

ORIGINAL RESEARCH

Barriers and Facilitators to Screening for Anxiety and Intimate Partner Violence

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Background: Periodic universal screening for anxiety and for intimate partner violence (IPV) for women and adolescent girls are national clinical practice recommendations. However, screening rates in primary care settings are low. This study aimed to increase awareness and adoption of screening for anxiety and for IPV in women and adolescent girls by identifying screening barriers and facilitators to inform clinical resource development.

Methods: Two-phase, qualitative study using semistructured interviews to identify screening barriers and facilitators; thematic analysis of interview data using a rapid evaluation approach.

Results: Twenty-seven clinicians and staff members were interviewed in 12 clinics in 2 primary care networks in Oregon. All participants recognized the importance of screening in primary care settings but were generally unaware of screening recommendations and insurance coverage and were unsure of their clinic's policies and practices, citing a lack of protocols for referrals for positive screens. Barriers to both anxiety and IPV screening included screening fatigue, lack of metrics, uncertain documentation and reporting, and unclear referral and follow-up procedures. For IPV screening specifically, barriers included discomfort with screening, privacy concerns, and perceived low occurrence. Facilitators for both services included leveraging existing screening practices and electronic health record tools, and clear recommendations for universal screening best practices.

Conclusion: Implementation of routine screening for anxiety and IPV in women and adolescents in primary care is low but may improve with targeted clinician resources and education. Workflow diagrams and resource guides responsive to identified screening barriers and facilitators, including clarification of insurance coverage for preventive services, and resources to support implementation of protocols of screening methods, clinical documentation, and referrals for anxiety and IPV in primary care settings, could improve screening practices. (J Am Board Fam Med 2025;38:1049–1063.)

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Introduction

Periodic universal screening for anxiety and for intimate partner violence (IPV) for women and

adolescent girls aged 13 years and older are national clinical practice recommendations.^{1–4} They are based on evidence of effectiveness^{5–8} and supported by the

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Health Resources and Services Administration (HRSA) for coverage by most insurance plans under the preventive services mandate of the Affordable Care Act (ACA).⁹ Although anxiety and IPV are recognized as significant public health problems that disproportionately affect women,^{10–12} routine screening in primary care practice is not widely delivered.

Benefits of universal screening are supported by indirect evidence of effectiveness in reducing adverse health outcomes.^{7,13–15} While several barriers to anxiety and IPV screening have been identified in previous studies,^{16–19} including time constraints, concerns about patient privacy and safety, inadequate training, and lack of support resources for patients who screen positive,²⁰ it remains unclear how to support screening in clinical practice.

The goal of this project was to increase awareness and adoption of universal screening for anxiety and for IPV for women and adolescent girls—two, separate, HRSA-supported recommendations developed by the Women’s Preventive Services Initiative (WPSI). These preventive services were selected because they are unique to the WPSI and either predated other recommendations (anxiety screening)^{1,3} or are more expansive than existing recommendations (IPV screening)^{4,21} and provided an opportunity to focus on the specific impact of HRSA-recommended preventive services for women. This report describes the methods and results of a two-phase, qualitative research project to identify current practices for screening for anxiety and IPV in primary care settings and describe barriers to and facilitators of screening. Findings from this qualitative research informed the development of clinical support materials to improve adoption of anxiety and IPV screening in primary care practice (Figures 1 and 2).

Methods

This qualitative study was based on semistructured interviews of clinicians and staff in primary care clinics to 1) understand current screening practices, and 2) identify barriers and facilitators to implementing recommended preventive services to inform the development of clinical support materials. The protocol was approved by the Oregon

Health & Science University (OHSU) Institutional Review Board (STUDY00025057).²²

Setting

This project included 27 clinicians and staff from 12 clinics in 2 primary care clinical networks in Oregon, the Oregon Rural Practice-based Research Network (ORPRN) and the OHSU and Hillsboro Medical Center (HMC) health system.^{23,24} Networks included different primary care settings that varied by affiliation, size, funding mechanism, location, and patient population (Table 1) and serve patients who represent a wide range of populations including those in urban and rural communities, Medicaid recipients, and adolescents receiving care at school-based health centers, among others.

Sampling and Recruitment

Participants were recruited between January and April 2023 from eligible clinics using a purposive recruitment strategy,²⁵ based on variation in clinic size, type, location, and patient population. Clinicians and administrators or managers were contacted via e-mail and invited to participate and/or recommend clinic staff eligible for an interview about their clinic’s anxiety and IPV screening practices. Snowball sampling was used to identify additional clinic staff who could also respond to questions about screening practices.²⁶

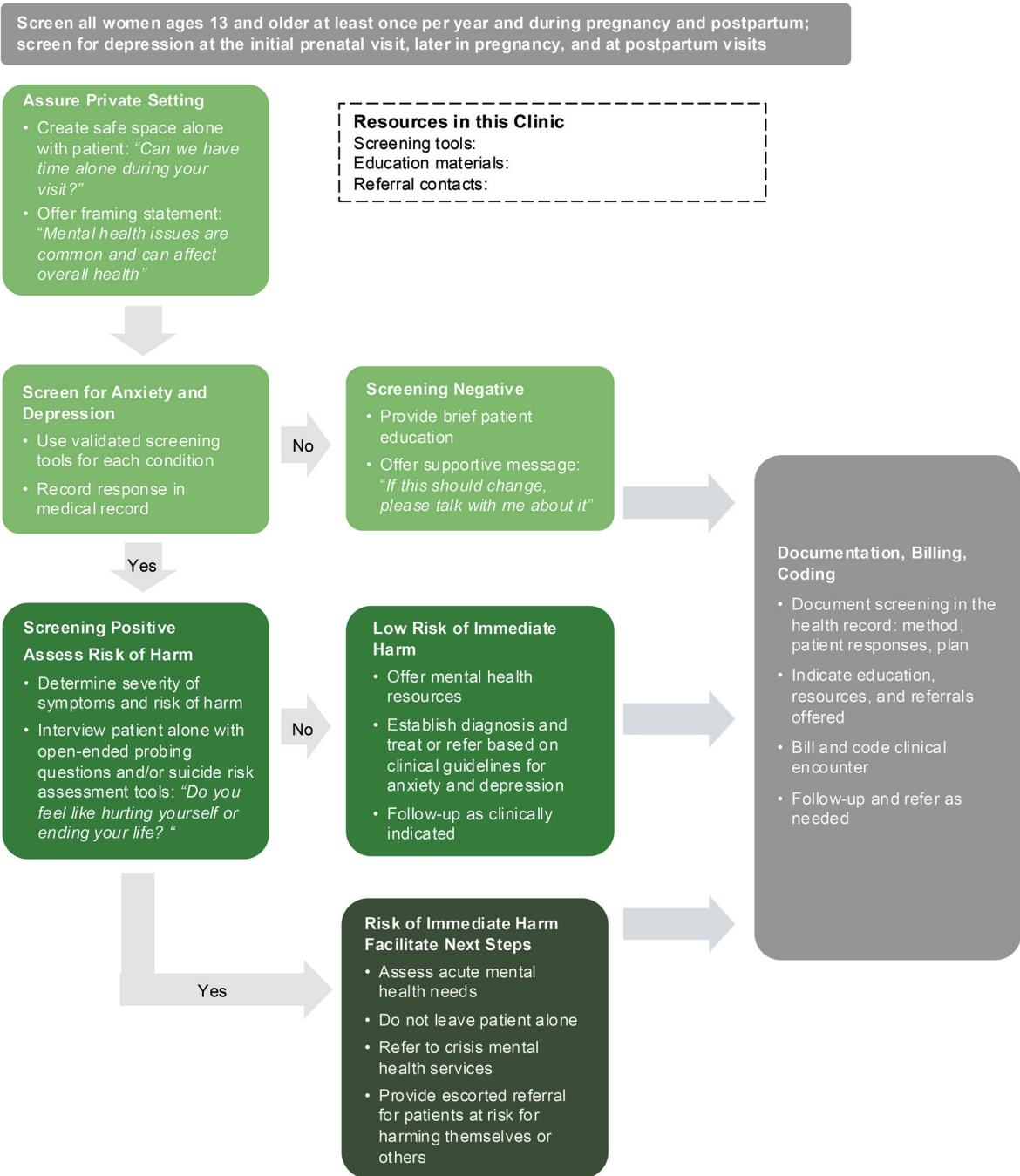
Data Collection

Twenty-seven semistructured key informant interviews were conducted to identify existing clinic practices, barriers, and facilitators for implementing anxiety and IPV screening. Interview questions were open-ended to collect participants’ input on clinic policies and workflows related to screening practices at the clinic and individual clinician level. Questions concerned multi-level barriers and facilitators to screening, how screening policies are created and approved at each clinic, desired resources to increase adoption of screening, and overall perception and impacts of screening for anxiety and IPV in the clinics (Table 2). The interview guide (see Supplement) was pilot tested with 1 clinician and revised based on feedback from participants to optimize wording and question sequence. Two master’s level research analysts (CB, TWL) with qualitative training and experience conducted interviews via teleconference with video, teleconference without video, or telephone, based on participant preference. Interviews were recorded with

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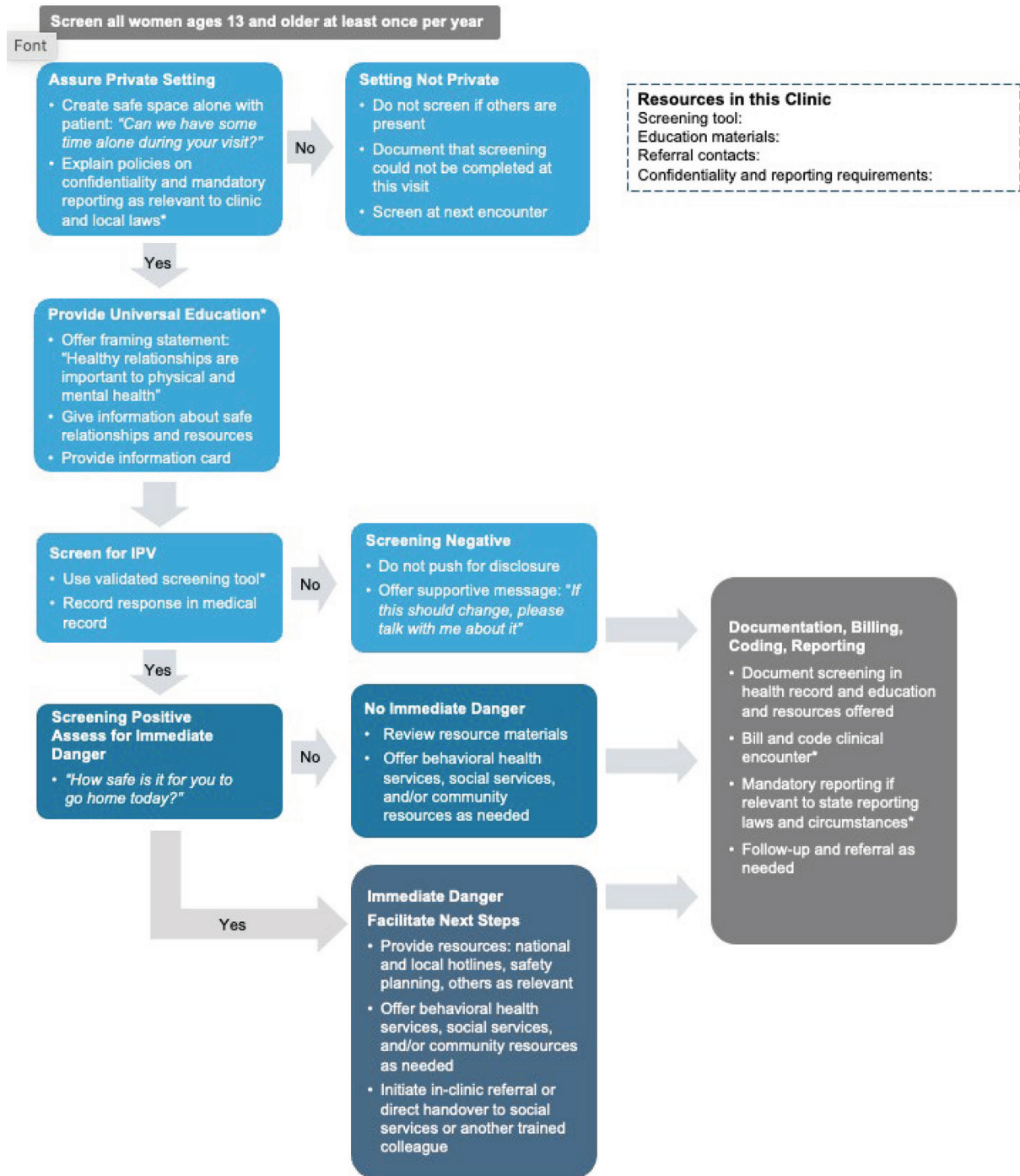
Figure 1. Screening for anxiety and depression workflow diagram.

Screening for Anxiety and Depression Clinical Workflow



Notes: The workflow diagram includes screening for both anxiety and depression; outlines progressive steps in the screening process, including assessment for self-harm when indicated; and allows for customization. *An Anxiety and Depression Resource Guide provides additional information.

Figure 2. Screening for Intimate Partner Violence (IPV) workflow diagram.



Notes: The workflow diagram outlines progressive steps in the screening process, including assessment for safety when indicated; incorporates universal IPV education regardless of screening status; and allows for customization. *An IPV Resource Guide provides additional information.

participants' consent and lasted approximately 45 minutes. Interview data were transcribed using professional transcription software (Webex or Rev.com). The interviewers met regularly throughout

data collection to assess gaps in responses and determine data saturation, specifically that no new findings or themes were emerging from continued data collection.²⁷

Table 1. Clinic and Participant Characteristics

Clinic type	n = 12
Health system	7
Independent	2
FQHC or RHC*	3
Clinic specialty	
Family medicine	11
Other, mixed practice	1
Clinic location	
Rural	8
Urban	4
Participant role	n = 27
Primary care clinician	7
Medical director	3
Behavioral health consultant/social worker	5
Medical assistant	2
Administrative staff/practice manager	5
Quality/compliance manager	3
Other	2

Abbreviations: FQHC, federally qualified health center; RHC, rural health center.

*Included in the total number of clinics.

Data Analysis

Baseline clinical practices were examined through a thematic analysis using a rapid evaluation approach to inform the development of the interview guide.²⁸ A qualitative analysis matrix (Table 3) was developed based on the interview guide for preliminary review of interview transcripts to categorize data and identify relevant patterns and themes. Matrix domains served as column headers and each individual interview was represented in its own row. Two qualitative analysts (CB, TWL) independently populated the matrix with transcript data from 2 interviews and reviewed each other's responses for

consistency. Transcript data were populated into matrix cells, organizing data for each interview into the respective domains of interest. Data were primarily copied directly from transcripts, but in some instances, summaries were used to optimize data management. The 2 analysts then completed the matrix for subsequent interview transcripts on a rolling basis as interviews were completed. Following completion of data entry from all interviews, analysts (CB, SLA, TWL) reviewed the matrix and created analytic memos to compare data across participants and identify patterns and emergent themes. Using a systematic and iterative process, patterns and themes were refined through a consensus forming approach, including identifying exemplary quotations. Final themes were reviewed and validated by all investigators through group discussion and consensus.

Results

A total of 27 interviews were conducted at 12 clinics (4 clinics in the OHSU/HMC network and 8 clinics in the ORPRN network).

Current Screening Policies and Practices

As a preliminary step to understand existing practices, a review of current screening practices in a representative sample of eligible clinics was conducted to inform question development for the interview guide (see Supplement). In some cases, there was discordance between participants from the same clinic about which screening methods were used. There were no differences in screening protocols (ie, recommended frequency, tool, and

Table 2. Selection of Structured Interview Questions for Primary Care Clinicians and Staff (n = 27 Participant Interviews)

1.	I will ask you to tell me a little bit about yourself and your thoughts and experiences with screening women and adolescent female patients for IPV and anxiety
2.	Can you discuss how your clinic is involved in screening for IPV?*
3.	Do you have standing protocols available to guide IPV screening in your clinic?*
4.	Outside of your standing protocols, what symptoms in a patient or family would prompt you to screen for IPV?*
5.	Can you walk me through how you document a screening for IPV in your EHR?*
6.	Who else is involved in the screening or documentation? (prompts: MA, behavioral health, social worker, PCP)
7.	What happens at the clinic if a patient screens positive? Who / which roles are involved?
8.	Do you have any concerns about universal screening for IPV?*
9.	What are facilitators and barriers to adopting a new screening tool?
10.	What are your clinics protocols for establishing new screening tools?
11.	How do you typically learn about new guidelines and recommendations? What about changes to existing guidelines and recommendations?
12.	Do have any final thoughts or suggestions for improving the screening of women patients for IPV and/or anxiety?

*A parallel question format was used for anxiety screening, in place of IPV as above.

Abbreviations: EHR, electronic health record; IPV, intimate partner violence; MA, medical assistant; PCP, primary care physician.

Table 3. Rapid Qualitative Analysis Matrix Domains

Participant Information	Anxiety Screening	IPV Screening
ID #	Clinic	Clinic
Role	ID	ID
Age	Role	Role
Gender	Description of clinic	Description of clinic
Race/Ethnicity	Are there standing protocols for anxiety	Are there standing protocols for IPV
Years at current practice	Anxiety Tool(s) used	IPV Tool(s) used
Years in profession	Anxiety Protocol and Workflow	IPV Protocol and Workflow
	Realities on the ground	Realities on the ground
	Symptoms that would trigger further questions	Symptoms that would trigger further questions
	Training	Training
	Documenting	Documenting
	What happens when someone screens positive?	What happens when someone screens positive?
	Telehealth piece	Telehealth piece
	Barriers	Barriers
	Facilitators	Facilitators
	Protocols for implementing new procedures	
	How do you stay up-to-date?	

Abbreviations: ID, participant ID; IPV, intimate partner violence.

procedure) within clinics for specific population groups (eg, male/female, adolescent/adult). For both preventive services, clinics used the same tool and screening protocol within the clinic for all adult patients. Clinics used the adolescent version of the screening tools for relevant populations but otherwise did not have different screening protocols for specific types of patients. All participants reported awareness of the importance of screening for anxiety and for IPV and identified the primary care setting as appropriate for screening, although they were often unaware of screening recommendations and ACA coverage.

Anxiety

Five of 12 clinics described having a universal anxiety specific screening practice because of patient populations with high rates of anxiety and/or the perception that this was an essential practice to provide quality care. When implemented, anxiety screening was conducted using the General Anxiety Disorder (GAD) screening tools, GAD-2 or GAD-7. Screening frequency, tool, and procedure did not differ for adult populations (eg, based on age, gender, or pregnancy status). The remaining 7 clinics used the GAD-7²⁹ for diagnostic purposes for patients who reported anxiety symptoms or used the GAD-2 for initial assessment of patients reporting symptoms. For clinics with a universal anxiety screening

protocol, screening workflows were identified for in-person visits while few clinics had integrated universal screening for telehealth visits. For most respondents, screening for depression, which was routinely done in most clinics, was perceived as a proxy for anxiety screening, which was not routinely done. One participant described the overlap between depression and anxiety screening in the following quote:

“I feel like we kind of already do [screen for anxiety] by talking about the depression screen, because everybody well, not everybody, but almost everybody has a score other than 0” -Medical Director, TIC

Intimate Partner Violence

Nine of 12 clinics described some type of universal screening for IPV, but respondents were generally unsure of current clinic-wide policies and practices. Like anxiety screening, IPV screening frequency, tool, and procedure were the same within a clinic for all adult populations. A variety of screening approaches were used for IPV screening. Most clinics describing a universal screening approach with a brief screening tool for IPV as a part of another screening tool (eg, social needs assessment, behavioral assessment, annual wellness questions, or health history questions). Screening approaches ranged from forms available in the electronic health record (EHR), article forms, or verbal questions directly

Table 4. Summary of Screening Barriers and Facilitators

Barriers	Facilitators
Both IPV and Anxiety: <ul style="list-style-type: none"> • Screening fatigue • No required health maintenance metric 	Both IPV and Anxiety: <ul style="list-style-type: none"> • Leveraging existing screening practices • Built-in EHR screening tools • Universal screening of all adult populations
Primarily IPV: <ul style="list-style-type: none"> • Documentation and reporting • Highly sensitive topic • Low prevalence in daily practice • Inadequate follow-up and resources 	Primarily IPV <ul style="list-style-type: none"> • Special training for sensitive topics • Clear protocols for follow-up
	Primarily Anxiety: <ul style="list-style-type: none"> • Increasing prevalence means increased awareness of need to screen • Age-appropriate tool for adolescents

Abbreviations: EHR, electronic health record; IPV, intimate partner violence.

from clinicians. Although there was low compliance with universal screening, all clinicians reported screening patients who were perceived as presenting with signs or symptoms of IPV during a visit.

Barriers and Facilitators to Screening

Barriers to Screening

For both anxiety and IPV, barriers to screening included screening fatigue, or the burden of completing too many questionnaires and forms, for both clinicians and patients (Table 4). In addition, participants described a broader concern around lack of time for addressing required health maintenance, especially for patients presenting with multiple medical concerns. Participants reported that “lack of integration in the EHR” and the “inability to report or document screening” were perceived barriers to routine screening. One participant described how they hoped integrating screening into the EHR would help address these barriers in the following quote:

“I’m hoping with EPIC, there’s less paperwork. . . so it’s quicker. . . If there’s a way to make that side easier, I think it would help also because. . . what other ways we can ask the questions without having to have the paperwork, but obviously we want the documentation,

right? So, you got to figure out the happy medium.”
–Clinic Administrative Manager, C3D

Clinic participants described the lack of payment incentives or clinical performance measures as significant barriers to implementation for both anxiety and IPV screening, indicating awareness of the competing priorities in primary care where guideline recommendations that are monitored with quality metrics are prioritized because of limited time and resources.⁵⁰ Respondents had a lack of awareness that screening can be billed as a preventive service and expressed concerns about limited resources, unclear performance measures, and lack of follow-up protocols.

For IPV screening, additional barriers included concerns about documentation and reporting, with some reluctance to document positive screening results based on concerns about patient safety or privacy. Some participants noted the high resource demand, including appointment time and staff/clinician emotional toll, that made addressing positive IPV screening difficult. Further, the perception of the low prevalence of IPV in daily practice was a concern for additional investment in limited clinic resources. Participants also expressed concern that a positive screen would not be addressed and wanted a formal process in place for follow-up and resources if a patient screened positive. This concern is demonstrated in the following quote:

“I think it’s tricky. I think it’s really important, but I also think that if you can’t support somebody, I do believe that you shouldn’t screen because you are presenting a situation where maybe you’re gonna give someone hope that you can help them when you can’t.”
–Medical Director, T2A

Participants underscored their concern about the sensitive nature of documenting IPV and the potentially negative consequences for the patient. Participants felt it was extremely important to be cautious of which IPV-related information was recorded in the patient’s chart, particularly if a perpetrator had access to the patient record or a visit summary a patient may take home. Given the level of caution around documentation of IPV, participants said that screening follow-up was rarely noted in the EHR.

Facilitators for Screening

For both services, participants suggested having screening tools for anxiety or IPV built into the

EHR with automatic notifications or reminders. Additional feedback from participants included creating opportunities to leverage existing screening practices and workflows would also facilitate increased screening by reducing the burden on clinical staff and patients (Table 4). Implementing practices for universal screening that would not vary by patient population, other than established age-appropriate tools for adolescents, was also identified by participants as a strategy to help normalize routine screening and reduce stigma. Participants felt that universal screening would also reduce clinic staff bias and help to identify positive screens that might have otherwise gone undetected. For IPV, participants also identified populations that could benefit from additional attention or specialized approaches, including Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) populations, adolescents, Spanish speakers, migrant or refugee populations, and prenatal or postpartum patients, who they considered at increased risk for IPV. Participants felt individuals in these groups may respond better to tailored screening, education, and referral approaches. For anxiety, the increasing prevalence and awareness among participants increased understanding about the need to screen for anxiety. Some reported a shift in individual and clinic level screening practices attributable to increased awareness.

Interviewees identified other facilitators for screening including using existing screening practices. For example, participants suggested using existing screening workflows as a framework to facilitate protocols for implementing IPV screening. Specifically, participants described a preference for integrating IPV questions into existing forms such as social needs screening, annual wellness forms, or substance use screening. In addition, participants noted that bundling screening services could reduce the likelihood that individual screenings would be missed. Participants described the importance of a clear clinical workflow for addressing positive IPV screens, such as provision of community resources (eg, information for a local shelter), facilitating warm hand-offs (eg, calling resources with the patient during the appointment or bringing in an in-house community health worker or behavioral health provider),³¹ and referring the patient to an outside group, where follow up with the patient was shielded from the provider, in an effort to ensure patient privacy. A

participant talks about the importance of follow-up in the following quote:

"Part of it is if we ask the question [about IPV], we need to be ready for the answer. And what does that look like on the other side... cause our clinicians here at [Clinic Name] want to do everything for everyone because they are wonderful humans." -Practice Manager, T4A

Participants often noted that because experiencing IPV is a sensitive topic for patients, it requires staff to be trained and prepared to handle it appropriately. Many participants expressed concern that staff may not be comfortable or aware of the best approaches to address IPV with patients and discussed that, in addition to implementing an IPV screening workflow, clinics may also need to invest time and resources into training staff on IPV best practices for identification, management and referrals. Participants often felt this was an important first step to successful IPV screening implementation. Consideration for the sensitive nature of IPV screening was expressed by a participant, stating:

"... If someone were to be having something really bad happen, if they can... say yes instead of saying something out loud, because I know that can be hard if you're going through a violent situation. So I think it's good... it's just kind of reminding people... we give these screenings to everybody... just for your own wellbeing." -Office Manager, C7C

Discussion

Interviews with 27 clinicians and staff in 12 primary care practices in a variety of community settings indicated that current practices and policies for anxiety and IPV screening vary widely. While some clinics reported screening for anxiety or IPV, variation in reported workflows, confusion around best practices, and limited documentation highlighted opportunities to improve implementation of recommended screening services. For anxiety screening, clinics commonly perceived it as part of depression screening, despite differences between the 2 conditions and separate screening tools and recommendations. For IPV, participants reported concerns about limited resources in place for referrals when screening was positive. For both preventive services, clinicians and staff were often unaware of screening recommendations and ACA coverage and acknowledged efforts to prioritize screening services that were more clearly attached to performance metrics. For

IPV specifically, concerns about privacy and safety were an important barrier to screening.

Universal screening for anxiety can identify patients experiencing unrecognized symptoms and lead to effective treatments in adults and adolescents.⁷ Brief screening instruments demonstrate comparable accuracy to longer instruments and are applicable to primary care practices. However, screening may not be appropriately implemented in practice. While some clinics reported screening for anxiety in this study, several relied on the patient health questionnaire (PHQ) as a universal screening tool because of the perceived overlap between anxiety and depression. Improved understanding of these differences could lead to more effective screening. In addition to the WPSI recommendation, a recent U.S Preventive Services Task Force (USPSTF) guideline for universal anxiety screening (B recommendation)¹ may help increase awareness of the differences between screening for anxiety and depression.

Clinical support materials responsive to barriers to and facilitators for screening for anxiety and IPV may facilitate implementation of screening in primary care practice. During this project, clinical support materials were developed in response to low screening rates and inconsistent screening practices identified by key informant interviews. Qualitative analysis of the interviews showed that participants believed screening could be facilitated by education; clarification of insurance coverage for screening; and resources and standardized protocols for screening methods, documentation, and referrals for patients with positive screening results. Participants suggested coupling screening for anxiety with screening for depression, which is more commonly implemented, to optimize the opportunity to screen for both conditions using screening tools appropriate for each condition. In addition, participants expressed uncertainty about how to assess the risk for self-harm when screening for anxiety and depression and for patient safety when screening for IPV.

Primary care is the most common first contact with the health care system and has been identified as an increasingly important setting for IPV screening and referrals.³² Utilization of health care services is 20% higher among women experiencing current or past IPV,³³ providing many opportunities to deliver appropriate IPV-related care. Despite research supporting the importance of identifying best practices for IPV screening and

referral,³⁴ recent studies have focused on specific components or considerations for screening rather than factors influencing screening uptake.³⁵ Access to services may occur through multiple clinical pathways,²⁰ including services to treat an IPV-related condition, such as an injury resulting from acute trauma as a direct consequence of IPV; or when receiving care for different reasons, such as during a routine maternity visit.^{2,4} The WPSI recommends universal IPV screening, at least annually, and, when needed, providing or referring for initial intervention services.⁴

Limitations of this project include its reliance on a small number of participants from clinical networks in one region of the United States. However, the sample represented a variety of clinic settings, including urban and rural clinics, and participants with different clinical roles. Findings may not be applicable in other states since Oregon has a unique payment context with Coordinated Care Organizations (CCOs), or managed care organizations for Medicaid-insured patients, that affects incentives and how clinics prioritize efforts in their practice. Recently, Oregon added the “SDOH: Social Needs Screening and Referral” measure in 2023 to the set of incentive measures, which includes an IPV metric, potentially impacting rates of IPV screening in incentivized clinical settings. Importantly, interviews about screening practices are subject to recall bias or social desirability bias, resulting in participants who may overestimate the amount of screening conducted.³⁶ Similarly, clinics’ screening policies may not be followed precisely by all clinic members.

How to effectively measure the frequency of screening given the high level of concern around documenting IPV in the patient record, remains a challenge. Despite the lack of new research, the findings from this project indicate that implementation of recommended services in primary care settings is low and that clinician resources and education could improve uptake. Additional studies support increased education and training as strategies to address clinicians’ perceived barriers to IPV screening. Future research directions for IPV screening include standardizing approaches for data audit and data capture to learn how to measure changes in screening practices. Further evaluation of effective metrics for routine anxiety and IPV screening and changes in screening practices over time is needed. Site observations to observe screening interactions and follow-ups could help identify

missing information about clinical workflows. Protocols and universal workflows, including information about additional resources and referrals could also improve screening uptake and ensure patient safety, confidentiality, and follow-up to reassure patients and clinical staff. Clinicians and staff participating in this study, along with experts and clinicians reviewing the clinical workflow diagrams, endorsed the clinical applicability of the one-page workflow diagrams of the screening process and the resource guides providing detailed information and resources. However, these materials serve only as a starting point for implementing screening in individual clinics and health systems.

Clinical workflows require additional customization to meet specific needs of individual practices and settings, such as choosing screening tools; creating protocols and assigning roles for screening, referrals, and follow-up; identifying local resources within and outside health systems; documenting encounters; and coding and billing for services, among others. Integration with the health system EHR, providing adequate staffing and scheduling, and training clinicians and staff, including designated clinical advocates, require additional efforts beyond the scope of the support materials.³⁷ Nonetheless, clinical support materials may bridge essential gaps in the implementation of screening and have potential to improve identification and management of anxiety and IPV.

Improvement in rates of screening for anxiety and IPV may occur through additional efforts, including development of national and health system quality metrics for screening. Next steps in this project include dissemination of training materials to support clinician education. Awareness around current screening recommendations and coverage, and the availability of brief, clinically validated, and effective screening tools could also improve application of recommended preventive services.

Conclusion

Implementation of routine screening for anxiety and IPV in women and adolescents in primary care is low but may improve with targeted clinician resources and education. Workflow diagrams and resource guides responsive to identified screening barriers and facilitators, including clarification of insurance coverage for preventive services, and resources to support implementation of protocols

of screening methods, clinical documentation, and referrals for anxiety and IPV in primary care settings, could improve screening practices.

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Appendix

Interview Guide

CLINIC MEMBER

PREVENTIVE SERVICE TEST SITES/ WOMEN'S PREVENTIVE SERVICES INITIATIVE IMPLEMENTATION PILOT PROGRAM

Greeting

Hi.
My name is...
Thank you for agreeing to do this interview.

Information sheet review / Consent

Have you had a chance to look at the Information Sheet that I sent you? I can also email another copy if you need one. Do you want to take a look? What questions can I answer for you?

Permission to record

Do I have your permission to record this interview? Great. I am going to turn on the recording device and ask you that question again for the record.

[Turn on the recording device.]

Do I have your permission to record this interview?

Purpose of the interview

I am speaking with you today because your clinic has agreed to participate in a study related to screening women patients for interpersonal violence, or IPV, and anxiety. In turn, I will ask you to tell me a little bit about yourself and your thoughts and experiences with **screening women and adolescent female patients** for IPV and anxiety.

Introduction of Interviewer

I'd like to start by telling you a little bit about myself. I am [name]. I work at [name].

1. Could you tell me about yourself?

Probes:

- o Educational background
- o Role in clinic
- o What are your direct care responsibilities
- o Prior work experience – how you came to be working at this clinic
- o Other experiences

2. Can you tell me a bit about your clinic?

Probes:

- o Size, location, community/ patients served, priorities

Thanks for sharing that. Now, I would like to talk with you about screening practices in your clinic. Let's focus on IPV screening first. Please think about your work in the clinic when you consider the following questions.

1. Can you discuss how your clinic is involved in screening for IPV.

IF RESPONDENT HAS INDICATED SOME TYPE OF IPV SCREENING PRACTICE:

I would like to drill down into some specifics around your IPV screening practices

2. Do you have standing protocols available to guide IPV screening in your clinic?

Probes:

- o Can you describe if you use these protocols and when?
- o If IPV screening tools are used, do you know their names?
- o Which screening tools do you most commonly use?
- o Can you describe to us how you were trained on these protocols?
- o Are your screening protocols implemented universally? How do screening practices differ for a) women b) by age or pregnancy status, and/or c) female or female-identifying adolescents?

3. Outside of your standing protocols, what symptoms in a patient or family would prompt you to screen for IPV?

4. Can you walk me through how you document a screening for IPV in your EHR?

Probes:

- o Where in the chart is it documented?
- o Is there a specific procedure code used to chart this?
- o Do you document in free text fields?

5. Who else is involved in the screening or documentation? (prompts: MA, behavioral health, social worker, PCP)

6. What happens at the clinic if a patient screens positive? Who / which roles are involved?

7. How would screening and documentation differ for a telehealth visit compared to an in-person visit?

IF RESPONDENT DESCRIBES NO IPV SCREENING PRACTICES AT THEIR CLINIC:

8. Has your clinic considered implementing IPV screening? How would you go about finding out what the guidelines are? How would you find a screening tool?
9. Have you considered doing IPV screening as part of your personal practice? How would you go about finding out what the guidelines are? How would you find a screening tool?
10. Are there any indications from a patient or family would prompt you to screen for IPV?
11. Can you walk me through how you would document a screening for IPV in your EHR.
12. *Only ask if screening happens in some form:* What happens at the clinic if a patient screens positive? Who / which roles are involved?
13. How would screening and documentation differ for a telehealth visit compared to an in-person visit?

FOR ALL RESPONDENTS

14. How do you think the providers and staff at your clinic would respond to universal screening for IPV?
 - Probe:
 - o Do you have a sense if providers expect questions around IPV to be asked by a specific clinical service/team or at a specific point in time (e.g., as part of prenatal care)?
15. How do you think your patients would respond to universal screening for IPV?
16. What kinds of infrastructure changes do you think would be needed to do universal IPV screening?
 - Probes:
 - o Changes in scope of practice? Changes in formal policies? Changes in information systems or electronic records systems? Staffing? Other?
 - o What kind of approvals will be needed? Who will need to be involved?
 - o Can you describe the process that will be needed to make these changes?
17. Do you have any concerns about universal screening for IPV? Can you elaborate on those?
18. What are facilitators and barriers to adopting a new screening tool?

Now let's shift gears to focus on screening for anxiety. Again, please think about your work in the practice when you consider the following questions.
19. Can you discuss how your clinic is involved in screening for anxiety.
 - Probes:
 - o If there is no explicit tool, do you have any other screening tools that you feel cover anxiety (e.g., SBIRT)?

IF CLINIC HAS INDICATED SOME TYPE OF ANXIETY SCREENING PRACTICE:

I would like to drill down into some specifics around your anxiety screening practices

20. Do you have standing protocols available to guide anxiety screening in your clinic?
 - Probes:
 - o Can you describe if you use these protocols and when?
 - o If Anxiety screening tools are used, do you know their names? (Prompts: do you use the GAD-2, or the BA)
 - If there are multiple tools, which screening tools do you most commonly use?
 - o Can you describe to us how you were trained on these protocols?
 - o Are your screening protocols implemented universally? How do screening practices differ for a) women b) by age or pregnancy status, and/or c) female or female-identifying adolescents?
21. Outside of your standing protocols, do you screen patients for anxiety if they have anxiety symptoms? If so, what screening tool or tools do you most commonly use? What are common symptoms that you see that prompt you to screen for anxiety?
22. What about patients who don't have any symptoms? Do you ever screen those patients for anxiety? What types of patients would you consider screening, even if they don't have symptoms? Do you use the same screening tools previously described?
23. What happens at the clinic if a patient screens positive? Who / which roles are involved?
24. Can you walk me through how you document a screening for anxiety in your EHR?
25. Who else is involved in the screening or documentation? (prompts: MA, behavioral health, social worker)
 - Probes:
 - o Do you know of anyone at your clinic who screens patients for anxiety even if they have no symptoms?
26. Does screening differ for adolescent patients compared to adult patients? What additional considerations are there for you for adolescent patients? Prompt for differences for adolescents in all follow-up prompts and questions.
27. How would this differ for a telehealth visit compared to an in-person visit?

IF RESPONDENT DESCRIBES NO SCREENING PRACTICES AT THEIR CLINIC:

28. Has your clinic considered implementing anxiety screening? How would you go about finding out what the guidelines are? How would you find a screening tool?

IF RESPONDENT DESCRIBES NO SCREENING PRACTICES AT THEIR CLINIC:

28. Has your clinic considered implementing anxiety screening? How would you go about finding out what the guidelines are? How would you find a screening tool?
29. Have you considered doing anxiety screening as part of your personal practice? How would you go about finding out what the guidelines are? How would you find a screening tool?
30. Are there any symptoms in a patient or family would prompt you to screen for anxiety?
31. Can you walk me through how you document a screening for anxiety in your EHR.
32. *Only ask if screening happens in some form:* What happens at the clinic if a patient screens positive? Who / which roles are involved?
33. Who else is involved in the screening or documentation? (prompts: MA, behavioral health, social worker)
Probes:
 - o Do you know of anyone at your clinic who screens patients for anxiety even if they have no symptoms?
34. Does your thought process differ for adolescent patients compared to adult patients? What additional considerations are there for you for adolescent patients? What about pregnant patients?
35. How would this differ for a telehealth visit compared to an in-person visit?

FOR ALL RESPONDENTS

36. How do you think the providers and staff at your clinic would respond to universal screening for anxiety?
37. How do you think patients at your clinic would respond to universal screening for anxiety?
38. What kinds of infrastructure changes do you think would be needed to implement universal anxiety screening?
Probes
 - o Changes in scope of practice? Changes in formal policies? Changes in information systems or electronic records systems? Other?
 - o What kind of approvals will be needed? Who will need to be involved?
 - o Can you describe the process that will be needed to make these changes?
39. Do you have any concerns about universal screening for IPV? Can you elaborate on those?
40. What are facilitators and barriers to adopting a new screening tool?

Thank you for all that great information. Now I would like to shift gears to talk about how information is shared and disseminated in your clinic.

41. What are your clinic's protocols for establishing new screening tools?
Probes
 - o How are new screening tools proposed?
 - o Who is generally involved in these decisions?
42. How do you typically learn about new guidelines and recommendations? What about changes to existing guidelines and recommendations?
43. How do you typically find out about new information at the clinic, such as new initiatives, accomplishments, issues?
44. When you need to get something done or to solve a problem, who are your "go-to" people at your clinic?
Probe
 - o Can you describe a recent example?

Thank you for taking the time to speak with us today. You have provided us with a lot of great information today.

Before I close, I would like to ask if you have any final thoughts or suggestions for improving the screening of women patients for IPV and/or anxiety?

Finally, I have a few final questions related to your background. You have the right to decline to answer any or all of the following:

- What is your age?
- *[if not answered previously]* How long have you been practicing medicine?
- How would you describe your racial/ethnic background?
 - American Indian/Alaska Native
 - Black/African American
 - Other, specify: _____
 - Asian
 - White/Caucasian
 - Refused
 - Native Hawaiian/Other Pacific Islander
 - More than one race

- **Are you Spanish, Hispanic, or Latino?**
 - Yes
 - No
 - Refused

- **With which gender do you identify?**
 - Man
 - Woman
 - Non-binary
 - Other: _____
 - Prefer not to say

Closing: Do you know anyone at your clinic who screens patients for IPV or anxiety even if they have no symptoms? If yes, could we get their name and role, after we turn off the recording?