

Patient-Centered Care for Interpersonal Violence in the Veterans Health Administration

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Melissa E. Dichter, PhD, MSW

Katherine M. Iverson, PhD

Rachel Kimerling, PhD

Anne G. Sadler, PhD, RN



Intimate Partner Violence (IPV): Overview

- **IPV includes:**
 - **Physical** violence (hitting, punching, stabbing)
 - **Sexual** violence (forced or coerced sexual behavior, reproductive coercion)
 - **Psychological** violence (threatening, belittling, controlling behaviors, social isolation)
 - **Stalking** (following, spying, sending repeated unwanted messages, refusing to stay away)
- **More than 1 in 3 women in the US** experience physical violence, rape, or stalking by an intimate partner in their lifetime
- Major source of **morbidity** and **mortality** for women and is associated with:
 - A wide variety of acute and chronic physical and mental health problems
 - Social/economic impacts (financial insecurity, homelessness, unemployment)
 - Social/health risks (suicide/suicidal ideation, homicide, substance misuse, unplanned pregnancies)

IPV among Women Veterans

- Women veterans at high risk for IPV
 - Lifetime IPV among military women: 33%
 - Past-year IPV among women VA patients currently in an intimate relationship: 29%
- Health concerns associated with IPV among women Veterans
 - Injury
 - Infectious diseases
 - Digestive system disorders
 - High body mass index
 - Poor self-perceived health
 - PTSD
 - Depression
 - Anxiety
 - Substance-related disorders
 - Sleep disturbances

Healthcare Provider Response

- Considerations in screening
 - Who should screen? Who should be screened?
 - What questions should be asked?
 - Where/when/how often should patients be screened?
 - How should patients be screened?
 - Why should we screen?
- Considerations beyond screening: Next steps
 - Intervention may begin with – but doesn't end at – screening
 - Response to disclosure
 - Support/services
 - Documentation
 - Follow-up

Methods

- Patient perspectives
 - Study 1: Focus groups with 24 women veteran patients of the VA Boston Healthcare System in Fiscal Years (FY) 2012-2013
 - Study 2: In-depth interviews with 25 women veteran patients of the Philadelphia VA Medical Center in FY 2013
- Provider perspectives
 - Study 3: In-depth telephone interviews with 12 VA primary care providers throughout New England in FY 2012
 - Study 4: In-depth telephone interviews with 15 VA clinicians (primary care, mental health, social work) in the mid-Atlantic region in FY 2013

Patient and Provider Perspectives on Screening and Response

IPV Screening Should be Routine

I think it's one of those subjects that if you don't screen for it and start the conversation with the person, then you don't detect and don't treat. The downstream social consequences and medical complications are huge, so I think [IPV screening] has a lot of value.

No one ever asked me about it. You know, I was walking around with a black eye and not a single question. So I may have talked about it if I had been given the chance, but I wasn't going to bring it up on my own.

Ask again!

- Patients may not be ready to disclose the first (or second) time they are asked... Give options about when and to whom to disclose

I said “no” because I didn’t feel like talking about it. At that time, I wasn’t ready to talk about it or get in to it with anybody. There were a lot of things I didn’t tell [my doctor] when I first started seeing her. But once you get to know a person and you know the doctor, you can start opening up and saying different stuff.

Make it Safe to Disclose

I don't think I'd be comfortable talking to [my PCP]. She did ask once and then I shut down on her so she never asked again. I felt like she was judging. I did not feel safe.

I had a partner who went to my appointments with me, and when I tried to ask for help, I couldn't because that person...was right there. ...I would say she could stay out here [in the waiting room], and [the provider] would be like, "No, she can come in!"...and I can't ask for help because of it.

Asking Shows You Care

It's nice that somebody actually cares about stuff other than your blood pressure.

If you're not ready to tell, but you see that question, you know that they care and they're interested, and they may be able to help. It's like a signal that this is something we care about here.

Benefits of Disclosure

Disclosure, itself, may be a therapeutic intervention

If I could have spilled my beans a long time ago when I started coming here, I definitely would have, and I think that would have made me feel so much better. Just to be able to talk, it probably would have prevented me from, you know, wanting to harm myself, if I felt like I had somebody to talk to... to speak with someone, it helps. It goes a long way.

Need for Support in Responding to Disclosure

- Need for concrete information and resources, in addition to a supportive and compassionate ear

I think the scariest thing is, if I ask the question, she says “yes” and then we don’t have anything to offer her, well, how horrible is that for both of us?

Instead of telling me, “This is what you ought to do for your safety,” she wanted to make me feel, I felt, that she could relate to me, and that I shouldn’t be that hard on myself. That’s nice, but what do I do? I got a restraining order. Now what do I do?

Recommendations for an IPV Specialist

It would be really valuable to have a staff member who is very, very well versed in [responding to IPV disclosures]... you know, well versed with the ins and outs of the community, what to do, what not to do, what questions not to ask...

[It would be nice to have] somewhere where if I was just beat up by my boyfriend I could, like, knock on your door and come talk to you. You know like just so that, to get it off my chest you know and like know that there is somebody there to talk to.

Healthcare System Considerations: Documentation in EMRs

- Benefit: documentation of experience, continuity of care
- Concerns: privacy and confidentiality
- Recommendations: transparency about the documentation and discussion about rationale for, and concerns about, documentation

I had a tooth extracted one of these young interns... he brought up the discussion of something that I had discussed with my psychiatrist in privacy... Then I come to find out that any staff member that has a computer can put in my last 4, can read my record. What privacy is that? So after that I was very, I was very skeptic, you know, who I talk to and what I say... I ain't talking to you if you're typing it up into the machine.

Healthcare System Considerations: Integrated, Team-based Services

- Benefit: coordination and continuity of care, availability of, and integration with, SW and MH

I like the healthcare system at the VA because everything is tied in, so the physician is sitting right there and can send an email to whomever, say the social worker, to take a look at this and follow-up.

- Concerns: privacy and confidentiality, comfort with multiple providers

One of the downsides of [the team-based approach] is... that could basically allow [the patient] to be exposed to any one of those seven [people]. I think keeping it within a more confined few providers it's safer and more trusting.

VA-specific Considerations

- Concern about loss of benefits in an integrated system

I wouldn't be surprised if there are women in the [housing] program who are in abusive relationships right now but will say nothing, will do nothing, because they feel as though they're between a rock and a hard place... if you say something about it, do you lose your voucher because you're no longer together, or do you lose the size of your apartment because you're no longer together, or if you have children, do you risk having your children taken away, because you don't say anything, because your husband is abusive to you?

- Utilization of community-based services

In the private sector you're kind-of in the community so you're referring naturally into the community immediately. But in VA, you know, we kind-of only refer to ourselves. There are several restrictions, or bureaucracy. Getting through that sometimes can be a mine field. You know, and then we may lose that opportunity to effect change for that female that has expressed the need or at least showed us that she has a need.

Policy and Clinical Implications

- Patients and providers support screening women for IPV and provision of follow-up support
- Style matters (sensitivity, connectedness, eye-contact)
- An in-house IPV specialist may serve to “fill the gaps”
 - Support/information for providers
 - Support/information for patients
 - Liaison with community
 - Ongoing training and education
 - Programming and outreach
- Policy and practice considerations
 - Documentation
 - Access to benefits
 - Privacy
 - Safety

References

- Dichter, M. E., Cerulli, C., & Bossarte, R. M. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Women's Health Issues, 21*, S190-S194.
- Dichter, M. E., & Marcus, S. C. (2013). Intimate partner violence victimization among women veterans: Health, healthcare services use, and opportunities for intervention. *Military Behavioral Health, 1*: 107-113.
- Dichter, M. E., Marcus, S. C., Wagner, C. & Bonomi, A. E. (2014). Associations between psychological, physical, and sexual intimate partner violence and health outcomes among women veteran VA patients. *Social Work in Mental Health, 12*, 411-428.
- Iverson, K. M., King, M., Resick, P. A., Gerber, M. R., Kimerling, R., & Vogt, D. (2013). Clinical utility of an intimate partner violence screening tool for female VHA patients. *Journal of General Internal Medicine, 28*, 1288-1293.
- Iverson, K. M., Wells, S. T., Wiltsey-Stirman, S., Vaughn, R., & Gerber, M. R. (2013). VHA primary care providers' perspectives on screening female veterans for intimate partner violence: A preliminary assessment. *Journal of Family Violence, 28*, 823-831.
- Institute of Medicine. (2011). *Clinical preventive services for women: Closing the gaps*. Washington, DC: National Academy of Sciences.
- Patient Protection and Affordable Care Act, 42 U.S.C. § 2713 (2010).
- Sadler, A. G., Booth, B. M., Mengeling, M. A., & Doebbeling, B. N. (2004). Life span and repeated violence against women during military service: Effects on health status and outpatient utilization. *Journal of Womens Health, 13*, 799-811.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*, 237-246.
- U.S. Preventive Services Task Force. (2013). *Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement*. (AHRQ Publication No. 12-05167-EF-2). From: <http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>

Thank you!

Melissa.Dichter@va.gov

Appendix

Patient participant demographics

		Study 1 (N = 24)	Study 2 (N = 25)
Age (mean)	Years	50.6	42.8
Race/Ethnicity (%)	Black/African American	37.5	54.2
	White/Caucasian	37.5	19.0
	Hispanic/Latina	N/A	19.0
	Other	8.4	9.5
Education (%)	> High school diploma	83.3	76.2

Provider participant characteristics

Study 3 (N = 12)

- Provider type: primary care providers
 - 9 physicians
 - 3 nurse practitioners
- Gender: 83.3% female
- Location: VHA VISN 1 (New England)

Study 4 (N = 15)

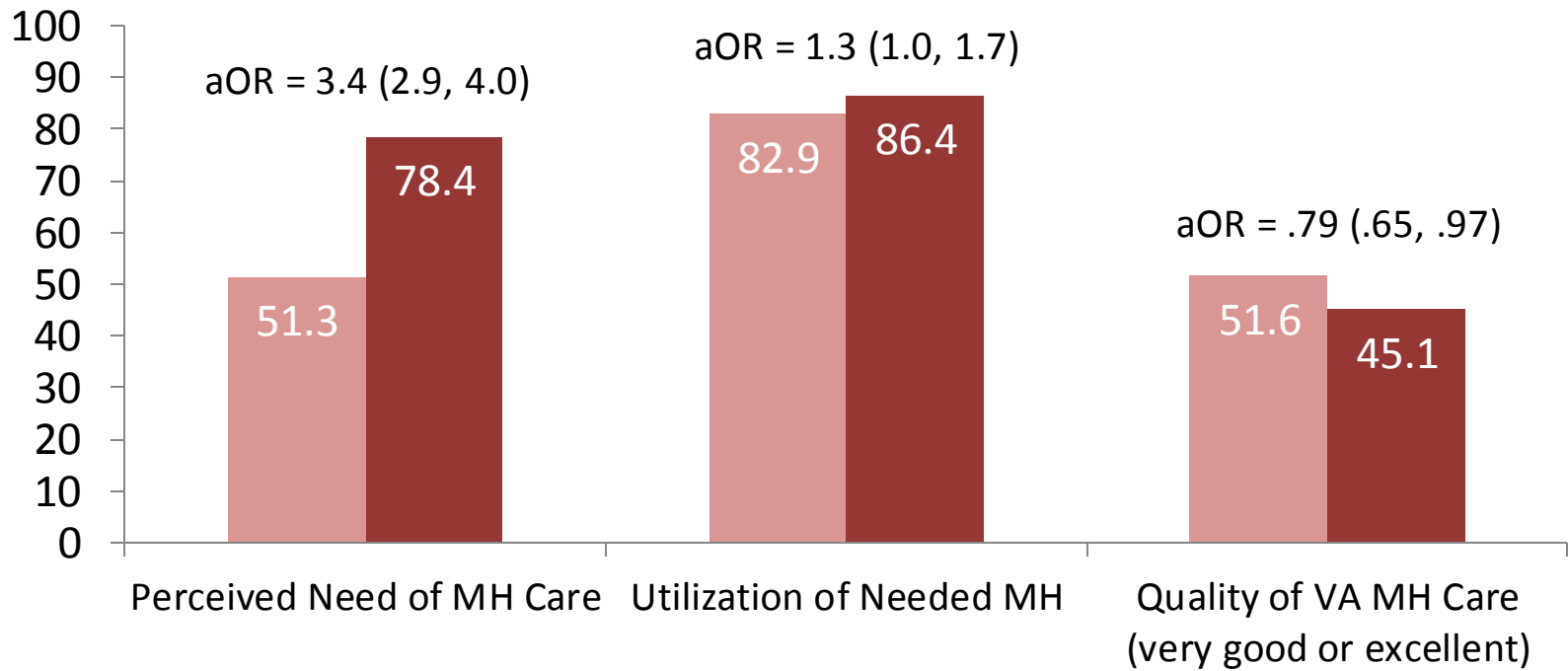
- Provider type: women's health clinicians
 - 5 nurses
 - 3 physician assistants
 - 2 social workers
 - 2 psychologists
 - 2 physicians
 - 1 primary care nurse practitioner
- 100% female
- Location: VHA VISN 4 (Mid-Atlantic)

The WOMAN Study

Women's Overall Mental Health Assessment of Needs

- Nationally representative telephone survey of 6287 women Veteran VA primary care users
 - 84% participation rate
 - Linked to VA administrative data to characterize mental health diagnoses and utilization
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- National prevalence of lifetime interpersonal violence
 - Access to MH care
 - Gender Sensitive Access and Quality Indicators

Access to Mental Health Care



NO IPV IPV

AOR adjusted for age, race