

Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers

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## Table of Contents

Abstract.....	3
Introduction.....	4
Significance of the Problem.....	4
Clinical Question .....	6
Focus Areas.....	7
Project Short and Long Term Goals .....	7
Global Impact.....	8
Organizing Framework .....	8
Project Design.....	11
General Approach.....	11
Setting .....	11
Procedural Steps.....	12
HIPAA Concerns .....	15
Project Results .....	17
Analysis of the Results.....	21
Organizational Impact/Implications to Practice and Policy.....	25
Future Directions for Research and Practice .....	26
Limitations .....	28
Conclusion .....	29
References.....	31
Appendices.....	35

**ABSTRACT****Phase II Site:** Joint Base Lewis McChord**DNP Project Title:** Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers**Authors:** Kim, I. O., Mahoney, J. J., & Negard, J. T.**Background or Problem/Issue:** The Department of Defense (DoD) is working to address sexual assault in the military through sexual assault prevention, education, and reporting programs. To date, few programs in many military outpatient clinical settings are in place to identify patients with a previously unreported history of sexual assault, and the guidelines for documenting and providing appropriate treatment are lacking. Many cases of sexual assaults (SA) remain unreported, leaving high numbers of survivors without care or assistance (Farris, Schell, & Tanielian, 2013). These traumatic experiences can interfere with a person's sense of well-being, creating a disequilibrium often expressed in physical illness which may impair the individual's ability to carry out daily functions (Farris et al., 2013). Additionally, SA survivors are three times more likely to be at risk for mental health conditions, including depression, anxiety disorders, and substance abuse (Conard, Young, Hogan, & Armstrong, 2014).**Clinical Question or Purpose:** How do health care providers (HCPs) attached to Madigan Army Medical Center (MAMC) and assigned to outpatient primary care, OB/GYN, and Behavioral Health, document a patient's disclosure of a previously unreported sexual assault in an Electronic Health Record (EHR)?**Project Design:** A one-time cross-sectional web-based questionnaire was disseminated among outpatient healthcare providers attached to Madigan Army Medical Center between the dates of 11 January 2016 – 19 February 2016. A total of 114 responses were included for analysis.**Analysis of the Results:** Most of the HCPs (n=96, 85%) in the outpatient clinical setting have provided care for at least one patient reporting a SA history, and 35.4% (n=40) have cared for more than 20 patients over the course of their clinical practice. But, less than half (40.6%, n= 45) reported having a SA CPG in their current clinical setting, and 39.6% (n=44) did not know if their clinic had one or not. Most significantly, 69.1% (n=76) of all HCPs in the outpatient clinical setting reported that a patient had disclosed to them a previously unreported SA, yet only 42.4% (n=47) reported properly using an ICD-9 or ICD-10 code specific to SA to document a SA diagnosis. Finally, HCPs reported the primary barriers to documenting in the EHR a patient's delayed disclosure of a SA were patient stigmatization (n=30, 30.6%) and lack of training (n=29, 29.6%).**Organizational Impact/Implications for Practice:** The HCPs who participated in this project reported relying on previous limited training or the use of personal judgment to make a decision of how a diagnosis was coded in the EHR. HCPs also utilized personal experience that may or may not be adequate based on current evidence based practices. Proper documentation and use of ICD-9 or ICD-10 code for sexual assault, will address the gap between the number of sexual assaults committed and those reported. This gap may contribute to the relay of inaccurate data back to the DoD, which in turn continues to direct the focus of sexual assault training towards SA prevention and early reporting by the survivors. This project offers support to advise the DoD to place emphasis on HCP training in the provision of informed accurate documentation practices, the delivery of optimal, compassionate care of patients who present to outpatient clinics with a history of undisclosed SA, including those SA related health care issues. By receiving proper sexual assault care as early as possible, the DoD may be able to lessen the costs of long-term care effects created by the initial trauma (Conard, Young, Hogan, & Armstrong, 2014).

### Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers

The Department of Defense (DoD) is working to address sexual assault in the military through sexual assault prevention, education, and reporting programs. To date, few programs in many military outpatient clinical settings are in place to identify patients with a previously unreported history of sexual assault, and the guidelines for documenting and providing appropriate treatment are lacking. Many cases of sexual assaults (SA) remain unreported, leaving high numbers of survivors without care or assistance (Farris, Schell, & Tanielian, 2013). These traumatic experiences can interfere with a person's sense of well-being, creating a disequilibrium often expressed in physical illness which may impair the individual's ability to carry out daily functions (Farris et al., 2013). Additionally, SA survivors are three times more likely to be at risk for mental health conditions, including depression, anxiety disorders, and substance abuse (Conard, Young, Hogan, & Armstrong, 2014).

### **Significance of the Problem**

#### **Sexual Assault Rates**

Sexual assault has become a priority for the DoD in recent years (DoD, 2014). For Fiscal Year (FY) 2012, it was estimated that approximately 26,000 active duty service members had been victims of sexual assault. This equates to 6.1% of active duty women (n~12,100) and 1.2% of active duty men (n~13,900). Since 2006, the incidence of sexual assault has remained at approximately 5% of the total number of respondents to DoD surveys of active duty service members, but the total number of SA reported are steadily increasing. In 2012, only 13% (n=3,374) of the estimated total number of assaults were reported (DoD, 2014). The following year a 50% increase in the number of sexual assaults was reported (n=5,061) (DoD, 2014). As opposed to viewing this as increasing incidence of acts of sexual assaults occurring, this may

indicate greater confidence in the reporting process of sexual assault, and perhaps, greater trust in care providers.

The FY 2013 DoD annual report supports the conclusion that increased reporting of sexual assault was due to increasing trust in the reporting system (DoD, 2014). The military's sexual assault prevention, education, and reporting programs appear to be reaching the targeted audience, bolstering knowledge and confidence for reporting these occurrences (Farris et al., 2013). Another aspect of the FY13 reporting numbers is that 10% of the total reports are from assaults that occurred prior to entering military service (DoD, 2014). In previous years, this percentage had never been over 4%. This figure may indicate that the sexual assault prevention programs in place throughout the military are encouraging a climate that supports reporting and obtaining care for those who have become survivors at any time in their lives.

### **Barriers to Seeking Care/Reporting Sexual Assault**

Though the rate of reporting of sexual assault has increased, the gap between reported sexual assaults (SA) and the estimated actual incidence of SA remains great. Despite command support and education for reporting sexual assault, survivors offer many reasons for not reporting the SA or for reporting SA later in life. For example, service members have admitted that there is a lack of understanding of what constitutes sexual assault or how and why it should be reported. Other service members are reluctant to report the assault, as their attacker may be a superior officer or a supervisor (Farris et al., 2013). Additionally, being a service member of a small, tight-knit unit, the fear of negative performance reports out of retaliation, and the punishment for taking part in prohibited behavior prior to the assault such as underage drinking, drugs, or fraternization, all contribute to decreased reporting (Farris et al., 2013).

According to Munro (2014), survivors' perceptions of the social stigma attached to the incident and the belief that the assault was not serious enough to warrant using services also prevent reporting. The lack of knowledge of where to find post-assault care was also found to be a barrier. HCPs must keep in mind that the healthcare community is responsible for minimizing the structural barriers to seeking care for those patients with a previously unreported history of sexual assault (Munro, 2014).

### **Role of Healthcare Professionals**

The gap in sexual assault reporting exists and may not only be due to the survivor's reluctance to report, as HCPs have reported barriers to properly documenting the care for SA survivors. HCPs have reported they are not comfortable diagnosing SA due to lack of time in the daily schedule to handle the SA adequately, and a lack of education and discomfort in a process that is not clearly defined with an evidence based clinical practice guideline has also been identified (Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013; McCall-Hosenfeld, Weisman, Perry, Hillemeier, & Chuang 2014).

Ensuring HCPs are properly trained in assessing, coding, caring for, and documenting sexual assault is paramount to supporting and treating the increasing number of survivors reporting a SA. Proper support and follow-up care is necessary for the well-being of those in whom a previously unreported sexual assault is identified, as it will give these survivors a chance to receive appropriate treatments for any new, recurrent, or unresolved symptoms resulting from the original sexual assault incident.

### **Clinical Question**

#### **Clinical Inquiry Question**

How do health care providers (HCPs) attached to Madigan Army Medical Center (MAMC) and assigned to outpatient primary care, OB/GYN, and Behavioral Health, document a patient's disclosure of a previously unreported sexual assault in an Electronic Health Record (EHR)?

### **Focus Areas**

The aim of this Doctor of Nursing Practice (DNP) project was to explore the challenges and barriers for HCPs attached to MAMC and assigned to outpatient primary care, OB/GYN, and Behavioral Health, to using the appropriate ICD-9 or ICD-10 codes in the Armed Forces Health Longitudinal Technology Application (AHLTA) for documenting a patient's disclosure of a previously unreported sexual assault. The investigators of this DNP project sought to identify if barriers to documentation reported in the literature (such as a lack of knowledge of the proper codes, comfort level in documenting sexual assault, or lack of education on current best practice and clinical practice guidelines) are also reported among the MAMC HCPs.

### **Project Short Term Goals**

The short-term goal of this DNP project was to gather data from HCPs attached to MAMC and assigned to outpatient primary care, OB/GYN, and Behavioral Health, to using a confidential web-based email questionnaire. Data was analyzed for correlations to existing literature on challenges and barriers to documentation. This data and subsequent findings will provide guidance on best practice for provider training to be used by phase II investigators of future DNP projects at MAMC.

### **Project Long Term Goals**

The long-term goal of this DNP project is the creation of standardized training and dissemination to HCPs attached to MAMC to improve documentation for the proper care of

sexual assault survivors who present to outpatient primary care, OB/GYN, and behavioral health clinics with a history of a previously unreported sexual assault. Afterwards, the same exploratory web-based questionnaire will be disseminated to the HCPs to determine adequacy of training.

### **Global Impact**

Standardized training disseminated to all DoD medical facilities will impact documentation for the optimal care of patient of sexual assault survivors who present to outpatient primary care, OB/GYN, and behavioral health clinics with a history of a previously unreported sexual assault. Additionally, identifying and addressing healthcare providers' barriers to proper documentation a patient report of a previously undisclosed sexual assault may increasing the DoD reporting rates of sexual assault, as improving healthcare providers' current documentation practices is necessary to address the gap between the number of SAs reported and the total number of assaults committed.

### **Organizing Framework**

The Donabedian framework was used to guide this DNP project, as it was optimal for assessing the providers' challenges and barriers to documenting previously undisclosed sexual assaults, with the goal of maximizing patient care outcomes and standardizing sexual assault (SA) documentation variances (Lawson & Yazdany, 2012). A HCP's lack of awareness regarding proper documentation may result in disparities for the care of SA survivors. This is the first step in understanding the discrete components of the providers' proper documentation and potential gaps in patients' care outcomes.

Donabedian (2003) defined quality assurance as "all actions taken to establish, protect, promote and improve the quality of health care". He did not believe that quality could be assured or guaranteed, but that the goal should be to increase the probability that the health care



delivered would be better quality over time (Block, 2006). The targets of quality assurance are services provided to patients, in addition to the functions and activities provided by all members of the healthcare team both directly and indirectly patients (Block, 2006).

Figure 1. The Donabedian Framework



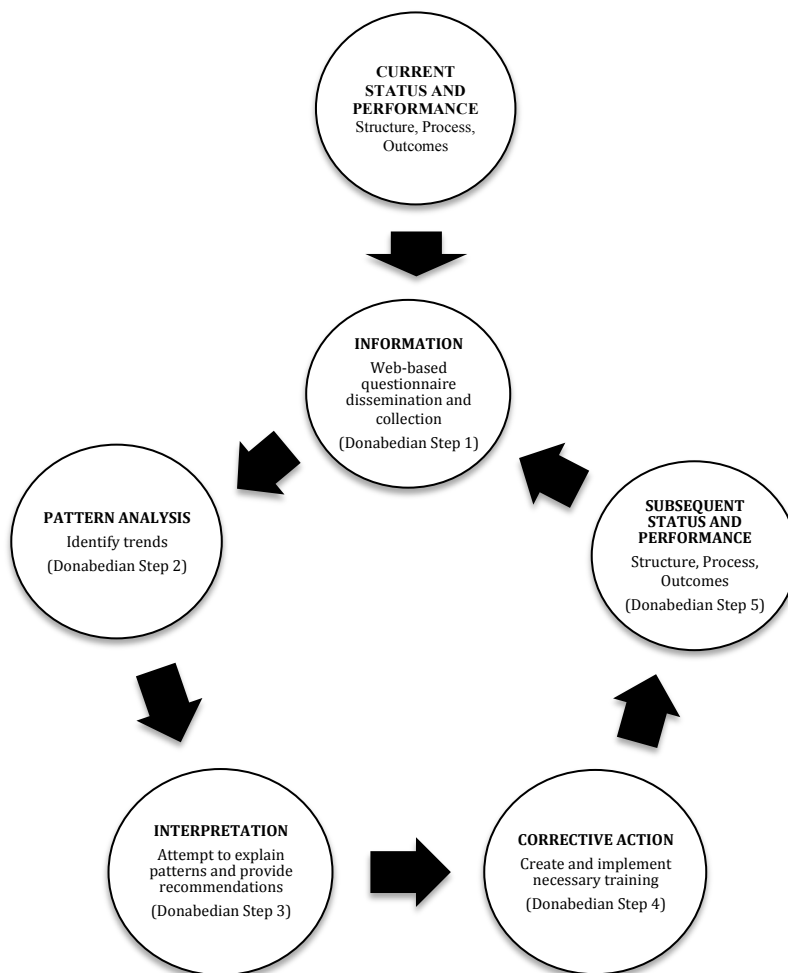
The Donabedian Framework was created as a method for assessing the quality of care delivered. This framework (Figure 1) includes three related concepts: structures, processes, and health outcomes. Structures are the physical and organizational aspects of care settings, and processes rely on the structures to provide the resources and mechanisms to provide patient care. The relationship between the structures and processes lead to the outcomes, which is the quality of patient care (McDonald, Sundaram, & Bravada, 2007). For this project, the structures were identified as the outpatient HCPs, the processes were the proper documentation of sexual assault, and the health outcomes were the receipt of appropriate care for the SA survivor.

To improve the quality of healthcare, it must be monitored, evaluated, and readjusted. These are continuous activities, and Donabedian created the Quality Monitoring Cycle (Table 1) to explain how to perform that function. The cycle is meant to be performed over and over again, as quality monitoring is continuous, just as healthcare delivery never rests (Block, 2006). Figure 2 is a visual representation of the Quality Monitoring Cycle and it was used to guide the procedural steps of this DNP project.

Table 1. *The Quality Monitoring Cycle*

1. Obtain data on performance
2. Perform pattern analysis – an epidemiological activity that identifies time, place, person, and function
3. Provide interpretation by advancing hypotheses that might explain the patterns observed.
4. Take preventive, corrective, or promotive action based on the causal hypotheses that have been advanced (i.e., resources, duties, functions, procedures, education).
5. Obtain data on subsequent performance to determine the consequences of the actions taken.

*Note.* Table created from material in Donabedian, A. (2003). *An introduction to quality assurance in health care*. New York, NY: Oxford University Press. Table adapted from Block, D. (2006). Quality improvement in healthcare – Donabedian’s principles of quality improvement. In D. Block (Ed.), *Healthcare outcomes management: Strategies for planning and evaluation* (pp. 9-24). Sudbury, MA: Jones and Bartlett Publishers

Figure 2. *The Quality Monitoring Cycle*

*Note.* Figure adapted from American Physical Therapy Association. (2011, February 1). *Outcomes assessment in physical therapy education*. Retrieved from [http://www.apta.org/uploadedFiles/APTAorg/Educators/Assessments/Outcomes\\_Assessment/OutcomesAssessment\\_Full.pdf](http://www.apta.org/uploadedFiles/APTAorg/Educators/Assessments/Outcomes_Assessment/OutcomesAssessment_Full.pdf)

## **Project Design**

### **General Approach**

For this DNP project, a convenience sampling of HCPs attached to MAMC was used. A web-based questionnaire was created and disseminated to explore outpatient primary care, OB/GYN, and behavioral health clinic HCPs' challenges and barriers to using ICD-9 or ICD-10 codes to document a patient's disclosure of a previously unreported sexual assault. A web-based questionnaire approach was chosen based on the advantages such as: access to specific, sometimes difficult-to-find populations, speed of data access, and decreased costs for both data collection and data entry (Duffy, 2002).

The population selected to participate in this DNP project were HCPs working in outpatient clinics at Madigan Army Medical Center (MAMC), to include medical doctors (MD), doctors of osteopathy (DO), nurse practitioners (NP), physician's assistants (PA), licensed specialist clinical social workers (LSCSW/LCSW), licensed clinical mental health counselors (LCMHC/LMHC), licensed professional clinical counselors (LPCC/LPC), doctors of psychology (PsyD). Licensed providers that were not listed on the questionnaire were provided the option to write-in their profession in the comments section.

Participants were asked to complete an 11-item questionnaire regarding challenges and barriers currently encountered when documenting a patient's disclosure of a previously unreported sexual assault. All responses were confidential with no personally identifiable information collected (see Appendix L).

### **Setting**

The setting for this DNP project was MAMC, which is the second largest health readiness platform in the Army's Medical Department. It is located in Tacoma, Washington on

Joint Base Lewis-McChord (JBLM). This facility serves over 100,000 beneficiaries to include Active Duty, dependents, and retiree populations. MAMC is a tertiary care facility, with numerous specialty services, a Level II trauma emergency room, and a 220-bed inpatient capacity. On an annual basis, over one million outpatient visits are completed.

*Target Population* - The target population for this DNP project included all HCPs attached to MAMC outpatient clinics, both male and female, who are no longer in student status. There were no regards for race or ethnicity in the target population.

*Inclusion Criteria* – All non-student military or civilian licensed HCPs working within the MAMC primary care clinics, in addition to those HCPs working at the specialty clinics of OB/GYN and Behavioral Health were asked to participate. Providers had to have authority to enter ICD-9 and ICD-10 codes into the AHLTA Assessment/Plan (A/P) section for patient encounters.

*Exclusion Criteria* – All military or civilian primary care providers working in MAMC outpatient clinics who are in student status (NP students, medical students, interns, etc.) were excluded from participation in this questionnaire, due to limited patient exposure and training.

### **Procedural Steps**

1. Partnered with Madigan Department of Clinical Investigations office to attend Protocol Development Workshop in May 2015 to discuss project feasibility and receive advice from Madigan researchers on project implementation.
2. *Creation of Questionnaire* – Due to the lack of a valid and well-structured questionnaire regarding challenges and barriers to SA, an 11-item web-based questionnaire was constructed to ask primary care providers about their ICD coding behaviors when documenting a patient encounter after disclosure of a previously unreported sexual

assault (see Appendix L). Eleven items were used as literature has shown that shorter questionnaires minimize survey fatigue (Zapier, 2016). The aim was to determine if the providers had been trained in documenting sexual assaults, and if there were barriers to properly documenting an ICD-9 or ICD-10 code for a sexual assault. Using current literature, the web-based questionnaire was developed using responses and barriers reported by medical providers to various healthcare topics, such as counseling patients, disclosure of intimate partner violence, and discussing obesity (Khandalavala, Rojanala, Geske, Koran-Scholl, and Guck, 2014; Searight, 2009; Sutherland, Fontenot, and Fantasia, 2014).

The first three items were basic demographics (years of practice, gender, and type of provider) and the last was an open comment box to allow a respondent to add additional information. Items four through seven were used to identify how many sexual assault patients a provider had cared for in their career, if a patient had ever disclosed a previously unreported sexual assault, if the provider had received training regarding how to document a sexual assault in an Electronic Health Record, and if there was a clinical practice guideline regarding sexual documentation currently in place at the provider's workplace. Items eight and nine queried if a provider had ever used the ICD-9 or ICD-10 codes associated with sexual assaults, and if not, there was an open text box to enter the codes that were used and an explanation for why this was done. Finally, question ten was a multiple-select that allowed providers to choose several barriers that might keep them from entering a sexual assault diagnosis into a patient's chart, and offered an open text box to enter perceived barrier's that were not listed in the answer choices. (see Appendix L).

3. *Pilot Study* - A pilot study was conducted to ask for feedback and confirm content of questions constructed. The web-based questionnaire was sent to nurse practitioners working at three different Military Treatment Facilities (MTFs) in the United States. These providers reviewed the questionnaire and then further offered to distribute the questionnaires to other providers in their clinics. Pilot participants were asked to keep track of the amount of time required to complete the eleven items and provide suggestions for improvement. Ten questionnaires were distributed and eight were returned. No one included the length of time it took to complete the study, but some HCPS provided feedback that was incorporated into the final version.
4. Wrote and submitted a protocol for Institutional Review Board approval. The protocol package included a copy of the web-based questionnaire and email scripts that accompanied each email and as part of the morning meetings at which the investigators introduced the topic and recruited participants. There was also a copy of a flyer that had been approved by MAMC Public Affairs Office (PAO) to advertise the study (see Appendix M).
5. Obtained IRB approval and uploaded letter of determination into required locations (see Appendix N).
6. Met with a MAMC Informatics Supervisor to incorporate the web-based questionnaire into Survey Monkey and to create the target population email addresses master list.
7. Prior to dissemination of the web-based questionnaire, the investigators attended morning meetings at outpatient clinics to introduce the project and recruit participants. The purpose of meeting face-to-face with providers was to create buy-in by clinic managers

and increase participation. The flyers were also posted in provider work areas and designated break-rooms.

8. Proceeded with data collection.
  - a. January 11 – Feb 19, 2016: an email was sent out to all providers every Monday night to maximize participation on Tuesday mornings. The emails were sent out weekly to remind providers of the ongoing project. A link was included with the email that would take the participant to the web-based questionnaire (see Appendix J).
9. Upon completion of data collection, data analysis was conducted.

*Description of the Recruitment and Prescreening Process* - All primary and specialty care providers meeting inclusion criteria were provided an opportunity to complete an 11-item questionnaire. To maintain the confidentiality of the participants, prescreening took place by the Department of Clinical Investigations Informatics Supervisor. The informatics supervisor was responsible for creating a master list of government email addresses for all primary and specialty care providers at MAMC who meet the inclusion criteria. Prior to dissemination of the questionnaire, investigators attended the morning meetings of each clinic at least once to provide a short (no longer than 5 minutes) overview of the project and its importance (see Appendix J, Presentation Script for Morning Provider Meetings). The web-based questionnaire was then emailed to each provider on the master list. A flyer was also placed in the provider workrooms to remind them to complete the web-based questionnaire (see Appendix M).

### **HIPPA Concerns**

*Confidentiality* - No identifiable information was collected from those who participated in the project. All responses returned through Survey Monkey were encrypted. IP address info

was embedded in a returned questionnaire, but was not tied to any particular individual. The information requested was the minimum necessary to meet the research objectives while providing the highest levels of privacy for the subjects. The surveys were de-identified, and there was no way of linking the results with any specific individual. The investigators were not able to identify if a provider had or had not volunteered to take the survey.

*Coercion* - All participants were informed before beginning the web-based questionnaire that participation was completely voluntary. Participation in the web-based questionnaire signified a desire to participate without the threat of coercion or promise of reward (see Appendix K).

*Volunteerism* - All participants in the web-based questionnaire volunteered their information freely and were not compelled in any way to participate.

*Protection against risks* - Participants of the web-based questionnaire were free to withdraw participation at any time by simply not completing the web-based questionnaire. All participants were free from negative consequences.

*Data Safety* - The data from the web-based questionnaire was confidential with no IP address collected from participants. After collection the data was stored electronically on a firewall and encrypted password protected secure server at MAMC. Only the investigators and the informatics specialist had access to any data collected.

*Health Insurance Portability and Accountability Act (HIPPA) Compliance* - In accordance with federal regulations for adequate protection of human subjects the investigation team members have been certified by completion of the Human Subjects Protection for Research sponsored by MAMC. This particular project was ruled exempt by the MAMC IRB office as no patient/provider information was collected.



*Inclusion of women and minorities in clinical research* - There was no exclusion from this study based on gender, ethnicity, or race.

*Inclusion of children* - No children were included as participants in this project.

*Consent process* - A cover sheet was included with the web-based questionnaire, and completion of that questionnaire implied consent (see Appendix K). The cover sheet named the principal investigator, a general statement why this study was being done, inclusion criteria, study expectations, estimated length of time, potential benefits to the participant (no personal benefit), risks to the study (no known risks with taking an online survey), confidentiality and privacy of answers, the voluntary nature of the study, the subject's ability to withdraw at any time, and contact information.

### **Project Results**

Descriptive statistics were used to analyze, organize, summarize, and describe the collected data regarding provider knowledge of the ICD-9 and ICD-10 codes used for sexual assault, and the ways in which providers document a patient's history of a previously unreported sexual assault. Provider responses were collected through email distribution of questionnaires using Survey Monkey. Any unusual data was checked for possible data entry error and verified prior to any analyses being performed. An initial confirmatory analysis was performed by the investigators and by consulting with the MAMC informatics specialist. The data was stored on a secure, encrypted server, and the informatics specialist oversaw any corrections to the data, merging of databases, and distribution of data for analyses.

Of the 117 questionnaires received, an effort was made to eliminate non-target respondents when the collection period ended. This was completed by reading each individual response and excluding responses that did not meet inclusion criteria based on demographics and

comments provided. Three questionnaires were eliminated, which left 114 for final analysis. No items were required, which has been shown in the literature to ensure a greater number of responses within the shortened collection time for this project (See Limitations), yet the investigators do appreciate that this approach introduces non-response bias (TRC, 2009). Respondents were allowed to skip items prior to submission, so the total of responses for each question do not always add up to 114 (Zapier, 2016). The average time to complete the questionnaire was 5 minutes. All data for questions 1-8 is listed in Table 2.

Table 2. *Summary of Data from Questions #1-8 for all Providers*

	n	%
Years of practice in profession		
1 – 5 years	11	9.7
6 – 10 years	15	13.3
11 – 20 years	47	41.6
more than 20 years	40	35.4
Gender		
Male	56	50.4
Female	55	49.6
Type of provider		
MD	39	34.5
PA	5	4.4
NP/APN	16	14.2
DO	5	4.4
LSCSW/LCSW	17	15.0
LMHC/LCMHC	3	2.6
LPCC/LPC	1	0.9
Psy D	7	6.2
PhD (unspecified)	12	10.6
PhD (Clinical Psychologist)	4	3.6
LMFT	4	3.6
Number of SA patients cared for		
0	17	15.0
1 – 9	37	32.8
10 – 19	19	16.8
more than 20	40	35.4
Trained to document report of SA		
Yes	65	58.6
No	46	41.4
Use of a CPG in current clinic		
Yes	45	40.6
No	22	19.8
I don't know	44	39.6

Patient disclosure of unreported SA		
Yes	76	69.1
No	34	30.9
Use of SA ICD-9 or ICD-10 codes		
Yes	47	42.4
No	60	54.0
N/A	4	3.6

*Note: SA = sexual assault. CPG = clinical practice guideline. ICD = International Classification of Disease. n = number of respondents. There were 114 questionnaires returned, but not all were complete as some questions were skipped by respondents.*

Of the 114 responses, 50.4% (n=56) were male and 49.6% (n=55) were female. HCPs identified as follows: Medical Doctor (MD, n=39, 34.5%), Licensed Specialist Clinical Social Worker (LSCSW/LCSW, n=17, 15.0%), Nurse Practitioner (NP/APN, n=16, 14.2%), unspecified PhD (n=12, 10.6%), Doctor of Psychology (PsyD, n=7, 6.2%), Doctor of Osteopathy (DO, n=5, 4.4%), Physician's Assistant (PA, n=5, 4.4%), Clinical Psychologist PhD (n=4, 3.6%), Licensed Marriage Family Therapist (LMFT, n=4, 3.6%), Licensed Mental Health Counselor (LMHC/LCMHC, n=3, 2.6%), and Licenses Professional Clinical Counselor (LPCC/LPC, n=1, 0.9%).

For length of time practicing, 9.7% (n=11) reported practicing in their profession for 1-5 years, 13.3% (n=15) reported 6-10 years, 41.6% (n=47) reported 11-20 years, and 35.4% (n=40) reported practicing for over 20 years. The number of SA patients HCPs reported caring for were 0 (n=17, 15.0%), 1-9 (n=37, 32.8%), 10-19 (n=19, 16.8%), and more than 20 (n=40, 34.4%).

More than half (n=65, 58.6%) reported they had previous training for documenting SA, and 40.6% (n=45) were currently using a SA CPG in the clinical setting, while 39.6% (n=44) said they did not know if a CPG existed. The majority of HCPs (n=76, 69.0%) reported that while providing patient care, a patient had disclosed a previously unreported sexual assault. Additionally, 42.4% (n=47) responded they have used an ICD-9 or ICD-10 code to document a reported SA.

There were 98 HCPs who answered the question regarding barriers to entering a sexual assault diagnosis into a patient's chart (see Table 3). Eight barriers were listed to choose from, and the option was provided to select more than one answer. There was also a free-text comment box allowed for respondents to write-in a barrier not available on the list. The comments were read individually and two new categories were formed based on the responses: "patient request" and "no barriers". The remaining comments were explanations from the providers why they had chosen specific barriers, so no further adjustments to the data were necessary as no new information was provided.

The barriers in order from most to least often chosen were: patient stigmatization in medical record (n=30, 30.6%), lack of training or knowledge of how to care for sexual assault survivors (n=29, 29.6%), time since assault (n=24, 24.6%), lack of a clinical practice guideline (n=21, 21.4%), referring patient to a specialty service (n=19, 19.4%), time constraint of appointment (n=13, 13.3%), patient request (n=11, 11.2%), no barriers (n=9, 9.2%), age of patient (n=3, 3.0%), and sex of patient (n=2, 2.0%).

Table 3. *Summary of Data for Question #10 for all Providers*

	n	%
Which of the following barriers might keep you from entering a sexual assault diagnosis into a patient's chart? Select all that apply.		
Lack of training / Knowledge (of how to care for sexual assault victims)	29	29.6
Time constraint of appointment	13	13.3
Age of patient	3	3.0
Sex of patient	2	2.0
Patient stigmatization in medical record	30	30.6
Time since assault	24	24.6
Lack of a clinical practice guideline	21	21.4

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Referring patient to a specialty service	19	19.4
Patient request	11	11.2
No barriers	9	9.2

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*Note: There were 98 respondents to this question. Respondents had the choice to select more than one barrier. n = number of times an item was selected by all of the respondents. %=(n/N) where N=98*

### **Analysis of the Results**

After reviewing the data, the investigators found that most of the HCPs (n=96, 85%) in the outpatient clinical setting have provided care for at least one patient reporting a SA history, and 35.4% (n=40) have cared for more than 20 patients over the course of their clinical practice. But, less than half (40.6%, n= 45) reported having a SA CPG in their current clinical setting, and 39.6% (n=44) did not know if their clinic had one or not. Most significantly, 69.1% (n=76) of all HCPs in the outpatient clinical setting reported that a patient had disclosed to them a previously unreported SA, yet only 42.4% (n=47) of all HCPs reported to properly using an ICD-9 or ICD-10 code specific to SA to document a SA diagnosis. This finding may be a contributing factor to why a gap exists between the number of documented reports of SA reporting and actual occurrences of SA (DoD, 2014).

Further evidence that may contribute to this gap was discovered in the answers provided to the question regarding HCPs' barriers to entering a SA diagnosis into the EHR (see Table 3), the comments for why a SA ICD-9 or ICD-10 code wasn't used in the EHR (see Table 6), and in the open comments allowed at the end of the questionnaire (see Table 7). When all of this data was reviewed, patient stigmatization (n=30, 30.6%) and lack of training (n=29, 29.6%) were the top two barriers listed for not documenting a sexual assault in the patients' EHR. These findings support the literature that healthcare providers report a "lack of training" in offering accurate and comprehensive care.

After reviewing the data for all HCPs, the investigators further examined responses from the top three providers, as they accounted for 63.1% (n=72) of all respondents (see Table 4). Those providers were MD (34.2%, n=39), LCSW/LCSW (14.9%, n=17), and NP/APN (14.0%, n=16). Again, since not all questionnaires were completed, the total of responses for each question do not always add up to the total number of respondents for each profession and should be carefully interpreted.

Table 4. *Summary of Data from Questions #1-8 for MDs, NPs, and LCSWs, and Compared to Data for All Providers*

	Medical Doctors n (%)	Nurse Practitioners n (%)	Licensed Clinical Social Workers n (%)	Totals n (%)	All HCPs (N = 114) n (%)
Years of practice in profession					
1 – 5 years	1 (2.5)	4 (25.0)	0 (0.0)	5 (6.9)	11 (9.7)
6 – 10 years	7 (18.0)	1 (6.3)	1 (5.9)	9 (12.5)	15 (13.3)
11 – 20 years	15 (38.5)	3 (18.7)	10 (58.8)	28 (38.9)	47 (41.6)
more than 20 years	16 (41.0)	8 (50.0)	6 (35.3)	30 (41.7)	40 (35.4)
Gender					
Male	31 (79.5)	3 (18.8)	4 (25.0)	38 (53.5)	56 (50.4)
Female	8 (20.5)	13 (81.2)	12 (75.0)	33 (46.5)	55 (49.6)
Number of SA patients cared for					
0	8 (21.0)	6 (37.5)	0 (0.0)	14 (19.7)	17 (15.0)
1 – 9	15 (39.5)	7 (43.7)	3 (17.7)	25 (35.2)	37 (32.8)
10 – 19	7 (18.5)	0 (0.0)	3 (17.7)	10 (14.1)	19 (16.8)
more than 20	8 (21.0)	3 (18.8)	11 (64.6)	22 (31.0)	40 (35.4)
Trained to document report of SA					
Yes	27 (71.0)	11 (68.8)	5 (29.4)	43 (60.6)	65 (58.6)
No	11 (29.0)	5 (31.2)	12 (70.6)	28 (39.4)	46 (41.4)
Use of a CPG in current clinic					
Yes	16 (43.3)	8 (50.0)	4 (23.5)	28 (40.0)	45 (40.6)
No	6 (16.2)	3 (18.7)	6 (35.3)	15 (21.4)	22 (19.8)
I don't know	15 (40.5)	5 (31.3)	7 (41.2)	27 (38.6)	44 (39.6)
Patient disclosure of unreported SA					
Yes	21 (55.3)	7 (46.7)	15 (88.2)	43 (61.4)	76 (69.0)
No	17 (44.7)	8 (53.3)	2 (11.8)	27 (38.6)	34 (31.0)
Use of SA ICD-9 or ICD-10 codes					

Yes	14 (36.9)	7 (43.7)	11 (64.7)	32 (45.1)	47 (42.4)
No	23 (60.5)	8 (50.0)	6 (35.3)	37 (52.1)	60 (54.0)
N/A	1 (2.6)	1 (6.3)	0 (0.0)	2 (2.8)	4 (3.6)

*Note: SA = sexual assault. CPG = clinical practice guideline. ICD = International Classification of Disease. n = number of respondents for the respective profession. Respondents left some items blank, so n will not always equal N for the respective profession.*

For the most part, the data for these three HCP professions combined mimicked that of all HCPs. The differences were found when the three professions were compared, and some of those differences were notable. The majority of MDs and NPs reported caring for 1-9 SA patients (n=15, 39.5%; n=7, 43.7% respectively), but the LCSWs' reported caring for more than 20 patients (n=11, 64.6%). In fact, every LCSW (n=11) reported they had cared for at least one SA patient, whereas 21.0% (n=8) of MDs and 37.5% (n=6) NPs reported they had never cared for a SA patient.

Additionally, 71.0% (n=27) of MDs and 68.8% (n=11) of NPs reported they had received training on how to document a reported SA, yet 70.6% (n=12) of the LCSWs reported they had never received any training. Additionally, LCSWs report having cared for more SA patients per provider than the MDs and NPs, and a greater percentage of the LCSWs (88.2%, n=15) reported a patient had disclosed a previously unreported SA. These percentages were much less for the MDs (55.3%, n=21) and NPs (46.7%, n=7).

The LCSWs (n=4, 23.5%) were also the smallest group to report that they were following a SA CPG in the current clinical practice, as opposed to MDs (n=16, 43.3%) and NPs (n=8, 50.0%). Yet, a greater percentage of LCSWs (64.7%, n=11) had used a SA ICD-9 or ICD-10 code than MDs (36.9%, n=14) or NPs (43.7%, n=7).

When the barriers to entering a SA diagnosis into a patients' EHR were analyzed, the three professions differed again (see Table 5). The MDs (n=12, 36.4%) and the NPs (n=6, 42.9%) chose lack of training as the primary barrier, which closely correlates with the numbers

of respective respondents that reported never having received training. But, the LCSWs reported patient stigmatization (n=4, 26.7%) and patient request (n=4, 26.7%) as their primary barriers. Patient stigmatization was the second most often selected barrier for the MDs (n=9, 27.3%) and the NPs (n=4, 28.6%), and it should be noted that the NPs also selected the referral of a patient to a specialty service as their second most often selected barrier (n=4, 28.6%).

Table 5. *Summary of Data for Question #10 for MDs, NPs, and LCSWs and Compared to Data for All Providers*

	Medical Doctors (N = 33) n (%)	Nurse Practitioners (N = 14) n (%)	Licensed Clinical Social Workers (N = 15) n (%)	Totals (N = 62) n (%)	All HCPs (N = 98) n (%)
Which of the following barriers might keep you from entering a sexual assault diagnosis into a patient's chart? Select all that apply.					
Lack of training / Knowledge (of how to care for sexual assault victims)	12 (36.4)	6 (42.9)	2 (13.3)	20 (32.3)	29 (29.6)
Time constraint of appointment	8 (24.2)	2 (14.3)	1 (6.7)	11 (17.7)	13 (13.3)
Age of patient	2 (6.1)	0 (0.0)	0 (0.0)	2 (3.2)	3 (3.0)
Sex of patient	2 (6.1)	0 (0.0)	0 (0.0)	2 (3.2)	2 (2.0)
Patient stigmatization in medical record	9 (27.3)	4 (28.6)	4 (26.7)	19 (30.6)	30 (30.6)
Time since assault	6 (18.2)	1 (7.1)	3 (20.0)	10 (16.1)	24 (24.6)
Lack of a clinical practice guideline	6 (18.2)	1 (7.1)	3 (20.0)	10 (16.1)	21 (21.4)
Referring patient to a specialty service	4 (12.1)	4 (28.6)	2 (13.3)	13 (21.0)	19 (19.4)
Patient request	6 (18.2)	0 (0.0)	4 (26.7)	10 (16.1)	11 (11.2)



No barriers	2 (6.1)	0 (0.0)	2 (13.3)	4 (6.5)	9 (9.2)
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*Note: Respondents had the choice to select more than one barrier. N = the total number of respondents that answered for the respective profession. n = the number of times an item was selected, which could range from 0 to N. % = (n/N).*

Though no specific barriers to care reported specifically by MDs or LSCSW/LCSWs was found in current literature, the findings from this survey data supports previous findings regarding HCPs' comfort level on documenting sensitive issues, patient stigmatization, and patient confidentiality as barriers to patient care (Chelvakumar et al., 2014). Dossa and Welch (2015) found that providers tend to face ethical dilemmas when documenting sensitive patient encounters because they sense the need for complete medical documentation, but also feel the need facilitate continuity of care and protect patient's confidentiality. According to Munro (2014), survivors' perception of the social stigma attached to SA is one of the barriers to seeking care, and the NPs' perception of stigmatization may deter them from properly documenting the SA in the EHR, which may could undermine the patient's quality of care. Additionally, providers struggle with documenting clinically relevant but sensitive information, and that there is a lack of consistency in documenting stigmatizing information, which then leads to the inability to facilitate coordinated, continuous care because providers cannot be certain how to interpret what is or is not in the chart (Dossa & Welch, 2015). Understanding that the proper documentation of sexual assault requires different resources and training, such as the knowledge between acute versus delayed reporting of SA, may also be an important dimension to consider in understanding barriers to proper documentation (Munro, 2014).

### **Organizational Impact/Implications to Practice and Policy**

This study revealed important information regarding the HCPs' challenges and barriers to accurate documentation in the EHR of patient disclosure of a previously unreported sexual assault. The current findings from this DNP project, which include limited institutional training

and a confusion of the presence of a clinical practice guidelines (CPG), suggests there is a lack of consistency among providers of how to care for this patient population. The HCPs who participated in this project reported they relied on previous training or used personal judgment to make a decision of how a diagnosis was charted in the EHR, as comments were made that a military members EHR was never truly private (see Table 7). They also noted current lack of training and utilized personal experience that may or may not be adequate based on current CPGs.

Without the proper documentation of an ICD-9 or ICD-10 code for sexual assault, there will always appear to be a gap between the number of sexual assaults committed and those that are reported. This gap may result in the relay of false data back to the DoD, which in turn continues to direct the focus of sexual assault training towards SA prevention and early reporting by the survivors. The DoD will also need to place an emphasis on HCP training regarding proper documentation and care of patients who present to outpatient clinics with a history of undisclosed SA, as well as SA related health care issues. If these patients are diagnosed properly early on, it may lessen the costs of medical care as the root problem can be treated rather than continually attempting to treat the long-term effects created by the initial trauma (Conard, Young, Hogan, & Armstrong, 2014).

### **Future Directions for Research and Practice**

This DNP project has provided a wealth of data in regards to provider challenges and barriers in the documentation of a patient's disclosure of a previously unreported sexual assault. Data suggests that training or education for providers in the documentation of a previously unreported SA requires continued development. Large percentages of reporting providers

indicate they have not received training in how to handle these situations and do not have knowledge of existing clinical practice guidelines within their clinics.

Current literature indicates that increasing knowledge of clinical practice guidelines and providing standardized training for providers, will increase competency, confidence, and positive patient outcomes regardless of the patient's complaints (Kuhn et al., 2015; Opiyo & English, 2015; Smith et al., 2013). The utilization of clinical practice guidelines has also been shown in the literature to improve patient and provider satisfaction and increase positive health outcomes (Kuhn et al., 2015; Milone, Burg, Duerson, Hagen, & Pauly, 2010; Schanne et al., 2016). Increased education of sexual assaults and their prevalence for providers also promotes increased screening by providers for sexual assault. This increase in education can be translated into improving provider documentation of previously undisclosed sexual assaults (DeLahunta & Tulskey, 1996; Witt et al., 2015). Through increasing standardized training and education on the documentation of previously unreported sexual assault, these investigators believe that the challenges and barriers to accurate documentation will diminish. Additional studies and survey of HCPs across MTFs and civilian facilities are needed. As such, the incoming Phase II DNP cohort and faculty will address the need for standardized provider training and adherence to existing clinical practice guidelines, or the creation and implementation of a standardized CPG if one does not exist for use in the outpatient setting.

MAMC's current *Move to Health* initiative aligns with this DNP project and illustrates how patients are better served when providers are trained to identify their needs and underlying medical conditions and then documenting properly so that other providers can follow their treatment plan (Madigan Army Medical Center, n.d.). For these reasons, it is vital that the

incoming DNP cohort focus on standardized provider training for previously undisclosed non-acute sexual assault.

### **Limitations**

Several limitations were encountered during the implementation of this DNP project. First, this was an exploratory cross-sectional tool that captured data from only one MTF. Therefore, generalizability to all DoD MTFs should be done with caution.

Another limitation was that the questionnaire itself. Though it was crafted based on current literature regarding common barriers listed by HCPs to providing proper patient healthcare, it had not been previously tested and therefore offers limited validity. To temper this limitation, a pilot study was performed as previously described to determine if it correlated with the literature. The results from the pilot study supported moving forward with dissemination of the questionnaire. However, it was realized after the data collection was completed that bias might have been introduced into the questionnaire itself. Because the investigators were specifically interested if either the lack of a clinical practice guideline or the lack of training for caring of sexual assault patients were the most common reasons for improper EHR documentation, the lack of training was the first answer choice provided under the question regarding barriers (see Appendix L). In general, survey tool development was not the intent of this translation DNP project, and the investigators are aware of the non-response bias and other limitations of results. With this in consideration, the investigators and onsite informatics specialist spent critical time and review in the cleaning of data to ensure key information data results would be reported accurately to the best of their ability.

A final limitation encountered was that the web-based questionnaire was also distributed to all medical providers attached to MAMC rather than to just those providers who met the

inclusion criteria. It was not discovered until after IRB approval had been granted that a mailing list could not be created to meet the inclusion criteria as he had been previously thought. In an effort to eliminate the inclusion of erroneous data, a new email script was written that specifically asked the HCPs to not submit the questionnaire if they did not work in the areas of outpatient primary care, OB/GYN, or Behavioral Health. For future projects, it is imperative that all stakeholders and investigators work collaboratively from the beginning to minimize these types of errors.

### **Conclusion**

Sexual assault is a traumatic experience that can interfere with a person's sense of well-being, and often impairs the individual's ability to carry out daily functions. Sexual assault survivors may experience a wide range of symptoms related to the assault. These symptoms may include pain, anxiety, depression, and other related medical conditions (Farris et al., 2013). If proper documentation occurs in the EHR, providers will be able to optimize care for symptom management and be more proactive in the care of patients with a history of SA.

To the knowledge of these investigators, this DNP project is the first of its kind conducted in the outpatient setting at MAMC to identify healthcare providers' challenges and barriers to documenting patient disclosure of previously unreported sexual assault. The findings from this DNP project suggest there are several challenges in provider documentation.

Patient stigmatization is the leading barrier identified by this military HCP population in the proper documentation of a patient's history of SA. This is followed by a reported lack of training, time since assault, and the lack of a CPG in the clinic setting. These barriers may lead to symptom care, but not root-cause care. Further investigation and replication of this questionnaire is necessary to determine consistency with the documentation practices at other MTFs in the

DoD. Consistent findings would encourage HCPs and investigators to advance the development of standardized training for SA documentation in the EHR training, as well as promote the creation of a CPG to optimize the care of SA survivors.

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Appendix A  
The Quality Monitoring Cycle

Table 1

*The Quality Monitoring Cycle*

- 
1. Obtain data on performance
  2. Perform pattern analysis – an epidemiological activity that identifies time, place, person, and function
  3. Provide interpretation by advancing hypotheses that might explain the patterns observed.
  4. Take preventive, corrective, or promotive action based on the causal hypotheses that have been advanced (i.e., resources, duties, functions, procedures, education).
  5. Obtain data on subsequent performance to determine the consequences of the actions taken.
- 

*Note.* Table created from material in Donabedian, A. (2003). *An introduction to quality assurance in health care*. New York, NY: Oxford University Press. Table adapted from Block, D. (2006). Quality improvement in healthcare – Donabedian’s principles of quality improvement. In D. Block (Ed.), *Healthcare outcomes management: Strategies for planning and evaluation* (pp. 9-24). Sudbury, MA: Jones and Bartlett Publishers

Appendix B  
Summary of Data from Questions #1-8 for all Providers

Table 2

*Summary of Data from Questions #1-8 for all Providers*

	n	%
Years of practice in profession		
1 – 5 years	11	9.7
6 – 10 years	15	13.3
11 – 20 years	47	41.6
more than 20 years	40	35.4
Gender		
Male	56	50.4
Female	55	49.6
Type of provider		
MD	39	34.5
PA	5	4.4
NP/APN	16	14.2
DO	5	4.4
LSCSW/LCSW	17	15.0
LMHC/LCMHC	3	2.6
LPCC/LPC	1	0.9
Psy D	7	6.2
PhD (unspecified)	12	10.6
PhD (Clinical Psychologist)	4	3.6
LMFT	4	3.6
Number of SA patients cared for		
0	17	15.0
1 – 9	37	32.8
10 – 19	19	16.8
more than 20	40	35.4
Trained to document report of SA		
Yes	65	58.6
No	46	41.4
Use of a CPG in current clinic		
Yes	45	40.6
No	22	19.8
I don't know	44	39.6
Patient disclosure of unreported SA		
Yes	76	69.1
No	34	30.9
Use of SA ICD-9 or ICD-10 codes		
Yes	47	42.4
No	60	54.0
N/A	4	3.6

*Note: SA = sexual assault. CPG = clinical practice guideline. ICD = International Classification of Disease. n = number of respondents. There were 114 questionnaires returned, but not all were complete as some questions were skipped by respondents.*

Appendix C  
Summary of Data for Question #10 for all Providers

Table 3

*Summary of Data for Question #10 for all Providers*

	n	%
Which of the following barriers might keep you from entering a sexual assault diagnosis into a patient's chart? Select all that apply.		
Lack of training / Knowledge (of how to care for sexual assault victims)	29	29.6
Time constraint of appointment	13	13.3
Age of patient	3	3.0
Sex of patient	2	2.0
Patient stigmatization in medical record	30	30.6
Time since assault	24	24.6
Lack of a clinical practice guideline	21	21.4
Referring patient to a specialty service	19	19.4
Patient request	11	11.2
No barriers	9	9.2

*Note: There were 98 respondents to this question. Respondents had the choice to select more than one barrier. n = number of times an item was selected by all of the respondents. %=(n/N) where N=98*

Appendix D  
Summary of Data from Questions #1-8 for MDs, NPs, and LCSWs; and Compared to Data for All Providers

Table 4

*Summary of Data from Questions #1-8 for MDs, NPs, and LCSWs; and Compared to Data for all Providers*

	Medical Doctors n (%)	Nurse Practitioners n (%)	Licensed Clinical Social Workers n (%)	Totals n (%)	All HCPs (N = 114) n (%)
<b>Years of practice in profession</b>					
1 – 5 years	1 (2.5)	4 (25.0)	0 (0.0)	5 (6.9)	11 (9.7)
6 – 10 years	7 (18.0)	1 (6.3)	1 (5.9)	9 (12.5)	15 (13.3)
11 – 20 years	15 (38.5)	3 (18.7)	10 (58.8)	28 (38.9)	47 (41.6)
more than 20 years	16 (41.0)	8 (50.0)	6 (35.3)	30 (41.7)	40 (35.4)
<b>Gender</b>					
Male	31 (79.5)	3 (18.8)	4 (25.0)	38 (53.5)	56 (50.4)
Female	8 (20.5)	13 (81.2)	12 (75.0)	33 (46.5)	55 (49.6)
<b>Number of SA patients cared for</b>					
0	8 (21.0)	6 (37.5)	0 (0.0)	14 (19.7)	17 (15.0)
1 – 9	15 (39.5)	7 (43.7)	3 (17.7)	25 (35.2)	37 (32.8)
10 – 19	7 (18.5)	0 (0.0)	3 (17.7)	10 (14.1)	19 (16.8)
more than 20	8 (21.0)	3 (18.8)	11 (64.6)	22 (31.0)	40 (35.4)
<b>Trained to document report of SA</b>					
Yes	27 (71.0)	11 (68.8)	5 (29.4)	43 (60.6)	65 (58.6)
No	11 (29.0)	5 (31.2)	12 (70.6)	28 (39.4)	46 (41.4)
<b>Use of a CPG in current clinic</b>					
Yes	16 (43.3)	8 (50.0)	4 (23.5)	28 (40.0)	45 (40.6)
No	6 (16.2)	3 (18.7)	6 (35.3)	15 (21.4)	22 (19.8)
I don't know	15 (40.5)	5 (31.3)	7 (41.2)	27 (38.6)	44 (39.6)
<b>Patient disclosure of unreported SA</b>					
Yes	21 (55.3)	7 (46.7)	15 (88.2)	43 (61.4)	76 (69.0)
No	17 (44.7)	8 (53.3)	2 (11.8)	27 (38.6)	34 (31.0)
<b>Use of SA ICD-9 or ICD-10 codes</b>					
Yes	14 (36.9)	7 (43.7)	11 (64.7)	32 (45.1)	47 (42.4)
No	23 (60.5)	8 (50.0)	6 (35.3)	37 (52.1)	60 (54.0)
N/A	1 (2.6)	1 (6.3)	0 (0.0)	2 (2.8)	4 (3.6)

*Note: SA = sexual assault. CPG = clinical practice guideline. ICD = International Classification of Disease. n = number of respondents for the respective profession. Respondents left some items blank, so n will not always equal N for the respective profession.*

Appendix E  
Summary of Data for Question #10 for MDs, NPs, and LCSWs, and Compared to Data for all Providers

Table 5

*Summary of Data for Question #10 for MDs, NPs, and LCSWs, and Compared to Data for all Providers*

	Medical Doctors (N = 33) n (%)	Nurse Practitioners (N = 14) n (%)	Licensed Clinical Social Workers (N = 15) n (%)	Totals (N = 62) n (%)	All HCPs (N = 98) n (%)
Which of the following barriers might keep you from entering a sexual assault diagnosis into a patient's chart? Select all that apply.					
Lack of training / Knowledge (of how to care for sexual assault victims)	12 (36.4)	6 (42.9)	2 (13.3)	20 (32.3)	29 (29.6)
Time constraint of appointment	8 (24.2)	2 (14.3)	1 (6.7)	11 (17.7)	13 (13.3)
Age of patient	2 (6.1)	0 (0.0)	0 (0.0)	2 (3.2)	3 (3.0)
Sex of patient	2 (6.1)	0 (0.0)	0 (0.0)	2 (3.2)	2 (2.0)
Patient stigmatization in medical record	9 (27.3)	4 (28.6)	4 (26.7)	19 (30.6)	30 (30.6)
Time since assault	6 (18.2)	1 (7.1)	3 (20.0)	10 (16.1)	24 (24.6)
Lack of a clinical practice guideline	6 (18.2)	1 (7.1)	3 (20.0)	10 (16.1)	21 (21.4)
Referring patient to a specialty service	4 (12.1)	4 (28.6)	2 (13.3)	13 (21.0)	19 (19.4)
Patient request	6 (18.2)	0 (0.0)	4 (26.7)	10 (16.1)	11 (11.2)
No barriers	2 (6.1)	0 (0.0)	2 (13.3)	4 (6.5)	9 (9.2)

*Note: Respondents had the choice to select more than one barrier. N = the total number of respondents that answered for the respective profession. n = the number of times an item was selected, which could range from 0 to N. % = (n/N).*

Appendix F  
Summary of Data from Question #9

Table 6

*Summary of Data from Question #9*

*If you don't/wouldn't use a sexual assault related ICD-9 or ICD-10 code, what code would you use and why?*

Last time was about 15 years ago, don't know which code I used

I have used the code in the past

I would not use a code, as currently assigned to ASAP and under IMCOM we do not code BH dx and only SUD. This is change as we move to MEDCOM

I would not refuse to use a code.

PTSD

PTSD. The case was several years ago and prior to military service. The treatment was focused on resulting symptoms.

Typically I would describe the sexual assault in my A/P if the patient desires. I have seen instances where private or confidential diagnoses have been spread when included in the EMR

Z91.410 Personal history of adult physical and sexual abuse (if known) T76.21XA Adult sexual abuse, suspected, initial encounter

Confidentiality concerns lead me to use descriptors like skin abrasion, pelvic pain, Headache, etc.

If patient requests that it not be included in her record then I wouldn't use the code

Do not know.

Would pick something related to the issues presented if client did not want to address the incident in counseling yet

Permanent on her problem list-pt usually doesn't want that

I see people who have developed PTSD or another BH disorder as a result of the assault. I diagnosis for that.

DSMIV/V codes; BH uses DSM

There is a difference in documenting active duty versus family member, male versus female and MEDCOM versus the rest of the world. I allow the patient to have a choice in the documentation and have allowed several to change providers when we couldn't agree.

I am not familiar with either of these codes; I don't code in my profession. I only am involved in direct care after they may or may not have already been identified as sexual assault victims.

ICD 10 coding was instituted after I left my position as a Sexual Assault Care Coordinator.

Would not necessarily think to document this separately with an ICD10 code unless this was the only reason person was presenting. Would like to confirm that this is true before entering into medical record-based on pt's story only, then the diagnosis is alleged but not confirmed

Generally due to confidentiality issues

It depends on how confidential the patient records can be made. Those codes in a person record can create more stigma in wrong hands. I believe we need to have a higher security wall when dealing with this patients

Coding is done by the coders. I don't assign ICD-9 or ICD-10 codes to my visits

Something along the lines of Patient counseling: safe sex. Would do so for potential privacy concerns? However, I have and do use the ICD code when appropriate, mostly.

PTSD if symptoms warrant or other behavioral health diagnosis pertinent to current symptoms. Sometimes concern about patient privacy if no one is immediately in danger.

Depending on the pt's presentation, possibly PTSD, Acute Stress Disorder, Anxiety Disorder NOS, Major Depressive Disorder, Adjustment Disorder, etc.

I would use the code for an acute sexual assault that presented as a sexual assault or if a sexual assault was the



---

cause for the visit. In the case of a previous sexual assault it would depend on the context of the disclosure and the association with the reason for presentation. If not coding a sexual assault I would code the symptoms more generally and discuss the issue(s) in the text of the encounter note

Work is in ASAP and we would refer out to specialty services for treatment for this, have been told to only document substance abuse diagnoses.

Alleged sexual assault - I was trained to do this in a lot of things that are criminal but not verifiable

I would need to find out.

Depending on clinical presentation, more than likely PTSD.

Disease of primarily sexual transmission

Until October 2015, codes utilized were from DSM IV TR or DSM 5

I would not, in an effort to protect Pt's privacy

What they're presenting to BH for (symptomology, not origin of symptomology)- i.e.- Adjustment Disorder, PTSD, etc

Not within my specialty

I normally use the codes for either PTSD, Anxiety Disorder NOS, or Adjustment Disorder depending on their symptoms. I was unaware that we were supposed to use those other codes, I thought that they were only something that FAP was supposed to use.

Those I have seen with a prior sexual assault already had that diagnosis usually quite remotely. I was not seeing them for something thought to be unrelated.

I used DSM IV in various versions until ICD-10 started in use at my clinic but have not had a sexual assault case that needed a dx since switch to ICD happened.

90791 I would be seeing this person for an intake and would refer them on to a provider with the appropriate experience.

Usually, it is in the context of their patient history and not the primary reason for the evaluation (ie patient reports a prior event in the remote past). I did not know a code existed for a history of sexual assault. .

Feels too personal

---

*Note:*

Appendix G  
Summary of Data from Question #11

Table 7

*Summary of Data from Question #11*

*Comments.*

Rare procedures like this are better done by select group of providers that are fully trained, especially in regards to forensic evidence collection

I have asked for guidance in the past if I was not sure how to report or what the practice guidelines are for a case of sexual assault

This is a much needed process and most importantly for all 51 Army ASAP programs that will merge into MEDCOM on or around 1 Oct 16. 300 plus licensed ASAP clinicians will work under the BH department and will need training on how to document SA.

I have no problems reporting or taking care of sexual assault victims in the Federal system I have worked in. I have received extensive training and I have always had the necessary available resources (such as rape kits) to support this type of investigation even at austere locations.

Not using a code does not mean the document does not reflect the documentation of a sexual assault, just that the proper code may not have been chosen.

More difficult to find codes in ICD10

I'm not sure this related to me. I have seen sexual assault victims in the past, but not in the last 5-6 years, and I do not provide care in a Primary Care Setting. Please disregard my responses if you feel I am not the type of professional you were wanting to survey.

I have never seen a MEDCOM soldier who reported a sexual assault - even a restricted report, have their privacy honored. Many of the details are kept restricted but never the fact they were assaulted. I am convinced this is due to the Medical Company looking into the EMR.

Sexual assault disclosure and treatment still hold stigma in the military system. As a result, keeping the information confidential and referring the patient to SHARP may result in timely disclosure and treatment.

I have rarely seen pts for initial visit related to sexual assault. Usually that has occurred in the ED.

If event occurred in the distant past and has been properly addressed and processed, not an active concern, it would likely not be noted as a diagnosis but rather mentioned as a relevant data point for therapy .

I am a specialty provider working in a specialty clinic, answer would have been very different if they did not say "in primary care" as I have treated 20+ folks for SA along with being the first to be reported to and having had training, etc..

Patients may note that they have had sexual assault in their history.

I believe, based on my interactions with my peers, that more patients report to me as a female provider than to my male counterparts. I have had many men and women report to me; and am very familiar with guidelines for calling the SHARP reps and appropriately coding the encounter. Some of my male counterparts seem to be less familiar with the process, and they describe this lack of familiarity being associated with not having to do it very often.

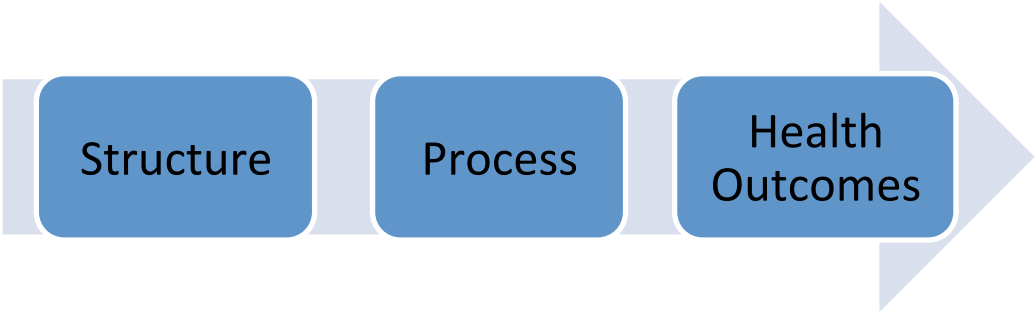
I don't work in primary care. I work in a BH specialty clinic. There is a difference between a PsyD and a PhD

*Note:*

Appendix H  
The Donabedian Framework

Figure 1

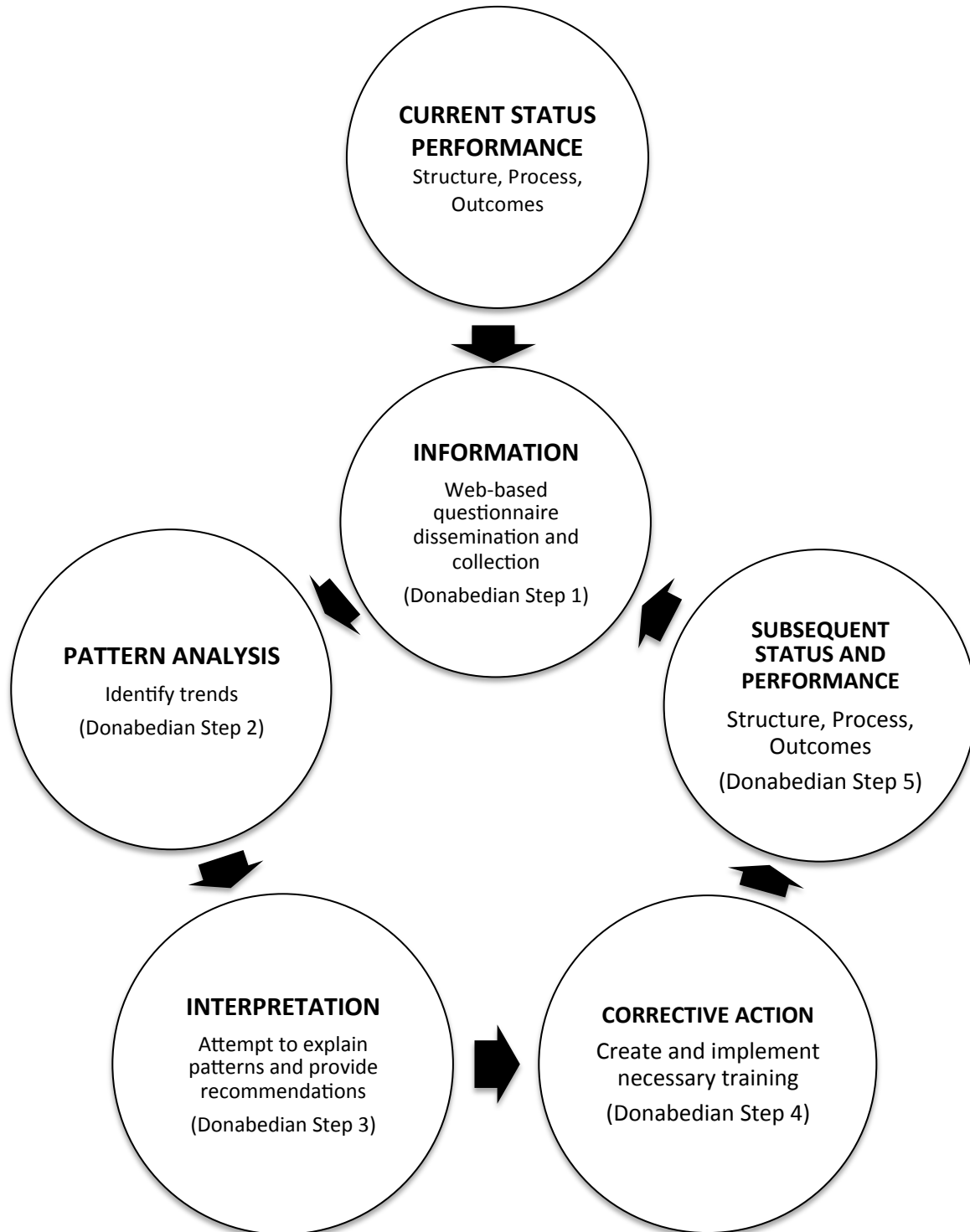
The Donabedian Framework



Appendix I  
The Quality Monitoring Cycle

Figure 2

The Quality Monitoring Cycle



Appendix J  
Email Sent to Healthcare Providers / Script for Morning Provider Meetings

Dear Sir/Ma'am,

We are writing to ask for your participation in our online questionnaire "Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers". This study has been approved by the Madigan IRB office and is a requirement for completion of our Doctor of Nursing Practice (DNP) degree at the Uniformed Services University, Daniel K. Inouye Graduate School of Nursing.

Our study is for the purpose of gathering data from Primary Care Providers in order to explore the facilitators and barriers to documenting sexual assault within the outpatient setting at Madigan Army Medical Center. Your answers will be completely confidential and no personally identifiable information is requested. The data will be analyzed to support practice improvement in the care and treatment of patients of sexual assault. Your participation is greatly appreciated. Because this study is aimed at providers in Primary Care, Family Medicine, OB/GYN, and Behavioral Health, we ask if you do not work in one of these specialties that you please not answer the survey and disregard this email as it has reached you in error.

The web-based questionnaire should take no more than 10 minutes to complete and can be accessed via the following link: <https://www.surveymonkey.com/r/JWMTSLV>

Very respectfully,  
Uniformed Services University DNP Cohort 2016  
MAJ Imshin Kim  
CPT Jeremy Mahoney  
CPT Jeffry Negard

Appendix K  
Madigan Army Medical Center Research Study Information Sheet

This research study being conducted at Madigan Army Medical Center is titled “**Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers**”. **Lieutenant Colonel Bradley E. Franklin, DNP, FNP-BC is the Principle Investigator.**

**Why is this study being done?**

Researchers are exploring the facilitators and barriers for primary and specialty care providers in the outpatient setting to using the appropriate ICD-9 or ICD-10 codes for the documentation of previously unreported sexual assaults.

**Will you be included?**

Up to 200 primary care and specialty providers will be asked to participate in this study. Your participation is completely voluntary! Deciding not to participate will not be associated with any negative repercussions, as participation is confidential with no tracking of provider compliance.

**What is expected?**

If you agree to participate, you will be asked to complete an online questionnaire regarding sexual assault documentation using available ICD-9 and ICD-10 codes.

**How long will it take?**

The questionnaire should take no longer than 10 minutes to complete, and your participation in the study is finished once the questionnaire is submitted.

**Will I benefit from participating?**

The information you provide may help improve education in regards to proper sexual assault documentation, and the information gathered may also be incorporated in the formation of a DoD Clinical Practice Guideline (CPG).

**What are the risks to this study?**

There are no known risks associated with the study.

**Confidentiality/Privacy of your identity?**

No protected health information or identifiable information will be collected for this research, and your responses remain completely anonymous. You will not be linked in any way to the study or to any publications that may result from the research.

**Can I choose to be part of the study?**

Yes, it is your decision to participate or not participate. Participation includes completing and submitting the online questionnaire.

**Can I change my mind and withdraw?**

Providers participating in the survey can withdraw from participation up until the time they submit the completed questionnaire.

**Contact Information.** If you have questions about the study contact the research faculty: *LTC Bradley E. Franklin; (253) 477-3944; brad.e.franklin.mil@mail.mil*. For questions about your rights as a research participant, contact the Madigan Department of Clinical Investigation, telephone (253) 968-0149, or the Madigan Staff Judge Advocate Office, telephone (253) 968-1525.

Appendix L  
Questionnaire

**Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers**

**Directions:** Please indicate your answers for the following demographics and questions.

- 1) **How many years have you been practicing in your profession:** [1-5 6-10 11-20 20+}
- 2) **Gender:** Female Male
- 3) **Type of provider:** MD, PA, NP/APN, DO, LSCSW/LCSW, LMHC/LCMHC, LPCC/LPC, Psy.D, Other (fill-in)
- 4) Approximately how many sexual assault patients have you cared for in your experience as a primary care provider? [ 0 1-9 10-19 20+ ]
- 5) Have you ever received training for the proper procedures in documenting a reported sexual assault in the primary care setting? **Yes No**
- 6) Does your unit currently follow any Clinical Practice Guideline or other established guideline for documenting sexual assault? **Yes No I don't know**
- 7) Has any patient ever disclosed a previously unreported sexual assault to you while you were providing care in a primary care setting? **Yes No**
- 8) Have you ever used the ICD-9 or ICD-10 codes specific to a reported sexual assault (*for example: V15.41 or Z91.410 Personal History of Sexual Assault; E960.1 Rape; T74.21 Adult Sexual Abuse*)? **Yes No N/A**
- 9) If you don't/wouldn't use a sexual assault related ICD-9 or ICD-10 code, what code would you use and why? (open text box...)
- 10) Which of the following barriers might keep you from entering a sexual assault diagnosis into a patient's chart? Select all that apply.
  - a. Lack of training / Knowledge (of how to care for sexual assault victims)
  - b. Time constraint of appointment
  - c. Age of patient
  - d. Sex of patient
  - e. Patient stigmatization in medical record
  - f. Time since assault
  - g. Lack of a clinical practice guideline
  - h. Referring patient to a specialty service
  - i. Other (open text...)
- 11) Comments:

Appendix M  
Flyer

**PROVIDERS TAKE 10  
MINUTES TO HELP VICTIMS**

IDENTIFYING THE BARRIERS  
AND FACILITATORS FOR PROVIDERS  
TO DOCUMENTING REPORTS OF

**SEXUAL  
ASSAULT**

[WWW.SURVEYMONKEY.COM/R/JWMTSLV](http://WWW.SURVEYMONKEY.COM/R/JWMTSLV)

**SURVEY OPEN  
11 JAN 2016 - 19 FEB 2016**

Take this survey at:  
[www.surveymonkey.com/r/JWMTSLV](http://www.surveymonkey.com/r/JWMTSLV)  
Uniformed Services University of the Health Sciences,  
DNP-FNP Resesarch Project

Project Title

**“Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers”**

Questions about the study: LTC Bradley E. Franklin, (253) 477-3944; [brad.e.franklin.mil@mail.mil](mailto:brad.e.franklin.mil@mail.mil)

Questions about your rights as a research participant: Madigan Department of Clinical Investigation (call 253-968-0149) or Madigan Staff Judge Advocate Office (call 253-968-1525). By answering this survey, consent for the use of the recorded data is implied. No personally identifiable information (PII) is recorded.



Appendix N  
IRB Letter of Determination



**DEPARTMENT OF THE ARMY**  
MADIGAN ARMY MEDICAL CENTER  
9040 JACKSON AVENUE  
TACOMA, WA 98431-1100

MCHJ-CLI

DATE: 01 February 2016

TO: LTC Bradley E. Franklin, AN  
FROM: Exempt Determination Official

SUBJECT: Exempt Determination - Correction  
STUDY TITLE: Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers

REFERENCE # 216016  
SUBMISSION TYPE: New Project  
REVIEW TYPE: Exempt

1. This research project has been reviewed and determined to be exempt from the regulatory requirements of 32 CFR 219, based on criteria under 32 CFR 219.101(b)(2). This regulation states:
  - (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.”
2. In the opinion of the Exempt Determination Official (EDO), your research meets the conditions for exemption under this regulation, because the only involvement of human subjects is their voluntary completion of an anonymous survey, responses are recorded in a manner that prevents their identification, directly or through identifiers and survey questions are benign in nature and would not place subjects at risk should their responses be disclosed.
3. You are authorized to distribute an anonymous electronic survey via SurveyMonkey to all non-student military or civilian licensed primary care medical providers working in MAMC and Okubo primary care clinics, OB/GYN and Behavioral Health outpatient clinics. The health care providers will be provided with a Research Subject Information Sheet that states their study participation is voluntary and to ask that no identifiers be included with their responses.
4. Any changes to the project must be submitted for review by the EDO prior to implementation.
5. DCI reminds you that a publication clearance is required for all written materials (i.e. manuscript or abstract) being submitted for publication/presentation.
7. At the completion of your study, you are requested to submit a study closure report explaining the outcome of the study. This report may be in the format of a publication (abstract or journal manuscript) or a brief summary.

MCHJ-CLI

SUBJECT: Exempt Determination- Correction

8. If you are scheduled to leave the institution (ETS, PCS, Deployment), please ensure that you either close the research study prior to leaving or designate a new Principal Investigator and inform the DCI. You are not authorized to take study data away from the institution.

9. If you have any questions, or if DCI can be of further assistance, please contact the Chief, Research Regulatory Service, 253.968.0149, or by e-mail at [Barbara.a.jones128.civ@mail.mil](mailto:Barbara.a.jones128.civ@mail.mil).



RICHARD O. BURNEY, MC  
COL, MC  
Exempt/Determination Official  
Madigan Army Medical Center

Appendix O  
Committee Membership Agreement Form

**DOCTOR OF NURSING PRACTICE PROJECT**  
**Committee Membership Agreement Form**

**Phase II Site Location:** MAMC/JBLM

**Graduation Year:** 2016

**Title of DNP Project:** Sexual Assault: ICD Coding Behaviors of Outpatient Service Providers

**Name(s) of DNP Project Student Team:**

1. MAJ Imshin Kim
2. CPT Jeramy Mahoney
3. CPT Jeffrey Negard
- 4.
- 5.
- 6.
- 7.
- 8.

**NOTE:** You may have 3-4 DNP committee members (including your DNP Committee Chairperson). The Phase II Site Director may also be on the Committee, as well as other USUHS faculty or others who may serve as content experts. All non-USUHS faculty selected for committee membership must be approved by the DNP Director.

**Names of Committee Members** (please type the name and obtain signatures):

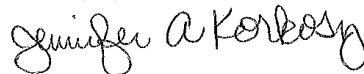
Chairperson: Laura Taylor

Signature:



Committee Member: Lt Col Jennifer Korkosz

Signature:



Committee Member:

Signature:

Committee Member:

Signature:

**Date:** 28 August 2015

## Appendix P CITI Certificates

### COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI) OUSD P&R HUMAN RESEARCH CURRICULUM COMPLETION REPORT Printed on 08/29/2013

**LEARNER** imshin kim (ID: 3692267)  
**DEPARTMENT** FNP  
**PHONE** 518-456-2544  
**EMAIL** imshin.kim@ushus.edu  
**INSTITUTION** Uniformed Services University of The Health Sciences  
**EXPIRATION DATE** 08/28/2016

**SBR INVESTIGATORS**

**COURSE/STAGE:** Stage 1/1  
**PASSED ON:** 08/29/2013  
**REFERENCE ID:** 11106006

MODULE	DATE COMPLETED
History and Ethical Principles - SBE	08/29/2013
Office of the Under Secretary of Defense (Personnel and Readiness)	08/29/2013
2. Defining Research with Human Subjects OUSD P&R	08/29/2013
3. Regulatory Overview OUSD P&R	08/29/2013
4. Informed Consent OUSD P&R	08/29/2013
5. Privacy and Confidentiality OUSD P&R	08/29/2013
6. Internet Research OUSD P&R	08/29/2013
7. Research with Children OUSD P&R	08/29/2013
8. Research with Prisoners as Subjects OUSD P&R	08/29/2013
9. Research Involving Women of Childbearing Potential, Pregnant Women and Fetuses OUSD P&R	08/29/2013
10. Conflicts of Interest OUSD P&R	08/29/2013
11. Group Harms: Research with Culturally or Medically Vulnerable Groups OUSD P&R	08/29/2013
Introduction to CITI for Office of the Under Secretary of Defense (Personnel & Readiness) [OUSD(P&R)]-	08/29/2013

**For this Completion Report to be valid, the learner listed above must be affiliated with a CITI Program participating institution or be a paid Independent Learner. Falsified information and unauthorized use of the CITI Program course site is unethical, and may be considered research misconduct by your institution.**

Paul Braunschweiger Ph.D.  
 Professor, University of Miami  
 Director Office of Research Education  
 CITI Program Course Coordinator

**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI)****OUSD P&R HUMAN RESEARCH CURRICULUM COMPLETION REPORT**

Printed on 09/04/2013

**LEARNER** Jeremy Mahoney (ID: 3714256)  
**DEPARTMENT** gsn  
**PHONE** 435-671-3194  
**EMAIL** jeramy.mahoney@usuhs.edu  
**INSTITUTION** Uniformed Services University of The Health Sciences  
**EXPIRATION DATE** 09/03/2016

**SBR INVESTIGATORS**

**COURSE/STAGE:** Stage 1/1  
**PASSED ON:** 09/04/2013  
**REFERENCE ID:** 11177148

REQUIRED MODULES	DATE COMPLETED
2. Defining Research with Human Subjects OUSD P&R	09/04/13
3. Regulatory Overview OUSD P&R	09/04/13
4. Informed Consent OUSD P&R	09/04/13
5. Privacy and Confidentiality OUSD P&R	09/04/13
6. Internet Research OUSD P&R	09/04/13
7. Research with Children OUSD P&R	09/04/13
8. Research with Prisoners as Subjects OUSD P&R	09/04/13
9. Research Involving Women of Childbearing Potential, Pregnant Women and Fetuses OUSD P&R	09/04/13
10. Conflicts of Interest OUSD P&R	09/04/13
11. Group Harms: Research with Culturally or Medically Vulnerable Groups OUSD P&R	09/04/13
Introduction to CITI for Office of the Under Secretary of Defense (Personnel & Readiness) [OUSD(P&R)]-	09/04/13
History and Ethical Principles - SBE	09/04/13
Office of the Under Secretary of Defense (Personnel and Readiness)	09/04/13

**For this Completion Report to be valid, the learner listed above must be affiliated with a CITI Program participating institution or be a paid Independent Learner. Falsified information and unauthorized use of the CITI Program course site is unethical, and may be considered research misconduct by your institution.**

Paul Braunschweiger Ph.D.  
 Professor, University of Miami  
 Director Office of Research Education  
 CITI Program Course Coordinator

Training Initiative  
 at the University of Miami

**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)  
COURSEWORK REQUIREMENTS REPORT\***

\* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Jeffrey Negard (ID: 3023354)
- **Email:** jeffry.negard@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** Graduate School of Nursing
- **Phone:** 559-799-1751
  
- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Social and Behavioral Investigators and Research Study Team
- **Stage:** Stage 1 - Social and Behavioral In
  
- **Report ID:** 17158694
- **Completion Date:** 09/14/2015
- **Expiration Date:** 09/13/2018
- **Minimum Passing:** 80
- **Reported Score\*:** 88

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Belmont Report and CITI Course Introduction (ID: 1127)	09/08/15
Defining Research with Human Subjects - SBE (ID: 491)	09/08/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	09/08/15
Assessing Risk - SBE (ID: 503)	09/14/15
History and Ethical Principles - SBE (ID: 490)	08/29/15
The Federal Regulations - SBE (ID: 502)	09/14/15
Informed Consent - SBE (ID: 504)	09/14/15
Privacy and Confidentiality - SBE (ID: 505)	09/14/15
Records-Based Research (ID: 5)	09/14/15
Research with Children - SBE (ID: 507)	09/14/15
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	09/14/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	09/14/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	09/14/15
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	09/14/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	09/14/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	09/14/15
Internet-Based Research - SBE (ID: 510)	09/14/15

**For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.**

**CITI Program**  
 Email: [citisupport@miami.edu](mailto:citisupport@miami.edu)  
 Phone: 305-243-7970  
 Web: <https://www.citiprogram.org>

## Appendix Q DNP Project Completion Verification Form



Appendix J: Daniel K. Inouye Graduate School of Nursing  
DNP Project Completion Verification Form

### DOCTOR OF NURSING PRACTICE PROJECT Completion Verification Form

The DNP Project titled: **Sexual Assault: ICD Coding Behaviors of Outpatient Service Provider** was completed at JBLM, MAMC by the following student(s):

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>
MAJ Imshin Kim _____		_31 Mar 2016_
CPT Jeramy Mahoney _____		_31 Mar 2016_
CPT Jeffry Negard _____		_31 Mar 2016_
_____	_____	_____
_____	_____	_____

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership at the Phase II Site,
- Presentation to the DNP Project Team,
- Abstract/Impact Statement (Appendix I), and
- DNP Project Written Report.

Verified by:

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>
__Laura Taylor__ _____		_31 Mar 2016_ Senior Mentor
_____	_____	_____ Team Mentor
_____	_____	_____ Team Mentor
LTC Brad Franklin _____		_31 Mar 2016_ Team Mentor & Phase II Site Director

**\*\*Upload the completed form (w/signatures) into GSN906 Doctor of Nursing Practice Project Class of 20XX site in SAKAI.**

*Form Version: 5 Mar 2016*