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Gender-Based Violence

Using the Consolidated Framework for Implementation Research to Increase Provider Screening for Intimate Partner Violence in Rural Health Clinics

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ABSTRACT

Purpose: To demonstrate the utility of the Consolidated Framework for Implementation Research as a tool for conceptualizing and overcoming obstacles to the implementation of universal screening practices for intimate partner violence (IPV), with a particular focus on rural family practice settings. This article uses data from a 2014 statewide survey of rural primary care providers to identify potential leverage points for policy and practice changes.

Methods: The Physician Readiness to Manage Intimate Partner Violence was administered to 134 physicians and nurses at rural health clinics in a Midwestern state. Six scales measuring knowledge, attitudes, and behaviors were computed and analyzed with bivariate and logistic regression models to ascertain links between knowledge/attitudes and screening/response behaviors.

Findings: Knowledge and attitudes did not predict screening; rather, the number of hours of previous training on abuse and the organizational protocols of the clinics where providers were employed significantly increased the likelihood of frequent IPV screening.

Conclusions: Guided by Consolidated Framework for Implementation Research principles, the author concludes that external factors, that is, state or national policies mandating IPV screening in clinics, may be an effective way to increase provider identification of a major public health problem affecting women. Rural women may benefit especially from IPV screening during health care encounters, because there are few other supportive services for abuse survivors in rural areas.

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Consensus is growing within public health, and among health care providers in particular, that assessing and responding to intimate partner violence (IPV) should be an essential element of women's primary health care. Despite U.S. Preventive Services Task Force recommendations to implement routine IPV screening and treatment in primary health care settings (Moyer, 2013), it seems that such practices take place sporadically if at all (Coker et al., 2012). Yet health care providers have the potential to be an important resource for the prevention and treatment of IPV. Their potential may be amplified in rural areas, where community-based resources and traditional social services for survivors are scarce. Drawing on examples from a recent statewide survey of rural physicians and nurses, this article discusses the numerous conceptual and practical considerations that have posed challenges to the successful uptake of universal IPV screening protocols in rural practice. Based upon these data, the author then presents recommendations for policy changes using the Consolidated Framework for Implementation Research (CFIR). The purpose of this article is to provide concrete recommendations that health care policymakers, medical clinics, and health care providers themselves can use to modify or implement current screening practices and thus improve the quality of care their patients receive.

Health Care Settings and IPV

According to Campbell (1998), health care professionals in all settings and practice areas have an important role to play in

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creating an "empowerment zone" for women (p. 3). This empowerment zone has been conceptualized as trauma-informed clinical practice that works from an understanding of the prevalence, risk factors, and dynamics of IPV, "including the notion that IPV can be thought of as chronic traumatization" (Ford-Gilboe, Varcoe, Wuest & Merritt-Gray, 2010, p. 115). Examples of such practice might include universal assessment for abuse during clinic visits, advocacy and counseling offered on-site after any disclosures of abuse, awareness of community resources for survivors, recognition of risk factors for IPV and its associated health outcomes, and a caring, empowering clinic atmosphere that aims to minimize the potential for re-traumatizing patients who may be experiencing abuse. Despite a substantial body of theory and research on which to base trauma-informed clinical care, comprehensive approaches for addressing IPV and its numerous health consequences have yet to be widely integrated into health care systems (Ford-Gilboe et al., 2010; Ulrich & Stockdale, 2002). Responding to IPV after disclosure in a health care setting is left to the discretion of the individual physician, and only a handful of studies have proposed or tested interventions at primary health clinics (Coker et al., 2012; Wathen & McMillan, 2003). In fact, Wathen and McMillan (2003) found that most studies claiming to test a clinic-based intervention for IPV merely examined whether physicians screened for IPV and did not report on specific treatment protocols for responding to IPV in the event of a positive screen.

The complexity of the screening and response process has been described by O'Campo, Kirst, Tsamis, Chambers, and Ahmad (2011) who point out that resolution of abuse may not be the most appropriate outcome for screening—and indeed, that screening and referral interventions cannot, on their face, stop violence from occurring (Rhodes, 2012). Still, a review of six studies testing screening and referral interventions in a health care setting found modest improvements among IPV-exposed patients, such as fewer abusive episodes and survivors' accessing support services (De Boinville, 2013).

Barriers to Rural Health Care Providers' Screening for IPV

The rural setting presents several unique challenges to integrating IPV-informed practices into health care clinics. First, there is a dearth of research on IPV specific to the rural context in general, and large-scale and population-based studies focusing on rural women are nearly absent from the health and social sciences literature (Breiding, Ziembroski & Black, 2009; Lanier & Maume, 2009). There is also a lack of services for women, such as domestic violence programs (Peek-Asa, Wallis, Harland, Beyer, Dickey & Saftlas, 2011) and primary health care providers (American College of Obstetricians & Gynecologists, 2009; Ulrich & Stockdale, 2002). Rural residency is associated with greater disparities in women's health, including higher rates of suicide, heart disease, and cervical cancer, and rural women are proportionally less likely than urban women to receive preventive and specialized health care (American College of Obstetricians & Gynecologists, 2009). Health services may be spread out over a large catchment area, translating to lengthy travel times for clinic visits—and necessitating the use of a vehicle, as reliable public transportation is nonexistent in many rural regions (Stommes & Brown, 2002). Distance also lengthens an emergency medical unit's response time when acute care is required after an IPV-related injury. Additionally, rural women often perceive a lack of confidentiality surrounding health care delivery (Annan, 2008; Ulrich & Stockdale, 2002). Closer social networks and small communities make it likely that health care providers or their ancillary staff will know the survivor or her batterer personally. Websdale (1998) found that rural women felt particularly vulnerable at hospital emergency rooms, where they feared a lack of anonymity among staff or other patients would mean the perpetrator would discover that she had disclosed the abuse to others, thus inviting retaliation. Finally, there may be a tendency on the part of rural health care providers to overlook signs of abuse, or refrain from asking about abuse (Ulrich & Stockdale, 2002). Websdale (1998) found that physicians in rural Kentucky seemed to be unfamiliar with the dynamics of IPV. Many physicians cite a lack of effective interventions for IPV once the abuse was identified by the provider, forestalling preemptive screening for IPV (Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000).

The CFIR

As the awareness of IPV, and health care providers' role in detecting it, has increased, screening for abuse during routine and emergency patient examinations has become more commonplace yet not universal. Screening for IPV—that is, asking direct questions about the possibility of physical and/or sexual violence by a current or former intimate partner—is a relatively new practice in the health care field, and as with many new practices it has met barriers to successful implementation in many settings (MacMillan et al., 2009). One useful model that may aid understanding of the processes associated with integrating IPV screening and response practices into health care settings is the CFIR, developed by Damschroder et al. (2009). The CFIR is composed of five major domains, including intervention characteristics, outer setting, inner setting, characteristics of the individuals involved in the implementation, and the process of implementation. Because interventions are often "complex, multifaceted, and have many interacting components" (Damschroder et al., 2009, p. 3), the CFIR is depicted by an irregular shape reminiscent of a cell (the inner and outer setting, the organization, and the individuals involved in carrying out the intervention) and external organism (the intervention, its core components, and the process of implementation). Each of these constructs involves a synthesis of existing theories from implementation science in the health care field, implicitly suggesting that researchers select which constructs are most helpful in their particular study setting. As such, the CFIR is considered a metatheoretical model and does not specify hypotheses or interrelationships between constructs; rather, it provides a framework for "what works where and why" (Damschroder et al., 2009, p. 2). Figure 1 provides a visual of the CFIR process of implementation: the un-adapted intervention moving through the process of modifications that are required to fit the intervention to a particular organization or setting. Spirals at the bottom of the figure represent the ongoing and iterative process of implementation science. For the purposes of this study, the "outer setting" is defined as the state of Missouri, and the inner setting is the clinic itself. Providers' practices regarding IPV as well as the rural community context in which they work are thus filtered through these settings.

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