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Intimate Partner Violence: Screening and Intervention in the Health Care Setting

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Instructions: 2.3 contact hours will be awarded for this activity. A contact hour is 60 minutes of instruction. This is a Learner-paced Program. Vindico Medical Education does not require submission of the quiz answers. A contact hour certificate will be awarded 4-6 weeks following receipt of your completed Registration Form, including the Evaluation portion. To obtain contact hours:

1. Read the article: "Intimate Partner Violence: Screening and Intervention in the Health Care Setting," on pages 490-495, carefully noting the tables and other illustrative materials that are provided to enhance your knowledge and understanding of the content.
2. Read each question and record your answers. After completing all questions, compare your answers to those provided within this issue.
3. Type or print your full name and address and your Social Security number in the spaces provided on the Registration Form. Indicate the total time spent on the activity (reading article and completing quiz). Forms and quizzes cannot be processed if this section is incomplete. All participants are required by the accreditation agency to attest to the time spent completing the activity.
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Objectives: After studying the article, "Intimate Partner Violence: Screening and Intervention in the Health Care Setting," in this issue, the participant will:

1. Define intimate partner violence (IPV).
2. Describe the global significance of IPV.
3. Identify the health-related issues resulting from IPV.
4. Describe the FADE quality improvement model.
5. Explain the importance of universal screening for IPV in the health care setting.

AUTHOR DISCLOSURE STATEMENT

The author discloses that she has no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

COMMERCIAL SUPPORT STATEMENT

All author(s) and planners have agreed that this activity will be free of bias.

There is no commercial company support for this activity. There is no noncommercial support for this activity.

abstract

Background: The prevalence of intimate partner violence (IPV) has been documented in numerous populations and cultures. IPV is a universal social problem that affects individuals, families, and communities throughout the world. Research supports the idea that victims of IPV view health care providers as a source of help. However, nurses report feelings of inadequacy in their ability to screen for IPV.

Methods: This quality improvement project was undertaken to increase awareness of IPV by educating nursing staff working in the health care setting. The educational program was evaluated through pretests and posttests. A universal IPV screening question was added to the hospital admission intake procedure. Through retrospective chart reviews before and after the educational session, screening for IPV by the nursing staff was evaluated by examination of disclosure rates and referral data. Populations served or affected include nurses and ultimately victims of IPV.

Results: The findings support the idea that an educational program can increase nurses' confidence and competency in screening for IPV. The results of chart review will determine whether there is a significant change in behavior relative to the increase in knowledge.

Conclusion: Additional measures may be needed to enhance nurses' screening and interventional work with patients regarding IPV victimization.

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The prevalence of intimate partner violence has been widely documented in numerous populations and cultures (World Health Organization, 2002). Intimate partner violence is a universal social problem that affects individuals, families, and communities. According to the U.S. Bureau of Justice Statistics (2005), 1 in 320 households was affected by domestic violence. Although intimate partner violence can occur against men, 85% of all intimate partner violence is directed toward a female partner and perpetrated by a male partner. In 2001, 20% of all nonfatal violence against women was committed by a current spouse, former spouse, or dating partner (U.S. Bureau of Justice Statistics, 2005). Women are five to eight times more likely than men to be victims of intimate partner violence, and 90% of all domestic violence is abuse of women (Family Violence Prevention Fund, 2008). Women who are victims of intimate partner violence have considerably higher health care utilization and costs, even if the intimate partner violence has ended (Rivara et al., 2007).

The costs associated with intimate partner violence exceed $5.8 billion each year, $4.1 billion of which is for direct medical and mental health care services. Domestic violence accounts for 27% of all incidents of violence in the workplace and costs employers $3 billion to $5 billion annually in the form of increased health care costs, increased absenteeism, decreased productivity, and increased security (U.S. Department of Labor, 2007).

BACKGROUND

Intimate partner violence is defined as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, used by adults or adolescents against their intimate partners (Family Violence Prevention Fund, 2008). The term "intimate partner" is used to describe several types of couples: current or former; dating, cohabiting, or marital; heterosexual, gay, or lesbian (Centers for Disease Control and Prevention, 2006). The overwhelming health burden of intimate partner violence is borne by women who are injured by men (World Health Organization, 2002). Intimate partner violence affects women of every race and socioeconomic group (Family Violence Prevention Fund, 2008).

HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE ON VICTIMS AND THEIR FAMILIES

Women who have experienced intimate partner violence have more need of health care services than women overall (Campbell, 2002). Thirty-seven percent of women seeking help in emergency rooms are victims of intimate partner violence (U.S. Bureau of Justice Statistics, 2005). Women affected by intimate partner violence are more likely to have injuries of the face, head, neck, breasts, and abdomen than women injured in other ways (Campbell, 2002). Physical and psychological abuse is linked to a number of adverse physical health effects, including arthritis, chronic neck or back pain, migraine and other frequent headaches, stammering, visual difficulties, sexually transmitted infections, chronic pelvic pain, gastrointestinal problems, and other stress-related chronic illnesses (Campbell, 2002). On average, victims of intimate partner violence experience more surgical procedures, visits to physicians, and hospital stays throughout their lives than those without a history of abuse (World Health Organization, 2002).

Gynecological problems are the most common, and longest lasting, health difference between abused and non-abused women (Campbell, 2002). Up to 45% of pregnant women report a history of intimate partner violence, and the prevalence of intimate partner violence during pregnancy ranges from 6% to 22% (Gunter, 2007). A positive history of intimate partner violence can increase the risk of complications of pregnancy, including low weight gain, anemia, infections, and first- and second-trimester bleeding, as well as maternal rates of depression, suicide attempts, and tobacco, alcohol, and illicit drug use (Family Violence Prevention Fund, 2008). Homicide is a leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31% of maternal injury deaths (Family Violence Prevention Fund, 2008).

Depression and post-traumatic stress disorder are the two most common mental health effects of intimate partner violence (Campbell, 2002). Suicidal tendencies have also been associated with intimate partner violence, as have anxiety, insomnia, and social dysfunction (Campbell, 2002). Studies have shown that the incidence of alcohol and drug abuse is also higher in abused women than in non-abused women (Campbell, 2002).

In the United States, 15.5 million children live in families in which intimate partner violence occurred at least once in the last year, and 7 million children live in families in which severe partner violence occurred (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Children who witness domestic violence are more likely to exhibit behavioral and physical health problems, including depression, anxiety, violence toward peers, and self-destructive behaviors (Family Violence Prevention Fund, 2008). Children who experience childhood trauma, including witnessing incidents of domestic violence, are at greater risk for serious adult health problems, including tobacco use, substance abuse, obesity, cancer, heart disease, and depression, and are at higher

risk for unintended pregnancy (Anda, Block, & Felitti, 2003).

Death at the hands of an intimate partner has consistently accounted for 30% of female murders annually since 1976 (U.S. Bureau of Justice Statistics, 2005). In a study of women who survived attempted homicide by an intimate partner, the majority of attacks occurred when the woman was trying to leave the relationship, a time that is known to carry an increased risk of femicide (Nicolaidis et al., 2003).

Clearly, the problem of intimate partner violence has a direct and devastating effect on female victims and their children. The health consequences of intimate partner violence should be of interest to health care providers (Campbell, 2002). Abuse is a risk factor for many chronic illnesses and conditions, and the connection is only beginning to be understood in the health care arena (Campbell, 2002). Children, families, and women who experience abuse have significant and severe consequences (Flinck, Paavilainen, & Astedt-Kurki, 2004).

THE HEALTH CARE RESPONSE

Despite the inherent barriers involved in intimate partner violence screening and intervention in the health care setting, the benefits can be worth the effort. The importance of intimate partner violence screening and intervention in the health care setting is supported by a growing body of research (Coker et al., 2007; Hamberger & Phelan, 2006; Johnston, 2006; Nicolaidis et al., 2003; Olive, 2007; Yonaka, Yoder, Darrow, & Sherck, 2007). The indicators of intimate partner violence are not always evident, so it is more effective to screen universally (Family Violence Prevention Fund, 2008; Houry et al., 2004; Kelly, 2007; Nicolaidis et al., 2003; Willson et al., 2001; World Health Organization, 2002). Health care professionals need to understand the importance of competent intimate partner violence screening and intervention in the health care setting (Ellsberg, 2006; Family Violence Prevention Fund, 2008; World Health Organization, 2002).

THE SYSTEMS CHANGE PROJECT

The systems change project to enhance intimate partner violence screening and intervention by nursing staff was conducted in a mid-sized rural hospital. Nursing preparation for screening and intervention with women who were victims of intimate partner violence was the practice issue to be addressed initially. An increase in nursing staff knowledge was assessed. Then, through chart reviews, screening for intimate partner violence by the nursing staff was evaluated by examination of disclosure rates and referral data. The practice question to be addressed was:

"Can a thorough system needs assessment, an educational program for the staff, addition of a screening question to the admission intake procedure, along with addition of written policies and procedures, improve the competency of health care providers in screening and intervention relative to victims of intimate partner violence?"

The plan for implementation of the project was designed in two phases. Phase I was the educational program for the nursing staff. The ACE Star Model of Knowledge Transformation was used as a guiding framework for the training (University of Texas Health Science Center, 2004). The training was performed in-house, with the project planner serving as the trainer. The training program was tailored to reach the majority of the nursing staff, with the class offered on multiple days and at various times to allow all nurses an opportunity to attend. Educational sessions were conducted through a PowerPoint presentation with accompanying lecture and class discussion. A pretest and a posttest were administered before and after the educational sessions, respectively. The scores were compared to evaluate an increase in knowledge. The training content encompassed the following topics: intimate partner violence, including definition of the term, statement of the problem, the cycle of violence, and women's perspectives; screening and assessment, including questions to ask, what to look for on assessment, documentation, referrals, and safety behaviors; and the conclusion, including role-playing and summary. Continuing education units were awarded to the nursing staff who participated.

The chief nursing officer and the director of education for the target hospital were participating members of the project team. The intimate partner violence education was not mandatory. There are approximately 100 nurses in the organization. The nursing staff is approximately 90% female. There were two male nursing staff attendees. Several "change champion" intimate partner violence-educated nurses work in various departments of the hospital. There is a sexual abuse nurse examiner on call who has extensive education in intimate partner violence. Additionally, a reference notebook was placed on every unit, with screening and referral information available to all nursing staff.

Phase II included universal screening of patients for intimate partner violence. Universal screening was accomplished through the addition of a screening question to the admission intake procedure completed for all hospital patients. Completion of the admission intake procedure is a registered nurse duty. Registered nurses conduct the screening and offer intervention as indicated. The policy and procedure for universal screening

initially applied to the emergency department only. This policy and the screening procedure were extended to include all patients admitted to the medical, surgical, and mother/baby units of the hospital.

The FADE (focus, analyze, develop, execute) quality improvement model was used as a framework for the quality improvement project. This model involves several process stages, including: the focus stage, in which the process to be acted on is narrowed and defined; the analyze stage, in which data are collected and examined to explore possible root causes and potential steps for improvement; the develop stage, in which data-based detailed action plans are formulated; and the execute stage, in which plans are implemented and ongoing evaluation processes are begun (Duke University Medical Center, 2005).

A practice project to increase intimate partner violence screening and intervention can be coordinated using the FADE quality improvement model. For the focus stage, the project leader used research results, nursing faculty, mentors, team members, professional organizations, and other resources to define the need and narrow the scope. The analyze stage was accomplished through extensive literature searches, review of pertinent research articles, examination of data for commonalities, and identification of possible contributing factors. The develop stage occurred through the use of an action plan based on current evidence. The execute stage will continue the process and solidify quality improvement (Duke University Medical Center, 2005).

QUALITY IMPROVEMENT DOMAINS AND DIRECT EFFECT ON PATIENT CARE

Quality in health care can be described as providing the right care for each person every time. The ideals for health care quality include care that is safe, timely, effective, efficient, equitable, and patient-centered (Centers for Medicare & Medicaid Services, 2008). Safety is a prominent feature of the intimate partner violence screening and intervention initiative. Thirty-one percent of all American women report being physically or sexually abused by a husband or boyfriend at some time in their lives (Family Violence Prevention Fund, 2008). Additionally, between 1976 and 2002, approximately 11% of murder victims were determined to have been killed by an intimate partner (U.S. Bureau of Justice Statistics, 2005). Promoting awareness, discussion, and disclosure of intimate partner violence, with therapeutic intervention, can enhance safety for patients experiencing intimate partner violence (Shattuck, 2002).

Timeliness is crucial to the success of interventions geared toward preventing intimate partner violence. Intimate partner violence is a significant public health concern and a barrier to societal development (Ellsberg, 2006). Historically, the problem has been tolerated and ignored, and has been a source of shame and stigma (Stith, 2006). The time to effect a change in this public health concern is now.

A requisite for quality in health care is equity of care (Centers for Medicare & Medicaid Services, 2008). The practice project to increase intimate partner violence screening and intervention was an equitable undertaking. The screening question was added to the patient admission intake procedure for the hospital. Therefore, all patients were afforded the same opportunity for disclosure and help-seeking behaviors. The training component of the practice project was offered on multiple dates with times convenient to shift duty. This schedule was established to allow any interested nurses an opportunity to attend the training session.

Efficiency and effectiveness are considerations in evaluating quality in health care (Centers for Medicare & Medicaid Services, 2008). Efforts were made to ensure efficiency in the intimate partner violence screening and intervention clinical practice project. The screening item was added to the standard hospital admission procedure and has become a component of the admission process. Screening does not place extensive extra work on the staff. Referral phone numbers and information are posted at nursing stations. The training session was offered to enhance the competency and comfort of the nursing staff in conducting the screening and intervention. Effectiveness was measured both quantitatively and qualitatively.

Finally, the intimate partner violence screening and intervention practice project was patient-centered. A recent study found that 44% of victims of domestic violence talked to someone about the abuse; 37% of those talked to their health care provider. Additionally, in four different studies of survivors of abuse, 70% to 81% of patients studied reported that they would like their health care provider to ask them privately about intimate partner violence (Family Violence Prevention Fund, 2008). Further, to advance the competency of nurses conducting the screening, increase the comfort of both the nurse and the patient, and increase the safety of the patient, training was offered for the nursing staff. Most initial nursing educational programs do not include content on intimate partner violence (Davila, 2005). Nurses often express feelings of inadequacy and discomfort at the thought of screening patients for intimate partner violence (Johnston, 2006). Educational sessions are an effective way to develop nurses' skills and knowledge about intimate partner violence screening and intervention (Davila, 2006). Victims of intimate

key points

Intimate Partner Violence

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1. Intimate partner violence is a global epidemic that has devastating effects on victims and their children.
2. Nurses often express feelings of inadequacy and discomfort at the thought of screening patients for intimate partner violence.
3. Educational sessions are an effective way to develop nurses' knowledge and skills in intimate partner violence screening and intervention.

partner violence report a desire for nurses to screen for intimate partner violence privately and with a caring, supportive attitude in an environment where women are encouraged to make choices for their future (Johnston, 2006).

EVALUATION OF QUALITY MEASURES AND OUTCOMES

Outcomes are important in assessing the quality of health care delivered (Centers for Medicare & Medicaid Services, 2008). Measurable outcomes associated with the training session included a pretest and posttest and a training session evaluation. These were completed by the training participants. The pretest and posttest contained both quantitative and qualitative items in an attempt to obtain a comprehensive outcome assessment of the training sessions. For the educational phase of the project, the question to be evaluated was: "Can an educational program for the nursing staff improve nurses' knowledge regarding intimate partner violence screening and intervention in the health care setting?"

The question was tested by comparing the number of correct responses on the pretest before the educational session with the number of correct responses on the posttest after the educational session. Subjects were tested on their knowledge of intimate partner violence in general and on intimate partner violence screening and intervention techniques. Testing occurred at two points: before the educational presentation and after the educational presentation. A change in knowledge was noted, with subjects scoring significantly higher on the second test (M = 91.68%) than on the first test (M = 32.77%). Data scores on the pretest (M = 32.77, SD = 23.28) and posttest (M = 91.68, SD = 16.25) were compared.

Other outcomes to be measured relative to the practice project are associated with patient chart reviews. Chart reviews for 3 months before the educational program and 3 months after the educational program can yield additional data on nurse competency with patients relative to intimate partner violence screening and intervention. The charts were examined for screening, disclosure rates, and whether appropriate referrals were made when patients disclosed intimate partner violence experience. Proxy measures, such as chart reviews, can elicit information about the efficiency of intimate partner violence screening and intervention (Centers for Medicare & Medicaid Services, 2008). Chart review evidence can further validate the effectiveness of knowledge transfer in this organizational project (Ajmal & Koskinen, 2008). Chart review outcomes yielded no increase in the number of disclosures (n = 1 for both review periods). However, nurse charting of referrals showed improvement. There was no referral charted with the pre-training entry, but the post-training entry included documentation of an appropriate referral. The disclosure without a charted referral was shared with the director of nursing. The patient was contacted safely, and appropriate referral information was offered. Improvement in referral and documentation behavior was noted.

SUSTAINABILITY

The practice change will be long term because the overall change was encouraged by the accrediting body. Education for staff will be sustained through addition of the educational content to the annual nursing competency requirements for licensed nursing employees at the facility. Further, the project findings will be presented to nurses at professional organization meetings.

CONCLUSION

Intimate partner violence is a global epidemic (Ellsberg, 2006) that results in more than the obvious physical injuries. Intimate partner violence has been linked to a multitude of physical, emotional, and social health concerns (World Health Organization, 2002). Intimate partner violence results in long-term negative health consequences for survivors, even after the abuse has ceased (Campbell, 2002).

The health care setting is an optimal arena for women experiencing intimate partner violence to be identified and provided with support and referrals as indicated (World Health Organization, 2002). Yet, universal screening is not routinely performed in health care settings (Campbell, 2002; Gunter, 2007; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000). One significant contributing factor is the fact that nurses report feel-

ings of inadequacy and discomfort with intimate partner violence screening and intervention (Davila, 2006). A training program for nurses in intimate partner violence screening and intervention can result in increased skill and comfort with this screening and intervention (Larkin et al., 2000; Olive, 2007; Shattuck, 2002). Research findings support the need for universal screening, ongoing training and education for nurses, and an organized program for screening, with accompanying policies and procedures (Larkin et al., 2000; Olive, 2007; Shattuck, 2002). The ACE Star Model of Knowledge Transformation is a workable framework for a nurse training program (University of Texas Health Science Center, 2004). The FADE quality improvement model can organize quality improvement interventions with a practice project to promote intimate partner violence screening and intervention (Duke University Medical Center, 2005). A goal of any quality improvement project in health care is optimal patient outcomes. Nurse confidence and competency can be improved through a training program for intimate partner violence screening and intervention (Shattuck, 2002). Improvement in intimate partner violence screening and intervention techniques will benefit victims of intimate partner violence. Ultimately, the desired result is safe, healthy, patients with access to quality health care services.

REFERENCES

Ajmal, M. M., & Koskinen, K. U. (2008). Knowledge transfer in project-based organizations: An organizational cultural perspective. *Project Management Journal, 39*(1), 7-15.

Anda, R., Block, R., & Felitti, V. (2003). *Adverse childhood experiences study.* Retrieved from www.cdc.gov/NCCDPHP/ACE/index.htm

Campbell, J. (2002). Health consequences of intimate partner violence. *Lancet, 359,* 1331-1336.

Centers for Disease Control and Prevention. (2006). *Understanding intimate partner violence: Fact sheet.* Retrieved from www.cdc.gov/ncipc/dvp/ipv_factsheet.pdf

Centers for Medicare & Medicaid Services. (2008). *Quality improvement organizations: Overview.* Retrieved from www.cms.hhs.gov/QualityImprovementOrgs

Coker, A., Flerx, V. C., Smith, P. H., Whitaker, D. J., Fadden, M. K., & Williams, M. (2007). Partner violence screening in rural health care clinics. *American Journal of Public Health, 97*(7), 1319-1325.

Davila, Y. (2005). Teaching nursing students to assess and intervene for domestic violence. *International Journal of Nursing Education Scholarship, 2*(1), 1-14.

Davila, Y. (2006). Increasing nurses' knowledge and skills for enhanced response to intimate partner violence. *The Journal of Continuing Education in Nursing, 37*(4), 171-177.

Duke University Medical Center. (2005). *What is quality improvement?* Retrieved from www.patientsafetyed.duhs.duke.edu/module_a/methods/methods.html

Ellsberg, M. (2006). Violence against women: A global public health crisis. *Scandinavian Journal of Public Health, 34,* 1-4.

Family Violence Prevention Fund. (2008). *Get the facts: The facts on reproductive health and violence against women.* Retrieved from www.endabuse.org/userfiles/file/Children_and_Families/Reproductive.pdf

Flinck, A., Paavilainen, E., & Astedt-Kurki, P. (2005). Survival of intimate partner violence as experienced by women. *Journal of Clinical Nursing, 14*(3), 383-393.

Gunter, J. (2007). Intimate partner violence. *Obstetrics and Gynecology Clinics of North America, 34*(3), 367-388.

Hamberger, L. K., & Phelan, M. B. (2006). Domestic violence screening in medical and mental health care settings: Overcoming barriers to screening, identifying, and helping partner violence victims. *Journal of Aggression, Maltreatment, & Trauma, 13*(3), 61-99.

Houry, D., Feldhaus, K., Peery, B., Abbott, J., Lowenstein, S., al-Bataa-de-Montero, S., et al. (2004). A positive domestic violence screen predicts future domestic violence. *Journal of Interpersonal Violence, 19*(10), 955-966.

Johnston, B. (2006). Intimate partner violence screening and treatment: The importance of nursing caring behaviors. *Journal of Forensic Nursing, 2*(4), 184-188.

Kelly, P. (2007). Integrating intimate partner violence prevention into daily practice. *Journal of Psychosocial Nursing, 45*(4), 8-9.

Larkin, G., Rolniak, S., Hyman, K., MacLeod, B., & Savage, R. (2000). Effect of an administrative intervention on rates of screening for domestic violence in an urban emergency department. *American Journal of Public Health, 90*(9), 1444-1448.

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology, 20*(1), 137-142.

Nicolaidis, C., Curry, M., Ulrich, Y., Sharps, P., MacFarlane, J., Campbell, D., et al. (2003). Could we have known? A qualitative analysis of data from women who survived an attempted homicide by an intimate partner. *Journal of General Internal Medicine, 18,* 788-794.

Olive, P. (2007). Care for emergency department patients who have experienced domestic violence: A review of the evidence base. *Journal of Clinical Nursing, 16,* 1736-1748.

Rivara, F., Anderson, M., Fishman, P., Bonomi, A., Reid, R., Carrell, D., et al. (2007). Healthcare utilization and costs for women with a history of intimate partner violence. *American Journal of Preventive Medicine, 32*(2), 89-96.

Shattuck, S. (2002). A domestic violence screening program in a public health department. *Journal of Community Health Nursing, 19*(3), 121-132.

Stith, S. (Ed.). (2006). *Prevention of intimate partner violence.* Binghamton, NY: Haworth Press.

University of Texas Health Science Center. (2004). *The ACE Star model of knowledge transformation.* Retrieved from www.acestar.uthscsa.edu/Learn_model.htm

U.S. Bureau of Justice Statistics. (2005). *Intimate partner violence.* Retrieved from www.ojp.usdoj.gov

U.S. Department of Labor. (2007). *United States labor facts.* Retrieved from www.dol.gov

Willson, P., Cesario, S., Fredland, N., Walsh, T., McFarland, J., Gist, J., et al. (2001). Primary healthcare provider's lost opportunity to help abused women. *Journal of the American Academy of Nurse Practitioners, 13*(12), 565-570.

World Health Organization. (2002). *Facts: Intimate partner violence.* Retrieved from www.who.violence_injury_prevention/ipv.factsWHO.pdf

Yonaka, L., Yoder, M., Darrow, J., & Sherck, J. (2007). Barriers to screening for domestic violence in the emergency department. *The Journal of Continuing Education in Nursing, 38*(1), 37-45.