

Abstract

To improve intimate partner violence (IPV) service delivery, the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative's continuous quality improvement (CQI) team implemented a Breakthrough Series model Learning Collaborative with eight program sites. Using mixed-methods, we: examined post-Collaborative changes in Florida MIECHV home visitors' knowledge, system awareness, and confidence; identified strategies to address challenges in supporting families with IPV; and assessed post-Collaborative program improvements. The Collaborative included three interactive two-day sessions, six webinars, and testing strategies using the Model for Improvement (Plan-Do-Study-Act). Three online surveys assessed changes influencing IPV screening, referrals, and safety planning. Thematic content analysis of qualitative data revealed existing barriers and strategies to address challenges. Home visitors reported accurate knowledge (change: 2.3%-34.8%), confidence (change: 31.8%-37.9%), and system awareness (change: 22.7%-53.5%) for all items from baseline to final survey. There was also an increase in rates of IPV screening (change: 88.0%-91.0%) and referrals (change: 43.0%-100.0%). Strategies for addressing challenges in supporting families experiencing IPV were identified at the individual (self-care, continuous education); interpersonal (reflective supervision, trauma-informed approach); organizational (defining success, supportive agency/program, policies); and community (collaboration with IPV service providers) levels. Lessons learned from the MIECHV IPV Learning Collaborative informed future CQI projects.

Introduction

Supporting women experiencing intimate partner violence (IPV) is a challenge due to the complex, potentially dangerous, and often stigmatized nature of this problem. The prevalence of IPV among women in the US varies widely across cultural and geographical settings ranging from 27.8% to 45.3% (Smith et al., 2017) and has well-documented long-lasting physical (Dillon, Hussain, Loxton, & Rahman, 2013), sexual (Coker, 2007), mental (Lagdon, Armour, & Stringer, 2014), and emotional (Zlotnick, Johnson, & Kohn, 2006) health effects. This is especially so, when a woman is pregnant or parenting. IPV prevalence during pregnancy is between 3% and 9% (Alhusen, Ray, Sharps, & Bullock, 2015) and is associated with poor maternal health and birth outcomes like low birth weight and preterm birth (Shah & Shah, 2010). Approximately 25% of children witness IPV in their lifetime (Finkelhor, Turner, Shattuck, & Hamby, 2015) with adverse physical, emotional, behavioral, social, and cognitive outcomes (Kimball, 2016).

The Florida Maternal, Infant, and Early Childhood Home Visiting Initiative, Continuous Quality Improvement, and IPV

The national Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative provides evidence-based home visiting to pregnant women and families with young children through three different home visiting models—Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Reported rates of physical and psychological IPV among MIECHV program participants nationally are 10% and 7%, respectively (Michalopoulos et al., 2015), and may be under-reported. In 2010/2011, an initial needs assessment for Florida revealed that MIECHV target communities had higher average reported rates of IPV (8.2%) compared to the state average (6.1%) (Michalopoulos et al., 2015). From 2013-2016, Florida's MIECHV

Initiative provided home visiting services to approximately 1,400 families per year in 22 communities statewide (FL MIECHV, n.d.), with the following performance measures related to IPV: 1) maintain or increase the percentage of women screened for intimate partner violence (IPV) within six months of enrollment, 2) maintain or increase the percentage of women who are referred for IPV services within seven days of screening positive for IPV, and 3) maintain or increase the percentage of women who have a safety plan within one month of screening positive for IPV (Florida MIECHV, n.d.). In 2015, the state's continuous quality improvement (CQI) team selected IPV as a focus area for their first multi-site quality improvement Learning Collaborative.

CQI is a systematic approach to achieve program goals by incorporating elements such as regular data collection, effective utilization of technology, participation in cross-functional teams, customers involvement in decision making, and adapting work processes to incorporate new knowledge (Levesque et al., 2001). Home visiting programs, including state MIECHV programs, have utilized this approach in achieving various program goals such as increasing well child care, promoting breastfeeding, contraception, education, reducing child emergency department visits, injury prevention, prenatal care, and safety planning (Centers for Prevention Research and Development, 2016; Goyal, Ammerman, Massie, Clark, & Van Ginkel, 2016). For IPV, CQI involves focusing on IPV prevention, screening, and specific interventions (Ambuel et al., 2013; Duncan, McIntosh, Stayton, & Hall, 2006; McCaw, 2011).

Lack of education and training among home visitors can limit their ability to screen and make referrals in cases of IPV (Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008). Research has shown that the most effective way to train home visitors (HV) to support women experiencing IPV is through identification of its existence in families using appropriate screening

methods, referrals, and safety planning which also increases HV confidence in identifying and screening for IPV (Sharps et al., 2013). To tackle this, home visiting programs have implemented approaches, such as creating a supportive visitor-participant relationship, partnering with violence prevention organizations to offer site-specific training, technical assistance, and systematic development of specific IPV interventions (Chamberlain, 2008; Jack et al., 2012).

The Florida MIECHV IPV Learning Collaborative

The state MIECHV leadership and CQI team used the Breakthrough Series Model developed by the Institute for Healthcare Improvement (IHI) (Institute for Healthcare Improvement [IHI], 2003) to develop the Learning Collaborative. This model is an implementation improvement method that modifies existing knowledge in a specific topic to attain novel levels of increased performance amongst participating organizations, typically within a year (Series & Kilo, 1998). A team of expert faculty members was assembled to develop a “change package” —a set of program improvement strategies to test for—and to serve as advisors to state and local implementing agencies’ staff throughout the Collaborative. Faculty included an executive from the Florida Coalition Against Domestic Violence with experience in home visitation, an attorney and law professor specializing in IPV, an epidemiologist from the Division of Violence Prevention in the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention, representatives from each of the three home visiting models, and a university researcher on family violence.

The 10-month long Collaborative (August 2015 to May 2016) involving eight local implementing agencies included three in-person learning sessions; monthly webinars; and training, implementation, and submission of the Plan-Do-Study-Act (PDSA) test plans and results. This approach allows programs to refine changes prior to full implementation and builds

a culture of quality improvement and data-based decision making, which—along with shared teaching across faculty and peers—leads to accelerated and sustainable improvement (Hunter, Rutter, Ober, & Booth, 2017) (Figure 1). The three interactive learning sessions (LS) were two-day meetings (in August, November, and March) that provided information to home visitors via didactic presentations, sharing of personal stories by IPV survivors, training on quality improvement methods and data reporting tools, and group activities. To ensure transmission of knowledge, staff who attended the LS shared key concepts from the sessions and engaged in specific activities with members of their team who did not attend. Throughout the Collaborative, an iterative process ensured that concerns or gaps noticed or discussed during each session were addressed in the next session, or through online webinars that included 1) screening for IPV, using PDSA cycles, and IPV Collaborative measurement; 2) rapid cycle testing and effects of IPV on children; 3) IPV among Hispanics/Latinos; 4) responding to DV in the African-American community; 5) female to male violence, male survivors, and batterer intervention programs; and 6) survivors' guide to the civil and criminal justice system.

This paper describes our evaluation of the impact of the IPV Collaborative on home visitors' service delivery related to IPV. The questions this evaluation study aimed to answer were: 1) What are the post-Collaborative changes in levels of knowledge, system awareness, and confidence among Florida MIECHV home visitors regarding IPV screening and supporting families experiencing IPV?; 2) What are current and potential strategies to address barriers/challenges to supporting families experiencing IPV?; and 3) What program improvements were evident after the implementation of CQI methods?

Methods

Data Collection

The MIECHV program evaluation was considered exempt by the Institutional Review Board at the University of South Florida. This was an exploratory and ecological study conducted at the organizational level to examine overall program-wide changes in staff knowledge, confidence, and awareness of resources. The study utilized a mixed-methods approach with home visiting staff in eight of ten Florida MIECHV program sites. Two sites were excluded because they were participating in a national Learning Collaborative at that time. Quantitative data was collected through a survey developed and pretested with the state-level program implementation team and an expert panel of IPV faculty to determine face validity. The survey included questions assessing prior training on IPV, confidence in providing IPV-related home visiting services, awareness of IPV-related services and systems, and IPV knowledge. Five items measured respondents' confidence in: discussing red flags with participants, screening for IPV, knowing how to react in cases of disclosure, creating safety plans, and preparedness to serve families affected by IPV reported on a 5-item Likert scale (strongly disagree/ disagree/ neutral/ agree/ strongly agree). System awareness utilized the same Likert scale with three items assessing respondents' awareness of when to make a child abuse report, knowledge of the name of a staff person at the local DV center, and familiarity with legal options. Nine true/false question items tested knowledge about forms of IPV, factors associated with IPV, and treatment options for IPV. Surveys were entered into a Qualtrics online survey platform and access links distributed via email to staff. Baseline responses (survey 1) and responses to surveys 2 and 3 were collected in August 2015, March 2016, and May 2016, respectively. Survey 2 was done after LS 1 and 2, while survey 3 was distributed after the third LS; these surveys also identified respondents' attendance at the Collaborative LS and participation in the online webinars.

Qualitative data was obtained through six guided discussion groups at breakout sessions

in each LS. For the first two LS, participants broke out into two groups: 1) HV only and 2) supervisors and/or administrators only. Discussion groups in LS1 and LS2 aimed to identify barriers/challenges in supporting families experiencing IPV and strategies to overcome them. LS3 breakout sessions involved mixed groups (HV and supervisors/administrators) focused on the successes, challenges, and impact of the Collaborative. Discussions were audio recorded, and flip charts used to record participants' responses during LS3.

Data Analysis

Descriptive statistics were computed for survey responses on confidence, system awareness, and knowledge. For items that assessed confidence and system awareness, “agree” and “strongly agree” were grouped together to indicate a positive response (i.e. respondent was aware of IPV systems), and the other responses were considered a negative response (i.e. not aware). Fisher's exact test was used to determine differences in knowledge, confidence, and system awareness between individuals who had received training prior to the Collaborative and those who had not (for survey 1) and differences between those who attended any LS/webinars versus those who did not (for surveys 2 and 3). Analyses were conducted using SPSS v23. Rates of participant screening, safety planning, and referrals (in accordance with the performance measures described above) were examined before, during, and after the Collaborative. After September 2016, the MIECHV funding body—Health Resources and Services Administration (HRSA)—no longer required safety planning to be reported, so only partial data was available for safety planning (HRSA, 2016). Audio recordings of discussions were transcribed verbatim, and transcripts were checked for accuracy. Data was managed using MAXQDA qualitative data analysis software. The codebook consisted of emergent codes from an initial summary of transcripts. All transcripts were coded by one member of the research team with a third of

transcripts (two of six) coded by two independent coders, and substantial agreement reached with a Cohen's Kappa of 0.63 (McHugh, 2012). Content analysis was conducted to identify participants' perceptions of existing challenges and strategies for addressing identified challenges. Following analysis, identified strategies were organized according to the socioecological model a theoretical framework that posits human behavior as being influenced by the interplay of individual- interpersonal-, organizational-, societal/community-, and policy-level factors (Coreil, 2010).

Results

There were 51, 58, and 53 participants, respectively, at the three learning sessions. Eighty home visitors were employed at that time, of which, 13 (16.3%) attended LS 1, 16 (20.0%) attended LS 2, and 15 (18.8%) attended LS 3. At baseline, 49 respondents completed the survey; 23 (46.9%) of them had received prior IPV training, nine (18.4%) reported web/online training, six (12.2%) reported a MIECHV in-person training, and 14 (28.6%) reported in-person training from another provider (respondents could select more than one option). Compared to baseline, 33 completed survey 2, and 16 (48.5%) had attended at least one of the first two LS. Eleven (33.3%) of survey 2 respondents had not received any other form of IPV training besides the Collaborative, and more than half had participated in three of the four webinars. Survey 3 was completed by 26 respondents, 18 (69.2%) of which had attended at least one LS, while 23 (88.5%) had participated in at least one webinar.

Confidence, System Awareness, and Knowledge after the Collaborative

There was a general increase in percentage of respondents reporting confidence, system awareness, and accurate knowledge regarding IPV service delivery. After LS1 and LS2, there was an increase in the percentage of those reporting confidence, system awareness, and

knowledge except for two knowledge items. The percent change ranged from 4.4% to 30.9% for knowledge, 22.6% to 41.9% for confidence, and 11.3% to 43.0% for system awareness. There was a decrease in the percent of accurate responses for survey items “I don't understand why anyone would stay in an abusive relationship” and “A problem with anger is the primary cause of IPV” (Tables 1 and 2, Figure 1). The percent change for individuals reporting confidence, system awareness, and knowledge regarding IPV service delivery was minimal from survey 2 to 3 (Figure 2). There was a slight increase in percentage of respondents demonstrating confidence except for the item “I feel prepared to serve families affected by IPV” for which there was a 4.0% decrease. There was an increase for system awareness ranging from 10.5% to 35.9%. As for confidence levels, the percent increase (range: 1.3% to 17.9%) from survey 2 to survey 3 for knowledge items was minimal. This time, four items showed a decrease compared to survey 2: “I only refer to the local DV center if the participant wants to leave the relationship;” “If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline;” “The primary cause of most IPV is alcohol and drug abuse”, and “If the participant chooses to stay in an abusive relationship, there is nothing I can do” (Tables 1 and 2 and Figure 1).

At baseline, a higher percentage of respondents who had received prior IPV training demonstrated confidence, system awareness, and knowledge of IPV service delivery compared to those without prior training. This difference was significant for confidence in screening for IPV, creating a safety plan, being prepared to serve families affected by IPV, and system awareness (familiarity with legal options for IPV survivors) but not for items testing IPV knowledge (Table 1). Also, for surveys 2 and 3, there were no significant differences in confidence, system awareness, and knowledge by LS or webinar attendance (Table 2) except for knowing when to refer to the local DV center stratified by attendance of LS at survey 3 (Table

2). Furthermore, 51.0%, 87.9%, and 88.5% of respondents, at baseline, survey 2, and survey 3, respectively, reported that their agencies had specific protocols about what to do when a participant discloses IPV (data not shown).

Program Improvement after CQI Methods

Overall, the Collaborative resulted in an increase in screening, referrals, and safety planning for IPV in the MIECHV program. The greatest improvement was reported for referrals to a certified DV center within seven days of disclosure—an increase from 43.0% (pre-Collaborative) to 100.0% (post-Collaborative). Participating sites maintained the gain in screening and continued to improve on timely referrals in the year following the Collaborative (Figure 3).

Strategies to Address Barriers/Challenges in Supporting Families Experiencing IPV

Several barriers and challenges to adequate IPV service delivery that were discussed during the breakout sessions, including: lack of confidence in implementing screening, difficulties building early rapport between HV and clients, discomfort in addressing IPV or other trauma, navigating cross-cultural contexts, and lack of knowledge on IPV topics (such as the effects of IPV on children) and of legal IPV resources. Other challenges mentioned were lack of IPV-specific curriculum, concern over sustaining gains from the Collaborative, challenges providing information for new staff, general staff stress, lack of awareness of home visitor's personal history including past trauma, and lack of policies for instances where a staff member is experiencing IPV. Strategies to solve these challenges were discussed during the breakout sessions; we organized these using the socioecological model as described below.

Intrapersonal level. At the individual level, staff discussed self-care and continuing education as important strategies helpful in reducing general staff stress, lack of knowledge on

IPV topics, and lack of confidence in implementing screening, among others.

Home visitors discussed specific ways they practiced self-care, and administrators and supervisors discussed how their self-care increased their ability to provide optimal support for HV which improves their interactions with participants: “...*taking care of yourself will allow you to support the staff—and encouraging them to take care of themselves as well because again, this [work] can be draining.*” Specific self-care practices discussed included getting feedback and guidance and using available resources, and one LS included a stress relief activity.

Home visitors talked about the importance of information or training on IPV to address their knowledge gaps regarding IPV service delivery. For example, HV felt they were not equipped to properly educate clients on the effects of IPV—especially on children—and how this ties into adverse childhood experiences. Staff believed that continuing education could address the lack of knowledge of legal IPV resources; a curriculum for addressing IPV; and sustainability of lessons learned from the Collaborative, including transmitting information to new staff hires.

Because of the CQI effort, training tools were created by some of the program sites to help provide education for their current and future staff:

“We created a PowerPoint for our assessment tool. We use the HARK on it... We created a PowerPoint and it’s kind of a clip of sitting down and using it, the assessment tool.”

Interpersonal level. Reflective supervision and trauma-informed/empathetic approaches were suggested to acknowledge home visitors’ personal histories with past trauma, instances where a home visitor is experiencing IPV, discomfort working with families experiencing IPV or other trauma, cultural factors that may promote IPV, and difficulties with rapport building.

Reflective supervision was explained by supervisor/administrators as an ongoing process of checking in with the HV and providing needed support, including referrals to resources. This

process included inquiring how HV felt about certain situations or if they felt equipped to serve a particular client based on the client's specific situation. HV getting feedback from peers on how best to proceed in specific circumstances was also part of the process:

"We're just doing a lot of constant checking with that person just to make sure that they're okay with what's—with working with this family, that it's not bringing something up for them, and that's difficult for them to work through."

Adopting a trauma-informed/empathetic approach was also recommended for building rapport with clients, administering the screening tool, handling ongoing trauma, overcoming home visitors' cultural biases and misunderstandings, all which act as barriers to IPV screening, referral, and safety planning. Staff recognized that empathy helps to build rapport with program participants, leading to more seamless and accurate screening. They also mentioned how hearing personal stories during the LS helped to provide insight regarding the reality of experiences of IPV and promoted understanding of clients' experiences and empathy building:

"It is personal, I mean we're not trying to make them dredge up their trauma, but it really does—it does give you insight. You get to ask them questions and you get to remember why you do this kind of work, why you're getting all up in the trauma."

Staff discussed how clients' cultural background may influence their unawareness or acceptance of IPV or their decision to stay in a violent relationship. Being cognizant and empathetic in these situations was discussed as a potential strategy for addressing the challenges:

"I think in our culture it's very common to think of the man, the macho culture. Like he's the one that says what to do, he's the one that has control. I have had families that only the man works, and so the woman is in the house with the baby. So, it is normal. It is what we know in our culture. So, it is difficult for them to recognize and to say, 'Yes, I'm

living in domestic violence because he limits my—I don't have money. If [he] leaves, he doesn't leave me any money to do the grocery [shopping], he doesn't really and whatever I need, I have to wait for him. I don't have transportation. I don't have friends.'"

Organizational level. At the organizational level, staff revisited their definitions of success and IPV-related policies. Home visitors discussed a sense of inadequacy at nondisclosure from clients when there were tell-tale signs of IPV in the home. Redefining success was a way for HV to acknowledge the support services they were providing. As such, success was defined as home visitors' ability to: recognize red flags, respond with appropriate referrals, and help the participant feel comfortable with her decisions. It was determined that success should not be measured based on eliciting disclosure/positive screens or by whether the client used the resources or education given to them but on the HV's role in providing information and offering services so that participants can make informed decisions: *"I think for me, success is when the woman or participant or client is feeling comfortable and confident with her decision and her choice."* Faculty stressed the need to veer away from seeing non-disclosure as "denial" or "lying" and staff were encouraged to let go of feelings of failure if participants made decisions different from what they recommended. This led to discussions on how referrals should always be provided for clients in case they need it for themselves (or someone else) at a later date.

The need for developing or refining IPV-specific organizational policies was recognized by staff, as many sites had no policies or inadequate policies for addressing IPV. Additional organizational policies were important to sustaining gains from the Collaborative, such as disseminating information to program staff who were unable to attend the LS and to new staff.

Community level. Collaboration with IPV service providers was identified at the community level: *"We have to really advocate for survivors at that level which is why the*

relationship with the [DV] centers is extremely important". Community IPV service providers, such as DV shelters, are uniquely trained to understand IPV and communicate with and provide services for survivors. Home visitors felt that local DV centers could be more involved with training sessions, help with skill-building activities, and improve HV understanding regarding how mandated reporting of IPV can impact the family.

Discussion

This study assessed the impact of a Learning Collaborative for IPV service delivery, which is difficult for many social services and family support programs. The Collaborative resulted in program changes across the state, local community systems and MIECHV sites, and improved home visitors' expertise. Additionally, relationships with local DV centers were strengthened, and policies developed. Program sites made changes in organizational operations, including staff training, reflective supervision, and improved understanding and use of data-driven planning. Following the Collaborative, there was an increase in the percentage of HV who expressed confidence and system awareness related to IPV service delivery and some IPV knowledge gains.

Individuals who had received training prior to the Collaborative reported confidence in screening, creating safety plans, awareness of legal options, and preparedness to serve families. Gains were also seen among participants who attended in-person trainings or webinars. This finding emphasizes the importance of ongoing IPV training, as lack of training has been identified as a barrier to screening among HV and other healthcare providers (Sharps et al., 2008; Sprague et al., 2012). Although studies have discussed service providers' discomfort with approaching conversations on IPV as a barrier to screening (Chamberlain & Perham-Hester, 2002; Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Todahl & Walters, 2011; Tower,

2006), we found that HV in this study viewed the potential discomfort of their participants as more of a challenge than their own discomfort. As noted in this and other studies, home visitors determined that an empathetic approach can enhance trust and rapport, improving screening for sensitive issues (Kulkarni, Bell, & Rhodes, 2012). Other challenges discussed by program staff are consistent with literature on barriers to addressing IPV screening among home visiting agencies and within healthcare systems, such as lack of education about IPV, lack of agency protocol/policy, and an unsupportive agency (Sharps et al., 2013; Sprague et al., 2012; Todahl & Waters, 2011).

Because of the CQI approach, some challenges were addressed during the Collaborative or potential strategies for overcoming them were discussed. Staff identified self-care, reflective supervision, and awareness of triggers as ways to manage home visitors' past or current trauma exposures. In addition to policies addressing IPV among program participants, workplace violence prevention policies were found to be important for responding to IPV situations involving program staff. Collaborative members emphasized the importance of sustaining and reinforcing skills and knowledge they had acquired through continuous education and training for new hires. Overall, the results of this Collaborative made a strong case for using trauma-informed approaches in home visiting, particularly for IPV.

Several staff in the Collaborative were initially dismayed by the reluctance of program participants to disclose their experience of IPV, even when there appeared to be a strong rapport with the HV. After receiving more training and hearing the testimonies of survivors at LS, they realized that disclosure may not occur right away, and that delayed disclosure is not necessarily an indicator of distrust. Staff gained an appreciation for the complexity of the situations they may encounter and the confidence, skills, and patience to screen, rescreen, and offer information and

resources in a safer and more effective way. Another lesson learned by staff in this Collaborative was that success was defined as meeting the needs of the participant at that point in time, and throughout the enrollment period, rather than defining success only as the IPV survivor leaving the relationship or moving out of the home.

Because of what was learned during the Collaborative, Florida MIECHV worked with the Florida Coalition Against Domestic Violence to modify the two-day, in-person training to include more practice on IPV screening, making referrals, and safety planning in order to sustain improved practices. While safety planning is no longer a HRSA performance measure, the Florida MIECHV Initiative recognizes that this is a vital part of working with IPV survivors. The first step when IPV is identified is to refer the survivor to the local certified domestic violence center where she can receive in-depth safety planning from a domestic violence advocate. However, we recognize that many will not be ready to speak to someone else which means the home visitor will need to initiate safety planning. Through the Learning Collaborative, it was gleaned that safety planning was not something home visitors felt comfortable doing. Currently, the IPV training has been revised to include adequate time for learning about and practicing safety planning, so that home visitors will feel more comfortable with the process.

Florida MIECHV also began funding reflective group consultation for all MIECHV supervisors in September 2016 allowing home visiting supervisors to process concerns related to staff or services provided. Finally, Florida MIECHV leadership is participating on the national Home Visiting CoIIN 2.0 Steering Committee, as well as on a national IPV Expert Panel to improve quality across other MIECHV programs. The materials and lessons learned by Florida are being used to inform the upcoming national IPV Learning Collaborative. In concert with these efforts, a toolkit is under development that will help support program sites that did not

participate in the Collaborative and bolster the efforts of sites that did participate to further sustain the gains.

Strengths and Limitations

Because this study was conducted at the organizational level, the surveys were anonymous and individual changes could not be measured. This study was further limited by unavailability of specific content of IPV training that participants had received prior to the baseline survey, though it highlights the importance of training. Another limitation was the lack of a standardized knowledge assessment tool; the knowledge scale used may not have been adequately aligned with the trainings. The survey was developed by the evaluation team, in collaboration with the expert panel and state-level program implementation team, thus a lack of a validated instrument is a limitation. Due to the small sample size, the study had limited statistical power to detect associations. There is also a possibility of bias due to the decrease in participants' response rates over time. Furthermore, the final N of 26 at the time of survey 3 is dominated by 23 persons (88.5%) that had attended a webinar and may be a biased sample compared to the 49 that originally completed the survey at baseline. In addition, it is possible that there was some bias due to non-response, and social desirability bias may have existed due to positively worded survey questions assessing confidence and system awareness. Despite these limitations, the study provides pilot data that can inform development of tools to assess knowledge, confidence, and system awareness related to IPV service delivery among community health workers. Furthermore, qualitative data obtained provided rich content on home visiting staff perceptions of factors enabling them to better deliver IPV services to families.

Implications for Policy and Practice

Findings from this study stress the importance of using CQI methods to improve IPV

service delivery. Although less than a quarter of home visitors attended each learning session, CQI efforts included having the supervisors and home visitors that attended the LS transmit the information back to other HVs in their agency. Furthermore, survey findings are indicative that the impact of not having all visitors attend the LS was minimal as there were no significant differences in survey items between individuals who attended the LS versus those who did not except for one item (as shown in Table 2). The IPV Collaborative led to increased awareness of gaps and steps to bridge those gaps, including organizational changes and enhanced partnerships with local DV agencies and other relevant organizations. Lessons learned from the Collaborative have been used to inform future CQI efforts within the Florida MIECHV program and other state MIECHV programs. Future considerations include integrating strategies to tackle challenges to IPV service delivery into regular program activities to improve home visitor's self-efficacy and promote sustainability. Implementing updated site-specific policies with corresponding guidelines and protocols for workplace violence, trauma among staff, IPV service delivery, and allowances for cutting-edge training and education will help create sustainable approaches to IPV.

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Table 1. Home Visitors' Confidence, System Awareness, and Knowledge of Intimate Partner Violence (IPV) Service Delivery at Baseline Stratified by Prior Training

	Total Indicated Agree/Strongly Agree (N=49)	HV with Prior Training (N=23)	HV without Prior Training (N=26)	P- value
	N (%)	N (%)	N (%)	
Confidence^a				
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	29 (59.2)	16 (69.6)	13 (50.0)	0.14
I feel confident screening participants for IPV	28 (57.1)	18 (78.3)	10 (38.5)	<0.01
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	27 (55.1)	16 (69.6)	11 (42.3)	0.05
I feel confident creating a safety plan with participants that disclose IPV	24 (49.0)	16 (69.6)	8 (30.8)	<0.01
I feel prepared to serve families affected by IPV	21 (42.9)	15 (65.2)	6 (23.1)	<0.01
System Awareness^a				
I know when to make a report to the child abuse hotline for IPV	36 (73.5)	19 (82.6)	17 (65.4)	0.15
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	19 (38.8)	11 (47.8)	8 (30.8)	0.18
I am familiar with the legal options (both criminal and civil) for survivors of IPV	10 (20.4)	8 (34.8)	2 (7.7)	0.02
Knowledge^b				
All IPV includes physical violence [False]	39 (79.6)	20 (87.0)	19 (73.1)	0.20
I don't understand why anyone would stay in an abusive relationship [False]	38 (77.6)	18 (78.3)	20 (76.9)	0.59
I only refer to the local DV center if the participant wants to leave the relationship [False]	33 (67.3)	18 (78.3)	15 (57.7)	0.11
If the participant chooses to stay in an abusive relationship, there is nothing I can do [False]	29 (59.2)	14 (60.9)	15 (57.7)	0.53
The primary cause of most IPV is alcohol or drug abuse [False]	23 (46.9)	13 (56.5)	10 (38.5)	0.16

If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline [True]	22 (44.9)	11 (47.8)	11 (42.3)	0.46
A problem with anger is the primary cause of IPV [False]	19 (38.8)	11 (47.8)	8 (30.8)	0.18
Couples counseling is an effective strategy for stopping IPV in families [False]	15 (30.6)	8 (34.8)	7 (26.9)	0.39
Anger management programs are effective in preventing the recurrence of IPV [False]	13 (26.5)	7 (30.4)	6 (23.1)	0.40

Notes: ^a Indicated agree/strongly agree, ^b Correct answers given

Abbreviations: IPV = Intimate Partner Violence, HV = Home Visitor, DV = Domestic Violence

BOLD indicates significant findings at 0.05 level of significance

Table 2. Home Visitors with High Confidence, System Awareness, and Knowledge of Interpersonal Violence Service Delivery by Attendance of Learning Sessions (LS)

	Survey 2				Survey 3			
	Total (N=33)	Attended LS (N=17)	Did not Attend LS (N=16)	P - Value	Total (N=26)	Attended LS (N=17)	Did not Attend LS (N=9)	P - Value
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)	
Confidence ^a								
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	27 (81.8)	14 (82.4)	13 (81.3)	0.64	24 (92.3)	16 (94.1)	8 (88.9)	0.58
I feel confident screening participants for IPV	28 (84.8)	13 (76.5)	15 (93.8)	0.14	24 (92.3)	15 (88.2)	9 (100.0)	0.42
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	29 (87.9)	16 (94.1)	13 (81.3)	0.28	24 (92.3)	17 (100.0)	7 (77.8)	0.11
I feel comfortable creating a safety plan with participants that disclose IPV	25 (75.8)	13 (76.5)	12 (75.0)	0.62	21 (80.8)	16 (94.1)	5 (55.6)	0.34
I feel prepared to serve families affected by IPV	28 (84.8)	14 (82.4)	14 (87.5)	0.53	21 (80.8)	15 (88.2)	6 (66.7)	0.38
System Awareness ^a								
I know when to make a report to the child abuse hotline for IPV	28 (84.8)	14 (82.4)	14 (87.5)	0.53	25 (96.2)	16 (94.1)	9 (100.0)	0.65
I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant	27 (81.8)	15 (88.2)	12 (75.0)	0.3	24 (92.3)	16 (94.1)	8 (88.9)	0.68
I am familiar with the legal options (both criminal and civil) for survivors of IPV	11 (33.3)	7 (41.2)	4 (25.0)	0.27	18 (69.2)	13 (76.5)	5 (55.6)	0.26
Knowledge ^b								
All IPV includes physical violence [False]	29 (87.9)	15 (88.2)	14 (87.5)	0.68	24 (92.3)	16 (94.1)	8 (88.9)	0.58

I don't understand why anyone would stay in an abusive relationship [False]	22 (66.7)	11 (64.7)	11 (68.8)	0.55	22 (84.6)	15 (88.2)	7 (77.8)	0.43
I only refer to the local DV center if the participant wants to leave the relationship [False]	27 (81.8)	14 (82.4)	13 (81.3)	0.5	19 (73.1)	16 (94.1)	3 (33.3)	0.006
If the participant chooses to stay in an abusive relationship, there is nothing I can do [False]	21 (63.6)	11 (64.7)	10 (62.5)	0.59	16 (61.5)	12 (70.6)	4 (44.4)	0.19
The primary cause of most IPV is alcohol or drug abuse [False]	18 (54.5)	12 (70.6)	6 (37.5)	0.06	14 (53.8)	7 (41.2)	7 (77.8)	0.11
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline [True]	25 (75.8)	14 (82.4)	11 (68.8)	0.31	19 (73.1)	13 (76.5)	6 (66.7)	0.46
A problem with anger is the primary cause of IPV [False]	11 (33.3)	8 (47.1)	3 (18.8)	0.09	13 (50.0)	8 (47.1)	5 (55.6)	0.50
Couples counseling is an effective strategy for stopping IPV in families [False]	16 (48.5)	8 (47.1)	8 (50.0)	0.57	17 (65.4)	12 (70.6)	5 (55.6)	0.37
Anger management programs are effective in preventing the recurrence of IPV ^c [False]	11 (33.3)	5 (29.4)	6 (37.5)	0.4	9 (34.6)	7 (41.2)	2 (22.2)	0.37

^a Indicated agree/strongly agree, ^b Correct answers Given, ^c Item was not answered by one home visitor for Survey 3

Abbreviations: IPV = Intimate Partner Violence, LS = Learning Session, DV = Domestic Violence

BOLD indicates significant findings at 0.05 level of significance

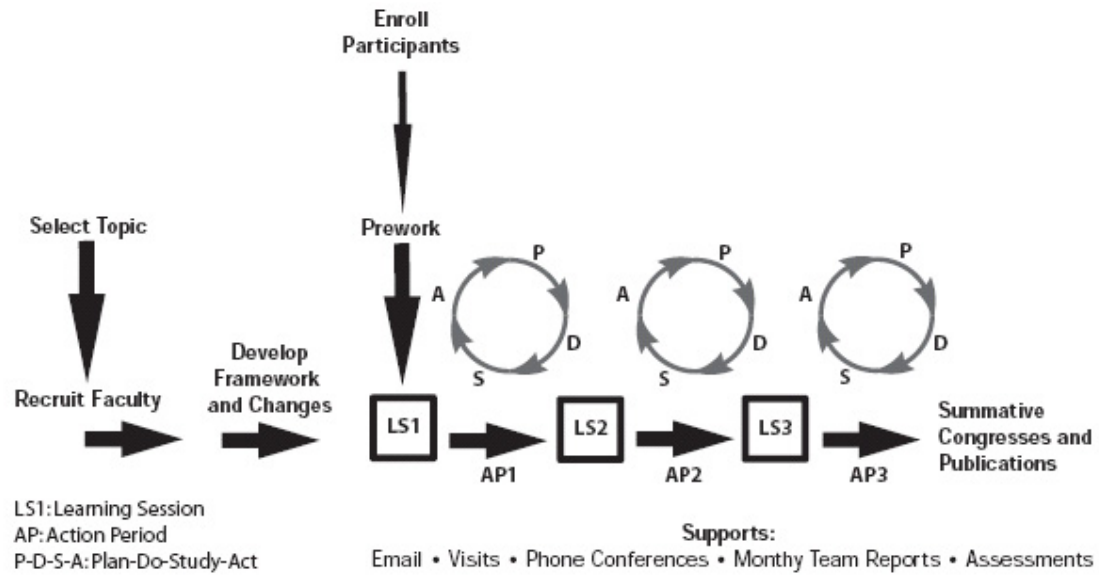


Figure 1. The Model for Improvement (Including Plan-Do-Study-Act (PDSA) cycles) Used at the Three Learning Sessions.

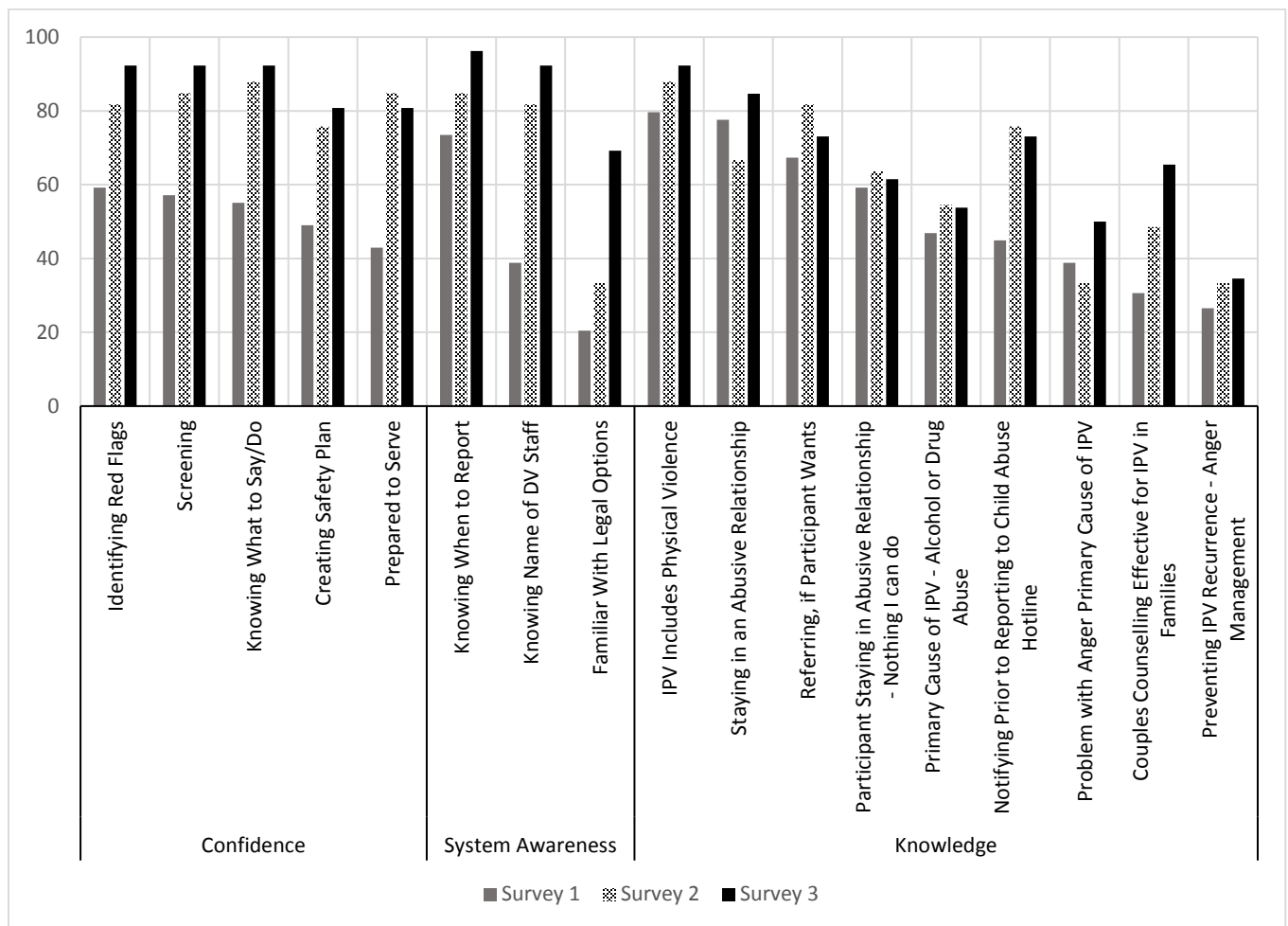


Figure 2. Home Visitors' Confidence, System Awareness, and Knowledge of Intimate Partner Violence (IPV) Service Delivery at Baseline and After Learning Sessions 2 and 3.

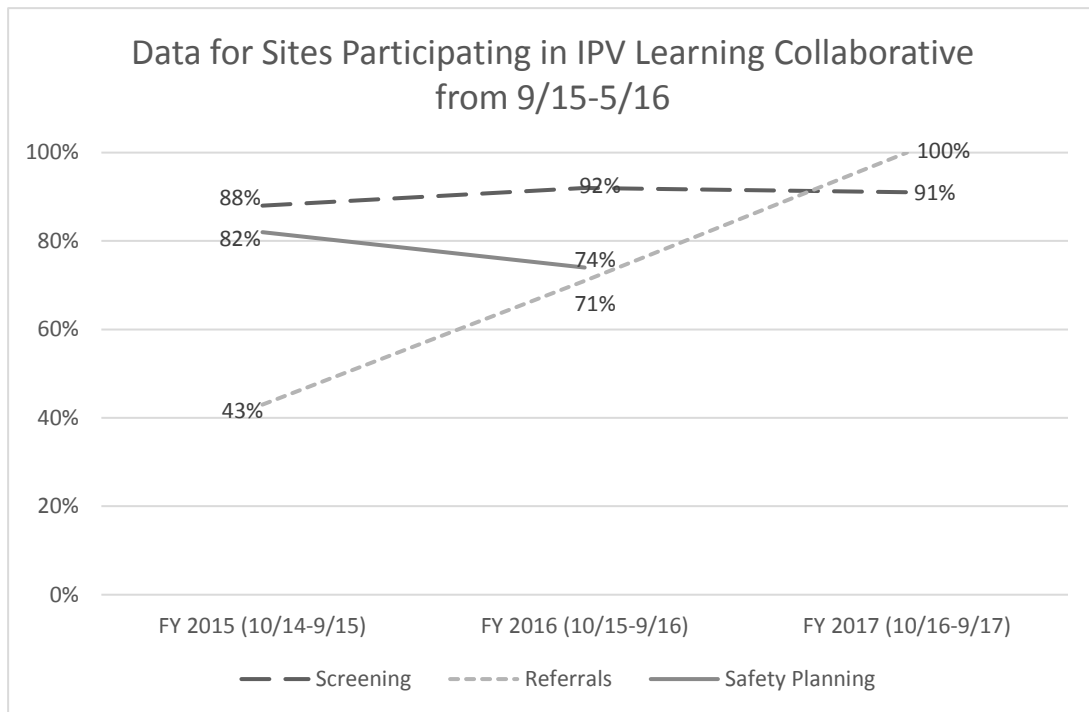


Figure 3. Rates of Intimate Partner Violence (IPV) Screening, Referrals, and Safety Planning.¹

¹ Funder stopped requiring data for safety planning after 9/30/16