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Intimate Partner Violence Screening and Response: Policies and Procedures Across Health Care Facilities

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A B S T R A C T

Purpose: This study examines policies and procedures for identifying and responding to intimate partner violence (IPV) among different types of health care settings.
Methods: This epidemiologic, cross-sectional, observational study design collected data from June 2014 to January 2015 through a telephone questionnaire from a stratified random sample of 288 health care facilities in Miami-Dade County, Florida. An overall response rate of 76.2% was achieved from 72 primary care clinics, 93 obstetrics/gynecology clinics, 106 pediatric clinics, and 17 emergency departments (EDs).
Results: There is a general awareness of the importance of IPV screening with 78.1% of facilities (95% CI, 73.9%–82.3%) reporting some type of IPV screening procedures. Wide variation exists, however, in how practices are implemented, with only 35.3% of facilities (95% CI, 29.5%–41.1%) implementing multicomponent, comprehensive IPV screening and response programs. Differences were also observed by setting with EDs reporting the most comprehensive programs.
Conclusions: This study yields important empirical information regarding the extent to which IPV screening and response procedures are currently being implemented in both clinic and acute health care settings along with areas where improvements are needed.

Intimate partner violence (IPV), defined as physical, sexual, psychological, or emotional abuse, or threat of abuse, by a current or former spouse or partner is a critical public health concern (Saltzman, Fanslow, McMahon, & Shelley, 2002). Approximately one-third of U.S. women report experiencing physical violence at some point in their life by a current or past partner (Breiding, Chen, & Black, 2014). Women who experience IPV are significantly more likely to experience adverse health outcomes (Bonomi, Anderson, Rivara, & Thompson, 2007; Breiding et al., 2014). These outcomes may include physical trauma, such as head and neck injuries; chronic gynecological, central nervous system, and stress-related health conditions; and long-term mental health problems such as depression, posttraumatic stress disorder, substance abuse, and suicidality (Campbell et al., 2002; Dutton et al., 2006; Kwako et al., 2011; Tam, Joyce, Gerber, & Tan, 2010; Woods et al., 2005). Survivors of IPV are more likely to seek health services compared with those with no history of victimization (Breiding et al., 2014; Plichta, 2007; Ulrich et al., 2003). As such, health care visits provide an opportune time for the identification of and intervention for IPV.

In recent years, there has been an unprecedented increase in national level support for the integration of routine screening and intervention into health care settings. The Institute of Medicine and the U.S. Preventive Services Task Force (USPSTF), along with numerous national health professional organizations, have developed recommendation statements and guidelines for routine screening and intervention for IPV (Institute of Medicine, 2011; Moyer & USPSTF, 2013). These recommendations were made in response to recent and adequate evidence indicating that there are effective instruments available for detecting current, past, and risk for future IPV in health care settings; that detection and early intervention result in numerous benefits including reductions in violence, abuse, and physical or mental harms; and that the risks of screening are minimal (Nelson,

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Bougatsos, & Blazina, 2012; U.S. Department of Health and Human Services [DHHS], 2013b). In addition, provisions included in the Affordable Care Act allow for the reimbursement of IPV preventative services making it easier for providers to include as part of routine care (U.S. DHHS, 2013a).

Despite these recommendations, little is known about the extent to which policies for IPV screening and response exist in practice, particularly since the increase in IPV screening research and advocacy over the past decade which informed the Institute of Medicine, USPSTF, and other recommendations. A few studies have examined actual IPV screening behaviors by providers and have found very low rates, indicating a disconnect between guidelines and practice. For example, Waalen, Goodwin, Spitz, Petersen, and Saltzman (2000) found screening rates of 1.5% to 13% among primary care and emergency room physicians and about 10% for obstetricians and gynecologists. Rodriguez, Bauer, McLoughlin, & Grumbach (1999) found similar rates (9%–11%) for routine screening of asymptomatic patients among a random sample of physicians in California and Borowsky and Ireland (2002) found rates between 5% and 18% for pediatric and family physicians and residents.

One major barrier to the implementation of IPV screening guidelines is a lack of consensus as to what constitutes the best practices for detection and intervention of IPV (Feder et al., 2009; Sprague et al., 2012). IPV screening protocols often differ based on factors such as when the screening should be conducted (e.g., first visit, every visit), what screening tool should be used and how it should be administered (e.g., self-administered, face to face), how providers/staff should be trained, and how to respond when an individual screens positive. Current practice guidelines provide few recommendations regarding these factors.

This lack of consensus may also play a role in ongoing international debates regarding the actual effectiveness of health care–based IPV screening. The usefulness of IPV screening within the health care system has come into question primarily as a result of several recent studies that found that screening did not improve outcomes; primarily, recurrence of partner violence and use of support services (Klevens, Sadowski, Kee, Garcia, & Lokey, 2015; MacMillan et al., 2009; O'Doherty et al., 2014; Rhodes et al., 2015). These results are in conflict with the universal screening recommendations made by USPSTF and others. The methods and intensity of screening and response procedures undoubtedly influence the overall success of these practices. Comparative effectiveness studies are needed to improve understanding of how procedural variations in IPV screening may influence desired outcomes.

The comprehensiveness of a screening program can also impact overall effectiveness. O'Campo, Kirst, Tsamis, Chambers, and Ahmad (2011) conducted a realist-informed systematic review to evaluate mechanisms through which IPV screening programs in health care settings are effective. Seventeen programs were identified evaluating IPV screening. Results indicated that those which used a "comprehensive" approach were more effective at increasing rates of IPV screening, disclosure, and identification compared with "noncomprehensive" programs. Comprehensive programs used a multicomponent approach that commonly included the use of effective screening protocols, provision of thorough initial and ongoing training, immediate access or referral to support services, and institutional support for IPV. As such, examining the comprehensiveness of IPV screening policies and practices in health care settings is an important indicator for evaluating effectiveness.

The purpose of this study was to examine policies and procedures for identifying and responding to IPV among different types of health care settings, namely, primary care, obstetrics/gynecology clinics (OB/GYN), emergency, and pediatrics, in Miami-Dade County, Florida. Specifically, this study aims to 1) estimate the proportion of health care practices in Miami-Dade County with policies and procedures in place for identifying and responding to IPV and 2) examine the comprehensiveness of these programs by synthesizing existing practices such as the timing of screening, the screening tool used and how it is administered, staff training, and inclusion of response protocols. This study is one of the first examining the potential impact of new research and guidelines for routine IPV screening on health care policies and is a first step in addressing the disconnect between clinical guidelines and actual clinical performance.

Material and Methods

Design and Sample

An epidemiologic, cross-sectional, observational study design was used to assess the aims of this study. Primary care, OB/GYN, pediatric, and emergency department (ED) facilities in Miami-Dade County were located through several health provider directories and compiled into a master database. Directory searches were conducted until no new facility listings were found. The master database was examined for duplicate entries by provider name and facility address. These duplicate entries were removed to prevent oversampling of large facilities (i.e., facilities with multiple providers at the same location) and providers with multiple office locations because they likely share the same policies and procedures.

A total of 1,208 unique health care facilities were identified and a total of 378 facilities were contacted for participation in the study (Table 1). Primary care, OB/GYN, and pediatric facilities were selected through stratified random sampling; all EDs were contacted. Of the 378 facilities selected, 288 agreed to participate, resulting in an overall response rate of 76.2%. Response rates differed by type of facility, ranging from 67.9% for primary care to 83.0% for OB/GYN.

Data Collection Procedures

Data were collected from June 2014 through January 2015. Trained study personnel contacted each randomly selected facility by telephone and asked to speak with an individual who was familiar with their facility's policies and practices. These individuals were informed of the study and asked if they would

Table 1
Sampling Procedures and Response Rates

Facility Type	Total no. in Sampling Pool	No. of Facilities Randomly Selected	No. of Facilities that Responded	Response Rate (%)
Primary care	820	106	72	67.9
OB/GYN	131	112	93	83.0
Pediatrics	236	139	106	76.3
ED	21	21	17	81.0
Total	1,208	378	288	76.2

Abbreviations: ED, emergency department; OB/GYN, obstetrics/gynecology clinics.