

Hanging Out or Hooking Up: Improving Adolescent Relationship Abuse Management

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Abstract

Healthcare providers have unique opportunities to educate patients on healthy relationships, however, research studies have suggested that these conversations are rare in the healthcare setting. The purpose of this quasi-experimental pilot project is to incorporate an educational intervention to improve primary and urgent care providers' management of adolescent relationship abuse. The population of sixty-seven pediatric primary care and urgent care providers at Children's Mercy Clinics were recruited to participate in this evidence-based project. The project's intervention consisted of educating providers on how to use the Hooking Up or Hanging Out safety card, while subsequently measuring self-reported provider behaviors, provider self-efficacy, and provider behavioral intentions. This educational strategy has the potential to improve health care delivery by improving the management of adolescent relationship abuse victims. Results of this project suggest the Hanging Out or Hooking Up training session improves healthcare providers' intention to discuss and to assess abusive relationships with adolescent patients. It is the responsibility of all healthcare providers to identify violence and to provide appropriated referrals and/or counseling. Preventing violence can improve clinical and social outcomes, promote quality of life, and decrease health care costs.

Keywords: adolescent relationship abuse, healthy relationships, primary care, urgent care, healthcare provider, intervention, education

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Not every patient grows up to learn an example of a healthy relationship. Some patients are involved in relationships that put them in unsafe and challenging situations. These situations have lasting consequences that have the potential to affect the patient for the rest of his or her lifetime. Miller and Levenson (2013) define adolescent relationship abuse (ARA) as “a pattern of repeated acts in which a person physically, sexually, or psychologically abuses another person in the context of a dating relationship in which one or both partners are minors” (see Appendix A for Definition of Terms). The intimacy of the partnership does not require sexual contact, but is defined more closely as having at least one component of a close personal relationship, including: emotional connectedness, routine physical and sexual contact, identification as a couple, and/or familiarity and knowledge about each other’s lives (CDC, 2015). Adolescent relationship abuse subgroups include physical, sexual, psychological, and cyber ARA, as well as reproductive coercion (Miller and Levenson, 2013). ARA is common; Martin, Houston, Mmari, and Decker (2012) estimate 40% of adolescents in the clinic-based setting experience physical or sexual violence. Although healthcare providers have unique opportunities to discuss healthy relationships with adolescent patients, conversations about ARA and healthy relationships in the healthcare setting remain uncommon.

Significance

Adolescent relationship abuse is associated with increased healthcare costs, adverse health conditions, social consequences, and adverse health behaviors (CDC, 2015). The CDC (2015) estimates that dating violence against women alone exceeds \$5.8 billion. Health risk behaviors associated with ARA include early age at onset of sexual activity, inconsistent or non-use of condoms, substance abuse, and weapons carry (Martin, Houston, Mmari, & Decker, 2012;

Miller et al., 2015). Adolescents experiencing ARA are more likely to have sexually transmitted infections, depression, eating disorders, unintended pregnancy, and suicidality (Martin, Houston, Mmari, & Decker, 2012; Miller et al., 2015). ARA is also associated with poor school connectivity and performance. Additionally, ARA is a significant risk factor for homicide; approximately 44% of female adolescent homicides are associated with ARA (Martin, Houston, Mmari, & Decker, 2012). Relationship abuse in adolescence is a risk factor for being involved in abusive relationships as victims and/or perpetrators as adults, thus continuing the cycle of violence throughout the lifespan (Exner-Cortens, Eckenrode, & Rothman, 2013; Cui, Ueno, Gordon, & Fincham, 2013; Jackson, Randell, & Miller, 2015).

Local Issue

Adolescent relationship abuse is an increasing concern, even at the local level. Children's Mercy Hospital performed a cross-sectional survey of fourteen to nineteen year olds in their emergency rooms (Randell, 2016). Of the 384 participants, 88% of patients screened reported a history of dating (Randell, 2016). The majority of the participants identified themselves as female (57%) and heterosexual (88%) (Randell, 2016). Among these adolescents, one in five reported a history of experiencing physical abuse; one in ten reported a history of experiencing sexual abuse; one in five reported a history of experiencing psychological abuse; six in ten reported a history of experiencing cyber abuse; and one in ten reported a history of experiencing reproductive coercion (Randell, 2016).

Diversity Considerations

ARA occurs across all socioeconomic classes, ethnicities, gender identities, and sexual preferences (Zweig, Dank, Yahner, & Lachman, 2013; Weil, Elmore, & Park, 2016).

Adolescence is a time of increased risk for abusive relationships, as relationship abuse is 1.5 to 2

times more common among adolescents than other age groups (Miller and Levenson, 2013; Zweig, Dank, Yahner, & Lachman, 2013; Weil, Elmore, & Park, 2016; Herrman, 2009). Current national statistics estimate one in five adolescent girls and one in ten adolescent males admit to experiencing physical and/or sexual violence in a relationship (Silverman, Raj, Mucci, & Hathaway, 2001). The actual prevalence of ARA is possibly even higher, as many studies limit assessment of ARA to physical and sexual abuse. Additionally, some adolescents may not identify themselves as victims or turn to informal support (e.g. friends, peers) rather than formal resources (e.g. healthcare providers, school counselor) (Martin, Houston, Mmari, & Decker, 2012; Moore, Sargent, Ferranti, & Gonzalez-Guarda, 2015).

Problem, Purpose

Problem Statement

Pediatric Primary Care Providers (PCPs) and Urgent Care Providers (UCPs) have a great opportunity to detect and intervene with ARA, however, ARA screening in these settings remains low. By educating adolescents about healthy relationships, the healthcare provider can both address ARA and develop a rapport with patients. A good patient-provider connection encourages safety in one's future by increasing the likelihood the patient will seek formal support (Miller and Levenson, 2013).

Purpose Statement

The purpose of this project is to determine if the evidenced based intervention, Hanging Out or Hooking Up safety card (see Appendix B) education session improves the primary and urgent care providers' ARA management at Children's Mercy Hospital Clinics. The specific aims are to assess, before and after Hanging Out or Hooking Up training, provider self-efficacy around ARA interventions in the healthcare setting, provider intentions for behavior change

related to addressing ARA in the healthcare setting, and provider self-reported behaviors around ARA intervention in the healthcare setting.

The U.S. Department of Health and Human Services (DHHS), *Healthy People 2020* set the goal to reduce and prevent unintentional injuries and violence, subsequently reducing the consequences of injury and violence, by 2020 (DHHS, 2016). The U.S. Department of Health and Human Services (2016) recognizes that most violent events are predictable and avoidable, thus recommending education, identification, and prevention to reduce injury, disability, and death as a result of violent acts in order to improve the health of the nation. Despite this recommendation, screening tools around relationship abuse have only been validated in the adult population and are often too lengthy to use in the clinic setting (Rabin, Jennings, Campbell, Bair-Meritt, 2009). Additionally, the sensitivity and specificity of these screening tools in the adolescent population are unknown (Rabin, Jennings, Campbell, Bair-Meritt, 2009). Futures Without Violence recommends the use of the Hanging Out or Hooking Up safety card, a unique intervention designed to enable healthcare providers to provide universal education to adolescents about safe and healthy relationship behaviors, abuse relationship behaviors, and resources for adolescents experiencing ARA (Miller and Levenson, 2013).

Facilitators and Barriers

Facilitators to this proposed project include a group of providers at Children's Mercy Hospital who are passionate about ARA and violence prevention. This group is interested in educating providers about the Hanging Out or Hooking Up card, and subsequently educating adolescents on healthy relationships. The low cost required for this project (see Appendix C for Cost Table) is another factor that can both increase sustainability of the project, and acts as a facilitator to the project.

The biggest barrier for this project involves the cooperation of the primary and urgent care providers recruited in participation. Providers often identify several barriers to discussing ARA, including: time constraints, lack of awareness of the impact of ARA, a decreased comfort level with ARA, and fears about confidentiality and mandatory reporting. There are both legal and ethical implications that come with identifying ARA, which may make providers hesitant to participate in ARA identification and management. If a provider identifies ARA without intervention, the patient is left abandoned. Similarly, providers are often fearful of screening because they are not always educated on their scope of practice regarding ARA and the steps to take following the identification of ARA. With resources such as social workers at Children's Mercy Hospital, along with the educational intervention of this project, this barrier could be eliminated.

The final barrier is the provider's understanding of the importance of discussing healthy relationships with patients, ARA education, and the Hanging Out or Hooking Up safety card intervention. In order for the clinics to continue the project, providers must see the need for, and understand the impact of the education. If providers do not realize that their patients are being affected by adolescent relationship abuse, he or she might not understand the importance of attending the training session or incorporating the use of the Hanging Out or Hooking Up safety card into their practice. Providers must have a desire to actively participate in this training. Following their participation, the provider must perceive that the educational material was applicable and beneficial to their practice and patient population. Finally, the organization must be willing to financially sustain the program to continue the education to additional providers. The project would encounter major barriers to sustainability without buy-in from the providers and organization.

Review of the Evidence

PICOT

Does educating primary and urgent care providers on the Hanging Out or Hooking Up card improve the healthcare providers' management of ARA over three months?

Search Strategies

An extensive literature review using Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Medline databases was conducted in preparation for this synthesis of evidence. Key search words included: adolescent relationship abuse, teen dating violence, screening, identification, intervention, guidelines, referral, resources, screening barriers, violence health outcomes, and randomized control trials. The product of the extensive literature review included two systematic reviews (level I evidence), two randomized control trials (level II evidence), one longitudinal study (level IV evidence), one cohort study (level IV evidence), three meta-analysis (level V evidence), one qualitative analysis (level VI), two qualitative, descriptive studies (level VI evidence), and three cross-sectional surveys (level VI evidence) (see Appendix D for Synthesis of Evidence Table). The articles reviewed focused on adolescent relationship abuse, ARA identification, healthy relationships, screening practices, barriers to violence screening, and positive ARA screening intervention. Inclusion criteria included adolescent relationship abuse, teen dating violence, primary care setting, urgent care setting, emergency room, and original research studies. Exclusion criteria included domestic violence and child abuse. Randomized control trials were included if their publication date was on or after January 2006. The guidelines developed by Miller and Levenson (2013), The Joint Commission (2010), the United States Preventive Services Task Force (2013), The U.S.

Department of Health and Human Services (2003), and The Family Violence Prevention Fund (2004) were reviewed for this synthesis of literature.

Synthesis of Literature

Addressing ARA in the Healthcare Setting

Adolescents have historically been a challenging population in terms of violence assessment and intervention (Martin, Houston, Mmari, & Decker, 2012). Healthcare providers have regular contact with adolescents, providing them opportunities to intervene with adolescents who may or may not be experiencing ARA. These providers are positioned to provide assessment and intervention at all levels of violence prevention (Notarianni, Clements, & Tillman, 2007). Martin, Houston, Mmari, and Decker (2012) found that adolescents prefer turning to family or friends before seeking formal services for ARA. In fact, Moore, Sargent, Ferranti, and Gonzalez-Guarda (2015) note that 90% of ARA victims reported seeking help from informal sources, versus 62% of ARA victims who admitted to seeking help from formal services. When considering formal services, however, adolescents are supportive of discussing ARA with a healthcare provider. Primary care and urgent care providers have regular contact with adolescents, providing opportunities to address ARA through teaching about healthy and unhealthy relationship behaviors and ARA resources.

Research lacks recommendations for the best way to approach ARA and to understand adolescents' preferences for seeking support (Martin, Houston, Mmari, & Decker, 2012). Understanding adolescent slang and language is important when discussing violence with adolescents (Martin, Houston, Mmari, & Decker, 2012). Adolescents have a difficult time distinguishing dating violence from normative behavior, and they are highly responsive to peer influence. When surveying adolescents about healthy relationships, adolescents reported, "some

level of drama and disrespect as common and normative” (Martin, Houston, Mmari, & Decker, 2012). This skewed perception of the adolescent population increases the importance of educating the adolescent about healthy relationships (Martin, Houston, Mmari, & Decker, 2012). Through this education, adolescents may learn to appropriately define healthy relationships and prevent or quickly react to identifying violence. Gardner and Boellaard (2007) evaluated the impact of healthy relationships education in teaching relationship-building skills. This study suggested healthy relationship education correlates with long-term increases in self-esteem and decreases in dating violence (Gardner & Boellaard, 2007).

Studies suggest that adolescents might tell friends if he or she is experiencing ARA (Weisz & Black, 2009). Educating adolescents about healthy relationships offers another level of opportunity for violence prevention. It is possible that the adolescent will identify the relationship abuse of a friend or encourage the friend to seek help from formal services. After this identification, that adolescent may be able to provide the friend with the relationship abuse resources that the healthcare provider offered.

ARA Screening and Screening Tools

The National Survey on Teen Relationships and Intimate Violence results demonstrate that the majority of adolescents are involved in dating relationships, with up to 57% reporting a history of dating violence (Taylor & Mumford, 2016; Herrman, 2009). Tharp et al. (2011) found that despite several prevention strategies, the frequency of dating violence among adolescents has remained the same for the past ten years.

Current research recommends that all adolescents, 13 years and older, be screened for adolescent relationship abuse regardless of reason for visit or diagnosis (Herrman 2009; Miller et al., 2010). Policies, guidelines, and recommendations on ARA screening tools and methods,

however, are often incomplete, confusing to providers, or nonexistent. Additionally, there is a lack of guidelines for providers to follow after ARA has been identified. Ramachandran, Covarrubias, Watson, and Decker (2013) performed qualitative interviews to assess screening practices among healthcare clinics. Results determined there was significant variation in screening practices, including related referral and follow up procedures, despite the existence of a violence screening tool.

There is a lack of evidence that analyzes screening practices specific to adolescents (Ramachandran, Covarrubias, Watson, & Decker, 2013). Unlike assessment instruments in the adult setting, violence screening tools for the adolescent population have not been validated to determine whether or not they accurately identify ARA (Rabin, Jennings, Campbell, & Bair-Meritt, 2009). In fact, Rabin, Jennings, Campbell, and Bair-Meritt (2009) recognize that sensitivities and specificities vary widely among even the most commonly used violence screening tools, and there is a critical need for testing and validation of violence screening tools. Common ARA screening tools, such as Conflict Tactics Scale (CTS2), Braiker and Kelly's Relationship Questionnaire, Foshee's Victimization and Perpetration in Dating Relationship Scale, and Wolfe et al.'s Conflict in Adolescent Dating Relationship Inventory (CADRI) are too lengthy to use in the clinic setting. The U.S. Preventive Services Task Force (USPSTF) cautions that there is inadequate research done on violence screening tools to make recommendations for or against screening tools (Rabin, Jennings, Campbell, & Bair-Meritt, 2009).

Despite the lack of guidelines, recommendations, and screening tools, studies suggest that adolescents are interested in learning about dating and healthy relationships from the healthcare provider (Herrman, 2009). Adolescents want to learn about communication, assertiveness, and

relationships with others, and they are receptive to the idea of having these conversations with healthcare providers (Herrman, 2009).

Hanging Out or Hooking Up

Miller and Levenson (2013) offer an additional method to prevent violence and identify relationship abuse: universal patient education of healthy, consensual relationships. These recommendations change the focus of screening to providing universal education. This framework includes educating providers on how to have routine conversations with adolescent patients about both healthy relationships and how abusive behaviors may affect health (Miller & Levenson, 2013). These conversations in the healthcare setting have been linked to an increase in patient safety and improved health, and a decrease in risk for violence and unplanned pregnancy among the adolescent population (Miller & Levenson, 2013). Although the provider is not directly screening the patient for violence, he or she must be prepared in case the conversation and education elicits revelation of abuse. The Hanging Out or Hooking Up safety card, developed by Futures Without Violence, is a tool that can be used by healthcare providers to guide conversation with adolescent patients. This tool provides guidelines for addressing ARA in the healthcare setting, and assists the healthcare provider in providing universal education to adolescents about safe and healthy relationship behaviors, abuse relationship behaviors, and resources for adolescents experiencing ARA (Miller and Levenson, 2013).

Miller, et al. (2015) evaluated the effectiveness of the Hanging Out or Hooking Up safety card, relationship abuse education, and counseling in school health centers. This study evaluated the potential benefits of provider-delivered universal education and counseling interventions to address and prevent ARA (Miller et al., 2015). Through brief universal education and counseling interventions to adolescents of all genders, sexual orientation, and clinic visit types,

there was increased knowledge of ARA resources, increased self-efficacy to use harm reduction strategies, increased ARA disclosure, and decreased ARA victimization (Miller et al., 2015). Several studies have suggested efficacy of healthy relationships education and the use of the Hanging Out or Hooking Up safety card to address ARA in the school setting (Miller et al., 2015; DeKoker, Mathews, Zuch, Bastien, & Mason-Jones, 2014).

Miller et al. (2015) encourages providers to integrate the Hanging Out or Hooking Up safety card into every patient encounter, and encourages patients to take a safety card for both themselves and friends (Miller and Levenson, 2013). The Hanging Out or Hooking Up safety card is a palm-sized brochure that discusses healthy relationships, how to help a friend, and ARA resources (Miller et al., 2015; Miller and Levenson, 2013). Results of study suggested this education improved providers ARA recognition and knowledge of ARA resources (Miller et al., 2015). Additionally, adolescents who were provided the universal education were more likely to disclose unhealthy relationships and to help a friend in an unhealthy relationship (Miller et al., 2015).

McCauley et al. (2014) encourages providers to counsel all adolescents on healthy relationships, including consensual sex and safe sex practices pertinent to their sexual preferences. Dick et al. (2014) suggests a need to integrate ARA counseling into the clinical setting. ARA counseling can be easily introduced through the use of the Hanging Out or Hooking Up safety card. Notarianni, Clements, and Tillman (2007) recognize when the primary and urgent care provider promote healthy families and relationships, he or she is playing a role in reducing youth violence.

Theory

The theory used for the project is Dr. Patricia Brenner's "From Novice to Expert" theory (see Appendix E for Theory to Application Diagram). This theory was applied to evaluate how continued adolescent relationship abuse training and practice improves the providers' clinical competence regarding ARA. In the novice stage, the provider is limited in his or her ability to predict what could happen in a situation that deals with an ARA victim (Benner, 1982). In the second stage, advanced beginner, the provider has previously accumulated experiences that allow him or her to recognize components of ARA management (Benner, 1982). The provider in the next stage, competent, is able to recognize patterns and manage clinical situations with speed and accuracy (Benner, 1982). In the proficient level, the provider recalls past experience to view clinical scenarios as a whole, rather than parts in order to modify plans (Benner, 1982). Finally, at the expert level, the provider is no longer dependent on rules to guide actions, yet he or she has in-depth knowledge and background that allows the provider to guide their decision making (Benner, 1982). The purpose of this training session is to progress the provider in their journey from novice to expert in ARA management.

Methods

IRB Approval

Primary Institutional Review Board (IRB) approval was received from Children's Mercy Hospital IRB for this project to take place at Children's Mercy Hospital and Clinics (see Appendix F for IRB approval letter). Reciprocity approval was received from University of Missouri-Kansas City IRB (see Appendix G UMKC request to rely IRB approval letter). This project was determined to be a new research project that meets criteria for exempt determination. It was designed to determine best methods for educating primary and urgent care providers about ARA. Provider knowledge was evaluated pre- and post- training through analysis of the Student

Health and Risk Prevention (SHARP) survey (see Appendix H for Provider Training for SHARP surveys).

Collected data does not contain identifiable information, protecting human subjects and making this a minimal risk project. The risk for breach of confidentiality after survey completion is minimal since survey data is collected anonymously and is stored securely via secured server and password-protected access. Potential harm to participants involves distress due to the topic of ARA. To minimize this risk, participants were informed of the nature of the training prior to the start of the training session. Additionally, if participants wanted to speak with someone, a Children's Mercy Hospital social worker or Bridge Advocate was available. There was no direct benefit of project participation for individual participants, however, the project may help create interventions that improve ways of educating providers on how to manage ARA. This project took place at Children's Mercy Clinics among primary care and urgent care providers.

Ethical Issues

There are several ethical considerations related to ARA. Beneficence, or the act of doing good, should be considered within the intention of managing ARA. Providers should be educated that discussions alone are not enough, as it should be followed up with appropriate intervention when ARA is identified. When there is no referral or intervention, the provider may be doing more harm than good as the victim is at risk for retribution by their partner. Furthermore, privacy and confidentiality are highlighted as key ethical concepts. These concepts not only protect the patient from exposing confidential information, but also enhance their safety from their partner. Finally, given the commonality of ARA, justice or "just" care encourages extending the same quality of care to all vulnerable populations (Ghandour, Campbell, & Lloyd, 2015). Educating providers about ethical considerations can help manage these ethical concerns.

Funding

The total estimated cost of this project is \$1,175. The majority of the cost went to project development and implementation, at \$1,000. This cost allowed the student investigator to provide small compensation to the project team. The cost of printing the educational material supplies and SHARP surveys for providers was approximately \$75. Poster printing is approximately \$100. Food and presentation space was provided by Children's Mercy Hospitals for the providers who attend the training session. In addition to the contributions of Children's Mercy Hospital, a graduate assistance fund UMKC's Women's council assisted coverage of some project development and dissemination costs (see Appendix C for Cost Table).

Setting and Participants

The setting of this project was Children's Mercy Clinics, a freestanding tertiary care pediatric hospital located in the Midwest. These clinic settings are an adjunct facility of Children's Mercy Hospital, with an emphasis in primary or urgent care. The patient population at Children's Mercy is culturally and economically diverse, with emphasis in pediatric patients. Project participants were recruited from Children's Mercy primary and urgent care providers attending Hanging Out or Hooking Up training session. Providers must provide direct care to adolescents to meet inclusion criteria. There was no exclusion criterion as long as inclusion criteria were met. Voluntary sample, a non-probability sampling method will be utilized to support the data collection of this project (see Appendix H for Data Collection Template).

Evidence Based Practice Intervention

There are several steps in this evidence based practice intervention (see Appendix I for Intervention Flow Diagram). The first step in the EBP procedure is recruitment. Children's Mercy Clinic providers in primary and urgent care clinics were recruited to participate in the

training session. Provider recruitment focused on the healthcare professionals who provide direct patient care to the adolescent population. The providers were required to participate in the training at the time of their annual institutional required education, however, they were not required to participate in this project. The student investigator presented the recruitment script immediately before the training to recruit providers to participate in this project (see Appendix J for Recruitment Script). By completing the survey, the providers provided implied consent to participate in this project. Following consent, providers completed the pre-training survey as the pre-test to assess their current knowledge, comfort level, and practice habits regarding adolescent relationship abuse. This survey also assessed provider's demographics. This tool is public domain and can be freely used (Miller, Levenson, Monasterio, & Duplessis, 2014). The student investigator and preceptor conducted an hour-long training session. A PowerPoint was presented based on the recommendations of Miller and Levenson (2013). The PowerPoint outlined the definition and epidemiology of ARA, and introduced the intervention for universal provision of ARA education via the Hanging Out or Hooking Up safety card. Immediately following the training session, providers completed the immediate post-training survey as a post-test to reassess understanding and practice intentions of adolescent relationship abuse. Providers were asked to provide their e-mail address on a separate sheet of paper so that the student investigator could contact them for a three-month follow up survey. The e-mail address was not associated with any survey answers, and was accessible only to the project team. Three months following the training session, an e-mail was sent to the participating providers who provided their contact information to fill out a survey to determine the longevity of the new knowledge and to determine the perceived usefulness of information.

Recruitment and implementation of the training sessions occurred November 2016-January 2017. The three-month follow up occurred February 2017-April 2017. Final data collection and statistical analysis occurred in March-April 2017. April-May 2017 was dedicated to evaluating the program's effectiveness. At the end of the data collection period, summarized data was presented to the participating providers and at the Midwest Nursing Research Society's annual research conference (see Appendix K for Project Timeline Flow Graphic and Appendix I for Intervention Flow Diagram).

Change Process, EBP Model

The ACE Star Model of Knowledge Transformation framework encompasses the key concepts of discovery, evidence summary, translation, integration, and evaluation (Schaffer, Sandau, & Diedrick, 2012). This model can be used to guide the logic model of this project (see Appendix L for Logic Model). In discovery, there is pursuit for knowledge. Evidence summary incorporates a thorough systematic review process to devise a statement of evidence. In translation, there is development of a tool that guides practice. Through integration, there is a change in practice. Finally, in evaluation, there is attention to the influence of EBP practice change on quality improvement in health care (Schaffer, Sandau, & Diedrick, 2012). The goal of the ACE Star Model of Knowledge Transformation framework is to serve as a guidance outline for integrating evidence into practice (Schaffer, Sandau, & Diedrick, 2012). With successful integration of the evidence into practice, the likelihood of sustainability of the project is improved so that further education can be completed among additional providers.

Project Design

This project design is quasi-experimental and utilized a single group pre-test/post-test. Pre-test data was collected from the providers through administration of the SHARP survey

prior to the training session. The data measurement instrument for data collection was the provider training for SHARP survey (see Appendix H for Data Collection Template). All providers participated an hour-long the Hanging Out or Hooking Up training session. Immediately following the training session, the providers took the Immediate Post-Training SHARP survey. Both surveys were manually entered into a REDCap database by the student investigator. A three-month follow up survey was distributed via e-mail to project participants to determine the longevity of the providers' new knowledge and to determine the perceived usefulness of information. This survey information was directly entered into REDCap. The student investigator and statistician analyzed the data for comparison of the effectiveness of the education and disseminated the results. The data was anonymous, with a non-identifiable code used to track participation throughout the course of the project.

Validity

Internal validity was established through determining the relationship between the training session and providers' knowledge of ARA after the training session. Internal validity of this project may have been influenced by factors such as the providers' previous ARA training. Another factor that may have influenced the internal validity of the three-month follow up results was any additional education on related topics between the training session and follow up. External validity did not allow for the results of this project to be applicable to the general population. Given that the population of this project was specific to primary and urgent care providers who provided direct patient care to the adolescent population, the project results may not be able to be generalized away from this specific population.

Outcomes

The outcomes measured in this project included provider self-efficacy around ARA intervention in the healthcare setting, provider intentions for behavior change related to addressing ARA, and provider self-reported behaviors around ARA. Outcomes were assessed through pre- and post-intervention surveys. The measurement tool was the Provider Training for SHARP pre-training, immediate post-training, and three-month follow up surveys. Results of this project will guide potential modifications of the training, with the goal of increasing provider utilization of the Hanging Out or Hooking Up intervention. This project is relevant to Children's Mercy's mission to provide comprehensive healthcare at the highest level of clinical and psychosocial care. Subsequent studies could evaluate the implementation of the Hanging Out or Hooking Up intervention.

Measurement Instruments

The measurement instrument for the specified outcomes was the Provider Training for SHARP survey (see Appendix H). Surveys are useful in assessing self-reported provider behaviors, self-efficacy, behavioral intentions, support needed to address ARA in the healthcare setting, and demographics. These surveys have good face and construct validity, Cronbach's alpha >0.7. The Provider Training for SHARP survey is public domain and, for non-commercial purposes, does not require permission to be used (Miller, Levenson, Monasterio, & Duplessis, 2014). Permission to use and to modify surveys has been granted by survey authors (Personal communication, August 26, 2016) (see Appendix M for permission for use).

Data was collected through three surveys: pre-training, immediate post-training, and three-month follow up. Surveys were developed by Futures Without Violence for evaluation of the full Hanging Out or Hooking Up training and were modified to better match the one-hour Hanging Out or Hooking Up safety card training. A series of questions on each survey enabled

creation of an anonymous participant code; the three surveys were matched using this anonymous code.

The pre-training survey and immediate post-training survey were administered immediately before and immediately after Hanging Out or Hooking Up training, on paper. The student investigator entered answers from the paper surveys into a REDCap database.

The three-month follow up survey was administered three months after the training via e-mail with an embedded REDCap survey link; project participants entered data directly into the REDCap database. To enable administration of this survey via email, participants were asked to provide their name and email address at the time of the training. This information was collected separately from participant surveys to ensure survey data was collected anonymously.

Quality of Data

Standard descriptive statistics were used to summarize participant demographics and survey data for the sample as a whole. Sixty-seven providers participated in the pre-training and immediate post-training surveys. Data on reported behaviors and self-efficacy was analyzed for the sample as a whole and for individual participants. For pre/post comparisons of individual participants, the Wilcoxon Signed Rank test was used. For pre/post comparison of the sample as a whole, data was collapsed (5-point Likert scale) into three categories (self-reported frequency of behavior; all/most of the time, some of the time, not often/rarely) or two categories (self-efficacy; strongly agree/agree, undecided/disagree/strongly disagree); pre/post data for the sample as a whole was compared using the Wilcoxon Signed Rank test or paired t-test, as indicated by the data distribution. Missing data and outliers were excluded from analysis for that particular question.

The Provider Training for SHARP pre-training survey determined baseline data. The Provider Training for SHARP immediate post-training survey, which followed the intervention, determined post-training data. The Provider Training for SHARP survey collects provider demographic data, including: the respondent's clinic setting, training background, years of practice, gender, ethnic background, and age. Three months following the training session, providers filled out the SHARP three-month follow up survey, which completed the time period of data collection.

Evidence suggests efficacy of a nurse-delivered brief ARA intervention using the Futures Without Violence Hanging Out or Hooking Up safety card. However, there is no published evidence on the efficacy of Hanging Out or Hooking Up provider training that can be used as benchmark data for comparison.

Analysis

This project measured the primary and urgent care providers' self-reported behavior, self-efficacy, and behavioral intentions before and after the intervention. Descriptive statistics summarized the data. Chi-square, fisher's exact tests, and student's t-test were used to compare responses between participant subgroups. Pre- and post-survey results were compared using Wilcoxon Signed Rank test and paired t-test. Missing data was excluded from analysis. Results were examined to determine the outcome measures of the evidence-based intervention (see Appendix N for Statistical Analysis Table Template).

Results

Setting and Participants

Between November 2016 and January 2017, sixty-seven providers from Children's Mercy Hospital participated in this project. Providers practice at Children's Mercy's primary

and urgent care clinics, including Children's Mercy Broadway, Children's Mercy North, Children's Mercy East, and Children's Mercy West. Of the participants, the majority were registered nurses (68.7%), physicians (17.9%), and nurse practitioners (7.5%). Most participants in the project reported greater than ten years of experience providing adolescent health care (47.8%), with 31.3% of participants reporting five to ten years of experience, and 20.9% reporting less than five years of experience providing adolescent health care. When asked to describe gender, 94% of participants identified as female and 6% identified as male. Most participants described their ethnic background as Caucasian (92.5%).

Intervention Course

Each primary and urgent care clinic held the one-hour Hanging Out or Hooking Up training session, in which primary and urgent care providers were invited to participate in this project. Sixty-seven providers completed a pre-training and immediate post-training survey. Three months following the receptive training session, providers who offered their e-mail address were sent a three-month follow up survey. Of the sixty-seven participants, fourteen providers completed the three-month follow up survey. Twelve of the providers provided codes that could be matched via the anonymous code to their pre- and immediate post-training surveys, two providers did not provide matching codes.

Outcome Data

Provider self-reported behaviors were assessed in the pre-training survey to help determine a baseline for providers' current methods of assessing ARA and addressing healthy relationships (n=67). The majority of providers (>60%) reported that less than 25% of the time providers are talking to adolescent patients about healthy relationships, assessing patients' safety and discussing ways to stay safe in an unhealthy relationship. Additionally, greater than 70% of

providers reported being unaware of what local and national resources are available to assist teens around ARA; unsure of how to assess for ARA, sexual assault, and reproductive coercion among sexually active adolescents; and unsure of how to discuss safety planning with an adolescent who discloses an abusive relationship.

When assessing the providers' self-efficacy regarding ARA management, the training session resulted in significant improvements between pre-training and immediate post-training survey question responses ($p < 0.001$). Providers were asked to rank their abilities on a Likert scale. Prior to the training, on average, providers responded between agree and undecided with their understanding of how to discuss the limits of confidentiality with their adolescent patients. Upon review of immediate post-training survey responses, on average, providers responded between strongly agree or agree that the training session increased their understanding in how to discuss limits of confidentiality with their adolescent patients. The same association between pre-training and immediate post-training survey responses were found when the providers were asked to rank their understanding in the following areas: "The mandated reporting requirements relevant to ARA and sexual assault in my state"; "What local and national resources are available to assist teens around ARA"; "How to assess for ARA, sexual assault, and reproductive coercion among sexually active adolescents"; and "How to discuss safety planning with an adolescent who discloses an abusive relationship".

Behavioral intentions were measured to assess how the training session might impact the providers' willingness to convert methods learned in the training session into everyday practice. Survey responses showed greater than 90% of providers reported intentions to integrate healthy relationship discussion into all clinical encounters, to assess for patient safety, and to offer patients a safety card on ARA and healthy relationships. Furthermore, immediately following

the training session, 98.5% of providers reported confidence in how to assess for ARA, sexual assault, and reproductive coercion among sexually active adolescents. Finally, immediately following the training session, 89.4% of providers reported confidence in knowing how to discuss safety planning with an adolescent who discloses an abusive relationship. Between the pre- and immediate-post training surveys, the majority of participants reported increased understanding of ARA and intentions to address ARA.

The three-month follow up survey had a low response rate (n=12), however, the majority of participants continued to feel more confident in talking to patients about safe and healthy relationships (7, 64%), abusive relationships and ARA resources (8, 73%), and connecting patients to violence-related resources (7,64%). Despite the continued improvements in provider self-efficacy, three-month follow up self-reported behaviors were not significantly different than those reported in the pre-training survey.

Discussion

Successes

Successes from this project come from the ability to collect pre-training surveys and immediate post-training surveys quickly and without losing touch with project participants. This allows for improved quality of data due to few missing values. Provider receptiveness to the training session, as well as their responses towards immediate post-training behavioral intentions was very successful. Nearly all providers reported intentions to implement the use of the Hanging Out or Hooking Up safety card into their practice, with further intention to discuss healthy relationships with all adolescent patients.

Strengths

The strength of this project is highlighted in changes providers report between pre-training and immediate post-training survey responses. Because providers were present without interruption between these two surveys, there was no lost contact with providers and minimal opportunities for the providers to abandon participation. By having the training sessions at the providers' institution, there was more convenience and thus incentive for the providers to participate. The organizational culture of this institution also promoted this intervention by creating a setting that encourages patient safety and violence prevention. The organizational support among staff and institution proved to be promoters for the support of this project.

The components of the training session varied in degree of success. The pre-training survey, immediate post-training survey, and the training session itself were easy to implement and it was convenient for providers to participate. There were high participation rates among these components of the intervention. There were few missing values in this area of data collection.

Results Compared to Evidence in the Literature

Although there is no published evidence on the efficacy of the provider training session, results of this project were consistent with evidence in the literature around ARA assessment rates and provider self-reported behaviors. Project findings aligned with the current evidence in literature that healthcare providers have several barriers to identifying and addressing ARA, including their comfort level with having conversations with adolescents about ARA. Prior to training, providers report low rates of assessing safety and discussing ARA with patients, consistent with the results of other studies that report the lack of ARA assessment and intervention in the healthcare setting (Herrman, 2009).

Limitations

Internal validity was affected by biases in how questions were asked. Confounding factors include how the information was presented and which ARA resources were highlighted. Allowing the participants to take home the safety card may also influence their responses. For example, the Hanging Out or Hooking Up safety card contains a list of ARA resources, which may be a possible explanation for the provider's improved comfort levels with discussing ARA resources with the adolescent patient. There were minimal variations between the different presentations, including consistencies among PowerPoint presentations, resources, and safety cards. Internal validity was ultimately improved through the use of a precise intervention process and data collection period, consistent among each training session.

External validity was influenced through using project participants who come from the same institution. Because the parent healthcare institution is the same for all sites used, so are the patients these providers care for. Role bias results may affect external validity, as providers were among physicians, nurse practitioners, registered nurses, and certified nursing assistants.

Observed improvements in provider self-efficacy, self-reported behaviors, and behavioral intentions around ARA have the potential to weaken over time. Having the Hanging Out or Hooking Up safety cards printed and available to providers may allow them to not only be reminded of the training session, but may also encourage them to use the safety card to discuss healthy relationships with their adolescent patients. By continuing to offer training sessions, the number of providers trained to discuss healthy relationships and use the Hanging Out or Hooking Up safety card will increase. Providers should also be encouraged to repeat the training session as needed. Hosting training sessions on a routine basis may help improve the sustainability of these effects.

This project has several limitations, including being held in a single institution and having a small sample size. The low return rate for the three-month follow up survey (18%) further impacted the limitations of this project. Participation in this survey was voluntary, with no consequences for those who fail to respond. The efforts to minimize limitation impact were addressed through a maximum of two reminder e-mails to each provider, with hopes to improve participation. Another limitation in one training session group was that the training session was held over lunch break. Due to the busy schedules of providers, some providers were tardy to the training session. Since the training session had started prior to their arrival, they were unable to hear the recruitment script and to complete the pre-training survey before the start of the training session, which excluded these providers from project participation.

Interpretations

Expected results were hypothesized to suggest the training session improves provider self-efficacy, self-reported behaviors, and behavioral intentions. Although there was improvement in all of these areas, it was unexpected to find results of the three-month follow up survey to suggest that several providers continue to report low rates of reported behaviors around safety assessment. The problem and failure, with potential to further sway three-month follow up survey results, includes the small sample size to complete the final survey. With a better method to ensure that a greater number of providers complete all surveys, there is a potential for different outcomes when analyzing the long-term effects of the training session. Improvements in follow up participation or the training provided may also account for the difference between observed and expected outcomes.

Another strength of the project that improved the intervention's effectiveness comes from the targeted population that participated in the training session. These providers care for

adolescent patients on a daily basis, which increases the extent to which this information applies to their practice. Providers of the geriatric population, for example, would not find this training to be applicable or effective.

There is potential to improve the attainment of the outcomes of this training session, particularly in terms of information retention. Further modifications to the training session are recommended to improve the training provided and the clarity of the information presented in order to extend the training session's effects.

Expected and actual impact to health system, costs, and policy

The expected and actual project estimated and actual costs proved to be very similar. The majority of the costs for this project were intended for project dissemination. Dissemination costs were excluded from the cost table. This project and intervention's actual costs remained very low budget, which improves the potential for economic sustainability for future training sessions. The UMKC Women's Council Graduate Assistance Fund provided the funding sources for this project and intervention in its entirety.

The impact of this evidence-based practice intervention on the health system and policy are favorable, especially after continued improvements and modifications to the training session. By incorporating this training into the organization's policy for addressing safety and violence prevention in the healthcare setting, there is potential to not only improve the health system itself, but there is also potential to decrease the health care costs associated with violence among adolescents.

Conclusion

Practical Usefulness of Intervention

A one-hour Hanging Out or Hooking Up training session may better equip providers to address ARA, a common problem that negatively impacts adolescent health. The training session motivated provider to adapt current practice to assessed behaviors and increase self-efficacy on assessed topics. However, at three months, there were no significant behavior changes.

Primary and urgent care providers have been shown to have an important role in ARA identification, prevention, and intervention. These providers offer confidential and safe environments for adolescents to discuss abusive relationships that may be affecting the adolescent's health. Studies suggest that improving the providers' awareness and knowledge of ARA may improve his or her behavioral intentions in ARA management and discussing healthy relationships with adolescent patients, thus highlighting the importance of this training session. When these behavioral intentions are turned into actions, these practice habits promote primary prevention of ARA and encourage patient safety. Primary and urgent care providers have unique opportunities to educate adolescents on how abusive relationships are linked to health risks. The use of the Hanging Out or Hooking Up safety card in the primary and urgent care setting holds great potential for success.

Further Study or Implementation of Intervention

Subsequent studies are recommended to address how to achieve sustained practice changes around ARA. Other studies could evaluate the implementation of the Hanging Out or Hooking Up safety card intervention, including how often the primary and urgent care provider is using the safety card to discuss ARA and healthy relationships with adolescent patients. Additional research should focus on the identification rates of ARA in the adolescent primary and urgent care setting, including how often the discussion about healthy relationships prompts

an ARA disclosure. More research is needed to determine the effects of ARA education on improving intervention and follow up rates. Finally, research should be conducted to determine whether or not ARA victims are receiving appropriate referrals and intervention after ARA identification.

Dissemination

Primary dissemination plans include the presentation of findings to UMKC students and faculty, and to Children's Mercy Hospital faculty. A poster was presented at the 2017 UMKC Health Sciences Student Research Summit and the 2017 Midwest Nursing Research Society's annual conference in Minneapolis, Minnesota. Dissemination at all levels allowed the student investigator to present project findings to other healthcare providers, and to continue to educate providers about the importance of ARA interventions.

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Appendix A

Definition of Terms

Term	Definition
Adolescent Relationship Abuse	A pattern of repeated physical, sexual, or emotional abuse in the context of dating, in which one or both partners is a minor (Miller and Levenson, 2013). Incorporates the broadest definition of ‘romantic’ relationship among adolescents (Miller & Levenson, 2013). Subtypes include physical, sexual, psychological, or cyber ARA, or reproductive coercion.
Provider	Healthcare professional providing direct patient care in primary or urgent care setting. May include, but is not limited to, physician, nurse practitioner, registered nurse, care assistant, or certified nursing assistant.
Victim	Individual targeted for violence or abuse
Perpetrator	Individual carrying out violence or abuse
Hanging Out or Hooking Up	Safety card, developed by Futures Without Violence, used to provide adolescents with universal education on safe, consensual, and healthy relationships, and strategies to respond to health issues in trauma-informed manner (Miller and Levenson, 2013).
Abuse	Actions related violence, harmful, or immoral acts.
Cyber ARA	Use of technology to harass and control a romantic partner (Miller and Levenson, 2013).
Reproductive Coercion	Treats or acts of violence against a partner’s reproductive health or reproductive decision-making. Behavior to maintain power and control intended to pressure or coerce a partner into becoming pregnant or ending a pregnancy (Miller and Levenson, 2013).

Appendix B
Intervention Material: Hanging Out or Hooking Up Safety Card



Hanging out or Hooking up?

How Is It Going?

Does the person you are seeing (like a boyfriend or a girlfriend):

- ✓ Treat you well?
- ✓ Respect you (including what you feel comfortable doing sexually)?
- ✓ Give you space to hang out with your friends?
- ✓ Let you wear what you want to wear?

If you answered YES—it sounds like they care about you.

And on a Bad Day?

How often does the person you are seeing:

- ✓ Shame you or make you feel stupid?
- ✓ Pressure you to go to the next step when you're not ready?
- ✓ Control where you go, or make you afraid?
- ✓ Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.

Everybody Texts

Getting a lot of texts can feel good—"Wow, this person really likes me."

What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.

Be honest. "You know I really like you, but I really don't like it when you, text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatsnotcool.com.

What About Sex?

Can you talk to the person you are seeing about:

- ✓ How far you want to go sexually?
- ✓ What you don't want to do?
- ✓ Preventing STDs by using condoms?
- ✓ Birth control?

If you answered NO to any of these questions, maybe this person is pushing you to do things you don't want to do. Or you might not feel comfortable bringing this up. Try using this card as a conversation starter. "I got this card in a clinic and wanted to talk about it with you."



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What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- ✓ Make you feel safe and comfortable.
- ✓ Not pressure you or try to get you drunk or high because they want to have sex with you.
- ✓ Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- ✓ Tell your friend what you have seen in their relationship concerns you.
- ✓ Talk in a private place, and don't tell other friends what was said.
- ✓ Show them www.loveisrespect.org and give them a copy of this card.
- ✓ If you or someone you know is feeling so sad that they plan to hurt themselves and/or wish they could die—get help.
Suicide Hotline: 1-800-273-8255



FuturesWithoutViolence.org

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Funded by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services and the Office on Women's Health, U.S. Department of Health and Human Services.

If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-888-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest,
National Network (RAINN)
1-800-656-HOPE (1-800-656-4873)

**Appendix C
Cost Table**

Personnel	<i>Effort or # Hours</i>	<i>Total</i>
Lindsey Davis	<i>n/a*</i>	
Co-Investigator	<i>0.02 FTE</i>	
Co-Investigator	<i>0.01 FTE</i>	
Co-Investigator	<i>0.01 FTE</i>	
CMH Statistician	<i>0.01 FTE</i>	
Research Personnel	<i>0.01 FTE</i>	
Total personnel		1,000
Other direct costs		
Supplies	0	75
Poster Printing	0	100
TOTAL		1,175
*Ms. Davis will complete project hours outside of CMH FTE		

Appendix D

Synthesis of Evidence Table

Reference	Research Design & Evidence Level	Measures & Reliability	Intervention	Results
Addressing ARA in the Healthcare Setting				
Gardner, S.P., & Boellaard, R. (2007). Does youth relationship education continue to work after high school? A longitudinal study. <i>Family Relations</i> , 56(5), 490-500.	Longitudinal Study Level IV	n=72	Educational Session	<i>Healthy Relationships</i> correlated with decreased dating violence
Martin, C., Houston, A., Mmari, K., & Decker, M. (2012). Urban Teens and Young Adults Describe Drama, Disrespect, Dating Violence and Help-Seeking Preferences. <i>Maternal & Child Health Journal</i> , 16(5), 957-966. doi:10.1007/s10995-011-0819-4	Qualitative Analysis Level VI	n=32 ages 13-24	Focus Group	Adolescents identified barriers to seeking formal health services.
Moore, A., Sargent, K. M., Ferranti, D., & Gonzalez-Guarda, R. M. (2015). Adolescent Dating Violence: Supports and Barriers in Accessing Services. <i>Journal Of Community Health Nursing</i> , 32(1), 39-52. doi:10.1080/07370016.2015.991668	Meta-Analysis Level V	n=10	Literature Review	ARA victims more likely to turn to informal sources for help
Notarianni, M., Clements, P., & Tillman, H. (2007). Caring for the future: strategies for promoting violence prevention in pediatric primary care. <i>Journal Of The American Academy Of Nurse Practitioners</i> , 19(6), 306-314. doi:10.1111/j.1745-7599.2007.00230.x	Meta-Analysis Level V		Review of Literature	Nurse practitioners play an important role in preventing youth violence.
Weisz, A., & Black, B. (2009). Help-seeking and help-giving for teen dating violence. <i>Prevention Researcher</i> , 16(1), 12-16.	Qualitative, Descriptive Study Level VI	202 urban, African American 7 th graders	Interview	Adolescent perception of dating violence

ARA Screening and Screening Tools				
Herrman, J. (2009). There's a fine line... Adolescent dating violence and prevention. <i>Pediatric Nursing</i> , 35(3), 164-170.	Systematic Research Review Level I		Literature Review	Healthcare professionals to develop violence reducing interventions
Miller, E., Decker, M.R., McCauley, H.L., Tancredi, D.J., Levenson, R.R., Waldman, J., Schoenwal, P., & Silverman, J.G. (2010). Pregnancy, coercion, intimate partner violence, and unintended pregnancy. <i>Contraception</i> , 81(4), 316-322.	Cross-sectional Survey Level VI	n=1278 females, age 16-29	Survey	53% reported physical or sexual abuse
Rabin, R.F., Jennings, J.M., Campbell, J.C., & Bair-Merritt, H.M. (2009). Intimate partner violence screening tools: A systematic review. <i>American Journal of Preventive Medicine</i> , 36(5), 439-445.	Meta-Synthesis Systematic Review Level V	33 eligible studies		Sensitivities vary among violence screening tools; further validation is critically needed
Ramachandran, D., Covarrubias, L., Watson, C., & Decker, M. (2013). How You Screen is as Important as Whether You Screen: A Qualitative Analysis of Violence Screening Practices in Reproductive Health Clinics. <i>Journal Of Community Health</i> , 38(5), 856-863. doi:10.1007/s10900-013-9690-0	Qualitative Study Level VI	n=14 3 clinic practices	Qualitative interviews	Variation in screening practices among providers and organizations.
Taylor, B.G., & Mumford, E.A. (2016). A national descriptive portrait of adolescent relationship abuse: Results from the national survey on teen relationships and intimate violence. <i>J Interpers Violence</i> , 31(6), 963-988. doi: 10.1177/0886260514564070	Cross-Sectional Survey Level VI	n= 1804	Survey; Interview	(37%) reporting current- or past-year dating 69% reported lifetime ARA victimization Consistent reports of dating among different demographics
Tharp, A. T., Burton, T., Freire, K., Hall, D. M., Harrier, S., Latzman, N. E., & ... Vagi, K. J. (2011). Dating Matters™: Strategies to promote	Cohort Study Level IV	n=46, 6 cohorts	Teen dating violence prevention program	Frequency of adolescent dating violence

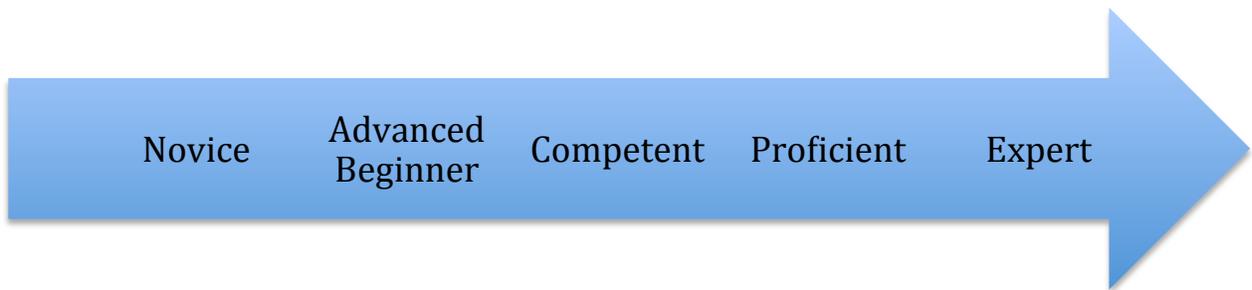
healthy teen relationships. <i>Journal Of Women's Health</i> , 20(12), 1761-1765. doi:10.1089/jwh.2011.3177				
Hanging Out or Hooking Up				
DeKoker, P., Mathews, C., Zuch, M., Bastien, S., & Mason-Jones, A.J. (2014). A systematic review of interventions for preventing adolescent intimate partner violence. <i>J Adolesc Health</i> , 54(1), 3-13. doi: 10.1016/j.jadohealth.2013.08.008	Systematic review of Randomized Control Trials Level I	8 articles, 6 RCT	Review of Literature	Interventions targeting violence among adolescents can be effective in preventing violence.
Dick, R.N., McCauley, H.L., Jones, K.A., Tancredi, D.J., Goldstein, S., Blackburn, S., Montasterio, E., & ... Miller, E. (2014). Cyber dating abuse among teens using school-based health centers. <i>Pediatrics</i> , 134(6). doi: 10.1542/peds.2014-0537	Cross-Sectional Survey Level VI	CI 95% OR 2.8 n=1008 14-19 year olds	Interview	Increased links of cyber dating abuse with risky sexual behaviors
McCauley, H.L., Dick, R.N., Tancredi, D.J., Goldstein, S., Blackburn, S., Silverman, J.G., & ... Miller, E. (2014). Differences by sexual minority status in relationship abuse and sexual and reproductive health among adolescent females. <i>J Adolesc Health</i> , 55(5), 652-8. doi: 10.1016/j.jadohealth.2014.04.020	Randomized Control Trial Level II	n=564 sexually active females age 14-19 95% CI	Logistic regression models	Homosexual females more likely to report sexual activity
Miller, E., & Levenson, R. (2013). Hanging out or hooking up: Clinical guidelines on responding to adolescent relationship abuse. <i>Futures Without Violence</i> , 2. Retrieved from https://www.futureswithouthoutviolence.org/userfiles/file/HealthCare/Adolescent%20Health%20	Guidelines			
Miller, E., McCaw, B., Humphreys, B.L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. <i>Journal of Women's Health</i> , 24(1),	Randomized Control Trial Level I	11 school health centers; 10 clusters n=1011; RCT;	Relationship abuse education and counseling	Adolescents in intervention group were more likely to disclose abuse.

92-99. doi: 10.1089/jwh.2014.4870		95% CI		
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Appendix E

Theory to Application Diagram

Benner: Novice to Expert Theory



Appendix F

Primary IRB Approval Letter: Children's Mercy Hospital IRB



Children's Mercy
Children's Mercy Hospital Pediatric Institutional Review Board

NOTIFICATION OF EXEMPT DETERMINATION

10/8/2016 10:30 AM

From: Office of Research Integrity
To: Lindsay Davis, Principal Investigator
CC: Lindsay Davis
Kimberly Sandoz

IRB#: 1600053
Study Title: Hanging Out or Hooking Up: Improving Adolescent Abuse Management
Host Org: Patient Care Services
The Children's Mercy Hospital
Protocol Name#: Improving AHA Management

Dear Davis,

On **8/28/2016**, the CMH Pediatric IRB reviewed the above-cited new IRB submission and determined that the study meets the criteria for an **exempt determination** under category **2 - Research involving the use of educational tests, surveys, procedures, interview procedures or observations of public behavior.** **IRB# 1600053 data is identifiable with disclosure, requires not subjects at risk of harm (00) (03) (07) (08).** This determination is valid from **8/28/2016 to 8/28/2018**.

The IRB has approved the following documents for use:

Protocol History	9/16/2016 9:58 AM	0.01
SHARPS	ABA Management - PDF of REQ/Can Survey	8/29/2016
Surveys	Tools (01) (01)	
Follow Up Survey Email List History	8/24/2016 9:34 AM	0.01
Study Information Sheet History	9/16/2016 9:55 AM	0.01

Additional Determination:

The IRB has determined that a Waiver of Documentation of Consent (Verbal Consent via a Study Information Sheet) is appropriate for this study. Please only use the most current stamped approved version available to you under the Documents tab of your study in Here.

This determination applies **only** to the activities described in the IRB submission listed above and does not apply should any changes be made. As the Principal Investigator, your responsibility to the IRB includes:

- **Submit a final report** to the ORI Office within 30 days of study completion. If the study is terminated for any reason the ORI Office must be notified immediately and a final report is to be submitted for study closure. Studies that continue past the expiration date require a submission of a new exempt determination **prior to the expiration date**.
- **Report any changes or deviations** in the protocol to the ORI Office. Any changes, revisions, or amendments to the protocol or changes in study conduct must be submitted to the ORI Office for IRB review and approval **prior to implementation** of the change, unless the change is imperative to subjects safety.

Sincerely,

Steph Swanson, M.D.
Co-Chair, CMH Pediatric Institutional Review Board

Dore Sommer, D.M.S.
Co-Chair, CMH Pediatric Institutional Review Board

Ryan McQuinn, M.S., P.M.P., C.I.P.
Director, Office of Research Integrity



Children's Mercy Hospital Patient Institutional Review Board

NOTIFICATION OF AMENDMENT APPROVAL

11/15/2018

From: Office of Research Integrity
To: Lindsay Davis, Principal Investigator
CC: Lindsay Davis
Kimberly Bentley

IRB#: 16000563
Study Title: Hanging Out or Hooking Up: Improving Adolescent Abuse Management
Funding Source: The Children's Mercy Hospital
Patient Care Services

Protocol Name: Improving ABA Management
Amendment Name: Amendment 1 for IRB Study #16000563
Dear Dana,

The CHM Pediatric IRB approved the above-stated amendment by expedited review under 45 CFR 46.215. The amendment was approved on 11/15/2018.

Approval is valid from 11/15/2018 to 01/25/2019.

Notable revisions approved as part of this amendment include:

Protocol Changes - Changed the dates of inclusion criteria.

The IRB approved the modified IRB0 application as of 11/15/2018 which included the following study documents:

Table with 3 columns: Name, Modified, Version. Row 1: Protocol | IRB002, 11/15/2018 8:38 AM, 0.01

Sincerely,

Doug Swanson, M.D.
Co-Chair, CHM Pediatric Institutional Review Board
Dana Sommer, B.M.S.
Co-Chair, CHM Pediatric Institutional Review Board

Ryan McQuinn, M.S., P.M.P., C.I.P.
Director, Office of Research Integrity

Office of Research Integrity
13200 N. 90th Street, 4th Floor
Overland Park, KS 66212-3998

Tel: 913.934.4347

Fax: 913.934.4347

Email: IRB@cmh.edu

Appendix G

Request to Rely: UMKC IRB

University of Missouri Kansas City
Research Compliance Office • Institutional Review Board
umkcirb@umkc.edu
816 235-5927

UMKC Request to Rely on an External IRB

HANDWRITTEN FORMS WILL NOT BE ACCEPTED

Instructions: Submit this form to request the UMKC IRB to Rely on a Partner Institution IRB. As the Reviewing Institution, an Institution is responsible for IRB review and continuing oversight. As the Relying Institution, an Institution codes IRB review and continuing oversight to the Reviewing Institution. The Principal Investigator is responsible for providing the Relying Institution with copies of all official documentation (approvals, etc.) from the Reviewing Institution's IRB. This document must be kept and available to the Office of Human Research Protections upon request.

Protocol Title: Hanging Out or Hooking Up: Improving Adolescent Relationship Abuse Management

Determining the IRB of Record

The following algorithm will determine which IRB should be the Reviewing IRB/IRB of Record

Where will the procedures with the highest magnitude of risk occur?:

Where is the majority of the procedures with the greatest risk of harm occurring?

If it is equally divided, then the IRB of the lead investigator will be the IRB of Record.

Participating Site: Children's Mercy Hospital

Where will the majority of the research procedures occur?:

Participating Site: Children's Mercy Hospital

From which site will the majority of the research subjects be recruited from?:

Participating Site: Children's Mercy Hospital

From which participating site is the Lead (Overall Study) Principal Investigator?:

Participating Site: Children's Mercy Hospital

Which participating site is the recipient of the grant?:

Participating Site: N/A

If the algorithm determines that UMKC should be the Reviewing IRB you must proceed to the IRBIC Personal application and submit for review to the UMKC IRB.

Has this study been reviewed and approved by another institutions?

[X] Yes [] No

If yes, please identify the institution: Children's Mercy Hospital IRB

Investigators

Please identify and provide contact information for Investigators involved in this study at all Partner Institutions

<p>CMH:</p>	<p>Lindsey Davis; Kimberly Randell; Jacqueline Bartlett; Donna O'Malley; Kelli Behr</p>	<p>Principal Investigator: Lindsey Davis BSN, RN, University of Missouri Kansas City DNP Student 2 Henson Staff Nurse 15910 Granada Street Unit 240 Overland Park, KS 66085 8163921520 lndavis@cmh.edu</p> <p>Co-Investigators: Kimberly Randell MD, MS Children's Mercy, 2401 Gillham Rd, KC MO 64108 816-559-9503 (ext. 49552) krandoll@cmh.edu</p> <p>Jacqueline Bartlett RN, PhD Children's Mercy, 2401 Gillham Rd, KC MO 64108 816-701-4534 (ext. 44534) jbartlett@cmh.edu</p> <p>Donna O'Malley RN, PhD Children's Mercy, 2401 Gillham Rd, KC MO 64108 816-960-8400 (ext. 68409) domalley@cmh.edu</p> <p>Research Personnel: Kelli Behr 816 882 1444 kbehr@cmh.edu</p>
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<p>KCUMB:</p>	<p>Contact Person Information:</p>	<p></p>
<p>KUMC:</p>	<p>Contact Person Information:</p>	<p></p>
<p>St. Lukes:</p>	<p>Contact Person Information:</p>	<p></p>
<p>Other Site:</p>	<p>Contact Person Information:</p>	<p></p>

UMKC/TMC Investigator Information

UMKC/TMC Investigator Name: Lindsey Davis

School and/or Dept: UMKC School of Nursing Are you a School of Medicine Student? Yes No

E-mail Address: lnd5h4@mail.umkc.edu Phone #: 8163921520

Additional Contact Person Information: Nancy Willis-Smith
 Phone: 417-625-9881
 willismith@umkc.edu

As the UMKC/TMC Investigator please provide a detailed summary of the study procedures you will be involved in:

This is a pilot study using pre and post surveys to assess provider outcomes after "Hanging Out or Hooking Up" training. A one-hour Hanging Out or Hooking Up training on AHA basics and use of the Hanging Out or Hooking Up safety card is being presented to CMH healthcare providers as part of routine clinical education. This study will enable formal assessment of provider self-efficacy, behavioral intentions and self-reported practices to address AHA before and after the training.

Training

Conflict of Interest

For all Partner Institutions you must show completion of CITI Training Course "Conflict of Interest"

CITI Training Certificate Attached

Human Subjects Research

For all Partner Institutions you must show completion of CITI training Course "Group 1 Biomedical Investigator"

Human Subjects Research Training Certificate Attached

Protocol Materials

Please provide the following pieces of information, as applicable:

<input checked="" type="checkbox"/>	Copy of IRB Application
<input checked="" type="checkbox"/>	Copy of Protocol
<input type="checkbox"/>	Copy of Grant
<input type="checkbox"/>	IRB, IRB/ethics, Adherence to Right, Approval This would include any applicable application to the TMC Privacy Board
<input checked="" type="checkbox"/>	Copy of IRB Approval
<input checked="" type="checkbox"/>	Conflict of Interest Disclosure For studies relying on the IRB from CMH, KU, or St. Luke's, completion of the UMKC Conflict of Interest Form is required. For studies relying on the IRB from UMKC, you must contact UMKC to determine the necessary steps to comply with their CCR processes.

Will any human subjects activities, including subject recruitment, enrollment, and/or study interventions/interactions, occur on UMKC/TMC property?

If yes, please explain the activities in detail here:

N/A

UMKC/TMC Investigator Signature: Lindsey Davis

UMKC IRB Office

This section is for UMKC IRB Office Use Only

UMKC IRB Representative Signature: [Signature]

UMKC Agrees to code IRB review to the following institutional IRB:

- Children's Mercy Hospital
- KU Medical Center
- Kansas City Univ. of Medicine & Biosciences
- St. Luke's
- Student Affairs confirmation if UMKC Agent is a student

Human Subjects Research Training (CITI Module) Date of Trainings: 08/02/2016

Conflict of Interest Training (CITI Module) Date of Trainings: 10/04/2016

Conflict of Interest Disclosure

Appendix H

Measurement Tools/Data Collection Template: Provider Training for SHARP Surveys

PRE-TRAINING SURVEY FOR PROVIDERS

Please take a few moments to answer the following questions. Your responses will be kept confidential. You may skip any questions that you do not want to answer, and can stop taking the survey at any time.

We greatly appreciate your taking the time to answer these questions for us as we aim to improve the violence prevention and intervention trainings for providers at Children's Mercy.

ARE YOU CURRENTLY PROVIDING DIRECT CARE TO ADOLESCENT CLIENTS (This includes mental health counseling, health education, clinical services, social services)?

- A) Yes
- B) No
- C) Not applicable

If you answered YES, please go to the next section. If you answered NO or NOT APPLICABLE, please stop the survey now.

Secret Subject Code

Please begin by creating a code that only you will know. When we ask you to complete a follow up survey in a few months to see how the training may have changed your practice, we will prompt you with the same questions to create your secret code. This allows us to link the two surveys without using any identifiable information.

1) Do you describe yourself as a male or female? (circle answer)

- A) Male
- B) Female

2) What is the first letter of your FIRST name?

**3) What is the first letter of your mother's or female caregiver's FIRST name?
(N/A if not applicable)**

**4) What is the first letter of your father's or male caregiver's FIRST name?
(N/A if not applicable)**

5) What is the first letter of your MIDDLE name?
(N/A if not applicable)

6) What is the first letter of the city where you were born?

7) How many siblings do you have?

8) What is your birth month and year? (Example: June 1965 would be entered as 0665)

9) Have you ever attended any professional development sessions specific to adolescent relationship abuse and sexual assault in adolescent health settings?

A) Yes – If yes, have you attended Hanging Out or Hooking Up training previously?

_____ No

_____ Yes

B) No

10) How often do you talk to your adolescent clients about healthy relationships?

1. All of the time (100%)
2. Most of the time (75% or more)
3. Some of the time (25% - 75%)
4. Not so often (10% - 25%)
5. Rarely (less than 10%)
6. Not applicable

11) How often are you giving your adolescent clients a safety card about healthy relationships?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

12) How often do you assess clients' safety and discuss ways to stay safe in an unhealthy relationship?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)

- E) Rarely (less than 10%)
- F) Not applicable

13) How often do you review the limits of confidentiality with your adolescent clients before asking about coercion or violence?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

14) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for a pregnancy test?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

15) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for an STI test?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

16) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for emergency contraception?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

17) In a visit for emergency contraception, how often do you ask a client about whether this was sex that they wanted to have?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)

- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

18) In a visit addressing alcohol and other drug use, how often do you ask whether their relationship may be affecting their substance use (including self-medication, managing fear or trauma)?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

19) In a visit addressing depression or suicidality, how often do you ask whether their relationship may be affecting their mood and self-worth?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

20) What are reasons that you may not address adolescent relationship abuse (ARA) and sexual assault (SA) during a clinic visit? (circle all that apply)

- A) Not enough time
- B) Concerns about reimbursement
- C) It is against the policy of the health system within which I work (for example, we do not provide any sexual or reproductive health services)
- D) The partner is present for the visit
- E) Worried about upsetting the client
- F) Not sure what to say if they disclose an abusive/violent relationship
- G) Afraid about what would happen if they told me
- H) Not sure how to ask questions without seeming too intrusive
- I) Not knowing where to refer them to
- J) Worried about mandated reporting
- K) Have already screened them at past visit
- L) Does not apply to my patient population
- M) Other _____

21) What ongoing support do you need to confidently incorporate discussion of ARA/SA in all your clinical encounters? (circle all that apply)

- A) Workshops and training sessions
- B) Protocols that include specific questions to ask
- C) List of violence-related resources and who to call with questions
- D) Case consultation
- E) Online training
- F) Other (Please specify)

I am competent in my understanding of:

1) How to discuss the limits of confidentiality with my adolescent clients

- Strongly Agree Agree Undecided Disagree Strongly Disagree

2) The mandated reporting requirements relevant to adolescent relationship abuse and sexual assault (ARA/SA) in my state

- Strongly Agree Agree Undecided Disagree Strongly Disagree

3) What local & national resources are available to assist teens around ARA

- Strongly Agree Agree Undecided Disagree Strongly Disagree

4) How to assess for ARA, sexual assault, and reproductive coercion among sexually active adolescents

- Strongly Agree Agree Undecided Disagree Strongly Disagree

5) How to offer contraceptive methods that are not partner dependent (i.e., longer acting contraceptives)

- Strongly Agree Agree Undecided Disagree Strongly Disagree

6) How to discuss safer partner notification with an adolescent with an STI diagnosis

- Strongly Agree Agree Undecided Disagree Strongly Disagree

8) How to discuss safety planning with an adolescent who discloses an abusive relationship

- Strongly Agree Agree Undecided Disagree Strongly Disagree
-

Currently, my practice is to:

9) Integrate healthy relationship discussions (including anticipatory guidance) into all my clinical encounters with adolescents

- Strongly Agree Agree Undecided Disagree Strongly Disagree

10) Discuss the limits of confidentiality with my adolescent clients before asking about coercion or violence

- Strongly Agree Agree Undecided Disagree Strongly Disagree

11) Assess for adolescent relationship abuse and sexual assault with any adolescent presenting for a reproductive health issue

- Strongly Agree Agree Undecided Disagree Strongly Disagree

12) Assess for client safety when discussing partner notification about an STI

- Strongly Agree Agree Undecided Disagree Strongly Disagree

13) Offer the client a safety card on ARA and healthy relationships

- Strongly Agree Agree Undecided Disagree Strongly Disagree

Please tell us a little about yourself. This information will help us better understand who we are reaching with these trainings. Please remember this information is anonymous and confidential, no names attached.

A. What is your training background including certifications (check all that apply)?

- Nurse practitioner (specify specialty area _____)
- Physician assistant (specify specialty area _____)
- Registered Nurse (RN)
- Licenses Practical Nurse (LPN)
- Care Assistant or Certified Nursing Assistant
- Respiratory Therapist
- Pediatrician
- Family Medicine physician
- Internal Medicine physician
- Clinic administrator/Practice manager
- Other _____

B. How many years have you been providing adolescent health care?

- Less than 5 years
- 5-10 years
- Greater than 10 years
- Other _____

C. How do you describe your gender?

- Female

- Male
- Transgender

D. How do you describe your ethnic background (check all that apply)?

- Caucasian/White
- African American/Black
- Native American/Native Hawaiian
- Asian American
- Pacific Islander American
- Hispanic/Latino(a)
- Multi-racial
- Other _____

E. What is your age?

- Less than 20 years
- 20-39 years
- 40-59 years
- Greater than 60 years

Thank you for your time!

IMMEDIATE POST-TRAINING SURVEY FOR PROVIDERS

The training today increased my understanding of:

- 1) **How to discuss the limits of confidentiality with my adolescent clients**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 2) **The mandated reporting requirements relevant to adolescent relationship abuse and sexual assault (ARA/SA) in my state**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 3) **What local & national resources are available to assist teens around ARA**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 4) **How to assess for ARA, sexual assault, and reproductive coercion among sexually active adolescents**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 5) **How to discuss safety planning with an adolescent who discloses an abusive relationship**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
-

Following the training today, I am more likely to:

- 6) **Integrate healthy relationship discussions (including anticipatory guidance) into all my clinical encounters with adolescents**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 7) **Discuss the limits of confidentiality with my adolescent clients before asking about coercion or violence**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 8) **Assess for adolescent relationship abuse and sexual assault with any adolescent presenting for a reproductive health issue**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 9) **Assess for client safety when discussing partner notification about an STI**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
 - 10) **Offer the client a safety card on ARA and healthy relationships**
 Strongly Agree Agree Undecided Disagree Strongly Disagree
-

Please circle at least one action item that you intend to do differently following the training today:

- A. Put up posters about adolescent relationship abuse and sexual assault
- B. Make safety cards available to all clients
- C. Work with medical records to insert a prompt into the chart to remind providers to assess for adolescent relationship abuse and sexual assault (ARA/SA)
- D. Offer an in-service training for all of my clinic staff on ARA/SA
- E. Set up a clinic protocol for assessing for ARA/SA for all emergency contraception or pregnancy testing visits
- F. Partner with school-based health education efforts to incorporate the promotion of healthy relationships
- G. Other (please be as specific as you can): _____

What ongoing support do you need to confidently incorporate discussion of adolescent relationship abuse and sexual assault in all your clinical encounters?

Additional Comments:

Thank you for your time!

FOLLOW UP SURVEY FOR PROVIDERS

Please take a few moments to answer the following questions referring back to the training in which you participated several months ago on promoting healthy relationships and addressing adolescent relationship abuse in clinical settings. Your responses will be kept confidential. You may skip any questions that you do not want to answer, and you can stop taking the survey at any time. We greatly appreciate your taking the time to answer these questions for us as we aim to improve the violence prevention and intervention trainings for providers in adolescent health settings.

ARE YOU CURRENTLY PROVIDING DIRECT CARE TO ADOLESCENT CLIENTS (This includes mental health counseling, health education, clinical services, social services)?

- A) Yes
- B) No
- C) Not applicable

If the answer is B or C, take them to a survey completion page – Thank you for your interest, but you are not eligible to take this survey as you do not provide direct care to adolescents. If the answer is A, go to the rest of the survey.

First, please complete the secret subject code (same questions you answered at the time of your baseline survey). This allows us to link the two surveys without using any identifiable information.

1) What is the first letter of your FIRST name?

**2) What is the first letter of your mother's or female caregiver's FIRST name?
(N/A if not applicable)**

**3) What is the first letter of your father's or male caregiver's FIRST name?
(N/A if not applicable)**

**4) What is the first letter of your MIDDLE name?
(N/A if not applicable)**

5) What is the first letter of the city where you were born?

6) How many siblings do you have?

7) What is your birth month and year? (Example: June 1965 would be entered as 0665)

8) Since the training have you attended any other professional development sessions specific to adolescent relationship abuse or sexual assault in adolescent health settings?

- A) Yes
- B) No

9) Since the training, I am more comfortable talking to adolescent patients about safe and healthy relationships.

- A) Strongly disagree
- B) Disagree
- C) Neutral
- D) Agree
- E) Strongly agree

9) Since the training, I am more comfortable talking to adolescent patients about abusive relationships and resources for adolescent relationship abuse.

- A) Strongly disagree
- B) Disagree
- C) Neutral
- D) Agree
- E) Strongly agree

10) Since the training, I am more comfortable talking to a client about when and how child abuse or law enforcement reports are made.

- A) Strongly disagree
- B) Disagree
- C) Neutral
- D) Agree
- E) Strongly agree

11) Since the training, I am more comfortable helping a client connect to violence related agencies and services.

- A) Strongly disagree
- B) Disagree
- C) Neutral
- D) Agree
- E) Strongly agree

17) Since the training, I am more comfortable working with a client to identify a safe adult with whom they can share sexual and violence-related concerns.

- A) Strongly disagree

- B) Disagree
- C) Neutral
- D) Agree
- E) Strongly agree

18) How often do you talk to your adolescent clients about healthy relationships?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

19) How often are you giving your adolescent clients a safety card about healthy relationships?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

20) How often do you assess clients' safety and discuss ways to stay safe in an unhealthy relationship?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

21) How often do you review the limits of confidentiality with your adolescent clients before asking about coercion or violence?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

22) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for a pregnancy test?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)

- E) Rarely (less than 10%)
- F) Not applicable

23) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for an STI test?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

24) How often do you assess for adolescent relationship abuse, sexual assault, and reproductive coercion when seeing a client for emergency contraception?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

25) In a visit for emergency contraception, how often do you ask a client about whether this was sex that they wanted to have?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

26) In a visit addressing alcohol and other drug use, how often do you ask whether their relationship may be affecting their substance use (including self-medication, managing fear or trauma)?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)
- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

27) In a visit addressing depression or suicidality, how often do you ask whether their relationship may be affecting their mood and self-worth?

- A) All of the time (100%)
- B) Most of the time (75% or more)
- C) Some of the time (25% - 75%)

- D) Not so often (10% - 25%)
- E) Rarely (less than 10%)
- F) Not applicable

28) Since the training, has the frequency changed with which you are implementing harm reduction strategies to reduce risk for unintended pregnancy (e.g., IUC insertions, emergency contraception)?

- A) Not applicable to my practice
- B) Increased since training
- C) Stayed about the same since training
- D) Decreased since training
- E) Other, please explain

Please list specific strategies

29) Since the training, has the frequency changed with which you are offering additional harm reduction strategies to protect clients experiencing abuse (e.g., safety planning with friends and family, ensuring safe access to violence-related resources)?

- A) Increased since training
- B) Stayed about the same since training
- C) Decreased since training
- D) Other, please explain

Please list specific strategies

30) Since the training, has the frequency changed with which you are conducting universal education about healthy relationships?

- A) Increased since training
 - B) Stayed about the same since training
 - C) Decreased since training
 - D) Other, please explain
-

31) Since the training, have you encountered more youth disclosing relationship abuse (ARA) and sexual assault (SA) experiences in the clinic since your ARA/SA training?

- A) More disclosures than before the training
- B) About the same number of disclosures
- C) Fewer disclosures than before the training

32) What ongoing support do you need to confidently incorporate discussion of ARA/SA in all your clinical encounters? (circle all that apply)

- A) Workshops and training sessions
- B) Protocols that include specific questions to ask
- C) List of violence-related resources and who to call with questions
- D) Case consultation
- E) Online training
- F) Other (Please specify)

Additional

Comments:

Thank you for completing this survey!

Appendix I

Intervention Flow Diagram, Procedure



Appendix J

Improving ARA Management: Recruitment and Consent Script

Before this training starts, I want to invite you to participate in a research project. We are asking you to take part because you are being trained to use the Hanging Out or Hooking Up safety card. Your participation is voluntary; your decision to participate or not won't change any present or future relationships with Children's Mercy Hospitals and Clinics or its affiliates. You'll still get the training regardless of your decision to participate in the project.

The reason for the project is to learn how the Hanging Out or Hooking Up safety card training may impact healthcare provider management of adolescent relationship abuse (ARA).

If you choose to be in this project, you'll take 3 short, anonymous surveys: a pre-training survey now, an immediate post-training survey right after the training is done today, and a follow up survey in 3 months. Each of the 3 project surveys should take less than 5 minutes to complete. We will ask you to provide your CMH email address so we can send you the 3-month follow up survey in 3 months. We'll keep the project email list on a secure CMH server; it will be password-protected, so only the project team can access it. Your survey answers are not linked in any way to your email address.

There are minimal risks associated with this project because the survey data is collected anonymously. We will minimize breach of confidentiality by secure storage of the project email list via secure CMH server and password-protected access.

There is no direct benefit to you as a project participant. The results of this project might help our organization create interventions that improve ways of educating providers on how to manage ARA. Ultimately, the goal of this project is to improve ARA intervention in the healthcare settings, and thus, both prevent ARA and decrease negative outcomes for those teens experiencing ARA.

Because this is a minimal risk project, you do not have to provide signed informed consent. Taking the surveys and providing us your email will signify your consent to participate in this project.

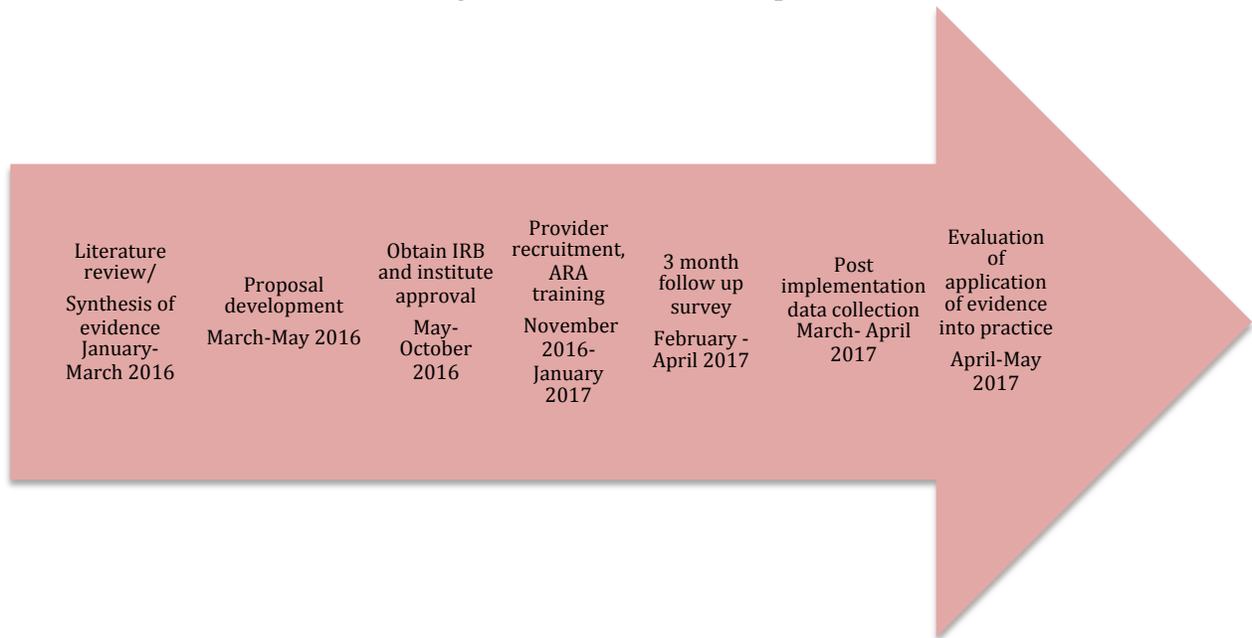
The principal investigator for this project is Lindsey Davis. You can contact her with any questions you have about the project. If you have any questions or concerns regarding your rights as a subject in this project, you may contact the Children's Mercy Hospital Institutional Review Board (IRB). Contact information for Ms. Davis and the CMH IRB is provided on your project information sheet.

Does anyone have any questions about this project?

If you choose to participate in this project, please complete the pre-training survey now. Your packet also contains the immediate post-training survey. Please wait to complete the post-training survey until AFTER today's training. After you complete the post-training survey, I'll collect the surveys.

Appendix K

Project Timeline Flow Graphic



Appendix L

Logic Model

Rev. 7/09, 1/2015
http://www.uwax.edu/ces/imcourse/interface/loop_M1_Overview.htm
 Logic-Model Worksheet content revisions by Lyla Lindholm for DNP Project. Not to be placed on web for public use. For UMKC DNP coursework only.

Logic Model for DNP Project

Student: Lindsey Davis

PICOTS: Does educating primary and urgent care providers on the *Hanging Out or Hooking Up* card, compared to prior Adolescent Relationship Abuse (ARA) education the healthcare provider's ARA management over three months?

	Intervention(s)		Outcomes -- Impact		
	Activities	Outputs Participation	Short (Completed as student)	Medium (after student DNP)	Long (after student DNP)
Evidence, sub-topics -Recommendations and guidelines -Rationale for screening -Provider education Major Facilitators or Contributors -Primary and urgent care providers' desire for an easy tool to screen for adolescent relationship abuse Major Barriers or Challenges -Confirmation of site -Legal and ethical issues associated with intimate partner violence -Relying on others	EBP intervention which is supported by the evidence in the input column Implementation of ARA education to improve provider management of ARA Major steps of the intervention 1. Discovery 2. Evidence summary 3. Translation 4. Integration 5. Evaluation	The participants (subjects) Primary Care Providers Urgent Care Providers Site Children's Mercy Hospital and Clinics Time Frame 3 months Consent Needed or other Consent needed by providers Person(s) collecting data Lindsey Davis Others directly involved Project Mentors Dr. Kim Randell Dr. Jacqueline Bartlett Dr. Donna O'Malley Dr. Nancy Willis-Smith	Outcome(s) to be measured with valid & reliable tool(s) -Provider self-reported behaviors, self-efficacy, and behavioral intentions by SHARP surveys Statistical analysis to be used -Analyze data to determine if implementing ARA education improved ARA management	Outcomes to be measured	Outcomes that are potentials

Appendix M**Permission for Tool Use**

Sent: Friday, August 26, 2016 10:28 AM

To: [Davis, Lindsey, N](#)

-----Original Message-----

From: Miller, Elizabeth

Sent: Wednesday, August 24, 2016 9:41 PM

To: Randell, Kimberly

Subject: RE: thank you and FU

*** This message was sent to you from an External Source. Please do not open untrusted links or attachments. ***

Absolutely, please feel to modify as much as you need to fit your needs. :)

-----Original Message-----

From: Randell, Kimberly, A

Sent: Wednesday, August 24, 2016 9:31 AM

To: Miller, Elizabeth

Subject: RE: thank you and FU

Good morning, all.

I'm working with a DNP student who would like to look at provider outcomes after the Hanging Out or Hooking Up training as her capstone project. We are using the one-hour version of the training for several of our clinics over the next 6 months, so she plans to simply survey providers involved in those trainings.

Is it OK for me to modify the SHARP provider surveys you sent? Because we know the clinic settings the trainings are being used in, we'd like to delete the survey questions about ARA/SA materials/guidelines/processes.

Kim

Appendix N

Statistical Analysis Table Template

PICOTS, include the “C”	Does educating primary and urgent care providers on the Hanging Out or Hooking Up safety card, compared to prior ARA education the healthcare provider’s ARA management over three months?
Purpose Statement	Pediatric Primary Care Providers (PCPs) and Urgent Care Providers (UCPs) have a unique opportunity to interact with patients experiencing ARA, however, conversations about ARA in the primary and urgent care setting remain low.
Null Hypothesis (required for statistician)	There is no statistically significant improvement between pre-training survey and post-training survey scores.
Independent Variable (intervention)	Hanging Out or Hooking Up Training Session
Primary Dependent Variable (Primary outcome measurement)	Post-training survey for adolescent providers
Statistical Comparison Test for Primary Outcome	Wilcoxon Signed Rank test and paired t-test
Secondary Dependent Variables, if present	N/A
Statistical Test(s) for Secondary Outcome	N/A
Demographics to be collected	Provider setting, training, background, number of years providing adolescent healthcare, gender, age, ethnic background
Statistical Test(s) for Demographics	Chi-squared
Priori or Post-Hoc power analysis if < 30 participants.	67 project participants

Appendix O

UMKC SoNHS Proposal Approval Letter



July 21, 2016

CMH IRB,

This letter serves to provide documentation regarding Lindsey Davis' Doctor of Nursing Practice (DNP) Project proposal. Ms. Davis obtained approval for her project proposal, Hanging Out or Hooking Up: Improving Adolescent Relationship Abuse Management, from the School of Nursing DNP faculty committee on July 21, 2016.

If I can provide any further information, please feel free to contact me.

Sincerely,

A handwritten signature in black ink that reads "Susan J. Kimble". The signature is written in a cursive style and is positioned above a thin horizontal line.

Susan J. Kimble, DNP, RN, ANP-BC, FAANP
Clinical Associate Professor
DNP Programs Director
UMKC School of Nursing and Health Studies
816-235-5962
kimbles@umkc.edu