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RESEARCH ARTICLE

Intimate Partner Violence Screening in the Veterans Health Administration: Demographic and Military Service Characteristics

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Introduction: Intimate partner violence (IPV) includes psychological, physical, or sexual aggression by a current or former intimate partner and is associated with a wide range of health and social impacts, especially for women. Women veterans may be at increased risk for experiencing IPV, and some Veterans Health Administration (VHA) facilities have initiated routine screening of female patients for past-year IPV. This study presents the first examination of clinical IPV screening responses recorded from female VHA patients across 13 facilities nationwide, and identifies associations with patient demographic and military service characteristics.

Methods: Electronic medical record data were extracted for a cohort of 8,885 female VHA patients who completed screening for experience of past-year IPV during a clinic visit between April 2014 and April 2016. Analyses, conducted in 2016, examined the overall proportion of patients screening positive for IPV, as well as associations by demographic and military service characteristics.

Results: Overall, 8.7% of patients screened positive for past-year IPV. Odds of screening positive for IPV were higher among women who were younger (aged <35 years); married; served in the most recent conflict era; experienced sexual assault or harassment during military service; or had not served in the military (non-veterans).

Conclusions: Study findings indicate a significant proportion of female VHA patients disclosing past-year IPV during clinical screening, and identify characteristics associated with increased vulnerability. Implications for future research and program implementation include addressing high-risk subpopulations and further investigating the impact of screening and follow-up care.
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INTRODUCTION

Intimate partner violence (IPV), defined as psychological, physical, or sexual aggression by a current or former intimate partner, presents a significant public health burden, especially for women.[1,2] An estimated 5.3 million U.S. women experience IPV each year, and nearly 42.4 million women experience IPV in the form of rape, physical violence, or stalking in their lifetime.[1] Survivors of IPV face acute and long-term IPV-related health sequelae, including elevated rates of depression, posttraumatic stress disorder, substance abuse, suicidality, sexually transmitted infections, musculoskeletal disorders, heart disease, and injury.[3–5] Prompt identification of patients affected by IPV may mitigate the associated health burden by facilitating linkages to appropriate health and social service resources.[6,7] The U.S. Preventive Services Task Force recommends that healthcare

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providers routinely screen women of childbearing age for IPV experience.[8]

The Veterans Health Administration (VHA) is the country's largest healthcare system, providing integrated primary, specialty, and behavioral healthcare to more than 5.8 million patients annually. VHA patients include U.S. military veterans and eligible spouses/dependents of veterans. Women veterans currently comprise 6.5% of the VHA patient population and are the fastest-growing sector of VHA patients.[9,10] In response to recommendations from the VHA Domestic Violence Task Force,[11] several VHA sites across the country have implemented screening for past-year IPV using the Extended Hurt Insult Threaten Scream (E-HITS) tool.[12] This study offers a first look at the clinical screening responses among female VHA patients and examines patient demographic and military service factors associated with positive IPV (IPV+) screens.

Although healthcare systems and providers are increasingly implementing IPV screening recommendations, little is known about the proportion of patients who screen IPV+ and the characteristics associated with IPV+ screens; available prevalence rates are derived primarily from survey-based research. According to national survey data, an estimated 5.9% of U.S. women experience rape, physical violence, or stalking by a current or former intimate partner each year; nearly 14% experience psychological violence annually.[1] Women who have served in the military report higher rates of lifetime IPV experience than women with no military service history.[5] In a telephone survey of a nationally representative sample of women veterans who use VHA primary care, 18.5% reported past-year psychological, sexual, or physical IPV.[13]

Women may be less likely to disclose experiences of IPV in a clinical setting than in the context of survey research. Patients face several barriers to disclosing IPV experiences to healthcare providers, including lack of comfort in the clinical encounter, concerns about potential negative consequences of disclosure, and not feeling ready to disclose or address experiences of violence.[14–17] Despite such barriers, screening is important to prompt disclosure for patients ready and willing to disclose[14,18] and is widely supported by patients and healthcare providers.[14,15,19]

The purpose of this study was to identify the proportion of female VHA patients screening past-year IPV+, and associations with demographic and military service characteristics. Knowing the responses to clinical IPV screening in VHA can inform the development of IPV programs and implementation strategies in VHA, including identification of specific high-risk patient populations. Additionally, findings from this large study of nearly 9,000 patients enrolled in a national health system may prove relevant to IPV screening efforts in other settings.

METHODS

Data Sample

Data for this study were extracted from the VHA Corporate Data Warehouse, a repository of electronic medical record data from VHA facilities nationwide.[20] As of April 2016, 13 of 150 VHA facilities had initiated routine IPV screening for women, through integration of the E-HITS screening tool into VHA's electronic medical record system. The sites were spread across 11 states throughout the U.S. including urban and rural locations. At these sites, a clinical reminder prompts staff to administer the E-HITS instrument to female patients in private during the clinical encounter. Screening may be conducted by a nurse or health tech or by a primary care, women's health, or mental health provider, and administered annually or biannually, with variation across sites. E-HITS clinical reminder responses were collected for all women screened at each of the 13 facilities between April 8, 2014 (earliest recorded screen date), and April 27, 2016 (date of data extraction). Approval for this study, including a waiver of informed consent given retrospective chart review, was granted by the Philadelphia VA Medical Center IRB.

Measures

The E-HITS[12] tool extends the 4-item HITS instrument[21] to include a measure of sexual violence. E-HITS asks individuals how often in the past year (from 1 = *never* to 5 = *frequently*) a current or former partner: *physically hurt you*, *insulted or talked down to you*, *threatened you with harm*, *screamed or cursed at you*, or *forced you to have sexual activities*. E-HITS total scores range from 5 to 25; a score of ≥ 7 or indicates an IPV+ screen, based on the balance of sensitivity and specificity found in prior research with female VHA patients.[22]

Demographic characteristics drawn from patient medical record data included self-reported age (at time of screening); race; ethnicity (Hispanic/Latino or not); marital status; and veteran status (veteran or non-veteran). Non-veteran VHA patients include eligible spouses or dependents of veterans. Military service characteristics (for veterans only) included period of service; branch of service; experience of military sexual trauma (MST, defined as unwanted sexual harassment or assault during military service, measured through a standardized VHA MST screen); and service in or in direct support of missions in Afghanistan (Operation Enduring Freedom [OEF]) or Iraq (Operation Iraqi Freedom [OIF] or Operation New Dawn [OND]).

Statistical Analysis

Analyses were conducted in 2016. Univariate analyses (frequencies and percentages) were calculated first to identify demographic and military service characteristics of the study sample. Next, E-HITS screening responses were examined, focusing on IPV+ screenings overall (proportion of screened patients scoring ≥ 7 on E-HITS), as well as by patient demographic and military service characteristics of those who screened IPV+. In addition to frequencies and percentages, ORs and AORs along with corresponding 95% CIs