	4
Risk Category	Moderate

Ms. Peachy	Risk Value
Part A + B Total points = 82	0
Part C Total points = 1	0
Part D Total Points = 1	1
HRSQ Score	1
Risk Category	Low

Appendix G
HRSQ Suggested Responses + Helpful Links

HRSQ Score	Risk Category	Pilot Study Suggestions for the Provider	Pilot Study Suggestions for Self-Help

7-10	Extreme	• *"I can see from your answers that you have really gone through a lot that no one should have to experience, and I also see that you are really struggling right now. Thank you for being so honest, which helps me to better understand you…"*
		• Introduce patient to the primary integration team during visit, if available; or, refer to treatment with a mental health provider ASAP and consult with psychiatrist or APRN
		  ○ further assessment for PTSD and/or other mental health disorders
		• Screen for suicide and addiction
		  ○ safety plan agreement PRN
		• Monitor closely for chronic health disorders associated with ACES
		• Office follow-up visit: within 1 week (or sooner PRN if no access to mental health provider)
		• Referral into intensive medical group visit program, if available (e.g. Complete Health Improvement Program; https://www.chiphealth.com/)
		• OR group medical visit (health and wellness)
			• Provide links that may be helpful to the patient:
			  ○ ACES too high: https://acestoohigh.com/
			  ○ Academy on Violence and Abuse (ACEs video, 3 min) http://www.avahealth.org/ace_study/ace_study_dvd_institutional_license/
			  ○ American Academy of Pediatrics (Toxic Stress and Resiliency Project): http://www.avahealth.org/ace_study/ace_study_dvd_institutional_license/
			  ○ CDC's website on ACES: https://www.cdc.gov/violenceprevention/acestudy/
			• Provide link(s) on improving resiliency:
			  ▪ http://www.embracethefuture.org.au/resiliency/index.htm? http://www.embracethefuture.org.au/resiliency/emotional_skills.htm
			  ▪ http://www.resiliencyskills.com/
			  ▪ https://www.psychologytoday.com/blog/in-the-face-adversity/201201/the-eleven-skills-and-attitudes-can-increase-resilience
			  ▪ http://www.apa.org/helpcenter/road-resilience.aspx
			• Provide link(s) for positive affirmations
			  ○ http://www.huffingtonpost.com/dr-carmen-harra/affirmations_b_3527028.html
			  ○ http://www.louisehay.com/affirmations/

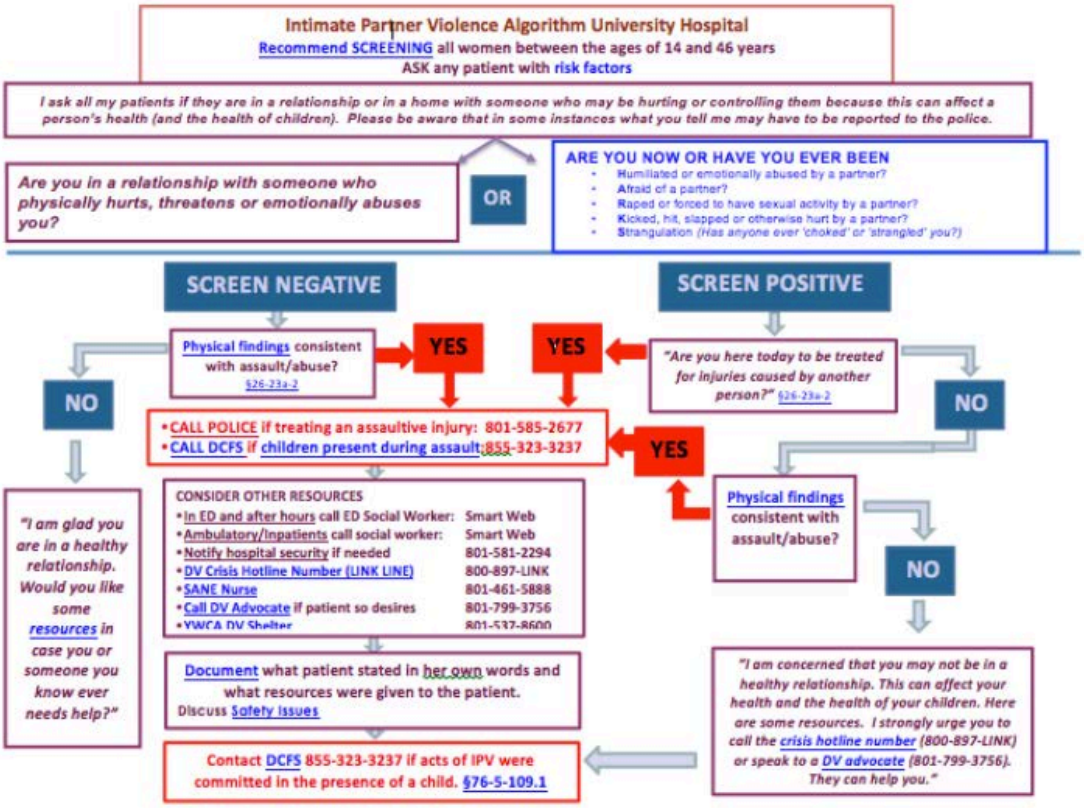
5 – 6	High	• *"I can see from your answers that you have gone through a lot that no one should have to experience, and I also see that you are having some struggles right now. Thank you for being so honest, which helps me to better understand you…"*
		• refer for additional assessment with a trauma-informed mental health provider; refer to psychiatrist or APRN ***PRN***
		  ○ further assessment for active PTSD and/or mental health disorders
		• screen for suicide and addiction
		• monitor closely for chronic health disorders associated with ACES
		• Follow-up within 1-2 weeks, earlier as needed
		• Referral into intensive medical group visit program (e.g. Complete Health Improvement Program; https://www.chiphealth.com/)
		OR group medical visit (health and wellness)
			• Trauma-focused guided meditation
			  ○ https://www.youtube.com/watch?v=uttz5kx5CI8&list=PLuxOFwKNfO4IMEqNlaLbmVjkd9O5iVOKO&index=4 (Naparstek)
			  ○ https://www.youtube.com/watch?v=e-RxDFgJOok
			  ○ https://www.youtube.com/watch?v=szDi0UVzrdo&feature=share
			  ○ https://www.youtube.com/watch?v=uttz5kx5CI8 https://www.youtube.com/watch?v=HT_ZvD94_kE&list=PLuxOFwKNfO4IMEqNlaLbmVjkd9O5iVOKO
			• Provide link(s) for building mindfulness, health and wellness
			  ○ http://www.ebay.com/gds/Four-Meditation-Practices-to-Quiet-Your-Mind-/10000000204777104/g.html?roken2=ti.pTGI6IExhbW9yZXV4
			  ○ http://www.ebay.com/gds/Five-Mindfulness-Practices-You-Can-Start-Today-/10000000204768545/g.html?roken2=ti.pTGI6IExhbW9yZXV4
			• Provide emotional regulation grounding skills
			  ○ https://www.anxietybc.com/sites/default/files/adult_hmptsd.pdf
			  ○ https://www.youtube.com/watch?v=MR57rug8NsM&list=PLuxOFwKNfO4IMEqNlaLbmVjkd9O5iVOKO&index=2
			Hands over heart
			  ○ http://lindagraham-mft.net/newsletters-and-quotes/exercises/resources-for-recovering-resilience-hand-on-the-heart/
			Deep restorative breathing
			  ○ http://www.yogajournal.com/article/beginners/breathing-for-relaxation/
			  ○ http://greatist.com/happiness/breathing-exercises-relax

3 – 4	Moderate	• *"I can see from how you answered this that you have some really good ways to cope with stress. I also see that you are having some struggles now that may be related to things that happened to you that should never happen to anyone. Thank you for being so honest, because it helps me to better understand you…"* • refer for additional assessment ***PRN*** ○ ***PRN*** screen for suicide, addiction and/or mental health disorders • Routine monitoring for health disorders associated with ACES • Follow-up within 3 months • Referred into group medical visit (health and wellness)	

1 – 2	Low	• *"I can see from how you answered this questionnaire that you have some really excellent ways to cope with stress and that you are not having too many struggles about your health. I do see that you've had some (minor, really significant) experiences earlier in life that don't seem to cause grief for you now, but wanted to check in with you on that…"*
		• refer for additional assessment ***PRN***
		  ○ ***PRN*** screen for suicide, addiction and/or mental health disorders
			• Provide crisis hot-lines and links ***PRN***:
			  ○ Suicide prevention (Utah): 1-800-273-8255 (also chat available) http://suicidepreventionlifeline.org/
			  ○ Domestic violence shelters: http://udvc.org/resources/domestic-violence-shelters
			  ○ "warm-lines" for mental health crises: 801-587-3000 http://healthcare.utah.edu/uni/clinical-services/crisis-diversion/
			  ○ Peer support groups by NAMI (for mental illness): http://www.namiut.org/find-resources-by-county

		• Routine monitoring for health disorders associated with ACES
		• LABS: routine
		• Follow-up within 3 months
		• Referred into group medical visit (health and wellness) ***PRN***
			• Provide NAMI contact information ***PRN***
			  ○ Local: 801-323-9900
			  ○ Toll-free: 877-230-6264
			• Provide 12-Step link/information ***PRN***
			  ○ Local: https://www.addiction.com/meetingfinder/
			  ○ National (on-line meetings): http://www.12step.org/social/online-meetings/

Appendix H
IPV University of Utah Policy Algorithm



Appendix I
IPV Resource Page for EPIC

Life Threatening Emergency.....911

Adult Protective Services...800-371-7897
Child Protective Services...855-323-3237
Crisis/Suicide Prevention...801-587-3000
Domestic Violence Hotline.800-897-5465
National Suicide Prevention 800-273-8255
Poison Control.....800-222-1222
Rape Recovery Crisis.....801-467-7273
Sexual Assault Hotline.....888-421-1100
Trafficking National Hotline
.....888-373-7888

ADULT AND CHILD ABUSE/NEGLECT
Adult Protective Services.....800-371-7897
Child Protective Services.....855-323-3237
Children's Justice Center.....385-468-4560
Guardian Ad Litem.....801-578-3962

DOMESTIC VIOLENCE
Domestic Violence Hotline.....800-897-5465
Family Justice Center.....801-236-3370
Legal Aid Society of Salt Lake
.....801-328-8849
Utah Office of Crime Victims..801-238-2360
YWCA Shelter.....801-537-8600

EDUCATION
Horizonte Instruction and Training
.....801-578-8574
Salt Lake Community College
.....801-957-4111
English Skills Learning Center
.....801-328-5608

EMPLOYMENT/JOB TRAINING
Department of Workforce Services
.....801-526-0950
Deseret Industries.....801-240-7202
LDS Employment Services....801-240-7240
Labor Commission.....801-530-6800
People Helping People.....801-583-5300

FAMILY SUPPORT SERVICES
Family Support Center (Crisis Nursery)
.....801-255-6881
Division of Child & Family Services
.....855-323-3237
Parenting Classes.....211
Support Groups.....211

FINANCIAL COUNSELING
AAA Fair Credit Foundation...800-351-4195
Cornerstone Financial Education
.....800-336-1245
NeighborhoodWorks Salt Lake
.....801-539-1590

FOOD ASSISTANCE
Food Pantries.....211
Food Stamps.....801-526-0950
Home Delivered Meals Seniors
.....385-468-3200
Utah Food Bank.....801-887-1275
WIC (Women, Infants & Children)
.....801-538-6960

HOUSING ASSISTANCE
Family Promise Shelter.....801-961-8622
Housing Authority.....801-487-2161
The Road Home.....801-359-4142
Youth Services.....385-468-4500

IMMIGRATION SERVICES
Catholic Community Services
.....801-977-9119
Refugee and Immigration Center
.....801-467-6060

MENTAL HEALTH
Salt Lake Co Crisis.....801-587-3000
UNI.....801-583-2500
Valley Mental Health.....801-270-6550

PEOPLE WITH DISABILITIES
711 Relay Utah.....711
Division of Services for People with
Disabilities.....877-568-0084
Sego Lily Center for the Abused Deaf
.....888-328-5486
Utah Parent Center/Autism Information
.....801-272-1051
Work Activity Center.....801-977-9779

RAPE/SEXUAL ASSAULT
Rape Recovery Center.....801-467-7273
Rape/Sexual Assault Crisis Hotline
.....888-421-1100
Sego Lily Center for the Abused Deaf
.....888-328-5486
UCASA.....801-746-0404

SENIOR CITIZENS
AARP.....866-448-3616
Salt Lake County Aging Services
.....385-468-3200

SEXUALLY TRANSIMITTED DISEASES/AIDS
Planned Parenthood Association
.....801-532-1586
Utah AIDS Foundation.....801-487-2323

SUBSTANCE ABUSE
Alcoholics Anonymous.....801-484-7871
Al-Anon Family Groups.....801-262-9587
Narcotics Anonymous.....877-479-6262
SL County Assessment and Referral Unit 801-468-2009
Tobacco Quit Line..888-567-TRUTH (8788)

UTILITIES
American Red Cross.....801-323-7000
Assist, Inc (Emergency Home Repairs)
.....801-355-7085
HEAT (Home Energy Assistance Target)
.....801-521-6107
Questar Gas (Customer Service)
.....800-323-5517
Utah Telephone Assistance Program
.....800-948-7540
Rocky Mountain Power.....888-221-7070

HELP WITH PRESCRIPTIONS
If you need a prescription but do not have health insurance, RxConnectUtah might be able to help:
http://www.health.utah.gov/rxconnectutah/
For discounted drug prices go to: goodrx.com

**Typing ".RESOURCE" will drop this into EPIC AVS or visit note

Appendix J
Screening Frequency Reminder Cards

HARK IPV **[Rooming/History Tab]** **-Provider completes in above TAB** **OR** **-Pull in smartphrase via ".HARK"**	**NOB** **Annual** **6 wk PP**
HRSQ **[mEVAL]** **-MA or Provider pulls in ".BCHCMEVAL" smartphrase**	**NOB** **Annual**
EDPS + PROMIS **[mEVAL]** **-MA or Provider pulls in ".BCHCMEVAL" smartphrase**	**NOB** **Annual** **Q trimester** **PP**

Appendix K
Defense Poster

Improving Screening and Referral for Violence Against Women: Interpersonal Violence and Adverse Childhood Experiences

Emily Miller, RN, BSN, DNP student, University of Utah College of Nursing

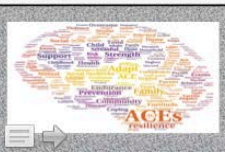
UNIVERSITY OF UTAH COLLEGE OF NURSING

BACKGROUND

- Landmark CDC and Kaiser study
- **ACES**
  - *"Single greatest unaddressed public health threat facing our nation today"*
  - Over 63% of Utahns
  - Any physical, emotional, sexual abuse or neglect, mental illness, substance dependence, incarceration, divorce, or domestic violence
- Resiliency = "an individual's ability to successfully adapt to life tasks in the face of social disadvantage by creating an acceptance of reality, developing skills to manage adversity, and push through hardships"
- **IPV**
  - behavior in a relationship that either causes physical, sexual, or psychological harm
  - IPV occurs in 1 in 3 women in Utah

PROBLEM + PURPOSE

- Improve interpersonal violence (IPV) screening and management in a large midwifery practice
- Implement adverse childhood experiences (ACE) and resiliency screening in the same practice
- Provide women's health providers in this practice with appropriate resources for both IPV and ACE/resiliency positive screens



METHODS

- Selected large midwifery practice for implementation
- Dr. Susie Wiet – "HRSQ" tool
  - Resiliency traits, self-perception, PTSD, ACEs
- meVal system + BirthCare HealthCARE
- ACE = Annual + New obstetrical patients
- IPV = Annual + NOB + Postpartum
- HARK IPV tool in EPIC
- IPV algorithm and ACE resources on PULSE

Content Experts: Susan Chasson, MSN, JD, FNP, CNM, SANE and Kathy Franchek, MD
Committee: Amanda Al-Khudairi, DNP, APRN, WHNP-C, Diane Chapman, DNP, APRN, FNP-C, Specialty track director Gwen Latendresse, PhD, CNM, FACNM, and assistant dean Pam Hardin, PhD, RN

RESULTS

- Accepted for use within midwife faculty practice
- LIVE on April 6th → Chart Reviews
  - IPV
    - 30 visits deemed "appropriate"
    - 50% completion rate for HARK in first two weeks
  - ACE
    - 82.22% completion rate (n=37) for HRSQ at Madsen
    - 33-36% completion rate (n=21, n=7) at all other clinics

DISCUSSION/FUTURE RECOMMENDATIONS

- IPV: Most that did not screen were not at practice meeting, partner was in room, or results show small sample size
- ACE
  - Catch patients via iPad in clinic
  - Reminder card
  - EPIC template
  - Midwife lead in practice working with meVal
- **FUTURE: Expand to all University clinics and collect prevalence data**
- Dissemination:
  - Local ACNM meeting acceptance
  - Submitted to National Nurse Practitioner Symposium
  - Trauma-Resiliency Collaborative Annual Symposium in Utah

meVal PERSONAL HEALTH ASSESSMENT