Providing education and resources to staff working with adult victims of intimate partner violence experiencing homelessness

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Abstract

Title: Providing education and resources to staff working with adult victims of intimate partner violence experiencing homelessness

Background: Homelessness impacts over half a million individuals in the United States and increases the risk of physical, emotional, social, and financial distress, potentially leading to violence, abuse or harm. Individuals experiencing intimate partner violence (IPV) are at an increased risk of becoming homeless. Homeless shelters in Duluth, MN, without specific IPV focus, do not have formal IPV training in place. The goal of this project was to educate staff and volunteers at a warming center in Duluth, MN on how to identify IPV, implement an evidence-based screening tool, and provide appropriate resource referrals to victims of IPV.

Synthesis and analysis of supporting literature: The literature revealed few studies having investigated the correlation between homelessness and IPV. Along with the current literature, The Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP) and the Transcultural Nursing Theory helped guide the use of the Partner Violence Safety (PVS) screening tool.

Project implementation: Training on IPV identification, screening and utilizing a resource referral algorithm was provided to staff members. Pre and post-implementation assessments were utilized to assess knowledge and confidence levels.

Evaluation criteria: Data collected from the pre and post-knowledge and confidence assessments was analyzed using Intellectus statistical software. This project's success is measured by statistical significance through alpha and *p*-value comparison.

Outcomes: Although the data revealed improvement in knowledge scores from an average of 78.25 % to 82.25%, no statistical significance was proven (*p*-value = 0.247). Despite this, confidence scores improved in all five categories revealing the positive impact of an IPV educational program.

Recommendations: Further research of IPV within homelessness is warranted. Implementing an educational program, along with the PVS screening tool and resource referral algorithm is recommended at all homeless shelters.

Providing Education and Resources to Staff Working with Adult Victims of Intimate Partner Violence Experiencing Homelessness

Intimate partner violence is a significant public health issue that has reached epidemic proportions (Lee et al., 2019). Intimate Partner Violence (IPV) is a term used to describe physical or sexual violence, stalking, or psychological harm by a current or former partner or spouse within a romantic relationship (Centers for Disease Control and Prevention [CDC], 2020). IPV includes physical, sexual, and emotional abuse and controlling behaviors by an intimate partner and is one of the most common forms of violence against women (World Health Organization [WHO], 2021). The term 'domestic violence' (DV) is used in many countries to refer to partner violence but the term can also encompass child or elder abuse, or abuse by any member of a household (WHO, 2012). For the purposes of this paper, DV encompassess IPV and focuses primarily on intimate partner relationships, versus family dynamics. The agency this project will take place at serves adults, and refers families with children to outside agencies. Therefore, IPV is a more appropriate term that will be utilized going forward.

IPV does not require sexual contact, and it can range from one episode to multiple episodes over many years, leaving a detrimental impact on its victims (CDC, 2020). Millions of people experience IPV each year in the United States (U.S.) (CDC, 2020). One in three American women will experience physical abuse and nearly half will experience psychological abuse by an intimate partner in their lifetime (Center for Disease Control and Prevention, 2020). The U.S. Department of Health and Human Services (2016) stated that 38% of all victims of domestic violence become homeless at some point in their lives. IPV occurs in all settings and among all socioeconomic, religious, and cultural groups; thus, IPV is a global burden primarily

borne by women (WHO, 2021). This quality improvement project is being implemented at a homeless shelter located in northern Minnesota to increase confidence in staff members' ability to screen and provide resource referrals to those experiencing IPV.

Problem Identification and Available Knowledge

It can be challenging for victims of IPV to afford their basic needs such as food, clothing and shelter incurring detrimental costs to society. In 2004, The University of California published a study stating that the societal costs of IPV in the U.S. are approximately $8.3 trillion annually. The costs incurred by the individual victim over their lifetime can range from $23,414 to $103,767 (CDC, 2020; Barta, 2018). These costs not only affect the victims but are also damaging to the United States economy as collectively victims of IPV lose approximately 8.0 million days of paid work each year. Additionally, between 21%-60% of IPV victims will lose their jobs due to reasons stemming from the abuse (National Coalition Against Domestic Violence, 2016). In Minnesota, nearly one third of women attribute their state of homelessness to IPV and in 2021 Minnesota IPV agencies provided services to almost 70,000 victims (Safe Haven, 2022). One quarter of violent crime victims reported in Minnesota are victims of domestic abuse, and despite this, 80% of domestic assaults go unreported (Safe Haven, 2022). Locally, in Duluth, Minnesota, the homeless population has increased by 25% between 2015-2020 (*Our community is in need*, 2021). The Duluth News Tribune reported that in 2020, 2,188 households, totalling 3,170 people total, received services through local programs for people experiencing homelessness. This figure includes 751 people experiencing homelessess for the first time (*Our community is in need*, 2021).

As in many other circumstances, communities of color are affected more severely as well, with systemic inequities often meaning lower income and less access to social and private services. According to the executive director of the Center for Survivor Advocacy and Justice (CSAJ), during the COVID-19 pandemic, the rates of abuse increased dramatically to about 50% among all populations. One in three white women reported having experienced domestic violence during this time and an estimated even higher rate for those disempowered by race, ethnicity, sexual orientation, gender identity, citizenship status, and cognitive physical ability (Kluger, 2021). The COVID-19 pandemic added a significant amount of stress to households. According to the American Journal of Emergency Medicine, domestic violence cases increased by 25-33% globally in 2020 (Boserup, McKenney & Elkbuli, 2020). Additionally, given COVID-19 restrictions, many intervention and support facilities are operating at decreased capacities, limiting available resources to victims (Gresham et al., 2021).

The Biden-Harris Administration has invested nearly $1 billion through the American Rescue Plan (ARP) legislation to provide supplemental funding for domestic violence and sexual assault service providers through the Family Violence Prevention and Services division (FVPS) of the Department of Health and Human Services (HHS). This also includes a historic investment to support community-based organizations that provide culturally-specific support for survivors of sexual assault and IPV (Hidlago, 2021).

Osuji and Hirst (2015) explored the experiences of women without children who are experiencing homelessness and what led to their circumstances, along with practical suggestions to address homelessness and IPV. They emphasize that it is imperative that community health workers and support staff build connections with interprofessional groups to provide women who

are victims of IPV with adequate support and resources (Osuji & Hirst, 2015). It is also important for these resources to be tailored to the individual's needs. Within the Duluth community there is an opportunity to provide individualized resource referrals to victims of IPV.

After the initial literature search, it is clear that there are limited current sources available that discuss IPV in persons experiencing homelessness. The literature is unclear if IPV screening in the homeless population is of the highest importance, given the situations of these individuals and their concerns for basic human needs first. For example, many individuals experiencing homelessness often experience mental health issues along with alcohol and drug misuse (CHUM Warming Center, 2022).

Additionally, Krishnan & Hilbert (1998) conducted a study to address issues of IPV and DV homeless shelters. Semi-structured interviews were done to explore similarities and differences between women who sought refuge at a homeless shelter versus those who sought refuge at a DV shelter. Gaining insight on these decisions can aid shelters to tailor their resources and personnel to best meet their client's needs. More participants at the homeless shelter ($n = 7$) compared to those at the DV shelter ($n = 3$) expressed that their present relationship was the first violent relationship they had experienced. Participants also indicated that they had not recently slept a full night due to fears of being killed by their partner. Although this study was relatively small and exploratory, it did provide insight on women experiencing homelessness in relation to DV. Many women turn to DV and homeless shelters for help as they lack personal resources and support. Shelter patrons could benefit from interacting with staff specifically trained on the screening and referral processes surrounding DV. There is a need for shelters to broaden their services and provide training for staff on the use of intake and referral processes and procedures.

These solutions can help to address the emerging issue of homelessness among women experiencing DV.

According to Thomas et al. (2018), the conversation around IPV lacks the perspective of people of color (POC) as the large majority of leadership roles in domestic/sexual violence organizations nationally are held by White women. This racial imbalance of power leads to a lack of inclusion and diversity of perspective on a topic that disproportionately affects POC and is a major injustice to the community in question. According to the National Alliance to End Homelessness website, only 13 percent of the general population are people of color but disproportionately account for 39 percent of people experiencing homelessness in the United States. This disparity has not improved over time, despite public recognition. ("Homelessness and Racial Disparities," 2020).

Project Agency

The Churches United in Ministry (CHUM), located in Duluth, MN, is a 501(c)(3) organization whose programs serve more than 8,000 low-income, homeless, hungry, isolated, or otherwise marginalized community members each year. CHUM is a chemical free, 80 bed, 24 hour drop in shelter serving over 100 homeless and low-income individuals daily (CHUM Center Services, 2022). This project will focus on the CHUM Warming Center. The CHUM Warming Center is a branch of CHUM and it functions as a drop in overnight shelter operating from six in the evening until eight in the morning during the months of November 1st through March 31st. Unlike the CHUM shelter, the CHUM Warming Center is a large and open room with limited privacy. Mats provided by the center are spread out on the floor for sleeping. The main purpose of the CHUM Warming Center is to provide immediate and short term shelter from the winter

elements. Additional services offered by the CHUM Warming Center include laundry facilities, internet access, phone and messaging services, storage lockers, coffee/snacks/meals, a community/ recreational room along with recreational activities (CHUM Center Services, 2022). The goal of this center aligns with CHUM as a whole, which is to help individuals stabilize and rebuild their lives by providing basic living essential services as well as outreach services addressing unfit living conditions, providing assistance with housing, medical and dental care, health insurance, and a source of income (CHUM Center Services, 2022). This project seeks to foster stable lives and enhance safety in a compassionate, holistic, and caring way.

The CHUM Warming Center provides a Health and Wellness Clinic within the facility that is staffed by a Registered Nurse (RN) who works 20 hours per week and provides basic health education, health screenings, and referrals to community health providers. The goal is to help clients establish a relationship with a primary-care physician, manage their medications, and assist with medication co-pays, as most of the patrons of the CHUM Warming Center are uninsured.

CHUM as a whole receives funding primarily through donations and relies heavily on volunteers to staff the center and the services provided. There are typically two staff members or volunteers serving at the CHUM Warming Center during their open hours and approximately 10 to 12 staff and/or volunteers hired per season. Additional services include three emergency food shelves that provide 388,000 pounds of food to 5,800 households in 2020. The school supply project provided supplies to 800 children of low-income families, and the household start-up assistance program helps individuals and families move from shelters to permanent housing (CHUM, 2022).

PICO Question

Among staff and volunteers at the CHUM Warming Center, how does providing specific intimate partner violence (IPV) education, compared to no education, affect staff confidence in screening and providing community resources to IPV victims?

Answering this question will help inform our project as it will specifically empower the CHUM Warming Center Staff to provide screening, education, and resource referrals to adults experiencing homelessness and IPV. This could enhance the likelihood of an individual discussing IPV and their ability to access help and resources. See Appendix A for Communication Matrix Log.

Literature Review, Matrix (table) Development, and Literature Synthesis

Searching the literature yielded the foundation to guide this project. See Appendix B for an in-depth literature matrix table. A search took place in multiple databases which include: the Saint Scholastica Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), SocINDEX, Cochrane, EBSCO, and Google Scholar. Key search words that were used include: domestic violence (DV), homeless, homelessness, intimate partner violence (IPV), homeless shelters, domestic abuse screening, IPV screening [AND] homelessness, DV screening, domestic abuse shelter, long-term solutions, domestic violence education, domestic violence staff education, homelessness systemic barriers, domestic violence systemic barriers, racial inequities, poverty, financial instability, housing instability, domestic violence [AND] education, domestic violence policies, COVID-19 [AND/OR] SARS-CoV-2 IPV rates, COVID-19 [AND/OR] SARS-CoV-2 [AND] homelessness, and domestic violence [AND] justice system. With the permission from Johns Hopkins University, their critical appraisal tool was used to rank the

evidence. Evidence can be ranked from Level I (strongest) to Level V (weakest). Multilevel (ML) is another option for ranking evidence and is used when more than one level of evidence is utilized. Emerging themes found in the literature include: various causes and contributing factors to homelessness and IPV, interventions and resources that have been used or are available, training and education for staff and homeless shelters, systemic barriers that contribute to homelessness and IPV, and possible solutions to address homelessness and IPV. See Appendix B for Evidence Level and Quality Guide and Appendix C for Literature Matrix.

System Barriers Contributing to Homelessness

There are ongoing systemic barriers contributing to homelessness. These barriers create a cyclical environment for violence and homelessness, specifically for those who are victims of IPV. Barriers identified within the literature include poverty, race, housing instability, education level, and discrimination within the justice system. Additionally, the emergence of the SARS-CoV-2 pandemic has disproportionately affected underserved and vulnerable populations.

Financial Instability

Intimate partner violence (IPV) cycles around control. Poverty as a system barrier is often quite difficult to overcome as those living in poverty are not able to control such things as the job market, price of housing or minimum wage (Sidlowski, 2017). Education, parents' marital status and location of birth are all uncontrollable factors contributing to the cycle of poverty. There is a distinct correlation between IPV and level of income; the lower the income, the higher the likelihood of IPV (Sidlowski, 2017).

DuMonthier & Dusenbury (2016) state, 74% of victims report remaining with their abusers due to economic or financial reasons. Abusers are aware of their victim’s financial

dependence and may manipulate victims through economic exploitation, such as withholding access to financial information, sabotaging employment opportunities, generating credit card debt, ruining credit scores, and committing identity theft (DuMonthier & Dusenbury, 2016). Perpetrators may attempt to control vital resources such as transportation and child care, further contributing to employment status and financial dependence. Challenges continue even if a victim is able to break from the abusive relationship and gain financial independence. Unforeseen costs occur with building financial freedom such as securing new accounts, fixing damaged property, and obtaining safety and security measures (DuMonthier & Dusenbury, 2016).

Internationally, studies support that women who are properly supported are more likely to flourish. Gupta et al. (2017) showed that low income women in Mexico City who received nurse-delivered interventions had reductions in reproductive coercion, increased safety planning, improvement in mental health which positively impacted quality of life, and increased use of resources in their community.

Housing Instability

Long et al. (2015) states, women who experience both IPV and low economic status are particularly vulnerable to becoming homeless. A critical factor that has been identified for survivors of IPV is housing and the ability to achieve long-term stability. However, both individual and system level barriers hinder a victim's ability to obtain housing. Obtaining permanent housing is challenging as some of the barriers victims encountered were unaffordability, landlord discrimination, and insufficient documentation (Gezinski & Gonzalez-Pons, 2019). When victims were turned away from domestic violence shelters, they

resorted to staying in a motel, car, homeless shelter, or even returning to the perpetrator (Gezinski & Gonzalez-Pons, 2019). Another contributing factor to housing instability is mental health. Women experiencing homelessness due to IPV victimization suffer greater negative mental health outcomes compared to those experiencing homelessness unrelated to IPV (Bryant, 2018). Poor mental health care can contribute to housing instability as mental health treatment options may disrupt work, income, and social life.

SARS-CoV-2

Boserup et al. (2020) stated that quarantine conditions have been associated with alcohol abuse, depression, and post-traumatic stress symptoms. Additionally, for individuals who are already plagued by domestic violence, stay-at-home orders may cause a catastrophic milieu.

Alabama, New York, Texas and Oregon reported a rise of approximately 10-27% in IPV cases during the first two months of the COVID-19 "stay at home" order in March of 2020 (Borsrup et al., 2020). In contrast, Kaiser (2022) reported some states saw a decrease of more than 50% of IPV calls because victims were not able to safely leave home to access services. Kaiser (2022) stated that 60% of survivors do not go to the police due to the complex cultural factors of victim-blaming, stigma, shame, fear, and intimidation. To combat the rise in IPV, the World Health Organization (WHO) launched a media campaign which aimed to raise awareness and make IPV educational information accessible in clinics and patient settings, as well as among policymakers and researchers (Newman, 2021).

Race

A significantly large number of ethnic minority women are disproportionately affected by IPV. According to the 2010 National Intimate Partner and Sexual Violence Survey, non-Hispanic

black women (44%) and multiracial non-Hispanic women (54%) were significantly more likely to have experienced rape, physical violence, or stalking by an intimate partner in their lifetime, compared to non-Hispanic white women (35%) (CDC, 2014). Multiple U.S. studies have consistently documented similar disproportionate rates (Stockman et al., 2015).

Education Level

Intimate Partner Violence (IPV) continues to disrupt educational attainment in astonishing ways. According to Dumonthier & Dusenbury (2016), 20% of women report post-traumatic stress disorder (PTSD) symptoms due to abuse, thus making it difficult to maintain financial independence through employment or educational status. In addition, the economic needs of victims often drive them to remain with the abuser longer, leading to ongoing economic abuse, contributing to PTSD, and further preventing educational growth (DuMonthier & Dusenbury, 2016). This cyclical pattern can create a disadvantage for future financial stability and independence as victims long-term educational attainment is significantly affected.

Justice System

Victims of IPV often avoid police involvement for fear of retaliation from their abuser in addition to potential harassment from professionals within the justice system (DuMonthier & Dusenbury, 2016). Stigma surrounding IPV response and treatment stems from the racist and sexist culture of society, specifically within police culture (Richardson, 2020). The treatment and resources IPV victims receive is negatively impacted by this stigma, contributing to ongoing abuse and lack of perpetrator conviction. Policing is a predominantly masculine profession, founded in a culture of shared beliefs, attitudes, and commonalities that contribute to the historically sexist behavior that encourages discrimination, victim blaming, and harrassment

(Richardson, 2020). Despite the Mandatory Arrest policies enacted in the United States that require police to justify reasons *not* to arrest a perpetrator of abuse, versus nonviolence related policies requiring justification *to* arrest someone, police still remain skeptical of victim's accounts and hold considerable reservations leading to under or misreporting of IPV cases (Richardson, 2020). Despite policy reform, these attitudes are what continue to devalue and blame victims of IPV. This further prevents progress, and contributes to the cyclical nature of IPV.

Pursuing criminal charges or incarcerating perpetrators can be problematic and difficult to manage in situations of financial dependency. Criminal justice involvement can be time consuming and costly, with little to no compensation for relocation, property damage, unemployment, healthcare and childcare costs, making it inaccessible for most victims. According to the Office of Violence Against Women (OVW) in 2014, only 0.87% of protection orders filed in the OVW-funded courts received economic relief in the form of debt assignment, spousal support, or payment of obligation and losses (DuMonthier & Dusenbury, 2016). This lack of economic relief is devastating to victims of IPV and discourages their abilities and desire to attain safety.

Interventions and Resources

There are a few resources available to victims of IPV in the greater Duluth/ Superior Area that include well connected advocacy programs, as well as emergency shelters. The Center Against Sexual & Domestic Abuse (CASDA) is a Superior, WI based resource for people experiencing sexual and/or domestic violence. Their services include a 24-hour help line, advocacy services, peer counseling, support groups, legal services, community education and

professional training, children's programming, an emergency shelter where patrons may stay up to 45 days or more, as well as a volunteer program and rural outreach (CASDA, 2022). Through this broad array of services, CASDA is able to serve the needs of IPV victims and their families, providing them with the resources they need.

The Program for Aid to Victims of Sexual Assault (PAVSA) is a Duluth, MN based advocacy program dedicated to the elimination of sexual violence through the support of victims, by connecting them to resources, educating the community, building awareness, and advocating for social change within the current systems available to victims of sexual assault (PAVSA, 2022). PAVSA's advocacy services are available through staff, volunteers, SANE nurses (Sexual Assault Nurse Examiner), Registered Nurses (RN), Nurse Practitioners (NP), Social Workers (LSW) and legal advocates who are trained to provide confidential support services. Similar to CASDA, these services include a 24/7 hotline, the SANE program, support groups and individual counseling, the legal advocacy program, the sex trafficking program, and the Sexual Assault Multidisciplinary Action Response Team (SMART). All of these programs aim to provide a multidisciplinary approach utilizing community service professionals and organizations to provide victim-centered services (PAVSA, 2022).

Safe Haven is a Duluth, MN based shelter and resource center for victims of IPV that includes a 24-hour crisis hotline, a 24-hour emergency shelter, safety planning, information and referrals, court advocacy, assistance in filing protective orders, gaining housing, employment, education, and childcare, community education, as well as youth and adult support groups (Safe Haven, 2022). They have a "drop-in" resource center with basic amenities and resources to connect victims with support in the community, along with a shelter to house victims of domestic

violence on a more long-term basis of up to 28 days. There are 10 rooms and 39 beds at the facility, some are shared rooms. Typically women, and sometimes their children, stay at the shelter for about a month and receive guidance, goal setting, resources and a plan for becoming independent. Safe Haven's mission is to advocate and empower women, children and all survivors of domestic violence and IPV by providing compassionate, non-judgemental support along with sustainable resources to enact lasting change. Several other referral sites are available within the Duluth and Superior communities. See resource referral algorithm Appendix D.

A review of the literature outlined many possible solutions to address the challenges that women experiencing homelessness and IPV face. Increased resources and knowledge will help to broaden the support shelters are able to provide while ensuring that the resources can be utilized long-term (Krishnan & Hilbert, 1998; Long, 2015). Benefits of integrating IPV screening into homeless programs were found by Schaffer (2012) and highlight the need for more work in the areas of risk prevention, education, and assessment. According to DeCandia et al. (2013), only 30% of homeless programs and 53% of domestic violence and IPV programs reported communicating with one another to meet families' needs. DeCandia et al. (2013) survey results found that despite reported familiarity, actual collaboration was less frequent among DV and IPV programs. This can result in lost opportunities for sharing expertise and can inhibit service delivery. Cross-trainings between systems should be commonplace (DeCandia et al., 2013). More research is needed to identify better long-term housing solutions for women who are homeless and experiencing IPV (Yakubovich et al., 2022). The literature has shown that there are lost opportunities to identify victims of IPV within the homeless population as well as providing

resource referrals to different community resources. Thus leading to the development of this quality improvement project.

Organizational Project Information

A diverse team with a broad range of experience is in place to help support and guide this project. Key stakeholders include Joel Kilgour with the CHUM Warming Center, Jaci Christiansen with Safe Haven, and Dr. Ferry and Dr. Starr with the College of Saint Scholastica.

CHUM Warming Center

Joel Kilgour is the director of the CHUM Warming Center, which is where this project will take place. Mr. Kilgour plays an integral part in the day to day operations and the organization as a whole. He works closely with staff, volunteers, community members, and visitors of the CHUM Warming Center. He provides guidance and direction on identified needs and logistics in regards to the CHUM Warming Center.

Safe Haven

Jaci Christiansen is the Community Engagement Coordinator for Safe Haven Women's Shelter. Victims of IPV utilizing the CHUM Warming Center can be referred to Safe Haven via the resource referral guide. This project will foster an improved partnership between Safe Haven and the CHUM Warming Center positively impacting victim outcomes. It is important for both organizations to work together to meet the needs of their clients.

The College of Saint Scholastica

Dr. Ferry and Dr. Starr are both professors at the College of St. Scholastica and are also serving as project chairs and advisors. They offer support, guidance, intellect, and connection with community resources and organizations. Both professors play an integral role in the

development of this project and serve as valuable mentors. All team members will keep in close communication throughout the course of this project.

Project Participants

Project participants will include volunteers and staff members at the CHUM Warming Center. Adults seeking services at the CHUM Warming Center, primarily individuals who are homeless experiencing IPV, may be impacted through implementation of this project. Inclusion criteria includes all staff and volunteers at the CHUM Warming Center who interact with and provide resources to any adult utilizing CHUM Warming Center services. Exclusion criteria includes those who do not wish to participate and do not give informed consent or those who do not interact with adults utilizing CHUM Warming Center services.

Gap Analysis

There is a gap between the current state and the desired or ideal state for the CHUM Warming Center. Currently, the CHUM Warming Center does not have a formal process in place to provide education about IPV or screen the clients they currently serve for IPV. Additionally, there is a lack of resource referrals that are available to victims of IPV to help them break the cycle, find support, and obtain safe housing. The desired state of the CHUM Warming Center would include staff education on IPV, how to screen for IPV, and how to provide appropriate resource referrals to those in need. Ideally, staff confidence will increase in their ability to address IPV. The gap between the current and desired state is due to a combination of factors including: lack of time, funding, and resources, staff that have not been formally educated on detecting and screening for IPV, as well as providing necessary resource referral information.

A few underlying or root causes can be identified that contribute to the current state. First, there is a knowledge gap, evidenced by staff being unaware of screening tool options and resources that are available. Second, there is a skills gap, evidenced by a lack of formal training or staff education in place regarding IPV. Third, there is a practice gap, evidenced by the fact that no screening tool has previously been utilized at the CHUM Warming Center to screen for IPV. It is evident that the gap between the current and desired state exists through direct communication with the CHUM Warming Center Director. The CHUM Warming Center Director stated that there is opportunity for improvement in education processes. See Appendix E for a table that outlines the gap analysis.

Needs Assessment

The organizational needs assessment helped to identify what is currently in place at the CHUM Warming Center in contrast to what should be in place, and what is needed to meet the goals and objectives of this project. There is a clear educational gap that identifies limited training and supervision amongst homeless service providers which limits the prompt identification of IPV in individuals experiencing homelessness. (DeCandia et al., 2013). This also inhibits individuals experiencing IPV from receiving adequate resource referrals. According to DeCandia et al. (2013), in depth training on IPV screening and safety planning for those working with the homeless population would prove beneficial in identifying victims of IPV and providing appropriate resource referrals. Through conversation with Mr. Kilgour, there were numerous contributing factors that were identified such as lack of time, inadequate training on the topic of IPV, and a lack of physical resources such as policies and referral information for victims of IPV. The needs assessment highlighted the importance of developing policy change to

improve education related to staff competency and confidence in supporting and providing resources to victims of IPV experiencing homelessness.

Strengths, Weaknesses, Opportunities, and Threats Analysis (SWOT)

A SWOT analysis was conducted to highlight internal and external positives and challenges, affecting the implementation of the intervention see Appendix F. Strengths discussed include: relevant expertise of staff and volunteers, diverse and quality services provided, a new facility, serving a vulnerable population, existing partnerships with community connections, and a comprehensive and easily accessible website. Weaknesses identified include: lack of a policy or screening tool for IPV in place, lack of a process to easily make formal resources available to clients, lack of volunteers amidst the COVID-19 pandemic, lack of time to properly educate and train staff, and a lack of knowledge in IPV detection, screening, and resources. The CHUM Warming Center is only open during the winter months, which provides a smaller window of opportunity for the implementation of this project. An additional weakness is that financial resources are limited as the CHUM Warming Center relies on donations, grants, and government funding for financial support.

Opportunities identified in the SWOT analysis include: continuing to build community resources and expand on new ones (i.e. collaboration with Safe Haven, CASDA, PAVSA), marketing to the community for increased awareness and funding, increase in mental health resources, and the Stepping On Up 5 year plan to address unsheltered and sheltered homelessness in the Duluth area. Threats include community attitudes, lack of community awareness, involvement and support, lack of funding, potential staff resistance to change, current policy limitations, and systemic barriers to affordable housing and employment.

Guiding Framework and Change Theory

This project focuses on quality improvement through the implementation of an IPV educational program to improve CHUM Warming Center staff knowledge and confidence in identifying, screening, and referring individuals who are homeless and experiencing IPV. Best Practice Literature and the Response to Intervention serve as the blueprint of the conceptual framework for this study (Grant and Osanloo, 2014). While changing clinical practice can be both complex and challenging, following a conceptual framework can guide the project to success (Melnyk and Fineout-Overholt, 2019). The conceptual framework chosen to help guide this project is the Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP). Permission for use was obtained from the Johns Hopkins EBP website (see Appendix R).

Johns Hopkins Nursing Evidence-Based Practice Model

The JHNEBP model has a problem-solving approach to clinical decision making within healthcare organizations that integrates the best available scientific evidence with the best available experiential evidence, including both the patient and practitioner (Melnyk & Fineout-Overholt, 2019). The JHNEBP considers both internal and external influences on practice and encourages critical thinking in the judicious application of such evidence to the care of the individual patient, population, or system (Melnyk & Fineout-Overholt, 2019).

The JHNEBP model begins by identifying a specific problem directly related to a specific population. This inquiry initiates the *Practice Question, Evidence, and Translation* (PET) process which is the core of the JHNEBP Model (Melnyk & Fineout-Overholt, 2019). *Figure 1* depicts the PET process which allows individuals and teams to gain new knowledge and insights that impact practice. At any point in the JHNEBP Model new questions may arise, resulting in a

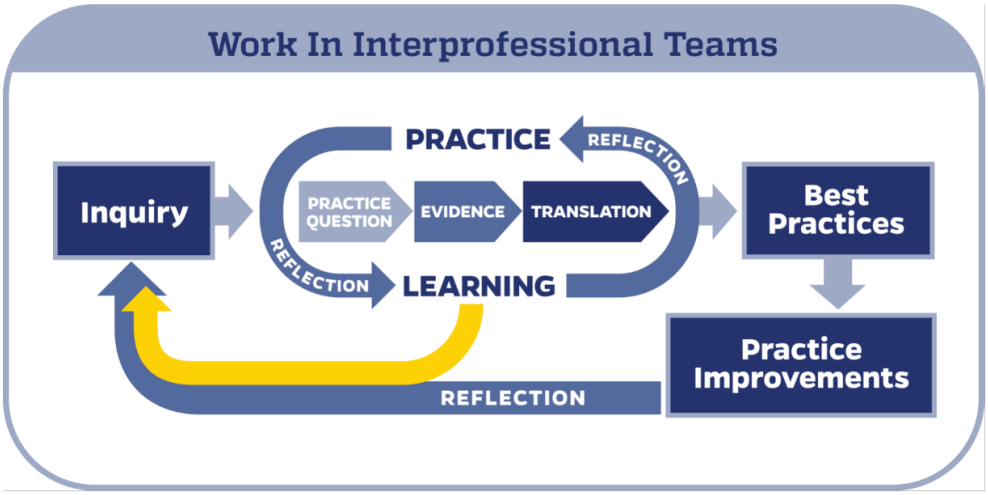
new EBP cycle. Thus, the JHNEBP Model is an open system. The system can be influenced by internal organizational factors such as culture or resources, and external factors such as legislation, quality measures, licensure, and accreditation. See Appendix G for the sub-steps located within the PET model.

The comprehensive literature review revealed a strong correlation between IPV and homelessness, thus prompting the *Practice Question* portion of the PET. The second step is to gather the *Evidence* through additional research. During this phase it was made evident just how common the correlation between IPV and homelessness was, not only in the U.S but around the world. The final step in the PET process is *Translation* which includes implementation, evaluation and dissemination (Melnyk & Fineout-Overholt, 2019). During the translation phase, the translation plan is incorporated into the organization's quality improvement framework. This allows changes to be effectively communicated and engages the organization in adoption of those changes (Melnyk & Fineout-Overholt, 2019).

This three phase process will be accomplished by following the guiding principles and strategic plan set forth by the CHUM Warming Center. Identifying those who are at risk or experiencing IPV and providing basic necessities, supports CHUM's mission of fostering stable lives, and organizing with and on behalf of members of the Duluth community who are experiencing homelessness, hunger, and marginalization (CHUM, 2017).

Figure 1

Practice Question, Evidence, and Translation (PET) Process



Note. The Johns Hopkins Nursing Evidence-Based Practice Model (2022). Reprinted with permission.

The Transcultural Nursing Theory

Several important elements must be present for change to be successfully accomplished. These elements are vision, belief, and a well-formulated strategic plan. Additional key elements necessary for change are agility, action, persistence and patience (Melnyk & Fineout-Overholt, 2019, p.429). The middle-range theory best suited for this project is The Transcultural Nursing Theory or Culture Care Theory by Madeleine Leininger. Transcultural Theory was developed in the 1950's, but only first appears in Leininger's Culture Care Diversity and Universality, published in 1991 (Gonzalo, 2021). In 1995, Leininger defined transcultural nursing as:

> "A substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures to provide culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways" (Gonzalo, 2021).

The focus of this theory is to encompass knowing and understanding different cultures concerning nursing and health-illness caring practices, beliefs, and values to provide meaningful

and efficacious nursing care services to people's cultural values and health-illness context (Gonzalo, 2021).

Cultural care preservation (Maintenance)

Cultural care preservation, also known as maintenance, includes assisting, supporting, facilitating, and enabling professional care that helps people of a particular culture to maintain their well-being and support illness recovery, disabilities management, or even death through the preservation of their cultural care values (Gonzalo, 2021).

Cultural care accommodation (Negotiation)

Cultural care accommodation, also known as negotiation, includes that same professional care that encourages people of a particular culture to negotiate with other healthcare providers to reach beneficial and satisfying health outcomes (Gonzalo, 2021).

Culture care repatterning (Restructuring)

Culture care repatterning, also known as restructuring, again includes that same professional care to assist people of a particular culture to modify or reorder their lifestyles moving towards a new and different healthier healthcare pattern, benefiting the people while respecting their cultural values and beliefs (Gonzalo, 2021).

Culture Inclusivity

Law and John (2012) state homelessness can be seen as a culture, and that Transcultural Theory is a useful guide in meeting the health needs of the homeless. Therefore, by providing information in both written and pictorial form for those identified at the CHUM Warming Center, the hope is to provide as many resources and information as possible. This includes, but is not limited to, different spoken languages, literacy levels, and varying degrees of cultural dynamics

as indicated. Law and John (2012) state social organization and resourcefulness are key to the survival of many homeless people. Integrating the Transcultural Nursing Theory as a guide for implementation will act as a blueprint for evidence based practice change at the CHUM Warming Center.

Aims/Goals/Objectives Clarified

Goal Statement

The goal of this project is to educate staff and volunteers at the CHUM Warming Center on how to identify and screen for victims of IPV and to provide resource referrals (see *figure 2*).

Objectives

Figure 2

Objectives to be Met

1. To educate 50% of the staff/volunteers at the CHUM Warming Center through a video presentation and informational handout on how to screen and identify victims of Intimate Partner Violence (IPV) within one month by November 2022.
2. To implement a knowledge assessment that will be administered before and after educational training. The pre and post-survey will be administered prior to staff and volunteer training and 2 to 4 weeks after training to assess staff understanding of the material and confidence in implementing the learned education by November 2022.
3. To collaborate with other organizations in the Duluth, MN area that serve the homeless population and victims of domestic violence (Safe Haven, CASDA and PAVSA) to obtain feedback and resources to assist with the implementation process by May 2022.
4. To gather resource information that can be distributed to CHUM Warming Center patrons on where victims of IPV can get food, shelter, and clothing after the CHUM Warming Center closes in the mornings by October 2022.
5. To disseminate project results to the director of the CHUM Warming Center by December 2022.

Note. Objectives to be met during implementation and post-implementation period.

Gantt Chart

A project plan was developed in the form of a Gantt chart (visualized in Appendix H) to outline a visual timeline of each task. The phases of the Gantt chart were created to correlate with the work breakdown structure (WBS). There are five phases that are utilized to organize these charts and structures.

Work Breakdown

The work breakdown structure (WBS), outlined in Appendix I, was developed as an organized list of various tasks to break down the work into various phases and subphases and helps to identify milestones throughout the project. The WBS has five main phases: design, plan, intervention, results, and evaluation. These phases will be discussed in the paragraphs below to explain the process of each phase in further detail.

The design phase is the first of five phases and includes five sub-phases within itself. First, the scope of the project was determined, and a gap analysis and needs assessment was conducted to identify the current state of the Warming Center compared to the desired state. This also illustrated areas for improvement. Next, objectives were developed to support the goal statement. Key stakeholders were identified during this phase, and meetings were conducted with stakeholders as well as frequent communication regarding progress of the project and development. A project charter/action plan was also developed to provide clear communication and roles for team members, as well as to provide a record of events and meetings that are held to support the project. The project charter/action is continuously updated throughout the entirety of the project.

During the second phase, or planning phase, project team members were identified, roles and responsibilities were discussed among team members, a project plan was developed, the Gantt Chart was created, and the WBS was developed. Subphases within the development of the WBS include: the tools and instruments used, the data collection process, plans for data analysis, available resources, budget plans, and a timeline.

The third phase is the intervention phase which includes two sub-phases. The first sub-phase involves implementing the intervention. This entails conducting the initial survey to assess staff knowledge and confidence related to IPV, providing education, and conducting the post-survey to assess post-intervention knowledge and confidence of staff members. The second sub-phase involves collecting data and numerically categorizing the results.

The results phase, which is the fourth phase, includes two sub-phases. The first of which includes analyzing findings. This breaks down further into reviewing initial survey results and post-survey results, and comparing the two. The second sub-phase is a summary of findings. Results will be summarized through numeric categorization for ease of understanding.

The evaluation phase is the fifth and final phase with three sub-phases. The first sub-phase includes discussing findings along with limitations. Next, the implications for practice relating to the doctorally prepared Nurse Practitioner will be discussed. Lastly, dissemination of findings will be discussed. These phases are fluid and may change over time in order to meet the needs of the project and participants.

Communication Matrix

The Communication Matrix is a visual used amongst group members illustrating the planned communication with the stakeholders of this project. Effective and timely

communication is crucial to ongoing project development. During the initial project phase, communication with stakeholders was completed via e-mail and Zoom video calls. Team members communicate on a continuous basis via text message and email if there is a time sensitive matter or urgent question.

Logic Model

A Logic Model was created to add a visual component of the project from start to finish. Upon the completion of designing and creating the educational materials, staff and volunteers were educated on the best practice methods for addressing such a stigmatized subject as well as the necessary steps needed following a positive screen. The Logic Model, found in Appendix J, illustrates the resources/inputs, activities, outputs, immediate outcomes and final outcomes necessary for carrying out this project.

For the activities created within the project to be executed successfully, the compliance of the resources and inputs is necessary. In order to address our need, there are certain activities that need to be followed such as designing questionnaires and surveys as well as educating staff and volunteers how to properly use the tools created. We expect that once carried out, these activities will produce evidence of service delivery. Following the delivery of the activities, the immediate outcomes will be reviewed. Within this review we expect that if the activities are carried out according to our education model, these activities will lead to intended changes immediately.

If the Logic Model is followed, expected changes will lead to the following outcomes: the creation of a policy for staff education and screening, options for long term safe housing for survivors, an action plan for future DNP students to craft, improved interactions between IPV

survivors and staff before, during, and after assessing for IPV, and finally, improvement in administration of assessments though updated technology.

Budget

This project is intended to assess confidence levels and therefore no income is expected initially. As a graduate program project, the cost of labor, researching, and implementing, is null to the stakeholders involved. However, once IPV screening is implemented and victims are referred to other community agencies, those facilities, in addition to the CHUM warming center, may have the potential to apply for grants to help supplement the direct costs associated with obtaining resource material.

The estimated direct costs associated with this project include items such as staff labor and materials including: paper, folder/binders, staples, professional posters, and video viewing equipment, for implementation. The estimated cost to the CHUM Warming Center is the hourly wage/salary paid to staff members during training hours. Fortunately, volunteers within the facility help keep expenses low. Additionally, volunteers and staff currently are required to do training on other topics, so this education was built into those sessions that are already accounted for in the CHUM Warming Center's budget. Paper and media material accounted for the largest portion of the project budget. Additionally, student labor for the production of the educational material is acknowledged, despite this being of no cost to the project budget. To offset the cost of materials required for this project, government health agencies such as Duluth Community Public Health offices, PAVSA, CASDA, and Safe Haven were asked to donate educational material on community resources for those experiencing abuse and homelessness.

The indirect costs associated with this project include the CHUM Warming Center space for orientation to the project and the cost of the internet or phone to keep staff informed of orientation sessions. Other indirect costs of software and programming associated include brightspace, Intellectus, IRB.net, CSS library, google, zoom, etc. Using the Train-of-Trainer (ToT) method of education the overall indirect expense of the project is minimal. The ToT model is utilized to engage master trainers in coaching new trainers that are less experienced with a particular topic or skill (CDC, 2019). Therefore, once support staff confidence reaches adequate levels with the use of the educational materials, as evidenced by improved post-survey results, this material can be used as a community resource and as a permanent implementation into staff and volunteer yearly onboarding education.

Return on Investment (ROI)

Over its lifespan, the cost of the project will be relatively low. Initial costs include time given by students, staff, and volunteers, as well as the cost of the materials and equipment needed for the video. Additionally, resource binders and educational materials for staff will need to be updated annually as evidence based practice changes and new resources become available. Gift cards or incentives for staff and volunteers were not provided. Staff who are currently employed by the CHUM Warming Center received their regular pay rate for hours spent during training. This additional IPV education will be built into their current training. The CHUM Warming Center already has a building that they use for training, so this is not an additional cost incurred to the project's expenses. Return on Investment (ROI) for this project is projected to be zero dollars.

Figure 3

Projected Costs for the Project.

Costs Incurred	Fixed or Variable	Dollar Amount
Staff	Variable	$0
Volunteers	N/A	$0
Materials (paper, folder/binders, staples, professional posters, and video viewing equipment for implementation)	Fixed	$150
Building/facility	Fixed	$0

Note. Budget utilized to calculate ROI.

Intellectus is a statistical analysis platform that was utilized for data analysis assistance. Quantitative data was examined using the results of the surveys that measure confidence on a scale of 1 to 5. These results were entered into Intellectus and a paired t-test was conducted. Visual illustrations of the data through tables and graphs were created. These results were then scrutinized and further reviewed by DNP students.

Methodology and Analysis

There is no educational programming provided to the staff and volunteers currently at the CHUM Warming Center that specifically pertains to the identification and screening for victims of Intimate Partner Violence (IPV). Research shows benefits of integrating IPV screening into homeless programs (DeCandia et al. 2013; CDC, 2020; Gómez-Fernández et al. 2019; Schaffer, 2012). Therefore, we proposed creating an educational intervention aimed to improve staff

confidence and competency in supporting and providing referral resources to victims of IPV experiencing homelessness.

Appendix A illustrates the necessary steps taken to apply for IRB approval. Participants were asked to sign an informed consent to participate (See Appendix L). After obtaining informed consent, an educational video discussing IPV was provided. This presentation included important background information and statistics, specifically in the Duluth, MN area, as well as information on identifying the signs and symptoms of IPV. Additionally, detailed instructions on how to use the Partner Violence Safety (PVS) screening tool were provided. Local and community resources were highlighted with their location, contact information, and available services. Lastly, a resource referral algorithm was provided to aid staff in identifying and providing appropriate resources.

The Partner Violence Safety (PVS) screening tool was chosen for implementation at the CHUM Warming Center due to its effectiveness in identifying victims of IPV and prompting further intervention. While there are numerous screening tools available to identify IPV, the PVS is an effective tool that has been used in Emergency Department (ED) settings nationwide since 1997 (Feldhaus et al., 1997). The PVS was chosen due to its sensitivity of 35-75% and specificity of 80-94%, when compared to other IPV screening tools, at identifying victims of IPV (Gómez-Fernández et al. 2019). The three questions of the PVS screening tool are:

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now? (Davis et al., 2003)

These three questions are an effective way to quickly identify victims of IPV and provide appropriate resource referrals. The PVS is one of the most useful screening tools for clinical application due to its consistency in sensitivity and specificity since its publication in 1997 (Feldhaus et al., 1997; Gómez-Fernández et al., 2019). Although these questions are seemingly invasive, it is a short screening that allows for a quick conversation between staff and victims that could lead to appropriate intervention. The PVS screening tool will be added to the CHUM Warming Center's current intake form for ongoing use.

A collection of printed educational materials was added to a resource binder located within the CHUM Warming Center for ongoing use. Amongst these educational materials included a list of resources within local IPV organizations. These resources help to address basic needs such as housing, food assistance, employment, childcare, etc. The instructional video will provide visual graphics depicting signs and symptoms of IPV that may include physical characteristics, emotions, demeanor, and "red flag" statements to help staff and volunteers with identifying IPV.

Information was presented on how to provide empathetic communication. This detailed the importance of appropriate body language, eye contact, active listening, and making empathetic statements free of judgment. The video included a thorough discussion of the IPV screening tool, including the who, what, when, where, and why of implementing it, emphasizing its necessity and effectiveness. In addition, the video discussed the resource algorithm located within the binder for ease of referral.

A pre-training confidence survey was created and administered to gauge staff and volunteer confidence levels prior to and after the educational intervention sessions. Appendices

M and N depict the survey that will be administered to assess staff confidence with situations pertaining to IPV. The pre and post-training confidence surveys also served as a benchmark for assessing the success of the educational intervention. Both the pre and post-confidence surveys consist of five questions that assess the staff or volunteer's understanding, confidence, and preparedness when encountering IPV at the CHUM Warming Center on a scale of 1 to 5. A rating by staff of "*1*" indicates not at all confident, a rating of "*2*" indicates slightly confident, a rating of "*3"* indicates somewhat confident, a rating of "*4"* indicates fairly confident, and a rating of "*5"* indicates completely confident in performing the questioned task.

Question one of both confidence surveys asks staff and volunteers how confident they are in their ability to observe physical signs of IPV. The second question addressed staff and volunteer confidence in engaging and listening empathetically to individuals experiencing IPV. The third question discussed staff and volunteers confidence levels in screening for victims of IPV. Question four addressed staff and volunteer confidence levels with understanding resources available to individuals experiencing IPV. Finally, question five addressed staff and volunteer confidence in providing resources to individuals experiencing IPV. An identical survey was given to staff and volunteers to assess confidence level changes after the implementation of the educational intervention. Additional open ended questions were included in the post-survey to assess satisfaction of the educational intervention in addition to asking for constructive feedback in order to make ongoing improvements, should this project be further developed in the future.

Measures that were chosen for studying the processes and outcomes associated with the intervention include an outcome measure, five process measures, and two balancing measures. For all measures, a Likert scale of 1-5 was utilized to assess confidence and scores from all five

questions and was totaled to assess the overall confidence levels before and after the educational intervention. Students collected the data once prior to the education and training intervention which took place in November of 2022 during the CHUM Warming Center's annual orientation, and immediately following the education and training intervention that was completed. A goal of 10 staff and/or volunteers were included in each measure. Overall confidence levels were compared and analyzed.

The outcome measure stated that 75% of staff and volunteers surveyed will report a higher overall confidence level of assessing, empathetically engaging, screening, understanding and providing resource referrals to those experiencing IPV. The five process measures state that 75% of staff and volunteers will report higher confidence levels in (1) observing physical signs of IPV, (2) listening and engaging empathetically, (3) screening for IPV, (4) understanding available resources, and (5) readily providing available resource referrals for IPV. Confidence levels for each individual question will be compared and analyzed.

Lastly, the balancing measures were analyzed to assess the ongoing development of staff and volunteer knowledge related to IPV to avoid a decrease or stagnancy in knowledge. One goal created was to have less than 15% of staff and volunteers show a decrease in scores or worsening confidence when assessing IPV. An additional goal is to have less than 15% of staff and volunteers show no overall change in scores or worsening confidence when assessing for IPV. Overall confidence levels were compared and analyzed for the two balancing measures. For further details see Appendix S.

As a measure to assess effectiveness of education, a knowledge assessment was utilized. The pre-knowledge assessment was created and administered to collect additional data on staff

understanding of IPV prior to the educational intervention. This assessment consists of 10 multiple choice, select all that apply, and true-false questions pertaining to the key points of the education provided (see Appendix O). A post-knowledge assessment was administered after the educational intervention, and consists of the same 10 questions as the pre-knowledge assessment to gauge knowledge retention.

IRB/Ethical Considerations

The Institutional Review Board (IRB) is formally regulated by the Food and Drug Administration (FDA) to review and monitor intended research involving human subjects, including vulnerable populations (*Institutional Review Boards (IRBs) and protection of human subjects in clinical trials,* 2019). IRB review is a required and important process that ensures the protection of the rights and overall welfare of human subjects within research. IRB conducts an initial review, as well as periodic reviews, monitoring the research process, including the steps, protocols, and materials used, to ensure the safety and wellbeing of human subjects in conducted research.

Completing the IRB application helped to inform and clarify the aims, goals, and objectives, relating to the intervention implementation plan for this project. The application also helped to identify characteristics of, and considerations for, project participants. Ethical considerations with regards to this project include, but are not limited to, maintaining confidentiality of collected demographic information, maintaining anonymity of participants, collecting informed consent, avoiding persuasion or pressure in project participation, and clearly disclosing the interest of researchers. This research is free of conflict of interest.

The online administered survey includes a demographic collection section that asks the age, date of birth, gender, ethnicity, residential location, education level, and marital status of participants. Surveys of participants were anonymous, participant names were not collected, demographic information was never shared, and researchers identified survey participants by date of birth during the pre and post-survey implementation data analysis to maintain privacy and confidentiality. Exclusion criteria included those who did not wish to participate and did not give informed consent or those who do not interact with adults utilizing CHUM Warming Center services as the research topic is not relevant to this group.

Before participants consented, an introductory statement was given to disclose the purpose, content, and sponsorship of the study as well as explain the participant's rights and involvement as it relates. This was done to maintain transparency and uphold the American Association of Public Opinion Research (AAPOR) Code of Ethics which requires the use of honesty, respect, and integrity when interacting with project participants (Fischer, 2020). In addition, the statement emphasized the voluntary nature of participation. This Project is in compliance with the American Nurses Association (ANA) and Health Insurance Portability and Accountability Act (HIPAA).

Implementation

This project received IRB approval on August 31st, 2022. Project implementation phase began in November 2022. Team members continued to communicate frequently with one another during this phase, while also communicating with key stakeholders. At the start of implementation in November 2022, prior to the educational intervention, staff received a pre-confidence survey and pre-knowledge assessment. DNP Students administered the

educational intervention through a pre-recorded video. After IPV education was provided, the post-knowledge assessment and post-confidence survey was administered. Confidence survey and knowledge assessment data was collected and analyzed within Intellectus during the implementation phase.

Results from Data Collection

During the in person orientation session at the Warming Center on November 16, 2022, DNP students presented their research to staff members and volunteers. Pre-confidence surveys and pre-knowledge surveys were distributed prior to the education session. To maintain anonymity, surveys were completed and placed in a securely sealed envelope. The educational presentation commenced and immediately following, staff and volunteers filled out the post-confidence and post-knowledge surveys. Completed forms were again anonymously collected and placed in the same sealed envelope with the results to be analyzed at a later date.

Confidence Pre and Post Assessment Surveys

Identical confidence surveys were administered prior to, and immediately after the educational intervention, in order to assess staff confidence in addressing IPV concerns within the setting of homelessness. The confidence survey consisted of 5 questions addressing staff confidence in their ability to identify physical signs of IPV, engage and listen empathetically, provide an appropriate screening tool, as well as understand and provide available resources.

Knowledge Pre and Post Assessment Surveys

In order to assess understanding and sufficient learning of the educational material, identical knowledge surveys were administered prior to, and immediately after the educational intervention. The knowledge survey consisted of 12 questions that were directly addressed in the

educational material. The survey was designed to gauge staff member's baseline knowledge and understanding of IPV prior to the educational intervention. The knowledge assessment was administered for a second time immediately after the educational intervention to test their understanding and retention of the material.

Analysis of Surveys

The data collected was analyzed using Intellectus Statistics. Using a two-tailed paired *t*-test, the results of each question from the pre and post-confidence and pre and post-knowledge survey were compared and analyzed.

Analysis of Confidence Results

Question one in the confidence survey asked "How confident are you in your ability to observe physical signs of intimate partner violence (IPV)?". The result of the two-tailed paired samples *t*-test was significant based on an alpha value of .05, $t(7) = -2.65$, $p = .033$, indicating the null hypothesis can be rejected. This finding suggests that confidence increased in the participants' ability to observe physical signs of intimate partner violence.

Question two of the confidence survey asked "How confident are you with engaging and listening empathetically to individuals experiencing intimate partner violence (IPV)?". When analyzing question two, the result of the two-tailed paired samples *t*-test was not significant based on an alpha value of .05, $t(7) = -1.87$, $p = .104$, indicating the null hypothesis cannot be rejected. This finding suggests that confidence did not increase in the participants' ability to engage and listen empathetically to individuals experiencing IPV.

Question three of the confidence survey asked "How confident are you with screening for individuals experiencing intimate partner violence (IPV)?". When analyzing question three of the

confidence surveys, the result of the two-tailed paired samples *t*-test was significant based on an alpha value of .05, $t(7) = -2.50$, $p = .041$, indicating the null hypothesis can be rejected. This finding suggests that confidence did increase in the participants' ability to screen for individuals experiencing IPV.

Question four of the confidence survey asked "How confident are you with understanding resources available to individuals experiencing intimate partner violence (IPV)?". When question four results were analyzed, the result of the two-tailed paired samples *t*-test was again significant based on an alpha value of .05, $t(7) = -4.25$, $p = .004$, indicating the null hypothesis can be rejected. This finding suggests that confidence in the participants' ability to understand resources available to individuals experiencing IPV did increase.

Question five of the confidence survey asked "How confident are you with providing resources to individuals experiencing intimate partner violence (IPV)?". When question five of the confidence survey was analyzed, the result of the two-tailed paired samples *t*-test was significant based on an alpha value of .05, $t(7) = -3.21$, $p = .015$, indicating the null hypothesis can be rejected. This finding suggests that confidence did increase in the participants ability to provide resources to individuals experiencing IPV. (See Appendix P for a visual graph representation comparing questions 1-5 pre and post-confidence survey).

Overall, confidence scores improved across all five questions, with four out of the five questions showing a statistically significant improvement. The question that did not demonstrate statistically significant improvement was regarding engagement and empathetic listening. However, confidence scores demonstrated statistically significant improvement regarding

observing physical signs of IPV, screening for IPV, understanding resources, and providing resources for those experiencing IPV.

Analysis of Knowledge Results

The results of the pre and post-knowledge assessment were analyzed through Intellectus Statistics using a two-tailed paired t-test. Pre and post-knowledge surveys were administered to eight of the 12 staff members at the Warming Center. Staff knowledge did improve from 78.25% pre-education to 82.25% post-education, however, no statistical significance was proven as evidenced by a *p*-value of >0.05 at 0.247. Additionally, the result of the two-tailed paired samples *t*-test was not significant based on an alpha value of 0.05, $t(7) = -1.26$, $p = .247$. The lack of statistical significance could be explained by time constraints relating to administration of the post education survey. The initial goal was to wait four to six weeks after the educational intervention to assess knowledge to allow staff adequate time to practice their learned skills to improve their confidence. However, due to time constraints related to staff availability and designated orientation time at the CHUM Warming Center, the post-educational intervention knowledge survey was administered immediately after the education. See Appendix Q for a visual graph representation of the pre and post-knowledge results.

Discussion of Data/Outcomes Interpretation

The warming center did not have the equipment necessary to project a video presentation, nor did they have a sound system to amplify the video's volume. DNP students provided the necessary equipment to present the educational material for staff viewing. However, sound amplification equipment was not available, contributing to the difficulty in hearing the presentation. This could account for the marginally improved post-knowledge scores.

Due to recent staffing shortages, the Warming Center had difficulty obtaining staff and volunteers, which inturn, delayed the implementation period and caused a lower sample volume

than originally anticipated. Originally the objective stated implementation would begin in September of 2022. However, due to the staffing shortages, implementation did not take place until November 2022. The delay in implementation led to time constraints limiting DNP student's ability to re-administer the surveys four weeks after implementation. Subsequently, a modification from waiting four weeks to administer the second confidence survey verses immediately after the educational program was made. This limitation could contribute to skewed confidence scores as participants did not have the opportunity to apply learned skills into practice. If staff had the ability to implement the screening tool in practice, there is the possibility that their confidence scores would have been higher. Furthermore, due to time constraints surrounding the Warming Center's required orientation schedule, the educational session was condensed to accommodate. This could account for the lower than expected results of pre and post-knowledge assessment.

Positive feedback highlighted how the education was clear, concise, comprehensive, short, and manageable. Constructive feedback from staff identified how the presentation could have been more engaging if presented live, rather than pre-recorded. Additional opportunities for improvement include having slides printed out ahead of time to take notes with, as well as including statistics about men.

Overall, the implementation of education on IPV revealed statistically significant improvement in staff confidence scores, despite the inability to prove statistical significance in knowledge improvement scores. Surveyed written feedback from staff indicated that further education regarding services to men was desired. Additional information on crisis shelters for women who did not meet criteria for discussed shelters was also highlighted. Furthermore,

several staff members endorsed prior knowledge and experience working with IPV screening, which may explain the lack of increase in average knowledge scores as well. This feedback may have contributed to the statistically insignificant results from the knowledge survey. The feedback provided insight for DNP students regarding strengths and weaknesses of the educational material and presentation. This feedback was thoughtfully considered and discussed amongst DNP students, and can be used as a guide for future projects that may take place in a similar setting to help increase the statistical significance of the next educational opportunity.

Dissemination

To disseminate learnings and results, a project poster was created and presented via a recorded three minute thesis video. An email communication summarizing the project results, along with the project poster, and three minute thesis presentation was shared with the director of the CHUM Warming Center. This presentation was also shared with peers and the project chair. Additionally, this scholarly paper was submitted to the Sigma Repository.

Conclusion

The literature reveals a strong connection between Intimate Partner Violence (IPV) and the increased risk of homelessness (Family and Youth Service Bureau, 2016; Osuji & Hirst, 2015). Experiencing both homelessness and IPV can significantly increase the number of adverse social determinants of health. This directly affects a victims' ability to lead a stable and productive life. Research shows benefits of integrating IPV screening into homeless programs (DeCandia et al. 2013; CDC, 2020; Gómez-Fernández et al. 2019; Schaffer, 2012).

In regards to IPV, there were knowledge, skills and practice gaps identified among staff members at the CHUM Warming Center. This project helped to close those gaps by improving

general knowledge of IPV in addition to increasing confidence levels in addressing IPV. Time constraints relating to staff recruitment and orientation schedule limited our results. This led to the elimination of assessing staff confidence after four weeks of implementing learned IPV screening skills. Instead the post-confidence surveys were administered immediately after the education session. If the post-confidence survey had been administered four weeks after the education, the results may have been different.

Implementing an educational program at the CHUM Warming Center, that included an IPV screening tool, helped to increase knowledge and confidence among staff members. Implementing an educational program at all homeless shelters that includes an IPV screening tool and local resource referral algorithm could help to increase knowledge and awareness of the impact of IPV within this population. Creating a community specific resource referral algorithm can improve efficiency in referrals to appropriate resources in order to break the cycle of homelessness related to IPV. Dissemination of these results to healthcare professionals could increase awareness of IPV and homelessness, and extend further compassion, empathy and support in practice.

This project could be sustained at the CHUM Warming Center, through continued use of the PVS screening tool and resource referral algorithm. Additionally, the education is available for ongoing use via pre-recorded video for future staff use if desired. Time may be an influential factor in whether or not this education will be provided in the future, as there are many other topics competing for time during orientation. The generalizability of this project is limited to individuals and communities impacted by IPV and homelessness. Although proper screening and additional resources could improve access to care for individuals or communities experiencing

IPV in any setting, this project addresses these concerns specifically within the setting of homelessness and therefore cannot be generalizable to the general population.

With the growing rate of homelessness directly related to IPV, it is essential that community members, healthcare professionals and homeless shelter staff stay informed and up to date on best practices. With improved knowledge and confidence for staff with regards to identifying and screening for Intimate Partner Violence, there is potential to break the cycle of homelessness and violence.

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Appendix A
Communication Matrix

Purpose/Objectives (see notes) DATE	Method Of Communication	Recipients	Notes
Project Management: 1/31/22	Zoom	Edling, Schultze, Scott	Meeting with DNP group to collaborate on DNP project
Project Management: 2/2/22	Zoom	Edling, Schultze, Scott, Kilgore, Ferry, Starr	Meeting with Joel (Director of Warming Center) and project chairs
Project Management: 2/7/22	Zoom	Edling, Schultze, Scott	Meeting with DNP group to collaborate on DNP project
Project Management: 2/9/22	Zoom	Edling, Schultze, Scott and large group students	Synchronous session meeting with DNP students to discuss DNP projects and give/receive feedback
Project Management: 2/18/2022	Zoom	Edling, Schultze, Scott, Baltazar, Turner, Ferry, Starr	Group meeting with project advisors
Project Management: 2/18/2022	Zoom	Edling, Schultze, Scott, Baltazar, Turner, Ferry, Starr, Kilgore	Meeting with Director of Warming center and group with advisors to discuss plan
Project Management: 3/7/22	Zoom	Edling, Schultze, Scott	Collaboration with DNP students to discuss the literature
Project Management: 3/8/22	Zoom	Edling, Schultze, Scott, Baltazar, Turner, Ferry, Starr	Collaboration with DNP students to discuss projects and expansion of projects at the Warming Center
Project Management: 4/4/22	Zoom	Edling, Schultze, Scott, Baltazar, Turner, Ferry, Starr	Discussed project progression, SMART goals/objectives, Paper 1a, 1b.
Project Management: 6/10/22	Zoom	Edling, Schultze, Scott, Starr	Discussed PICOT revision and project goals. Created a plan for ongoing project management including discussion with Joel and community partners.
6/23/2022	Zoom	Edling, Schultze, Scott and Starr	Editing paper due to SWOT/ needs assessment formatting issues.

7/5/2022	Zoom	Edling, Schultze, Scott	Recording for project proposal for IRB submission
7/11/2022	Zoom	Edling, Schultze, Scott, Starr	IRB and paper review with faculty
7/12/2022	Zoom	Edling, Schultze, Scott	IRB updates and paper edits
7/26/22	Zoom	Edling, Schultze, Scott	IRB updates and paper edits
7/27/2022	Zoom	Edling, Schultze, Scott	Paper updates and re-formatting/edits
7/28/2022	Zoom	Edling, Schultze, Ferry, and Starr	IRB discussion and finalization of IRB information, 3MTT
8/8/2022	Google Doc	Edling, Schultze, Scott	Submitted IRB application
09/16/2022	Zoom	Edling, Schultze, Scott	Collaboration meeting with other CHUM groups to discuss formatting/ presentation and posters.
09/18/2022	Zoom	Edling, Schultze, Scott	Recording of presentation
9/20/2022	Zoom	Edling, Schultze, Scott, Starr, Ferry, Baltazar, Turner	Collaboration meeting with project advisors and Warming Center large group
11/16/2022	Warming Center	Scott, Schultze, Baltazar, Turney	Implementation of project at Warming Center
11/17/2022	Zoom	Edling, Schultze, Scott	Data analysis and poster development with group
11/21/2022	Zoom	Edling, Schultze, Scott	Intellectus data analysis and 3 MT presentation with group

Appendix B
Johns Hopkins Nursing Evidence-Based Practice: Evidence Level and Quality Guide

Evidence Levels	Quality Guides
Level I Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis	**A High quality:** Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence **B Good quality:** Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence **C Low quality or major flaws:** Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn
Level II Quasi-experimental study Systematic review of a combination of RCTs and quasi-experimental, or quasi-experimental studies only, with or without meta-analysis	
Level III Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis Qualitative study or systematic review with or without a meta-synthesis	

Evidence Levels	Quality Guides
Level IV Opinion of respected authorities and/or nationally recognized expert committees/consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels	**A High quality:** Material officially sponsored by a professional, public, private organization, or government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years **B Good quality:** Material officially sponsored by a professional, public, private organization, or government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years **C Low quality or major flaws:** Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the last 5 years

Level V Based on experiential and non-research evidence Includes: • Literature reviews • Quality improvement, program or financial evaluation • Case reports • Opinion of nationally recognized experts(s) based on experiential evidence	**Organizational Experience:** **A High quality:** Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence **B Good quality:** Clear aims and objectives; consistent results in a single setting; formal quality improvement or financial or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence **C Low quality or major flaws:** Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial or program evaluation methods; recommendations cannot be made **Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference:** **A High quality:** Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field **B Good quality:** Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions **C Low quality or major flaws:** Expertise is not discernable or is dubious; conclusions cannot be drawn

Appendix C
Literature Matrix

Citation	Purpose	Research Design	Methodology	Findings	Conclusion	Critical Appraisal Tool & Rating (levels I-V)
Krishnan & Hilbert (1998)	The purpose of this study was to explore the similarities and differences between the experiences of women affected by both domestic violence and homelessness who sought help at a domestic violence or homeless shelter. Additionally, this study explored the variables involved in the selection of a specific shelter.	Exploratory qualitative study	Semi Structured interviews were conducted over a period of three months at two local domestic violence and homeless shelters in rural Southern New Mexico. Women were selected through purposive sampling and inclusion criteria were women over the age of 18 years, located at the shelter for at least one night, and affected by domestic violence and homelessness.	More participants (n = 7) at the homeless shelter compared to (n = 3) at the domestic violence shelter indicated that their present relationship was the first battering relationship they had been in. Participants reported that they were unable to sleep a full night oftentimes due to fear that their abuser would kill them or due to nightmares. Factors that contributed to the selection of a shelter included shelter staff and services, level of comfortability, and perceptions of the shelter.	When women are in an abusive relationship, they often become homeless in their attempt to flee, sometimes bringing their children with them. When experiencing domestic violence and homelessness, women often turn to formal support systems such as domestic violence or homeless shelters. Shelters need to broaden their resources and knowledge to meet the needs of women experiencing both homelessness and domestic violence.	**Level III**
Minsky-Kelly et al. (2005)	This study assesses barriers to identification and referral of domestic violence (DV) victims.	Qualitative analysis	The study took place in a large midwestern community. The community serves around 150,000 people. This integrated health care system consisted of two hospitals and a large multispecialty practice located in a medium-sized.	752 health care providers participated in a 3 hour training. Focus groups are conducted with staff in hospital departments that serve a high volume of women.	Responses to focus group questions identify system-wide and individual hospital department barriers.	**Level II**

Schaffer (2012)	The purpose of this study was to examine veteran partner violence incidents as a contributing factor to their homelessness and identify resources and refer positive screened veterans to the domestic relations clinic (DRC) for services	Descriptive Exploratory Study	Schaffer (2012) conducted the study in the Greater Cincinnati, OH area with 507 homeless veterans, from 2002 to 2007. Inclusion criteria included veteran status, homeless episode, substance abuse dependence, and completion of the DV/AS to categorize battering and abusive behaviors toward a partner. The social worker conducted a standardized psychosocial intake assessing each veteran for battering, abusive behaviors, and lethality. The treatment plan consisted of an open-end series of 13-week psycho-education groups that also highlighted the impact of military life conducted by a DRC social worker. The groups were geared towards enhancing cognitive, behavioral, emotional, attitudinal, beliefs, recovery, and renew values about themselves and their partners	The results showed a clear need of screening, outreach, referral, information, and advocacy services to identify homeless veterans in need of DRC treatment and intervention services. Although the study did not follow up on the impact of the intervention, nearly 60% of screened homeless veterans reported a need for domestic abuse intervention as measured by the DV/AS.	This study displays the benefits of integrating domestic violence screening into homeless programs and highlights the need for more work in the areas of risk prevention, education, and assessment.	**Level II**

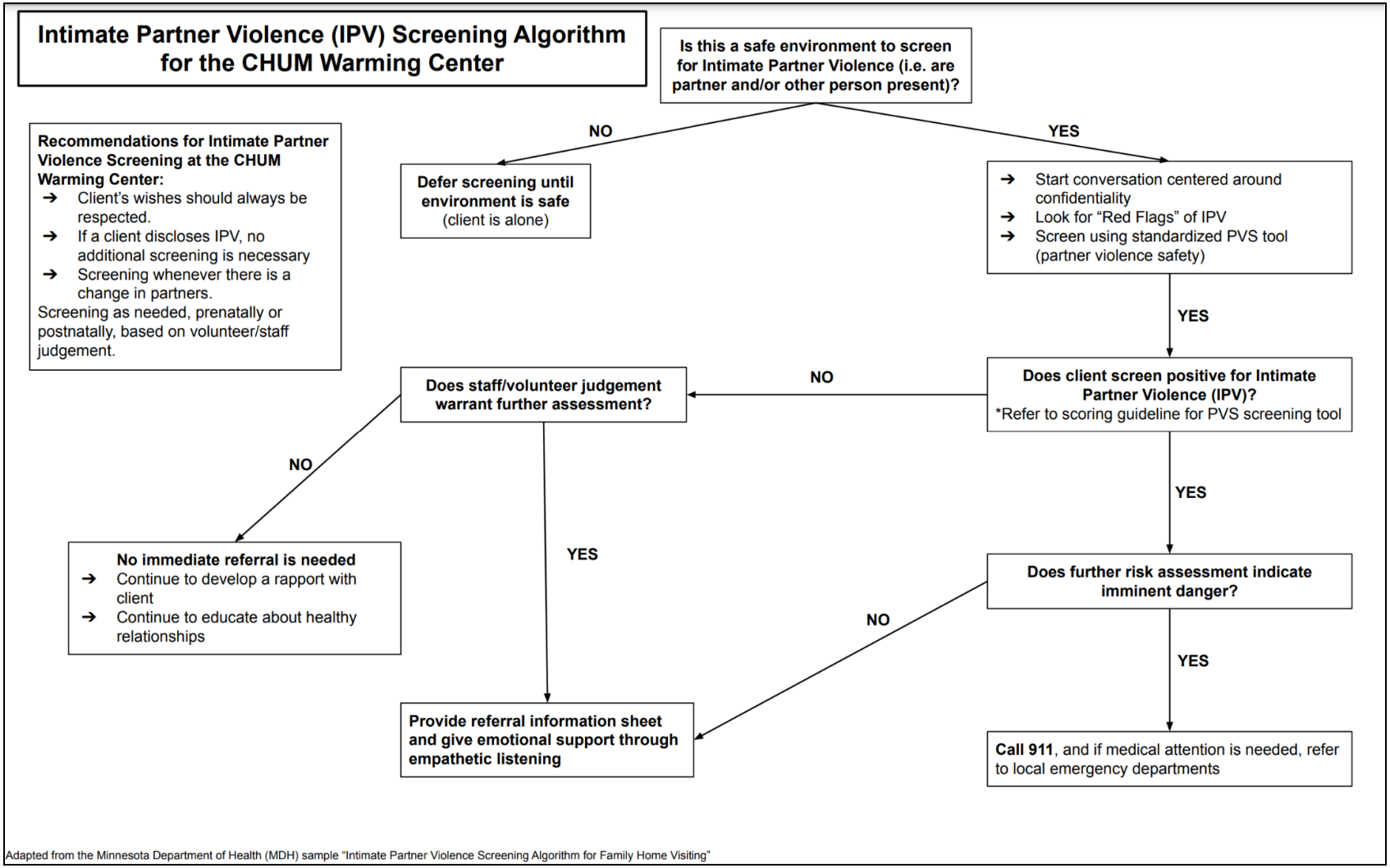
Beach et al. (2013)	The purpose of this article is to discuss a toolkit that was created to address the gap between DV and homeless service systems.	Comprehen sive lit review, a national survey, and comprehens ive in-depth interviews	The goal of this toolkit is to improve the lives of DV survivors who experience homelessness through enhanced service integration.	The most requested training from transitional housing DV providers were: 1) core skills to address DV and trauma-informed care; 2) understanding DV and; 3) best practices for addressing homelessness. The most requested training from homeless service providers (i.e. shelter, and transitional housing providers) were: 1) understanding child and family homelessness; 2) core skills in addressing DV and; 3) understanding best practices in addressing homelessness. It appears that providers in each system desire training relevant to the system they are currently working in, followed by training to expand their knowledge of best practices in the alternate system of care. For both systems, the fourth interest in training was collaborating across systems.	Despite reported familiarity with the systems, only 30% of homeless programs and 53% of DV programs reported communicating with one another to meet families' needs. It appeared from survey results that despite reported familiarity, actual collaboration was less frequent and possible opportunities for sharing expertise and enhancing service delivery might be lost. Both systems agreed that cross-trainings between systems were not commonplace, and that policy and service gaps impacted how DV and homeless programs interacted.	**Level V**
Thurston et al. (2013)	The purpose of this study was to explore the key systemic causes of homelessness and domestic violence for immigrant women, and the various causes. This study also explored the pathways into and out of homelessness, as well as which services are the most effective to help alleviate homelessness.	Longitudinal Qualitative Study	Three longitudinal qualitative interviews took place in three Canadian cities every three months among immigrant women with an experience of domestic violence and housing insecurity.	The results from the project were reported to the federal government and used locally in the cities. Data consistently showed that women who had access to affordable housing, secure employment with stable income, adequate English skills, education, knowledge of and access to resources, social support, and good health helped women to avoid homelessness. Several immigrant women were not fully aware of their rights, and were led to believe they had none by their partner.	In women who are homeless and experiencing domestic violence, systemic factors are relevant to prevention. Women experience a wide array of issues on their pathway of housing insecurity. Indicators for risk of domestic violence and homelessness are complex, and not always opposite one another. Finally, advocacy is essential for immigrant women to get out of an unsafe relationship and secure affordable housing. Advocacy is important in the development of public policy to ensure that immigrant women exercise their rights and receive culturally competent care and support.	**Level III**

Long (2015)	The purpose of this study was to examine how women become homeless, the role of informal and formal social supports, and long-term post shelter outcomes.	Exploratory qualitative study	Interviews were conducted on 15 current and former female participants in a transitional living program (TLP) about how they became homeless, where they lived while homeless, the abuse and other challenges they faced, and how they handled those challenges. Of note, all participants had experienced homelessness while trying to end abuse and each had at minimum one child.	This study demonstrated that through the process of seeking shelter, women learned how to find resources to meet their needs, however they needed external support to make ends meet. The women who were interviewed told their stories of their time in the shelter system in terms of how they were able to make the shelters, police, schools, and other resources work for them to meet their needs, which contrasts with how interventions with homeless people are often described as "conforming" to shelter rules.	This study found that the process of finding long-term supportive housing was not just about finding shelter, but about finding lasting resources. There are many common themes in women's stories about their homelessness and domestic violence, and surviving these takes perseverance.	**Level II**
Gupta et al. (2017)	This study aimed to assess whether an enhanced nurse-delivered intervention (IPV screening, supportive referrals, health/safety risk assessments and a booster counseling session after 3 months) would reduce IPV and improve levels of safety planning behaviors, use of community resources, reproductive coercion, and mental quality of life in low to middle income women living in Mexico City.	Cluster-randomized controlled trial	The study took place between 2012 and 2015 across 42 low-income serving public health clinics operated by the Ministry of Health (MoH) in Mexico City. 950 women (480 in control clinics, 470 in treatment clinics) with recent IPV experiences were enrolled and a baseline survey was administered in April 2013 followed by a 3 month follow-up survey and a 15 month follow-up survey. The intervention group received the nurse-delivered interventions and the control group received screening and a referral card from nurses.	The authors found that both the intervention and control groups showed a reduction in IPV over the course of 15 months but only women in treatment clinics reported significant improvements in the use of community resources. The authors argue that the nurse-delivered interventions may offer short-term improvements in addressing safety planning and mental quality of life as additional supportive services from nurses can be beneficial.	This study shows that low income women living in Mexico City may benefit from nurse-delivered interventions in order to improve outcomes in this population. Although the authors did not find a significant difference in IPV reduction between the intervention and control groups, the authors did find that women in the intervention group reported significant reductions in reproductive coercion, increased safety planning, improvement in mental quality of life, and significant improvements in the use of community resources.	**Level I**

Bryant (2018)	This study hypothesizes that women who are homeless because of IPV victimization are at a greater risk of experiencing more severe negative health outcomes.	The researchers used structured quantitative questions, as well as in-depth qualitative questions during the interview process	The researchers used structured quantitative questions, as well as in-depth qualitative questions during the interview process	The results of this study found that women who stated IPV victimization was the reason for their current episode of homelessness, is statistically significant for many negative health outcomes/access to healthcare, especially for being treated at an outpatient clinic, self-diagnosed depression and self-diagnosed anxiety. Thus, emotional or mental health problems are more severe in women who are currently homeless because of IPV victimization. The results for this study did show that IPV victimization does impact some negative health related outcomes of homeless women and there is a large percentage of women who list IPV as a reason for their homeless. This is evident as violence is so common throughout the homeless population.	This article showed that there are negative emotional and mental health consequences for homeless, IPV victims and that IPV victimization has a large impact on negative health outcomes/access to healthcare. Additionally it showed that there are severe negative mental health effects of homeless, IPV victims. Finally, this study used a large dataset, where women in four major Florida cities contributed to the provided data, thus this study is beneficial to the overall effects of homeless, IPV victims, as it shows the major concerns of negative emotional and mental health outcomes and the possible pattern of women in this target population. These findings support the need for research, stronger advocates for this population, and increased funding and constructive plans by community members and lawmakers.	Level III

Gilroy et al. (2019)	This qualitative study aims to specifically identify what types of interventions women residing in women's shelters felt would improve their economic solvency and decrease their risk for violence.	Qualitative study	Gilroy et al. (2019) conducted interviews consisting of structured questions asking participant's opinions. 21 women aged 28 to 52 years participated.	The results of this study were as expected and the participants highlighted the areas of addressing mental health, accountability, financial management classes, job skills and education, as well as other resources.	Through this study the authors were able to identify gaps in resources and intervention options for women experiencing homelessness after IPV. The authors were able to identify main desired areas of interest to help these individuals stay safe and prevent further violence.	**Level III**
Ragavan et al. (2019)	This systematic literature review aimed to identify community-based research approaches to domestic violence interventions to make recommendations for ongoing interventions.	Systematic Literature Review	The authors conducted a systematic review of the literature using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2009 checklist as a guide.	Ragavan et al. (2019) state that community-based research in domestic violence is relatively sparse and disjointed so the authors conducted a systematic literature review that found that other experts in the field agree that community-based research provides advantages as it stems from community expertise and is rooted in the needs of the community.	The literature review revealed that community-based research, although time and resource intensive, provides better outcomes for victims of domestic violence.	**Level I**
Yakubovich et al. (2022)	We aimed to systematically review the effects of housing interventions on the physical, psychosocial, and economic wellbeing of women experiencing IPV.	Systematic review	The authors searched 15 electronic databases and conducted an extensive grey literature and hand reference search between Jan 29, 2020, and May 31, 2021. They included controlled quantitative studies of housing interventions (from emergency shelter to permanent supportive housing) that were reported in English, without time restrictions, and examined any physical, psychosocial, or economic outcomes among women experiencing IPV	23 902 unique records were screened and the authors identified 34 eligible studies with quantitative data on the outcomes of housing interventions among women experiencing IPV. Most studies evaluated the outcomes of either shelter interventions (18 studies [53%]) or shelter plus some other programming (eight [24%]). The remaining eight studies evaluated longer-term housing solutions, including supportive housing (five studies [15%]), critical time interventions (one [3%]), transitional housing (one [3%]), and stay-at-home models (one [3%]). There was no cumulative evidence of disadvantages following any IPV-housing intervention. Evidence of benefits was strongest for mental health outcomes, intent to leave a partner, perceived safety, and housing and partner-related stress. Included studies were at high risk of bias across most domains (eg, confounding).	The authors found that there is clearly a link between women experiencing IPV and homlessness. The authors also stated that more research is needed to find better long-term housing solutions for women who are experiencing homlessness as a result of IPV.	**Level I**

Appendix D
Resource Referral Algorithm



Appendix E
Gap Analysis

Current State	Desired State	Identified Gap	Gap due to Knowledge, Skill and/or Practice	Methods Used to Identify Professional Practice Gap
- Staff have not been educated on IPV screening - No screening tool is currently in place - There is a lack of knowledge and understanding of available resources	- Staff education regarding screening and intervention options - Implement a screening tool - Create networked resources by providing a standardized process and algorithm that supports and encourages victims of domestic violence to seek help - Provide long term solutions	- Staff have not been educated on IPV screening and resources, and there are not any formal procedures for screening and resources	Knowledge - Unaware of screening tool options and resources that are available Skills - No formal training Practice - Have not used screening tool	- Direct communication with Warming Center Director regarding current procedures and services/resources - Needs assessment showed …. (if we do one put here)

Appendix F
SWOT Analysis Table

Strengths	Weaknesses
• Serves a vulnerable population • Experienced staff and volunteers • Diversity and quality of services available • Existing partnerships/community connections (PAVSA, CASDA, Safe Haven) available • New facility • Visible website	• Lack of time to properly train and educate staff members on new measures • Lack of volunteers, especially decreased capacity since COVID-19 pandemic • Lack of knowledge in IPV detection, screening and resources • Lack of screening tool/ policy for IPV • Lack of formal processes to make resources/ information available to clients of IPV
Opportunities	**Threats**
• Stepping On Up (5 year plan to address unsheltered and sheltered homelessness in Duluth, MN) • Increase in mental health resources • Marketing to the community for funding and awareness • Continue building community relationships ○ Collaboration with local law enforcement	• Community attitudes • Lack of community involvement and awareness • Lack of sustainable funding • Staff resistance • Current policy limitations • Barriers to affordable housing and employment

Appendix G
Example of the Johns Hopkins Nursing Evidence-Based Practice PET Chart

Johns Hopkins Nursing Evidence-Based Practice
Practice Question, Evidence, and Translation (PET)

PRACTICE QUESTION

Step 1: Recruit interprofessional team
Step 2: Develop and refine the EBP question
Step 3: Define the scope of the EBP question and identify stakeholders
Step 4: Determine responsibility for project leadership
Step 5: Schedule team meetings

EVIDENCE

Step 6: Conduct internal and external search for evidence
Step 7: Appraise the level and quality of each piece of evidence
Step 8: Summarize the individual evidence
Step 9: Synthesize overall strength and quality of evidence
Step 10: Develop recommendations for change based on evidence synthesis
- Strong, compelling evidence, consistent results
- Good evidence, consistent results
- Good evidence, conflicting results
- Insufficient or absent evidence

TRANSLATION

Step 11: Determine fit, feasibility, and appropriateness of recommendation(s) for translation path
Step 12: Create action plan
Step 13: Secure support and resources to implement action plan
Step 14: Implement action plan
Step 15: Evaluate outcomes
Step 16: Report outcomes to stakeholders
Step 17: Identify next steps
Step 18: Disseminate findings

Appendix H
GANTT Chart

GANTT Chart IPV Project

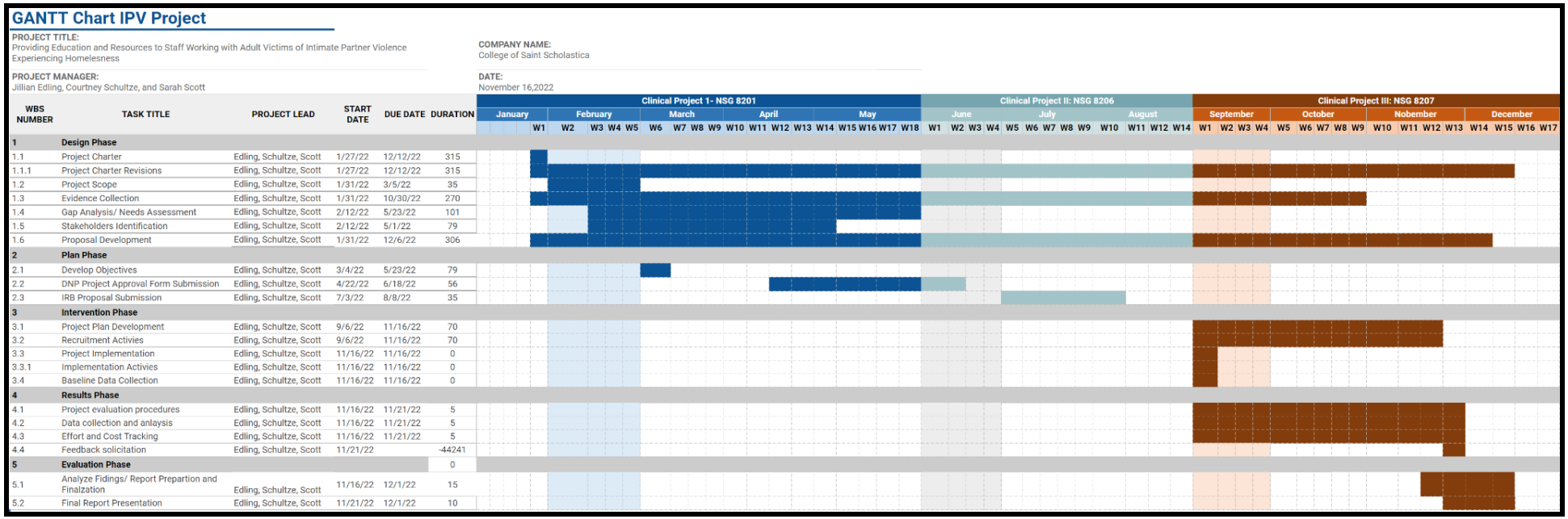
PROJECT TITLE:
Providing Education and Resources to Staff Working with Adult Victims of Intimate Partner Violence Experiencing Homelessness

COMPANY NAME:
College of Saint Scholastica

PROJECT MANAGER:
Jillian Edling, Courtney Schultze, and Sarah Scott

DATE:
November 16,2022

WBS NUMBER	TASK TITLE	PROJECT LEAD	START DATE	DUE DATE	DURATION
1	**Design Phase**				
1.1	Project Charter	Edling, Schultze, Scott	1/27/22	12/12/22	315
1.1.1	Project Charter Revisions	Edling, Schultze, Scott	1/27/22	12/12/22	315
1.2	Project Scope	Edling, Schultze, Scott	1/31/22	3/5/22	35
1.3	Evidence Collection	Edling, Schultze, Scott	1/31/22	10/30/22	270
1.4	Gap Analysis/ Needs Assessment	Edling, Schultze, Scott	2/12/22	5/23/22	101
1.5	Stakeholders Identification	Edling, Schultze, Scott	2/12/22	5/1/22	79
1.6	Proposal Development	Edling, Schultze, Scott	1/31/22	12/6/22	306
2	**Plan Phase**				
2.1	Develop Objectives	Edling, Schultze, Scott	3/4/22	5/23/22	79
2.2	DNP Project Approval Form Submission	Edling, Schultze, Scott	4/22/22	6/18/22	56
2.3	IRB Proposal Submission	Edling, Schultze, Scott	7/3/22	8/8/22	35
3	**Intervention Phase**				
3.1	Project Plan Development	Edling, Schultze, Scott	9/6/22	11/16/22	70
3.2	Recruitment Activies	Edling, Schultze, Scott	9/6/22	11/16/22	70
3.3	Project Implementation	Edling, Schultze, Scott	11/16/22	11/16/22	0
3.3.1	Implementation Activies	Edling, Schultze, Scott	11/16/22	11/16/22	0
3.4	Baseline Data Collection	Edling, Schultze, Scott	11/16/22	11/16/22	0
4	**Results Phase**				
4.1	Project evaluation procedures	Edling, Schultze, Scott	11/16/22	11/21/22	5
4.2	Data collection and anlaysis	Edling, Schultze, Scott	11/16/22	11/21/22	5
4.3	Effort and Cost Tracking	Edling, Schultze, Scott	11/16/22	11/21/22	5
4.4	Feedback solicitation	Edling, Schultze, Scott	11/21/22		-44241
5	**Evaluation Phase**				0
5.1	Analyze Fidings/ Report Prepartion and Finalzation	Edling, Schultze, Scott	11/16/22	12/1/22	15
5.2	Final Report Presentation	Edling, Schultze, Scott	11/21/22	12/1/22	10



Appendix I
Work Breakdown Structure Chart

Work Breakdown Structure (WBS) for DNP Project

Prepared by: Edling, Schultze, Scott **Date: 5/31/22**

1.0 Design Phase
- 1.1 Develop Project Scope
- 1.2 Conduct Gap Analysis & Needs Assessment
- 1.3 Develop Objectives
- 1.4 Identify Key Stakeholders
- 1.5 Develop Project Charter/Action Plan

2.0 Plan Phase
- 2.1 Identify Project Team Members
- 2.2 Discuss & Define Roles
- 2.3 Develop a Project Plan
- 2.4 Develop Gantt Chart
- 2.5 Develop WBS
  - 2.5.1 Tools & Instruments
  - 2.5.2 Data Collection Process
  - 2.5.3 Plans for Data Analysis
  - 2.5.4 Resources
  - 2.5.5 Budget
  - 2.5.6 Timeline

3.0 Intervention Phase
- 3.1 Implement Intervention
  - 3.1.1 Conduct Initial Survey
    - 3.1.1.1 Assess Staff Understanding & Readiness to Learn
  - 3.1.2 Provide Education
    - 3.1.2.1 Instructional Pamphlets & Informational Video
  - 3.1.3 Conduct Post Survey
    - 3.1.3 Assess Post Intervention Staff Understanding
- 3.2 Collect Data
  - 3.2.1 Numerically Categorize Results

4.0 Results Phase
- 4.1 Analyze Findings
  - 4.1.1 Review Initial Survey Results
  - 4.1.2 Review Post Survey Results
- 4.2 Summarize Findings
  - 4.2.1 Summarize Numerically Categorized Results

5.0 Evaluation Phase
- 5.1 Final Report
  - 5.1.1 Discuss Findings
    - 5.1.1.1 Discuss Limitations
  - 5.1.2 Discuss Implications for Practice
  - 5.1.3 Discuss Dissemination

Appendix J
Logic Model

Resources/ Inputs	Activities	Outputs	Intermediate Outcomes	Final Outcomes
In order to carry out our set of activities we will need the following:	*In order to address our need, we will carry out the following activities:*	*We expect that once carried out, these activities will produce the following evidence of service delivery:*	*We expect that if carried out, these activities will lead to the following intermediate changes:*	*We expect that if carried out, these activities will lead to the following changes:*
Staff and Volunteers	Development of an educational training for staff/volunteers	50% of staff/ volunteers received training/education	Decision-making and increased Safety	Increased confidence
Time	Distribution of educational material	Pre and post-surveys delivered	Enhanced knowledge/understanding of IPV for staff/volunteers	Action plan for future DNP students to continue work at agency
Research analysis and synthesis	Conduct a literature review. Provide best practice recommendations based on literature findings in an informational and instructional binder. Facilitate access to informational binders.	Facility received researched literature in the form of informational binders	Increased awareness and understanding of evidence based practice through available literature. Improved assessment, intervention, and communication methods amongst staff.	Improved staff and IPV victim interactions, interventions, and outcomes. Improved policy relating to evidence based intervention techniques and resource connections.
Educational materials	Create informational binder, video, and handouts. Emphasizing empathetic educational strategies	Facility received educational materials	Enhanced knowledge, skill and communication skills. Enhanced understanding of resources.	Improvement in IPV handling process.

Survey materials	Provide pre and post-surveys assessing knowledge and understanding of DV identification, assessment, and treatment, as well as readiness to learn	Baseline and post-intervention results are recorded and quantified	Survey results help to inform project relevance and effectiveness.	DNP students can assess survey findings and their implications for practice as well as help to inform continued research
Technology	Deliver relevant information through the incorporation of modern technology (video)	Distribution of educational material to staff in a modern and relevant manner	Staff retain relevant information through modern technology	Improved understanding of the IPV handling process. Improved future education through the use of modern technology
Project advisors	Communicate clearly, keeping advisors involved. Share and collaborate ideas	Provide education to staff/volunteers on screening and teaching methods as well as how to offer resources to those who may be unwilling to accept services.	Improved understanding of this IPV DNP project, including the current and improved processes for DV, resources available, and community partners in the Duluth, MN area.	Encouragement of future DNP students to continue research on this topic. Encourage policy improvement at the local, state, and national levels.
Community partners	Communicate with Safe Haven Women's Shelter. Communicate with Program for Aid to Victims of Sexual Assault (PAVSA). Communicate with the Center Against Sexual and Domestic Abuse (CASDA).	Regular communication, collaboration, and shared resources between local community partners	Improved collaboration between local community resources	Improved standards regarding the use and distribution of community resources.

APPENDIX K
IRB Approval Letter

The College of St. Scholastica

Institutional Review Board

DATE:	August 31, 2022
TO:	Courtney Schultze and [Dr. Lisa Starr]
FROM:	The College of St. Scholastica, Institutional Review Board
RE:	Providing Education and Resources to Staff Working With Adult Victims of Intimate Partner Violence Experiencing Homelessness
SUBMISSION TYPE:	New Project
ACTION:	NOT RESEARCH
REVIEW TYPE:	Expedited Review

Thank you for your submission of materials for your project. The College of St. Scholastica Institutional Review Board has reviewed your application and determined that the proposed activity does not meet the definition of research under the Code of Federal Regulations 45 Part 46.102 provided by the Department of Health and Human Services. As such, your project does not require ongoing review or approval from The College of St. Scholastica Institutional Review Board. We will retain a copy of this correspondence within our records.

Any modification to your project procedures that could change the determination of "not research" must be submitted to the IRB before implementation.

If you have any questions, please contact Nicole Nowak through the project email function in IRBNet or nnowaksaenz@css.edu. Please include your study title and reference number in all correspondence with the IRB office.

Best regards,

Nicole T. Nowak, Ph.D.
Chair, Institutional Review Board
The College of St. Scholastica
Duluth, MN 55811

Appendix L
Informed Consent to Participate in Study

The College of St. Scholastica

Providing Education and Resources to Staff Working with Adult Victims of Intimate Partner Violence Experiencing Homelessness

Informed Consent

You are invited to participate in a research study investigating staff and volunteers knowledge and confidence in current intimate partner violence (IPV) practices and available resources to patrons of the CHUM Warming Center located in Duluth, MN. This study is being conducted by Jillian Edling, Courtney Schultze, and Sarah Scott, graduate students in the Department of Graduate Nursing Studies under the supervision of Dr. Lisa Starr. You were selected as a possible participant because you are an employee or volunteer at the CHUM Warming Center, are greater than 18 years of age and have regular contact with patrons of the CHUM Warming Center experiencing homelessness. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

Study Purpose

The purpose of this study is to assess knowledge and confidence in staff and volunteer's understanding and ability to screen and provide appropriate referrals and resources for the patrons of the Chum Warming Center who screen positive for intimate partner violence (IPV). This project will measure staff understanding and confidence in their ability to identify physical signs of IPV, engage and listen empathetically to victims experiencing IPV, screen for IPV, understand available resources and provide appropriate resource referrals, independent of patron response. The majority of research involving IPV practice or policy improvement is conducted in the primary care, urgent care, or emergency department setting and very limited research is available on IPV specifically in the setting of homelessness.

This project will not measure or analyze the screening tool results within the intake form. Joel Kilgour has agreed to oversee the proposed project at the Chum Warming Center and gives approval to utilize the Chum Warming Center site for this project

Study Procedure

If you agree to participate in this study, we will ask you to sign this consent form, complete the pre-knowledge assessment and a pre-intervention survey to assess confidence. You will then complete the IPV education which will be a one time education/training (roughly 30-90 minutes). Then, you will take a post-knowledge assessment to assess understanding of education/training that was provided. You will then use what you have learned to screen patrons of the Chum Warming Center and provide resources if a need is identified. Finally, you will take a post-intervention survey to assess your confidence with IPV identification, screening and resource referral. This study will be done over the course of about 4-8 weeks, and if you agree to participate in this study, your time commitment will be approximately 2-3 hours total between education/training and time for surveys and assessments.

Risk of Study Participation

Psychological discomfort is a risk you as a participant might experience. This risk could be present if you screen someone who is experiencing IPV and they themselves have a past trauma experience with IPV or a similar situation. To aid you, the participant, with coping mechanisms, should you experience such discomfort, information has been included about the importance of self-care as well as skills to practice self-care into the educational training sessions. Additionally, social discomfort could be present as IPV can be a difficult and emotional topic to discuss.

Benefits of Study Participation

You may not directly benefit from your participation in this study. The information you will receive about IPV, including how to identify physical signs of IPV, engage and listen empathetically to victims experiencing IPV, screen for IPV, understand available resources and provide appropriate resource referrals, may be useful to your employment or volunteering practices, but this is not guaranteed.

Alternative to Participation

While you may learn useful information about IPV in the setting of homelessness from participating in this study, you can obtain similar information by researching reliable and credible sources and discussing this topic with knowledgeable professionals in your community.

Research Related Injury

No known research related injury is known, but if you do experience any research related injuries, please let the researchers know right away.

Confidentiality

The records of this study will be kept private. In any publication or presentations, we will not include any information that will make it possible to identify you as a subject. Your record for the study may, however, be reviewed by individuals at CSS with appropriate regulatory oversight. All data collected will be stored in a locked filing cabinet and/or on a password protected computer. To these extents, confidentiality is not absolute. Your consent form and data will be retained securely for five years after which time it will be destroyed.

Voluntary Nature of the Study

Participation in this study is voluntary. Your decision whether or not to participate in this study will not affect your current or future relations with CSS, the Department of Graduate Nursing Studies, or the CHUM Warming Center. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contact and Questions

The researchers conducting this study are Jillian Edling, Courtney Schultze, and Sarah Scott. You may ask any questions you have now, or if you have questions later, you are encouraged to contact Jillian Edling (jedling@css.edu), Courtney Schultze (cschultze@css.edu) or Sarah Scott (sscott4@css.edu).

If you have any questions or concerns regarding the study and would like to talk to someone other than the researcher, you are encouraged to contact the following individuals:

- Research Advisor - Lisa Starr (lstarr@css.edu)
- School of Nursing Dean - Sheryl Sandahl (ssandahl@css.edu)
- Nicole Nowak-Saenz, Ph.D., Chair of the Institutional Review Board at nnowaksaenz@css.edu

You may also contact any of the above-named individuals in writing or in person at The College of St. Scholastica, 1200 Kenwood Ave, Duluth, MN 55811.

You will be given a copy of this form to keep for your records.

Your signature below indicates that you have read and understand the information in this consent form. Your signature indicates that you want to participate in this study.

_____

Printed Name of Participant

_____

Signature of Participant Date Signed

_____

Signature of Investigator(s) Date Signed

Appendix M
Pre-Training Confidence Survey

Pre-Confidence Survey
Before Receiving Intimate Partner Violence Screening Education

What is your date of birth? (month/day/year)____/_____/_____ **Age:** _____
Please Circle or Fill in as Indicated:
Gender: Female / Male / Non-Binary / Other: _____ / Prefer not to disclose
Ethnicity: Caucasian / African-American / Latino or Hispanic / Asian / Native American / Native Hawaiian or Pacific Islander / 2 or More / Other: _____ / Prefer not to disclose
Residential Location: Duluth / Other: _____ / Prefer not to disclose
Occupation: _____
Education: High School Diploma / GED / Some College / Trade School / Bachelors / Some Graduate School / Masters / PhD / Doctorate / Other: _____ / Prefer not to disclose
Marital Status: Single / Married / Life Partner / Prefer not to disclose

On a scale of 1 to 5 (1 = not at all confident, 5 = completely confident) How confident are you with…	1 Not at all confident	2 Slightly confident	3 Somewhat confident	4 Fairly confident	5 Completely confident
1. How confident are you in your ability to observe physical signs of intimate partner violence (IPV)?	1	2	3	4	5
2. How confident are you with engaging and listening empathetically to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
3. How confident are you with screening for individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
4. How confident are you with understanding resources available to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
5. How confident are you with providing resources to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5

Please Circle as Indicated:
Have you experienced working with victims of intimate partner violence in the past? Yes / No
If yes, please explain:
_____
_____
In the past, have you received formal training for screening victims' of intimate partner violence? Yes / No
If yes, please explain:
_____
_____
In the past, have you ever been asked to distribute resource referral material? Yes / No
If yes, please explain:
_____
_____

*Completion and return of this questionnaire is an indication of your voluntary consent to participate in this study

Appendix N
Post-Training Confidence Survey

Post-Confidence Survey
Four weeks *After* Receiving Intimate Partner Violence Screening Education

What is your date of birth? (month/day/year)____/_____/_____ Age: _____

On a scale of 1 to 5 (1 = not at all confident, 5 = completely confident) How confident are you with…	1 Not at all confident	2 Slightly confident	3 Somewhat confident	4 Fairly confident	5 Completely confident
1. How confident are you in your ability to observe physical signs of intimate partner violence (IPV)?	1	2	3	4	5
2. How confident are you with engaging and listening empathetically to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
3. How confident are you with screening for individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
4. How confident are you with understanding resources available to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5
5. How confident are you with providing resources to individuals experiencing intimate partner violence (IPV)?	1	2	3	4	5

Provide feedback

a. What did you like or dislike about this training?

_____
_____
_____
_____
_____

b. Where do you see opportunities for improvement?

_____
_____
_____
_____
_____

*Completion and return of this questionnaire is an indication of your voluntary consent to participate in this study.

Appendix O
Pre and Post- Education Knowledge Assessment

Knowledge Assessment *Pre/Post* Education

1. How much has the homeless population increased in Duluth, MN between 2015-2020?

- ☐ 5%
- ☐ 15%
- ☐ 25%
- ☐ 35%

2. How many people who are homeless experience intimate partner violence (IPV)?

- ☐ 15%
- ☐ 38%
- ☐ 55%
- ☐ 78%

3. Is the below statement True or False?

Intimate Partner Violence (IPV) is a term used to describe physical or sexual violence, stalking, or psychological harm by a current or former partner or spouse within a romantic relationship. IPV includes physical, sexual, and emotional abuse and controlling behaviors by an intimate partner and is one of the most common forms of violence against women.

- ☐ True
- ☐ False

4. Which of these are "red flags"/physical signs of intimate partner violence? (select all that apply)

- ☐ Bruising and lacerations in various stages of healing
- ☐ Withdrawal
- ☐ Assertiveness
- ☐ Avoidant behavior
- ☐ Telling inconsistent stories or information
- ☐ Report getting a good nights sleeping

5. What are examples of empathetic listening? (select all that apply)

- ☐ Give your full attention and maintain eye contact
- ☐ Follow up questions
- ☐ Stand with your arms crossed
- ☐ Thank them for trusting you and sharing
- ☐ Able to sit in silence
- ☐ Interrupting with stories of your personal friends or family members who have had a similar experience

6. Choose the three questions that are included in the Partner Violence Screening Tool (PVS)?

- ☐ Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
- ☐ Do you feel safe in your current relationship?
- ☐ Do you often wonder where your next meal will come from?
- ☐ Is there a partner from a previous relationship who is making you feel unsafe now?
- ☐ Have you ever been worried you will have little to no access to money due to a past relationship?

7. Which situations indicate a need for a resource referral to be provided? (select all that apply)

- ☐ Someone reporting a partner who gives positive reassurance about how well you complete tasks in a non-judgment manner
- ☐ Someone reporting a partner showing extreme jealousy of them spending time with friends or time spent away from them.
- ☐ Someone reporting a partner respecting their time and upholding trusting boundaries
- ☐ Someone reporting that their partner controls finances in the household without discussion, including taking their money or refusing to provide money for necessary expenses.
- ☐ Someone reporting their partner pressuring them to have sex or perform sexual acts that they're not comfortable with.
- ☐ Someone reporting their partner intimidating them with weapons like guns, knives, bats, or mace.

8. Is the below statement true or false?

CASDA, PAVSA and Safe Haven are the three main *referral sites* in the Duluth/Superior area specifically designated for victims of intimate partner violence (IPV)?

- ☐ True
- ☐ False

9. Is the below statement true or false?

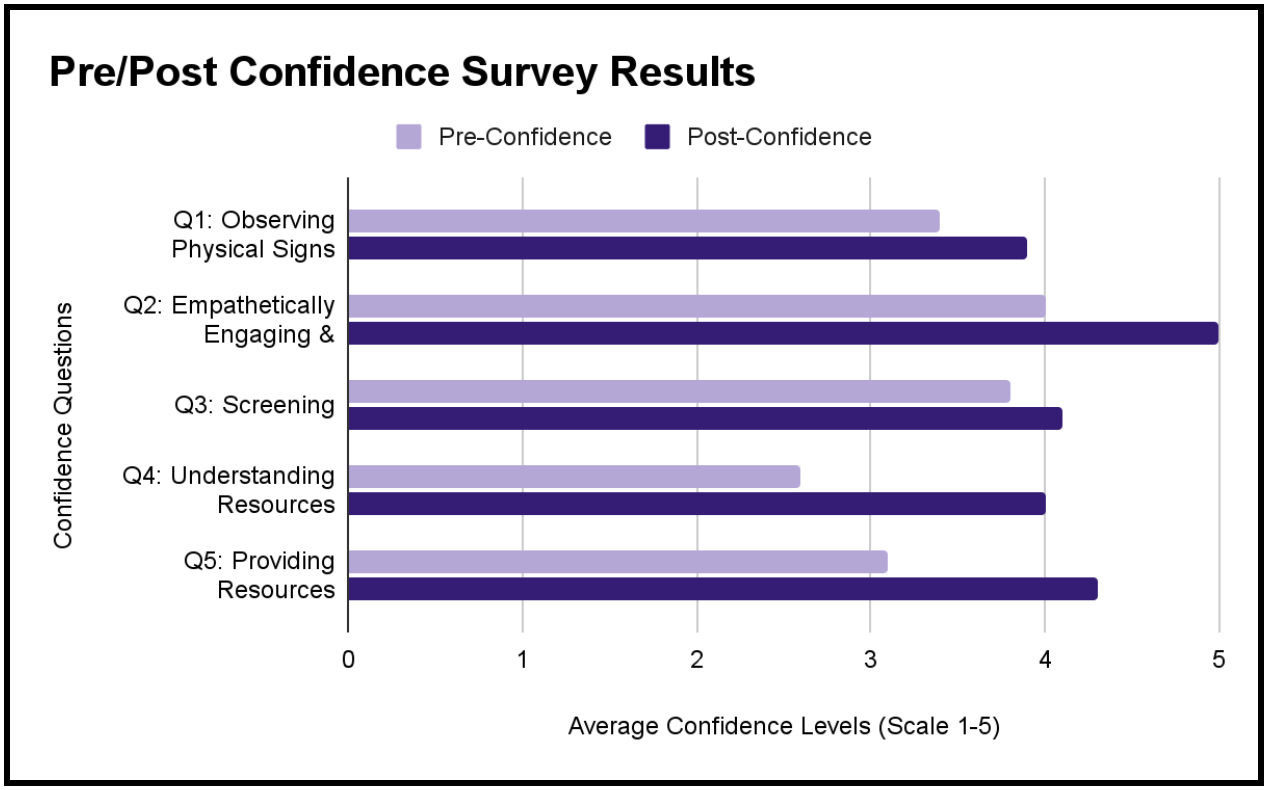
You can find the resource referral algorithm and additional information on resource referrals for victims experiencing IPV in a comprehensive binder located at the CHUM Warming Center.

- ☐ True
- ☐ False

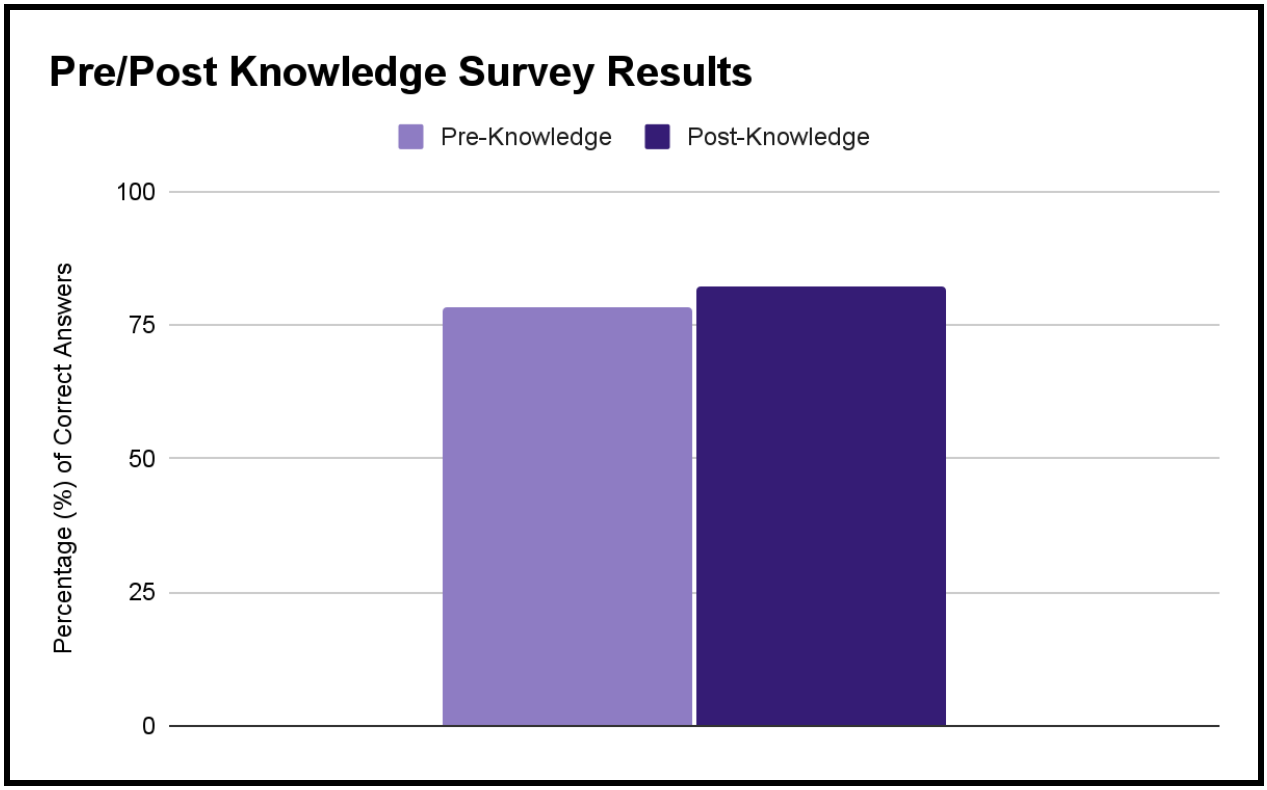
10. Which sites have a 24-hour crisis helpline available for victims specifically experiencing IPV? (select all that apply)

- ☐ CASDA
- ☐ PAVSA
- ☐ Salvation Army Duluth
- ☐ Safe Haven

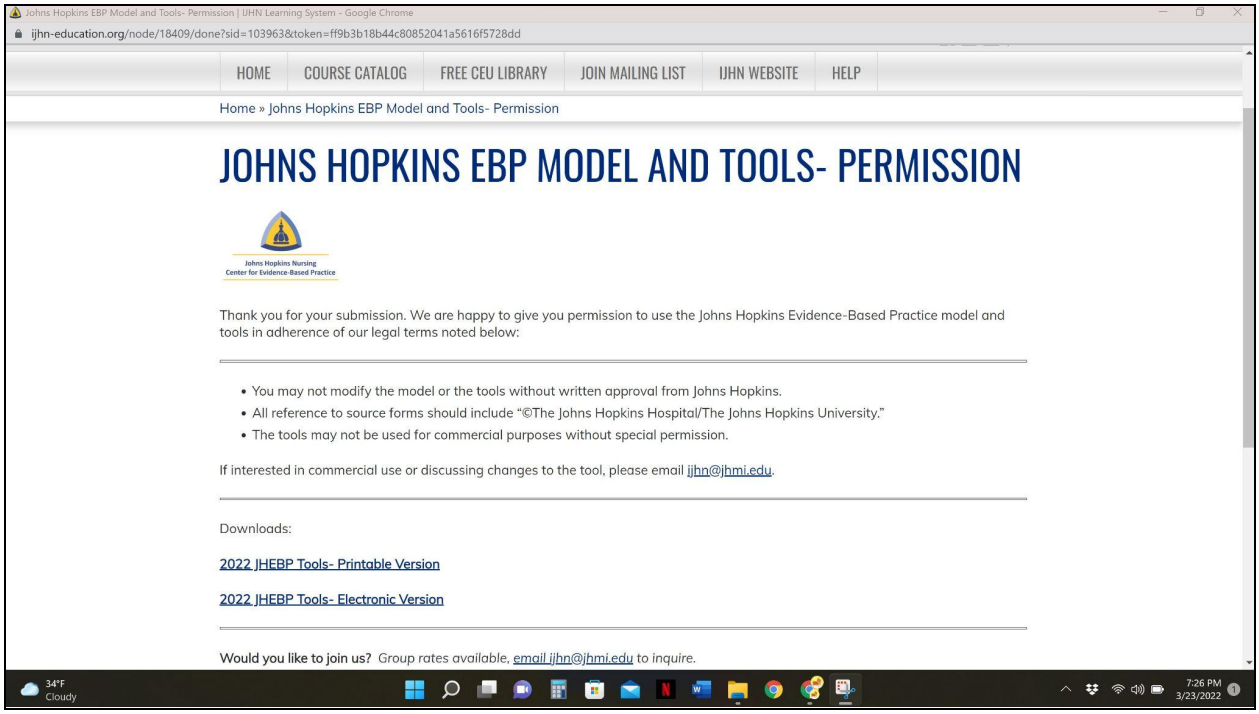
Appendix P
Cumulative Depiction of Pre and Post-Survey Results



Appendix Q
Pre and Post-Knowledge Survey Visual Results



Appendix R
Letter of Permission of Use



Appendix S
Outcomes Measures

Outcome Measure		
75% of staff/volunteers surveyed will state a higher overall confidence level of assessing, empathetically engaging, screening, intervening, understanding and providing resources and assistance to those experiencing IPV.	A scale of 1-5 to assess confidence level will be used. Scores from all six questions will be totaled to assess the overall confidence levels.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention. A goal of 10 staff and/or volunteers are to be included in this measure. Overall confidence levels will be compared and analyzed.
Process Measures		
75% of staff/volunteers surveyed will report higher confidence physically assessing individuals experiencing intimate partner violence (IPV).	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
75% of staff/volunteers surveyed will report higher confidence Engaging and listening empathetically to individuals experiencing intimate partner violence (IPV).	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
75% of staff/volunteers surveyed will report higher confidence Screening for individuals experiencing intimate partner violence (IPV).	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
75% of staff/volunteers surveyed will report higher confidence	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and

Intervening for individuals experiencing intimate partner violence (IPV).		once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
75% of staff/volunteers surveyed will report higher confidence Understanding resources available to individuals experiencing intimate partner violence (IPV).	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
75% of staff/volunteers surveyed will report more confidence providing available resources to individuals experiencing intimate partner violence (IPV).	A scale of 1-5 to assess confidence level will be used.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention for this question. A goal of 10 staff and/or volunteers are to be included in this measure. Confidence levels for this question will be compared and analyzed.
Balancing Measures		
Less than 15% of staff/volunteers will show a decrease in scores/worsening confidence in assessing IPV overall.	A scale of 1-5 to assess confidence level will be used. Scores from all six questions will be totaled to assess the overall confidence levels.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention. A goal of 10 staff and/or volunteers are to be included in this measure. Overall confidence levels will be compared and analyzed.
Less than 15% of staff/volunteers will show no change in scores/worsening confidence in assessing IPV overall.	A scale of 1-5 to assess confidence level will be used. Scores from all six questions will be totaled to assess the overall confidence levels.	Students will collect the data once prior to the education/training intervention and once after the education/training intervention. A goal of 10 staff and/or volunteers are to be included in this measure. Overall confidence levels will be compared and analyzed.