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Primary Care Providers with More Experience and Stronger Self-Efficacy Beliefs Regarding Women Veterans Screen More Frequently for Interpersonal Violence

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A B S T R A C T

Background: Military sexual trauma (MST) and/or intimate partner violence (IPV) are common experiences in the growing group of women veterans using the Veterans Health Administration health care system. And even though MST screening is closely monitored at the facility level, little is known about individual primary care provider (PCP) behavior with regard to screening women for MST and IPV.
Objectives: To understand how PCP experiences and beliefs regarding women's health care influence PCP-reported screening for MST and IPV.
Research Design and Participants: We administered a cross-sectional online survey from September 2014 through April 2015 (supplemented by a mailed survey between April and May 2015) to 281 PCPs in 12 Veterans Health Administration medical centers.
Measures and Analysis: Surveys measured PCP-reported screening frequency for MST and IPV, experience with women veterans, self-efficacy, gender-sensitive beliefs, and perceived barriers to providing comprehensive care for women. We used multivariable ordered logistic regression analysis to identify correlates of screening, weighted for nonresponse and adjusted for clustering.
Results: Ninety-four PCPs (34%) completed the survey. Being a designated women's health provider ($p < .05$) and stronger self-efficacy beliefs about screening women for MST ($p < .001$) were associated with reporting more frequent screening for MST. Being a designated women's health provider ($p < .01$), seeing women patients at least once per week ($p < .001$), and self-efficacy beliefs about screening women for IPV ($p < .001$) were associated with reporting more frequent screening for IPV.
Conclusions: Veterans Health Administration initiatives to enhance PCP opportunities to screen women veterans for trauma and to strengthen self-efficacy beliefs about comprehensive women's health care may increase screening of women veterans for MST and IPV.

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Women are the fastest growing subgroup of veterans who use the Veterans Health Administration's (VHA) services but remain a numerical minority (<10% of all patients; Frayne, Phibbs, & Friedman, 2012; Maisel et al., 2015; Yano, Washington, & Bean-Mayberry, 2008). Military sexual trauma (MST) and intimate partner violence (IPV) are common among women veterans who use VHA services. Up to 22% of women screened positive for MST in the VHA (Kimerling, Gima, Smith, Street, & Frayne, 2007), and 18.5% of women veterans using VHA care report past year IPV when screened (Kimerling et al., 2016). Data from national surveillance surveys indicate that rates of IPV are substantially higher among women veterans (33.0%) compared with women in the civilian community (23.8%; Dichter, Cerulli, & Bossarte, 2011).

To address the needs of this growing population, the VHA has implemented initiatives to address screening for two traumatic stress exposures with particular relevance for women veterans, namely, MST and IPV. These screenings most frequently occur within primary care settings. They are critical for raising providers' awareness of possible mental and physical health consequences of such conditions and for allowing connections of veterans to appropriate follow-up care, including appropriate safety planning for those experiencing IPV (Coker et al., 2002). Within the VHA, a one-time universal screen for experiences of MST has been mandated since 2000 (Kimerling et al., 2007; VHA, 2010). Screening rates for MST have risen over time and currently most VHA facilities exceed performance benchmarks, although some variability still exists across providers (Hyun, Kimerling, Cronkite, McCutcheon, & Frayne, 2012). More recently, the VHA's National IPV Assistance Program has recommended expanded screening of all women veterans for IPV (Broomfield, 2013; Department of Veterans Affairs, 2013; Sweeney et al., 2013). Because universal IPV screening is recommended but there is no policy mandating it, primary care provider (PCP) rates of IPV screening are low and tend to vary across providers (Gerber, Leiter, Hermann, & Bor, 2005; Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013; Kimerling et al., 2016).

Universal screening for IPV by PCPs is recommended by multiple professional organizations, including the American Medical Association (Yawn, Yawn, & Uden, 1992). Recently, the Department of Health and Human Services (U.S. Department of Health Human Services, 2013) recommended universal IPV screening by PCPs as part of a preventive care strategy. This plan was further supported by the Affordable Care Act's commitment to preventive services for women. Yet screening practices are generally low. A review of 35 research articles on providers' routine screening practices for IPV found 2% to 50% reported almost always screening (Alvarez, Fedock, Grace, & Campbell, 2016). As a specific example, in one study of California physicians, only 10% of the sample reported routine screening of new patients for IPV and only 9% reported routine screening during examinations (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999).

Given the importance of screening for MST and IPV to comprehensive women's health care within the VHA, it is important to identify factors that serve as facilitators or barriers to PCP screening for these sensitive experiences (Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). Some of the reasons for low screening rates are that PCPs with less experience and exposure to women veterans may be unaware of the high prevalence of MST and IPV among women veterans, suggesting that education about their prevalence among women veterans could increase provider awareness and potentially encourage screening (Iverson et al., 2015). Indeed, barriers to PCPs screening women for MST and IPV include low numbers of women veterans seen by PCPs who work in mixed gender settings (Yano et al., 2016). In addition, lack of knowledge about how to ask questions about abuse (Yonaka, Yoder, Darrow, & Sherck, 2007), time limitations and a lack of incentives for spending that extra time to screen for domestic violence (Miller, McCaw, Humphreys, & Mitchell, 2015), insufficient staff support (e.g., access to women nurses as chaperones for pelvic examinations), limited physical resources (e.g., not enough examination rooms equipped for pelvic examinations, Bergman, Frankel, Hamilton, & Yano, 2015), perceived patient discomfort with disclosure of abuse (Dichter, Wagner, Goldberg, & Iverson, 2015), and low self-efficacy beliefs about the ability to support patients who disclose (Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Yonaka et al., 2007) have been identified as additional barriers to screening for IPV. Some research has shown that comprehensive training for health care providers may increase self-efficacy for working with survivors of IPV (Dichter et al., 2015; Gadomski, Wolff, Tripp, Lewis, & Short, 2001; Miller et al., 2015), which may, in turn, lead to higher rates of screening.

The manner in which the level of experience with, and beliefs about caring for, women veterans influence PCPs' screening frequency for MST and IPV in the VHA, to our knowledge, has not yet been studied. We draw upon the Health Belief Model (HBM; Becker, 1974; Rosenstock, 1974) to understand the factors that influence more frequent screening of MST and IPV among women veterans by VHA PCPs. According to the HBM, we expected that PCPs who have more experience with women veterans and more openness to caring for women veterans would have an increased odds of screening more frequently for MST and IPV. Because MST screening is a mandated lifetime screen, whereas IPV screening is only a recommended annual screen, we expected stronger effects for IPV screening because of greater variability in screening rates.

Methods

Participants and Procedure

Data are from a cross-sectional online and supplemental mail survey administered as part of a larger study to improve primary care services for women (Yano et al., 2016). The survey was administered in two stages from September 8, 2014, through April 27, 2015. We first pretested the survey instrument with eight PCPs using cognitive interviewing techniques to enhance the validity of the questions. We incorporated the feedback into the final version of the survey to optimize its validity. RAND sent email invitations to 281 PCPs in primary care and/or women's health clinics at 12 VHA medical centers in 9 states. Participants for this investigation were the 94 PCPs (physicians, nurse practitioners, and physician assistants) whom completed a survey (34% response rate). All study procedures were reviewed and approved by both the VHA and RAND Institutional Review Boards.

Measures

Screening frequency was measured with two single items about PCPs' reported frequency of screening for MST and IPV for women patients at their VHA over the past year. PCPs indicated how often they performed screening services for women veteran patients over the past year (never, at least once over the past year, about once per month, at least two times per month).

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