



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Intimate Partner Violence
Assistance Program
Implementation Status and
Barriers to Compliance



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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) medical facilities' (facilities) compliance with select requirements for the Intimate Partner Violence Assistance Program (IPVAP) as well as the duties and perceived challenges of the IPVAP coordinators and Veterans Integrated Service Network (VISN) champions.¹ The purpose of the review was to evaluate the national status of the IPVAP implementation and identify perceived barriers to compliance.

VHA defines intimate partner violence (IPV) as violent behavior by a current or former intimate partner that includes physical and sexual violence, psychologically aggressive or coercive acts, and stalking.² In 2018, the National Center for Injury Prevention and Control reported that approximately 36 percent of women and 34 percent of men experienced physical violence, sexual violence, or stalking by an intimate partner during their lifetime.³

The prevalence of IPV among veterans and active duty service members varies across studies with rates estimated between 14 and 58 percent.⁴ Veterans and active duty service members are up to three times more likely to perpetrate IPV than civilians.⁵

IPV is associated with psychological consequences including anxiety, depression, posttraumatic stress disorder, and self-harm behaviors; physical health problems including heart and digestive

¹ VHA, "Veterans Integrated Services Networks (VISNs)", accessed July 5, 2022, <https://www.va.gov/HEALTH/visns.asp>. VHA is organized into 18 VISNs that are "regional systems of care working together to better meet local health care needs and provide greater access to care." VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. The IPVAP coordinator serves as the facility's subject matter expert, point of contact, and consultant for IPV-related issues and must be a licensed independent provider. The "VISN champion is a VISN staff member who volunteers or is appointed by the VISN Director" to support the VISN lead coordinator through duties such as technical assistance to IPVAP coordinators, assistance with budget reports, and communication of IPVAP-related information to VISN executive leaders.

² VHA Directive 1198, *Intimate Partner Violence Assistance Program*, January 24, 2019. VHA further notes that IPV "occurs on a continuum of frequency and severity which ranges from one episode that might or might not have lasting impact to chronic and severe episodes over a period of years. It can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation." *Merriam-Webster.com Dictionary*, "stalk," accessed December 20, 2021, <https://www.merriam-webster.com/dictionary/stalking>. Stalking is the act of pursuing another individual "obsessively and to the point of harassment."

³ National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2015 Data Brief – Updated Release*, November 2018.

⁴ Amy D. Marshall, Jillian Panuzio, and Casey T. Taft, "Intimate Partner Violence among Military Veterans and Active Duty Servicemen," *Clinical Psychology Review* 25, (2005): 862-876. Jennifer M. Gierisch et al., *Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches*, VA-ESP Project #09-010, August 2013.

⁵ Marshall et al., "Intimate Partner Violence among Military Veterans and Active Duty Servicemen."

conditions, and higher rates of chronic diseases; and risky health behaviors such as smoking, heavy alcohol use, and decreased preventative health care.⁶

The coronavirus (COVID-19) pandemic has resulted in a “marked increase in IPV incidence” due to multiple factors including financial, occupational, and home instability; mandatory lockdowns with remote work and school orders causing families to remain in the household for prolonged periods of time; and social distancing measures that may have contributed to victims’ isolation and inability to access supportive resources.⁷

In January 2019, VHA established an IPVAP directive and considered a medical facility “out of compliance” if a designated IPVAP coordinator or implementation of “the full scope of services” was not in place as of January 24, 2019.⁸ The Office of Care Management and Social Work Services, within the VHA Office of Patient Care Services, is responsible for “implementation,

⁶ Matthew J. Breiding, Michele C. Black, and George W. Ryan, “Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence—18 U.S. States/Territories, 2005,” *Annals of Epidemiology* 18, no. 7, (2008): 538-544. Michele C. Black, “Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians,” *American Journal of Lifestyle Medicine* 5, no. 5, (2011): 428-439. “Preventing Intimate Partner Violence,” Centers for Disease Control and Prevention, accessed December 22, 2021, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>. “Anxiety Disorders,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>. Anxiety is a temporary worry or fear when faced with a problem. Anxiety disorders involve anxiety that persists, gets worse over time, and interferes with a person’s ability to perform daily activities. “Depression,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/depression/index.shtml>. Depression is a mood disorder that impacts a person’s emotions, ability to think clearly, sleep, appetite, and daily functioning and lasts for at least two weeks. “Post-traumatic Stress Disorder,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>. Post-traumatic stress disorder develops in some individuals after exposure to a dangerous or frightening incident. Symptoms, including reexperiencing the event in some way, avoiding reminders of the event, physical agitation, and changes in mood or thinking, last longer than one month and impairs daily functioning. Donna E. Stewart and Simone N. Vigod, “Update on Mental Health Aspects of Intimate Partner Violence,” *Medical Clinics of North America*, 103, (2019): 735-749.

⁷ World Health Organization (WHO), “WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020,” March 11, 2020, accessed November 10, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam-Webster.com Dictionary, “pandemic,” accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). “COVID-19 and its impact on intimate partner violence,” Penn State Social Science Research Institute, accessed March 7, 2022, <https://covid19.ssri.psu.edu/articles/covid-19-and-its-impact-intimate-partner-violence>. Fernanda S. Rossi et al., “Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19,” *Journal of General Internal Medicine* 35, no. 9, (September 2020): 2728-2731, accessed March 7, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7325833/>.

⁸ VHA Directive 1198. “VHA Directive 1198, Intimate Partner Violence Assistance Program (January 24, 2019), *Frequently Asked Questions (FAQs)*, February 2019.” Intimate Partner Violence Assistance Program SharePoint.

management, administration and evaluation of the IPVAP.”⁹ The National Director of Social Work provides oversight for the “development and implementation of national directives, program initiatives, and VHA guidance related to the delivery of IPV assistance.”¹⁰ The National IPVAP Program Manager, who reports to the National Director of Social Work, provides “Oversight of the implementation, maintenance, and reporting requirements to support all components of IPVAP to include, but not limited to, promoting education and training, raising awareness, implementing screening, enhancing safety, and providing intervention.”¹¹

VHA provides guidance regarding role responsibilities for VISN and medical center leaders and staff. VISN-level governance includes an IPVAP VISN lead coordinator (VISN lead coordinator) and an IPVAP VISN champion (VISN champion). The VISN lead coordinator “serves as a regional conduit between the IPVAP National Program Manager and the field based IPVAP Coordinators in each VISN.”¹² The VISN champion supports the VISN lead coordinator through duties such as technical assistance to IPVAP coordinators, assistance with budget reports, and communication of IPVAP-related information to VISN executive leaders.¹³

Facility directors are responsible to implement the IPVAP including development of a “local protocol” to define “roles, responsibilities, processes, and procedures,” and the appointment of an IPVAP coordinator.¹⁴ The IPVAP coordinator serves as the facility’s subject matter expert, point of contact, and consultant for IPV-related issues and must be a licensed independent provider.¹⁵

⁹ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*.

¹⁰ VHA Directive 1198.

¹¹ VHA Directive 1198.

¹² VHA Directive 1198; VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*; VHA, Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program.

¹³ VHA Directive 1198; VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*. VHA Directive 1198 refers to the appointment of a VISN-level IPVAP point of contact (POC). In an interview with the OIG, the National Director of Social Work confirmed that the VISN-level IPVAP POC was the same role as the VISN champion as identified in the operating guide.

¹⁴ VHA Directive 1198.

¹⁵ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*; VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. A licensed independent provider, also referred to as a licensed independent practitioner, is a provider who is permitted by law, and the facility, to deliver patient care without supervision.

The OIG team conducted a national survey of IPVAP coordinators, VISN lead coordinators, and VISN champions as well as virtual interviews of select IPVAP coordinators and VISN champions.¹⁶

The OIG found that the majority of IPVAP coordinators' and VISN champions' open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity. Based on analyses of survey and interview data, the OIG found over half of the facilities did not have a local IPVAP protocol, as required.¹⁷ The absence of a local protocol may contribute to leader and staff confusion and lack of knowledge about IPVAP roles, responsibilities, process, and procedures.

Eighty-two percent of IPVAP coordinators reported over half of their time was dedicated to the role. Notably, the OIG found that the IPVAP coordinator serving the facility with the most patients and coordinator serving the facility with the least patients both reported dedicated time between zero and 25 percent.¹⁸ Given the absence of an apparent logical relationship between the IPVAP coordinators' dedicated time and the patient population size, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of population needs and IPVAP coordinator role demands.

The OIG assessed IPVAP coordinators' patient care, administrative, training, screening, community partnership, and program evaluation duties. The majority of IPVAP coordinators reported providing training at fewer than half of new employee orientation sessions and to fewer than half of IPV screeners.¹⁹ VHA recommended training at new employee orientation and acknowledged that IPVAP coordinators may not be afforded the time.

VHA requires all facilities to offer IPV screening and recommends screening all patients annually and asserts that, "at a minimum," women of child bearing age should be screened

¹⁶ VHA Directive 1198; VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*. The OIG did not independently review the survey results to assess the validity of the reported data.

¹⁷ VHA Directive 1198.

¹⁸ VHA Directive 1198. Although a full-time employee equivalent position "is optimal," the IPVAP coordinator may be a collateral duty if provided "adequate protected time" to satisfy the role responsibilities. VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period. For the purposes of this report, the OIG uses the terms protected time and dedicated time interchangeably.

¹⁹ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020. In a 2021 healthcare inspection report, the OIG found that VHA offered unclear guidance about IPV training responsibilities. The OIG made a recommendation to the Under Secretary for Health to establish clear IPV training guidance and this recommendation remained open as of July 6, 2022.

“routinely.”²⁰ While IPV screening is not mandatory, VA encourages “integrating care” and supports IPV screening “into routine workflow” with the frequency determined by each facility or VISN.²¹ Fourteen percent of IPVAP coordinators reported that their facilities did not implement routine IPV screening.²² IPVAP coordinators described challenges in IPV screening without a clinical reminder or mandatory status.²³

To ensure robust monitoring and oversight, the OIG would expect use of the standardized instrument for routine screenings nationally with identified benchmark metrics to establish baseline measures. Standardization of program evaluation procedures could facilitate ongoing performance improvement processes that ultimately determine the implementation of appropriate interventions.

Although IPVAP coordinators are identified as responsible for program evaluation, the OIG found that VHA did not establish standardized program evaluation methods or standardized measures. The National IPVAP Program Manager told the OIG that performance metrics have not been prescribed but were being monitored “through [IPVAP coordinators] reporting to us what they are doing” and that national templates and a dashboard were being developed to ensure standardized data collection. The VISN champions described their role as providing support for the VISN lead coordinator and noted that they did not have dedicated time for IPVAP responsibilities. In interviews, VISN champions identified the need for clearer expectations of the responsibilities of the VISN champion and VISN lead coordinator roles, a full time IPVAP coordinator, mandatory clinical reminder and screening completion, and a designated VISN IPVAP coordinator. Interviewed VISN champions suggested establishing a dedicated VISN champion position and clear role responsibilities would be desirable IPVAP improvements.

About half of VISN lead coordinators reported dissatisfaction with support from the VISN champion. The OIG concluded that clearer role expectations would likely support more effective leadership at the VISN level. Similarly, the OIG made recommendations to clarify elements of IPVAP that would promote standardization of service delivery and evaluation of critical outcomes across the system in an effort to support informed performance improvement initiatives.

²⁰ VHA Directive 1198. VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

²¹ VHA, Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program.

²² VHA, Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program.

²³ “VistA, Clinical Reminders, Version 2.0, User Manual,” VA Office of Information & Technology, accessed on April 5, 2022, https://www.va.gov/vdl/documents/Clinical/CPRS-Clinical_Reminders/pxrm_2_6_um.pdf. Clinical reminders are viewed in a patient’s electronic health record and directs “providers to perform certain tests or other evaluations that will enhance the quality of care for specific conditions. The clinicians can then respond to the reminders by placing relevant orders or recording clinical activities on patients’ progress notes.”

The OIG made seven recommendations to the Under Secretary for Health related to developing protocols at medical centers, evaluating the sufficiency of current guidance and operational status regarding IPVAP coordinators' dedicated time and population needs, determining guidance for dedicated administrative staff support, establishing standardized IPV staff training content and format as well as the evaluation of training efficacy, developing IPV screening requirements, expediting program evaluation processes, and evaluating guidance related to the roles and oversight functions of the VISN IPVAP champions and lead coordinators.

Comments

The Under Secretary for Health concurred with recommendations 1, 2, 4, 5, 6, and 7, concurred in principle with recommendation 3, and provided an acceptable action plan (see appendix B). The OIG will follow up on the planned actions until they are completed.



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Contents

Executive Summary	i
Abbreviations	viii
Introduction.....	1
Scope and Methodology	10
Results.....	12
Select Requirement Compliance and Oversight Authority	12
IPVAP Coordinator Duties and Challenges.....	14
Conclusion	24
Recommendations 1–7.....	27
Appendix A: Facility and VISN Locations That Did Not Submit Surveys.....	28
Appendix B: Under Secretary for Health Memorandum.....	29
OIG Contact and Staff Acknowledgments	33
Report Distribution	34

Abbreviations

IPV	intimate partner violence
IPVAP	Intimate Partner Violence Assistance Program
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) medical facilities' (facilities) compliance with select requirements for the Intimate Partner Violence Assistance Program (IPVAP) as well as the duties and perceived challenges of the IPVAP coordinators and Veterans Integrated Service Network (VISN) champions.¹ The purpose of the review was to evaluate the national status of the IPVAP implementation and identify perceived barriers to compliance.

Background

VHA defines intimate partner violence (IPV) as violent behavior by a current or former intimate partner that includes physical and sexual violence, psychologically aggressive or coercive acts, and stalking.² IPV ranges in severity, as well as frequency, from a single episode to multiple occurrences over years.³ In 2018, the National Center for Injury Prevention and Control reported that approximately 36 percent of women and 34 percent of men experienced physical violence, sexual violence, or stalking by an intimate partner during their lifetime.⁴ In the United States, a current or former intimate partner is responsible for killing one in five homicide victims and over half of homicides among women.⁵

The prevalence of IPV among veterans and active duty service members varies across studies with rates estimated between 14 and 58 percent.⁶ A 2013 review of eight studies reported 35

¹ VHA, "Veterans Integrated Services Networks (VISNs)," accessed July 5, 2022, <https://www.va.gov/HEALTH/visns.asp>. VHA is organized into 18 VISNs that are "regional systems of care working together to better meet local health care needs and provide greater access to care."

² VHA Directive 1198, *Intimate Partner Violence Assistance Program*, January 24, 2019. VHA further notes that IPV "occurs on a continuum of frequency and severity which ranges from one episode that might or might not have lasting impact to chronic and severe episodes over a period of years. It can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation." Merriam-Webster.com Dictionary, "stalk," accessed December 20, 2021, <https://www.merriam-webster.com/dictionary/stalking>. Stalking is the act of pursuing another individual "obsessively and to the point of harassment."

³ VHA Directive 1198.

⁴ National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2015 Data Brief – Updated Release*, November 2018.

⁵ "Preventing Intimate Partner Violence," Centers for Disease Control and Prevention, accessed December 22, 2021, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>.

⁶ Amy D. Marshall, Jillian Panuzio, and Casey T. Taft, "Intimate Partner Violence among Military Veterans and Active Duty Servicemen," *Clinical Psychology Review* 25, (2005): 862-876. Jennifer M. Gierisch et al., *Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches*, VA-ESP Project #09-010, August 2013.

percent of female veterans were victims of IPV.⁷ Veterans and active duty service members are up to three times more likely to perpetrate IPV than civilians.⁸

IPV is associated with psychological consequences including anxiety, depression, posttraumatic stress disorder, and self-harm behaviors; physical health problems including heart and digestive conditions, and higher rates of chronic diseases; and risky health behaviors such as smoking, heavy alcohol use, and decreased preventative health care.⁹

Identification of IPV victims and perpetrators is critical to prevention. Screening is central to identifying IPV to facilitate access to VA and community resources for assistance and care.¹⁰ A VA review of studies concluded that standardized screening protocols identified IPV more effectively than non-standardized screening and that screening completion increased with “initial and ongoing” provider training, “immediate access to referral services,” and “institutional support.”¹¹ The Joint Commission requires that hospitals use written criteria to assess patients for possible abuse at the initiation of and throughout medical care, maintain a list of community referral resources, provide relevant referrals, educate staff, “internally reports cases of possible abuse,” and report to external agencies consistent with the law.¹²

⁷ VA Evidence-based Synthesis Program, *Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches*, August 2013.

⁸ Marshall et al., “Intimate Partner Violence among Military Veterans and Active Duty Servicemen.”

⁹ Matthew J. Breiding, Michele C. Black, and George W. Ryan, “Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence—18 U.S. States/Territories, 2005,” *Annals of Epidemiology* 18, no. 7, (2008): 538-544. Michele C. Black, “Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians,” *American Journal of Lifestyle Medicine* 5, no. 5, (2011): 428-439. “Preventing Intimate Partner Violence,” Centers for Disease Control and Prevention website. “Anxiety Disorders,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>. Anxiety is a temporary worry or fear when faced with a problem. Anxiety disorders involve anxiety that persists, gets worse over time, and interferes with a person’s ability to perform daily activities. “Depression,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/depression/index.shtml>. Depression is a mood disorder that impacts a person’s emotions, ability to think clearly, sleep, appetite, and daily functioning and lasts for at least two weeks. “Post-traumatic Stress Disorder,” National Institute of Mental Health, accessed April 19, 2021, <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>. Post-traumatic stress disorder develops in some individuals after exposure to a dangerous or frightening incident. Symptoms, including reexperiencing the event in some way, avoiding reminders of the event, physical agitation, and changes in mood or thinking, last longer than one month and impairs daily functioning. Donna E. Stewart and Simone N. Vigod, “Update on Mental Health Aspects of Intimate Partner Violence,” *Medical Clinics of North America* 103, (2019): 735-749.

¹⁰ “VHA, Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program,” November 2013.

¹¹ VA Evidence-based Synthesis Program, *Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches*.

¹² The Joint Commission, *Standards Manual*, PC.01.02.09, January 1, 2022. “The hospital assesses the patient who may be a victim of possible abuse and neglect.” The Joint Commission, *Standards Manual*, PC.01.02.09, March 14, 2021, contains the same or similar information as in the January 1, 2022, PC.01.02.09 standard.

Effects of the Pandemic on IPV

The coronavirus (COVID-19) pandemic has resulted in a “marked increase in IPV incidence” due to multiple factors including financial, occupational, and home instability; mandatory lockdowns with remote work and school orders causing families to remain in the household for prolonged periods of time; and social distancing measures that may have contributed to victims’ isolation and inability to access supportive resources.¹³

With stay-at-home orders implemented to reduce the spread of COVID-19, victims may have been in the household with a perpetrator and as a result, unable to seek help for fear of increasing the risk of danger by being overheard by the perpetrator.¹⁴ Due to concerns about contracting COVID-19, victims may be hesitant to pursue medical attention related to IPV injuries or other concerns which reduces the opportunity for IPV screening and provision of resources.¹⁵ Further, in response to the stay-at-home orders, VHA staff canceled or conducted “non-essential health care visits” via telehealth further challenging the ability of healthcare workers to complete IPV screens and provide supportive resources.¹⁶

¹³ World Health Organization (WHO), “WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020,” March 11, 2020, accessed November 10, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam-Webster.com Dictionary, “pandemic,” accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). “COVID-19 and its impact on intimate partner violence.” PennState Social Science Research Institute, accessed March 7, 2022, <https://covid19.ssri.psu.edu/articles/covid-19-and-its-impact-intimate-partner-violence>. Rossi et al., “Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19,” *Journal of General Internal Medicine* 35, no. 9, (September 2020): 2728-2731, accessed March 7, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7325833/>.

¹⁴ Rossi et al., “Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19.”

¹⁵ “COVID-19 and its impact on intimate partner violence,” PennState Social Science Research Institute.

¹⁶ Rossi et al., “Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19.” Merriam-Webster.com Dictionary, “telehealth,” accessed March 9, 2022, <https://www.merriam-webster.com/dictionary/telehealth#:~:text=Definition%20of%20telehealth%20%3A%20health%20care%20provided%20remotely,homes%20while%20getting%20sound%20medical%20advice%20from%20professionals>. Telehealth is “health care provided remotely to a patient in a separate location using two-way voice and visual communication (as by computer or cell phone).”

Development of IPVAP

In May 2012, VHA chartered a Domestic Violence Task Force to develop a program focused on IPV-related care and resources for veterans and VA employees.¹⁷ In November 2013, VHA published 14 recommendations for program implementation including

- raising awareness,
- implementing a national program and leadership structure,
- standardizing screening,
- providing intervention and resource referrals,
- adhering to mandated reporting laws,
- training clinical staff, and
- establishing community partnerships.¹⁸

In January 2014, VHA appointed a National IPVAP Program Manager and initiated IPVAP implementation at six facilities.¹⁹ In June 2017, the six facilities completed the IPVAP implementation, and “promising practices” were identified to inform the IPVAP expansion nationally.²⁰ In 2018, the Senate Appropriations Committee directed VA to fund a full-time IPVAP coordinator at each medical facility and VHA required each facility to complete an evaluation and needs assessment.²¹

In January 2019, VHA established an IPVAP directive and considered a medical facility “out of compliance” if a designated IPVAP coordinator or implementation of “the full scope of services” was not in place as of January 24, 2019.²² In an interview with the OIG, the National IPVAP Program Manager said that the implementation status information was used to identify facilities that did not have IPVAP coordinators and provide national program office assistance. In October

¹⁷ VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*, November 2013. Domestic violence “refers more broadly to any violence that occurs in the home.” The National Director of Social Work told the OIG that in 2014 or 2015 a decision was made to focus on violence between veterans and their intimate partners and VHA Directive 1198 solidified the IPV terminology.

¹⁸ VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*.

¹⁹ VA Care Management and Social Work, *Intimate Partner Violence Assistance Program, 2018 Program Summary*, January 2019.

²⁰ VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) Evaluation and Needs Assessment,” June 29, 2018.

²¹ VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) Evaluation and Needs Assessment.”

²² VHA Directive 1198. VHA Directive 1198 supports the execution of critical recommendations as delineated in the VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*. “VHA Directive 1198, Intimate Partner Violence Assistance Program (January 24, 2019), *Frequently Asked Questions (FAQs)*, February 2019.” Intimate Partner Violence Assistance Program SharePoint.

2020, VA disseminated an operating guide intended to “help IPVAP Coordinators develop programs that adhere to the directive mandates.”²³

Veterans Health Care and Benefits Improvement Act of 2020

On January 5, 2021, legislation was passed that required a two-year VA pilot program to assess the “feasibility and advisability” of facilitating medical treatment, housing assistance, and other VA benefits for veterans who experienced IPV or sexual assault.²⁴ The legislation further requires that VA collaborate with community IPV shelters, rape crisis centers, state IPV and sexual assault coalitions, and other providers that serve IPV and sexual assault survivors.²⁵ Additionally, the pilot program may provide training to non-VA IPV and sexual assault service providers on engagement with veterans and the VA, as well as helping veterans access IPV and sexual assault emergency services, particularly in underserved areas.²⁶ On September 2, 2021, VHA initiated an assessment of current IPVAP “policies, programs and services” intended to establish “baseline data and metrics” for analysis of “pilot success.”²⁷ In September 2021, the National IPVAP Program Manager told the OIG that 10 sites would initiate the pilot program on October 1, 2021.

The legislation also required the Secretary of VA “in consultation with the Attorney General,” conduct a national study to determine the scope of IPV among veterans and their spouses and intimate partners by January 5, 2022.²⁸ The national study will consider expedited processing of benefits and temporary housing for veterans experiencing IPV, identify gaps in VA services, determine feasibility of providing sexual assault related services, determine the availability of IPV-related peer support services, and make recommendations for service expansion to individuals at risk of perpetrating IPV. The National IPVAP Program Manager told the OIG that the Center for Women Veterans was overseeing this aspect of the legislation. (See figure 1 for the timeline of key IPVAP-related legislation and VHA policies.)

²³ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

²⁴ Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Pub L. No. 116-315, §5304 – 5305 (2021).

²⁵ Veterans Health Care and Benefits Improvement Act of 2020, §5304 – 5305.

²⁶ Veterans Health Care and Benefits Improvement Act of 2020, §5304 – 5305.

²⁷ VA Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer memorandum, “Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) Megabus Act Section 5304 - Current State Assessment (VIEWS 5789635),” September 2, 2021.

²⁸ Veterans Health Care and Benefits Improvement Act of 2020, §5304 – 5305.

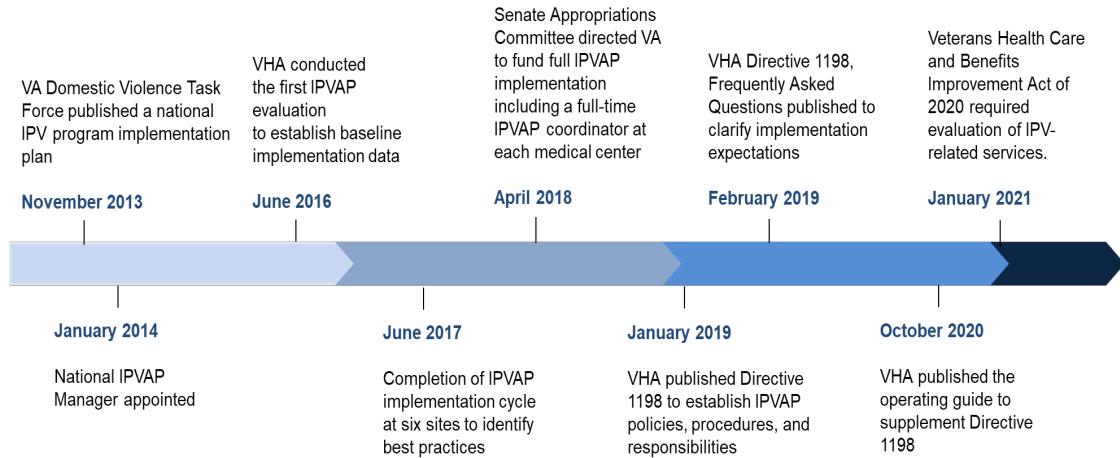


Figure 1. Timeline of key IPVAP-related VHA policies and legislation.

Source: The OIG review of relevant VHA policies and legislation.

IPVAP Organizational Structure

The Office of Care Management and Social Work Services, within the VHA Office of Patient Care Services, is responsible for “implementation, management, administration and evaluation of the IPVAP.”²⁹ The National Director of Social Work provides oversight for the “development and implementation of national directives, program initiatives and VHA guidance related to the delivery of IPV assistance.”³⁰ The National IPVAP Program Manager, who reports to the National Director of Social Work, provides “Oversight of the implementation, maintenance, and reporting requirements to support all components of IPVAP to include, but not limited to, promoting education and training, raising awareness, implementing screening, enhancing safety, and providing intervention.”³¹

The National IPVAP Program Manager told the OIG that the national program office did not have dedicated administrative support; however, funding was allotted in 2021 to allow hiring of staff to help with programming and administrative oversight.³²

²⁹ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*.

³⁰ VHA Directive 1198.

³¹ VHA Directive 1198.

³² The National IPVAP Program Manager reported the funding was for hiring from October 1, 2021, through September 30, 2022.

Five Leadership Council Committees, comprised of self-nominated IPVAP coordinators and facility-level champions (champions), develop topic-specific training materials, resources, and provide field support.³³ (See figure 2.) The National IPVAP Program Manager told the OIG that the committees were initially established by the original task force and evolved into the following five leadership council committees: Raising Awareness; Professional Development and Education; Professional Standards and Clinical Practice; Data Management and Program Evaluation; and Research and Evidence Based Practice.



Figure 2. IPVAP Organizational Structure

Source: VA Care Management and Social Work, Intimate Partner Violence Assistance Program, Operating Guide National Intimate Partner Violence Assistance Program, and National IPVAP Program Manager Interview.

VISN Roles and Responsibilities

Each VISN director must ensure that facilities in their VISN established IPVAP as directed in the 2013 implementation plan and the 2019 IPVAP directive. VISN-level governance includes an IPVAP VISN lead coordinator (VISN lead coordinator) and an IPVAP VISN champion (VISN champion). A VISN champion, IPVAP coordinator, or champion can also serve as a

³³ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*. The OIG used the term National IPVAP Program Manager for the “National Program Manager-IPVAP.”

VISN lead coordinator who “serves as a regional conduit between the IPVAP National Program Manager and the field based IPVAP Coordinators in each VISN.”³⁴

The “VISN champion is a VISN staff member who volunteers or is appointed by the VISN Director” to support the VISN lead coordinator through duties such as technical assistance to IPVAP coordinators, assistance with budget reports, and communication of IPVAP-related information to VISN executive leaders.³⁵ The National IPVAP Program Manager told the OIG that the VISN champion was a collateral duty and a supportive role and were made aware of information provided to IPVAP coordinators.

Facility Roles and Responsibilities

Facility directors are responsible to implement the IPVAP including development of a “local protocol” to define “roles, responsibilities, processes, and procedures,” and the appointment of an IPVAP coordinator.³⁶ The IPVAP coordinator serves as the facility’s subject matter expert, point of contact, and consultant for IPV-related issues and must be a licensed independent provider.³⁷ Although a full-time employee equivalent position “is optimal,” the IPVAP coordinator may be a collateral duty if provided “adequate protected time” to satisfy the role responsibilities.³⁸ The IPVAP coordinator is responsible for IPVAP implementation and compliance including a coverage plan, distribution of contact information, and attendance at VISN and national meetings. (See figure 3 for additional IPVAP responsibilities.)³⁹ Champions “are an extension” of the IPVAP coordinator and are providers within VA clinics and departments in different geographic locations who are trained by the IPVAP coordinator,

³⁴ VHA Directive 1198; VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*.

³⁵ VHA Directive 1198; VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*. VHA Directive 1198 refers to the appointment of a VISN-level IPVAP point of contact (POC). In an interview with the OIG, the National Director of Social Work confirmed that the VISN-level IPVAP POC was the same role as the VISN champion as identified in the operating guide.

³⁶ VHA Directive 1198.

³⁷ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*; VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. A licensed independent provider, also referred to as a licensed independent practitioner, is a provider who is permitted by law, and the facility, to deliver patient care without supervision.

³⁸ VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period. VHA Directive 1198. For the purposes of this report, the OIG uses the terms protected time and dedicated time interchangeably.

³⁹ VHA Directive 1198.

considered subject matter experts, and available to “respond to ‘same day’ or urgent/emergent positive IPV screens.”⁴⁰



Figure 3. IPVAP coordinator responsibilities.

Source: VHA Directive 1198.

Prior OIG Report

In a 2021 healthcare inspection report, the OIG found that VHA offered unclear guidance about IPV training responsibilities, and that Ralph H. Johnson VA Medical Center outpatient mental health staff did not consult with the facility’s IPVAP staff or document discussion of IPV resources or treatment options as expected. The OIG made a recommendation to the Under Secretary for Health to establish clear IPV training guidance and this recommendation remained

⁴⁰ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*.

open as of July 6, 2022. A recommendation to the Facility Director to ensure staff consultation with the IPVAP coordinator as appropriate was closed as of August 2021.⁴¹

Scope and Methodology

During the inspection period of May 2021 to March 2022, the OIG team conducted a national survey of IPVAP coordinators, VISN lead coordinators, and VISN champions as well as virtual interviews of select IPVAP coordinators and VISN champions.⁴² The OIG did not independently review the survey results to assess the validity of the reported data. The OIG team reviewed relevant laws, VHA policies, publications, and memoranda related to IPVAP. The OIG also interviewed the Executive Director, The Office of Care Management and Social Work Services; National Director, VA Social Work; and the National IPVAP Program Manager.

Survey Development and Distribution

The OIG conducted a national survey of IPVAP coordinators, VISN lead coordinators, and VISN champions to evaluate the duties and perceived challenges. The IPVAP coordinator survey focused on determining non-clinical and clinical duties, availability of administrative assistance, the effect of the COVID-19 pandemic on provision of IPVAP services, and adequacy of leadership support and resources to fill the role responsibilities. The survey assessed time served and dedicated time assigned to the role for IPVAP coordinators, VISN lead coordinators, and VISN champions.⁴³

The OIG distributed surveys to IPVAP staff identified by the national program office that included 160 IPVAP coordinators and 17 VISN champions.⁴⁴ The survey was completed by 135 of the 143 applicable IPVAP coordinators (94 percent) and 10 of the 14 applicable VISN champions.⁴⁵ See appendix A for the five locations that did not respond to the IPVAP coordinator survey and the four locations that did not respond to the VISN champion survey. The average patient population of the sites was 30,794 with a range from 7,646 to 82,741.

⁴¹ VA OIG, [*Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina*](#), Report No. 20-03763-207, August 3, 2021.

⁴² The OIG conducted all interviews virtually due to the COVID-19 pandemic.

⁴³ VHA Directive 1198.

⁴⁴ "Roster of IPVAP Coordinators – 1.15.2021," IPVAP.

⁴⁵ Of the 177 initial surveys deployed, 17 IPVAP coordinators and three VISN champions reported no longer serving in the role and therefore, the OIG excluded them from the survey.

The survey questions focused on IPVAP coordinator perceptions of duties, and adequacy of resources, as well as facility compliance with select aspects of the IPVAP directive including training and establishment of community partnership lists training. The survey also asked VISN lead coordinators and champions questions related to communication and support.

On August 24, 2021, the OIG deployed a supplemental survey to 125 staff who completed the initial May 2021 survey and were serving in the IPVAP coordinator role at the time of supplemental survey deployment. The OIG received 118 completed supplemental survey representing 115 facilities.⁴⁶ The supplemental survey inquired about compliance with select aspects of the IPVAP directive including development of a protocol, routine screening, and community partnership list maintenance, as well as IPVAP coordinator perceptions of the effect of COVID-19 pandemic restrictions on training, screening, and community partnerships.

Survey Analysis

The OIG analyzed survey responses by calculating the frequency of closed-ended responses to questions to determine respondents' perspectives on select aspects of the IPVAP coordinator and VISN champion roles and duties. The OIG also reviewed free text responses to further understand respondents' perspectives, including the explanations from IPVAP coordinators who indicated that they did not have adequate resources to fulfill their responsibilities, and administrative tasks they would delegate. The OIG assigned the individual responses to one or more of the identified resource categories that emerged.

Interviews

The OIG conducted telephone interviews with 25 IPVAP coordinators and seven VISN champions.⁴⁷ Interview sites were selected to include rural and urban geographic locations and diverse facility sizes and complexity levels.⁴⁸ Interview sites represented 24 facilities and 18 VISNs.⁴⁹ Five facilities were in rural areas and 19 in urban settings. The VHA-designated complexity levels of the 24 facilities include 15 high, 5 medium, and 4 low.

⁴⁶ VA Portland Health Care System, VA New York Harbor Health Care System, and VA Boston Health Care System each had two IPVAP coordinators respond to the supplemental survey.

⁴⁷ The OIG did not interview three VISN champions for this review due to their recent VHA employment and inability to respond to most interview questions.

⁴⁸ "Facility Complexity Model," VHA Support Service Center (VSSC). VHA's Facility Complexity Model is a data driven model that relies on data to identify workload and programs at each facility for the purposes of comparing complexity based on workload and programs at each facility.

⁴⁹ The OIG interviewed two IPVAP coordinators from one facility. The OIG initially selected 26 sites for IPVAP coordinator interviews; however, excluded two sites. The Eastern Oklahoma Health Care System IPVAP coordinator was no longer in the role and the Washington VA Medical Center IPVAP coordinator did not respond to the survey.

Interview questions inquired about the adequacy of time allotted to the role and duties, perception of resources to fulfill responsibilities, and identified implementation strengths, challenges, and needs. To assess the effect of COVID-19 on IPVAP, the OIG also included interview questions to collect information and perceptions related to 1) the effects of COVID-19 pandemic restrictions on community partnerships; 2) national program office of information and resources in response to the impact of COVID-19 on IPV nationally; and 3) level of support from facility, VISN, and national program office leaders.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat. 1101, as amended (codified at 5 United States Code (U.S.C.) App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Results

The OIG found that the majority of IPVAP coordinators' and VISN champions' open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity. Based on analyses of survey and interview data, the OIG found over half of the facilities did not have a local IPVAP protocol, as required.⁵⁰ The majority of IPVAP coordinators reported over half of their time was dedicated to the role, although both the IPVAP coordinators serving the facility with the most patients and the one serving the least patients reported a dedicated time between zero and 25 percent.

Select Requirement Compliance and Oversight Authority

The OIG reviewed VHA facility directors' compliance with IPVAP implementation including the development of a protocol to delineate "roles, responsibilities, processes and procedures" and the assignment of a licensed independent provider as the IPVAP coordinator.⁵¹ The National IPVAP Program Manager noted that the national program office established policy but was "not really the authority to ensure" compliance. The Executive Director, The Office of Care Management and Social Work Services told the OIG that medical center directors were "ultimately" responsible to adhere to directive. Additionally, the National IPVAP Program

⁵⁰ VHA Directive 1198.

⁵¹ VHA Directive 1198.

Manager told the OIG that while the national program office provided support for implementation, the “only recourse” the national program office had was to rescind funding.

IPVAP Protocol

Of the 115 facilities represented in the supplemental survey, 79 (69 percent) reportedly did not have a local protocol as required.⁵² Of the 36 IPVAP coordinators who reported protocols in place, 17 (47 percent) noted that the protocol was implemented greater than one year after the requirement was established.⁵³ The absence of a local protocol may contribute to leader and staff confusion and lack of knowledge about IPVAP roles, responsibilities, process, and procedures.

IPVAP Coordinator Assignment

All medical centers had an assigned IPVAP coordinator, and seven health care systems had more than one assigned IPVAP coordinator. Reported time serving in the IPVAP coordinator role ranged from less than a year to over six years, with an average of approximately two years. All but one of the 135 IPVAP coordinators reported being a licensed independent provider.⁵⁴ The majority of IPVAP coordinators (88 percent) reported having received adequate orientation to the role.

VHA recognizes a dedicated full-time IPVAP coordinator as “optimal,” and allows the assignment as a collateral duty if given “adequate protected time to fulfill the responsibilities of the role” with consideration of the “Facility size and complexity...and the size of the local IPV population.”⁵⁵ Of 135 respondents, 126 (93 percent) indicated that they provided IPVAP coordinator coverage for their healthcare system comprised of multiple sites. Independent of the number of patients at their respective facilities, 82 percent of IPVAP coordinators reported over half their time was dedicated to their role with 75 percent of those IPVAP coordinators reporting between 76 and 100 percent of dedicated time. Seven health care systems had more than one assigned IPVAP coordinator resulting in over 100 percent dedicated time. Notably, both the IPVAP coordinator serving the facility with the most patients and the one serving the least patients reported a dedicated time between zero and 25 percent. (See figure 4.) Given the absence of an apparent logical relationship between the IPVAP coordinators’ dedicated time and

⁵² VHA Directive 1198.

⁵³ VHA Directive 1198. Three facilities had two IPVAP coordinators respond to the survey. For one of the three facilities, the two IPVAP coordinators both responded that there was not a protocol in place. For the other two facilities, the two IPVAP coordinators provided contradictory responses and therefore, the OIG considered the facility to not have a protocol since both IPVAP coordinators did not report establishment of a protocol.

⁵⁴ The IPVAP coordinator who was not a licensed independent provider reported being in the process of obtaining licensure. The National IPVAP Program Manager and National Director of Social Work told the OIG that a non-licensed independent provider could be appointed as the IPVAP coordinator if working towards licensure and with clinical oversight by a licensed independent provider.

⁵⁵ VHA Directive 1198.

the patient population size, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of population needs and IPVAP coordinator role demands.

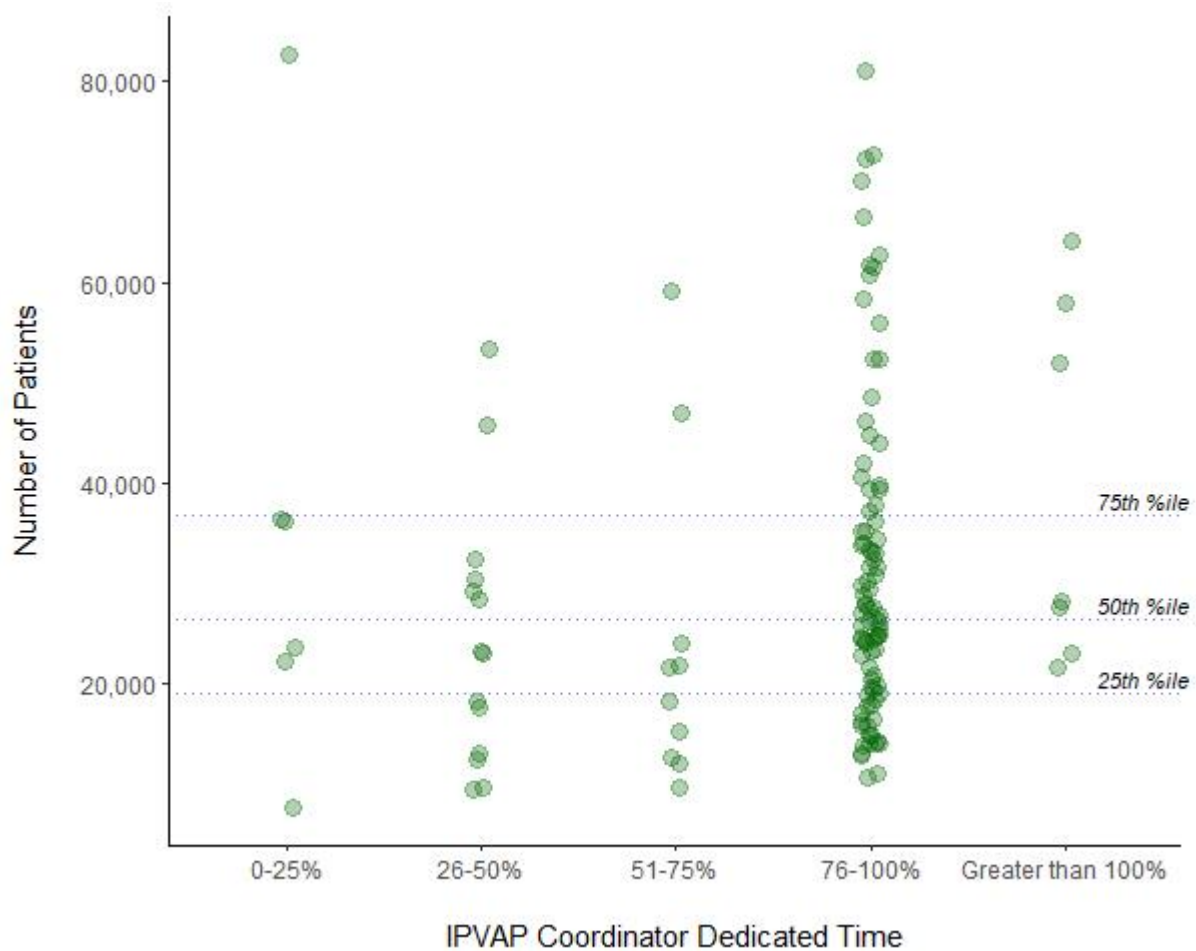


Figure 4. Patient population and IPVAP coordinator report of time dedicated to the role.
 Source: OIG analysis of the IPVAP coordinator survey.

IPVAP Coordinator Duties and Challenges

The OIG assessed IPVAP coordinators’ patient care, administrative, training, screening, community partnership, and program evaluation duties. The OIG found that almost half of the IPVAP coordinators described inadequate resources to fulfill their responsibilities. The majority of IPVAP coordinators reported providing training at fewer than half of new employee orientation sessions and to fewer than half of IPV screeners. Fourteen percent of IPVAP coordinators reported that their facilities did not implement routine IPV screening. Over 90 percent of IPVAP coordinators reported establishing and maintaining community partnerships. Although IPVAP coordinators are identified as responsible for program evaluation, the OIG

found that VHA did not establish standardized program evaluation methods or standardized measures.

Patient Care

IPV-related patient care duties included referring, safety planning, assessing, screening, making treatment recommendations, and providing group and individual therapy. (See table 1.)

Table 1. Reported Direct Patient Care Duties

Duty	Number of Respondents*	Percent
Referrals	130	96
Safety Planning	129	96
Assessment	128	95
Screening	124	92
Treatment Recommendations	118	87
Group Therapy	98	73
Individual Therapy	77	57
Family Therapy	22	16
Other	18	13

Source: *OIG analysis of the IPVAP coordinator survey.*

*135 IPVAP coordinators completed the OIG survey.

When interviewed, many IPVAP coordinators told the OIG that they also provided non-IPV-related patient care in various services including inpatient psychiatric units, emergency departments, primary care, specialty medical, and women's clinics. Additionally, IPVAP coordinators reported collateral duty assignments such as White Ribbon VA champion, and participation in facility, national, and community committees.⁵⁶

Administrative Duties

Reported IPVAP coordinator administrative duties included staff consultation, development of community partnerships, training, patient education and outreach, program evaluation, standard operating procedure development, and consult and records management. (See table 2.)

⁵⁶ “White Ribbon VA,” VHA, accessed September 2, 2021, <https://www.va.gov/health/harassment-free/>. White Ribbon VA is a national awareness campaign to eliminate acts of sexual assault/harassment, and domestic violence against women; VHA Directive 5019.01, *Workplace Violence Prevention Program*, August 23, 2021.

Table 2. Administrative Tasks

Duty	Number of Respondents*	Percent
Staff Consultation	128	95
Development of Community Partnerships	125	93
Trainings	125	93
Patient Education	123	91
Patient Outreach	119	88
Program Evaluation	118	87
Development of Standard Operating Procedures	115	85
Consult Management	114	84
Records Management	93	69

Source: OIG analysis of the IPVAP coordinator survey responses.

**135 IPVAP coordinators completed the OIG survey.*

Challenges

Almost half, 67 of the 135 IPVAP coordinators, described inadequate resources to fulfill their responsibilities. Of the 67 IPVAP coordinators, 46 (70 percent) indicated additional staffing would be helpful and 15 (22 percent) described additional funding would be useful to support program development, outreach, and training materials.

Of the 135 IPVAP coordinators, 119 (88 percent) reported lack of administrative assistance and 95 (80 percent) indicated that assistance would be helpful to fulfill responsibilities. Of the 95, 75 (79 percent) IPVAP coordinators reported that the assistance would be used to manage a variety of clerical tasks, such as phone calls, mailings, and ordering supplies. Between 36 and 55 percent of the 95 IPVAP coordinators also reported that administrative assistance would be helpful with education and training, awareness and outreach, data management, and scheduling. (See figure 5.)

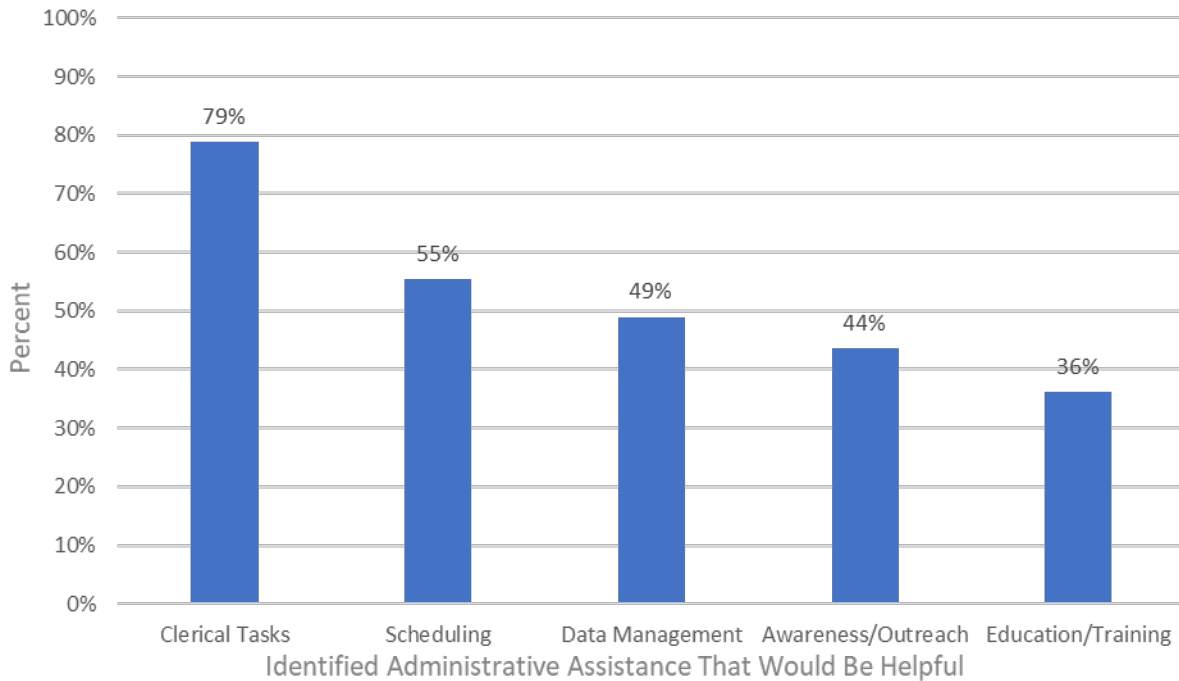


Figure 5. Percent of IPVAP coordinators identified tasks.

Source: OIG analysis of the IPVAP coordinator survey responses.

As noted above, 126 of 135 respondents (93 percent) indicated that they provided IPVAP coordinator coverage for their healthcare system comprised of multiple sites. However, 26 IPVAP coordinators (19 percent) also reported that not all sites within their healthcare system had IPVAP coverage. Of the 26, 8 IPVAP coordinators indicated that virtual coverage was available for all sites within the facility’s oversight while 14 reported lack of coverage in the facility’s community-based outpatient clinics, and 4 reported lack of coverage in specific service sites including primary care, emergency department, and mental health. IPVAP coordinators identified ongoing program implementation, workload demands, and staff shortages as barriers to providing IPVAP coverage to the entire healthcare system. Of the interviewed IPVAP coordinators, six described challenges with identifying champions to provide coverage throughout their healthcare system and identified workload demands, staffing shortages, and lack of staff buy-in as barriers.⁵⁷

Of the 135 IPVAP coordinators who responded to the survey, 22 (16 percent) reported also serving in the VISN lead coordinator role and were also asked to complete additional questions related to the VISN lead coordinator role. Twenty-one of the VISN lead coordinators met

⁵⁷ Merriam-Webster.com Dictionary, “buy-in,” accessed February 1, 2022, <https://www.merriam-webster.com/dictionary/buy-in>. Buy-in is the “acceptance and willingness to actively support and participate in something (such as a proposed new plan or policy).”

monthly with the IPVAP coordinators in the VISN as a group.⁵⁸ Of the 22 VISN lead coordinators, 7 reported that communication with the VISN champion was not sufficient and 11 reported inadequate support from the VISN champion for IPVAP implementation. One of the 22 VISN lead coordinators described communication with the national program office as inadequate and five reported lack of national program support for IPVAP implementation.

Training

VHA identified that all “general staff” should receive training on how to recognize IPV and where to obtain assistance, and recommended training at new employee orientation and annually. VHA acknowledged that IPVAP coordinators may not be afforded time to provide training in new employee orientation and suggested other training methods including brochures, awareness videos, or Talent Management System trainings.⁵⁹ The national program office provided accessible training resources; however, the OIG found that there was not standardized general staff training content.

VHA suggests that “specialized training” for providers engaged in IPV screening should include definitions, prevalence, clinical signs and symptoms, the screening protocol, health consequences, safety planning, treatment and referral resources, employee services, and documentation guidelines. The national program office suggested that specialized training may be provided during staff meetings, through paper forms, or scheduled trainings and did not provide standardized content.⁶⁰ As such, the educational interventions likely vary in what and how information is provided. Further, the effectiveness of training to ensure enhanced skills in IPV awareness, identification, and intervention may be significantly affected by the specific content and method of training. Without a standardized all employee training and the evaluation of outcome measures, the efficacy of the training is unknown.

A majority of IPVAP coordinators (68 percent) reported that IPVAP training was provided between zero and 50 percent of new employee orientation sessions from October 1, 2019, through September 30, 2020. Similarly, approximately half of IPVAP coordinators (51 percent) reported that between zero and 50 percent of IPV screening providers received specialized training during that time.

In response to the COVID-19 pandemic, the IPVAP reportedly provided “current information on resources and supports available via sharing resources on VA social media platforms, sharing

⁵⁸ One VISN lead coordinator reported meeting quarterly with the IPVAP coordinators in the VISN as a group.

⁵⁹ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

⁶⁰ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

information through internal emails, posting flyers and other materials, and working directly with patients to ensure safety is addressed.”⁶¹

In the supplemental survey, the OIG asked 118 IPVAP coordinators about the COVID-19 pandemic effects on IPVAP training in new employee orientation. Of the 118, 34 (29 percent) IPVAP coordinators reported no change in IPVAP training at new employee orientation and 24 (20 percent) reported the IPVAP training was never included in new employee orientation. Eight (7 percent) respondents indicated that IPVAP training was added to new employee orientation while 52 (44 percent) respondents indicated that IPVAP training was removed, reduced, or offered through alternative resources.

The 2021 OIG report recommendation to the Under Secretary for Health to establish clear IPV training requirements remained open as of July 6, 2022.⁶² Therefore, the OIG will continue to monitor VHA’s actions in response to the recommendation. Additionally, the OIG would recommend consideration of standardized content and format for general and specialized IPV staff trainings and evaluation of outcomes to determine training efficacy.

Screening

VHA requires all facilities to offer IPV screening and recommends screening all patients annually and asserts that, “at a minimum,” women of child bearing age should be screened “routinely.”⁶³ While IPV screening is not mandatory, VA encourages “integrating care” and supports IPV screening “into routine workflow” with the frequency determined by each facility or VISN.⁶⁴ Of the 118 supplemental survey respondents, 102 (86 percent) reported implementation of routine IPV screening and 16 (14 percent) reported not routinely screening at the time of the survey. Among those IPVAP coordinators who reported routinely screening for IPV, 67 percent reported screening both men and women and 33 percent reported screening women only.

Challenges

Fifteen of the 25 interviewed IPVAP coordinators described screening as one of the most challenging aspects of IPVAP implementation due to a lack of staff buy-in and absence of an

⁶¹ “Intimate Partner Violence and Novel Coronavirus Disease (COVID-19) Response,” VA IPVAP, accessed March 7, 2022, https://www.socialwork.va.gov/IPV/docs/COVID19-IPV-Staff-Factsheet_Final.pdf.

⁶² VA OIG, *Deficiencies in the Management of a Patient’s Reported Intimate Partner Violence*, Ralph H. Johnson VA Medical Center, Charleston, South Carolina, Report No. 20-03763-207, August 3, 2021.

⁶³ VHA Directive 1198; VA Care Management and Social Work, *Intimate Partner Violence Assistance Program, Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

⁶⁴ VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*.

IPV screening clinical reminder.⁶⁵ Six IPVAP coordinators suggested to the OIG that mandatory IPV screening be considered.

Over half (60 percent) of the 102 IPVAP coordinators who reported implementation of routine screening indicated that the COVID-19 pandemic influenced the frequency of IPV screening. Of note, 70 percent of those who indicated the pandemic affected IPV screening frequency reported decreased screening frequency, while 30 percent reported an increased screening frequency.

Community Partnerships

Establishing community partnerships is important to address IPV service gaps and ensure services across the continuum of care for all individuals affected by IPV. Community partnerships are critical for safe housing, resources, and treatment in response to reported IPV for VHA employees, patients, and their families.⁶⁶

Of the 135 IPVAP coordinators who responded to the initial survey, 121 (90 percent) reported having established partnerships with community resources and organizations including domestic violence organizations and services, other community organizations, housing resources and shelters, courts and law enforcement agencies, Vet Centers, Veterans Service Organizations, and state agencies.

Of the 13 IPVAP coordinators who reported not having established community partnerships, seven indicated pandemic-related restrictions as a barrier. Almost half of supplemental survey respondents reported that the pandemic diminished community partnerships. (See table 3.)

Table 3. Effect of COVID-19 Pandemic Restrictions on Community Partnerships

Effect on Community Partnerships	Number of Respondents *	Percent of Respondents
Diminished Partnerships	55	47
No Effect	48	41
Enhanced Partnerships	14	12

Source: OIG analysis of the IPVAP coordinator supplemental survey results

**One of 118 IPVAP coordinators did not complete this supplemental survey item.*

⁶⁵ “VistA, Clinical Reminders, Version 2.0, User Manual,” VA Office of Information & Technology, accessed on April 5, 2022, https://www.va.gov/vdl/documents/Clinical/CPRS-Clinical_Reminders/pxrm_2_6_um.pdf. Clinical reminders are viewed in a patient’s electronic health record and directs “providers to perform certain tests or other evaluations that will enhance the quality of care for specific conditions. The clinicians can then respond to the reminders by placing relevant orders or recording clinical activities on patients’ progress notes.”

⁶⁶ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

All IPVAP coordinators who responded to the applicable supplemental survey item reported maintaining a list of community resources, as required by VHA.⁶⁷ VHA does not specify a time frame requirement for maintaining the community resource list and IPVAP coordinators reported variable intervals of updates.⁶⁸ Over half (64 percent) of the supplemental survey respondents indicated that community resource lists were updated as needed, 16 percent reported updating quarterly, 14 percent reported updating annually, and six percent reported updating monthly. The OIG determined that IPVAP coordinators updated community resource lists as needed with their local communities.

Program Evaluation

VHA established an annual program evaluation to “assess program needs, identify best practices and assist with continued program implementation” that included six areas of evaluation.⁶⁹ IPVAP coordinators “lead the completion” of the annual program evaluation and are encouraged to identify areas of strength and “needed growth.”⁷⁰

Although the IPVAP coordinator is responsible for program evaluation (See figure 3 above), the OIG found that VHA did not establish standardized program evaluation methods or standardized measures.⁷¹ The National IPVAP Program Manager told the OIG that performance metrics have not been prescribed but were being monitored “through [IPVAP coordinators] reporting to us what they are doing” and that national templates and a dashboard were being developed to ensure standardized data collection. Further, the National IPVAP Program Manager reported developing IPVAP coordinators program evaluation skills including teaching them about “general program evaluation tools and methodologies” and talking “to them about engaging with their Quality Improvement office.”

In interviews with the OIG, seven VISN champions reported that there were no standardized performance metrics, and that metrics would be helpful to track outreach and outcomes, evaluate the status of the VISN programs, consider direction for program development and staffing needs, and provide leaders with data informed IPVAP briefings.

⁶⁷ One IPVAP coordinator did not respond to this item on the supplemental survey.

⁶⁸ VHA Directive 1198.

⁶⁹ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020. “Program Evaluation is a process that regularly evaluates a program and informs needed areas for improvement of services or procedures within the IPVAP environment.” The six implementation areas are 1) awareness and education, 2) coordination of services, 3) screening, 4) intervention, 5) program evaluation, and 6) records management. VHA Directive 1198.

⁷⁰ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

⁷¹ VHA Directive 1198.

Of the 24 IPVAP coordinators interviewed, 11 reported tracking or monitoring referrals, 10 reported not tracking or monitoring referrals, and 3 described tracking but not having a formal system.

In 2016, VHA conducted the first annual program evaluation that was intended to collect IPV practice baseline data at VA medical centers. The national program office initiated annual completion of the implementation evaluation in 2018 and published a program summary that reports summary data on program implementation including assignment of IPVAP coordinators, training, and screening. (See table 4.)

Table 4. Annual Program Evaluation Results*

Year	Assigned IPVAP Coordinators	Full Time IPVAP Coordinators	New Employee Training	Specialized Training	Men and Women Screened	Women Only Screened
2018	141	76	10 percent	46 percent	20 percent	42 percent
2019	143	92	45 percent	56 percent	29 percent	63 percent
2020	153	121	71 percent	42 percent	31 percent	74 percent

Source: VA/VHA Care Management and Social Work IPVAP Program Summaries, 2018 – 2020.

*The 2018 data was reported in the 2019 program evaluation report.

VHA facilities reported increasing implementation from 2018 through 2020, with a 2020 decrease in specialized training. VHA noted that “Due to the Coronavirus pandemic, in-person trainings decreased in 2020 but many were replaced by virtual modalities.”⁷²

The 2020 annual program evaluation reported 71 percent of the IPVAP coordinators offered new employee orientation or distribution of materials during the 12-month review period. However, this evaluation element did not establish the frequency or percentage of new employees trained.⁷³ In contrast, the OIG found that the majority of IPVAP coordinators (69 percent) provided IPVAP training at half or fewer new employee orientation sessions from October 1, 2019, through September 30, 2020.

The 2020 annual program evaluation and the OIG survey results indicated similar specialized training rates with fewer than half of IPV screening providers receiving specialized training during that time.

⁷² National Social Work Program VA Care Management and Social Work, *Intimate Partner Violence Assistance Program 2020 Program Summary*, December 2020.

⁷³ The specific annual program evaluation question was: “During the past 12 months, has training related to IPV been offered at your facility?” and included the following response options (both of which could be selected): “In new employee orientation (NEO) via live presentation” and “In new employee orientation (NEO) via distribution of materials.”

The national program office recommends screening all patients “regardless of gender, age, or relationship status (at least annually).”⁷⁴ The 2020 annual program evaluation and the OIG survey results were consistent in identifying the need for increased screening. Given that male veterans and active duty service members are up to three times more likely to perpetrate IPV than civilians as well as the critical role of screening in prevention, the OIG would expect ongoing focus in the establishment of routine screening procedures for men and women.⁷⁵

The 2020 annual program evaluation showed that 74 percent of facilities reported using the Relationship Health and Safety Screening, the nationally approved IPV screening template, and in January 2022, the National IPVAP Program Manager reported to the OIG that at least 90 percent of facilities utilized the Relationship Health and Safety Screening. However, the OIG found that 14 percent of IPVAP coordinators reported not routinely screening.

Through the VHA Support Service Center, IPVAP screening data is gathered from each facility that is utilizing the Relationship Health and Safety Screening.⁷⁶ The national program office “strongly recommends” that the Relationship Health and Safety Screening “be adopted as a clinical reminder” although “local discretion and clinic needs will dictate which form to use.”⁷⁷ IPVAP coordinators are encouraged “to monitor where screenings are being completed, the number of positive screens” and “if the appropriate interventions were utilized.”⁷⁸

To ensure robust monitoring and oversight, the OIG would expect use of the Relationship Health and Safety Screening for routine screenings nationally with identified benchmark metrics to establish baseline measures. Standardization of program evaluation procedures could facilitate ongoing performance improvement processes that ultimately determine the implementation of appropriate interventions.

VISN Champions Duties and Challenges

Four of the 18 VISNs did not have an assigned VISN champion at the time of the OIG survey deployment. The National IPVAP Program Manager told the OIG that the appointment of a VISN champion was not a requirement. The seven interviewed VISN champions reported that

⁷⁴ “Relationship Health and Safety Screening, Template with Instructions and Scripts,” IPVAP website.

⁷⁵ VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*, November 2013. Marshall et al., “Intimate partner violence among military veterans and active duty servicemen.”

⁷⁶ “Relationship Health and Safety Screening, Template with Instructions and Scripts,” IPVAP website. The Relationship Health and Safety Screening was made available to all VHA sites as of July 25, 2018. The VHA Support Service Center “creates and maintains advanced and secure data platforms, measurement systems, and analytic solutions that help providers work with Veterans and their families to make well-informed decisions,” accessed February 23, 2022, <https://www.va.gov/QUALITYANDPATIENTSAFETY/api/index.asp>.

⁷⁷ “Relationship Health and Safety Screening, Template with Instructions and Scripts,” IPVAP website.

⁷⁸ VA Care Management and Social Work, Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

they provided VISN oversight for multiple programs including IPVAP, homeless services, mental health, and special populations.⁷⁹

The VISN champions described their role as providing support for the VISN lead coordinator and addressing issues as necessary while the VISN lead coordinator role was more directly involved in the day-to-day IPVAP operations and provided guidance for IPVAP coordinators. The interviewed VISN champions all noted that they did not have dedicated time for IPVAP responsibilities. In interviews, VISN champions identified the need for clearer expectations of the responsibilities of the VISN champion and VISN lead coordinator roles, a full time IPVAP coordinator, the clinical reminder and screening being mandatory, and a designated VISN IPVAP coordinator. Interviewed VISN champions suggested establishing a dedicated VISN champion position and clear role responsibilities would be desirable IPVAP improvements.

The OIG concluded that clearer role expectations would likely support more effective leadership at the VISN level. Similarly, the OIG made recommendations to clarify elements of IPVAP that would promote standardization of service delivery and evaluation of critical outcomes across the system in an effort to support informed performance improvement initiatives.

Conclusion

The OIG conducted a review of facilities' compliance with select requirements for the VHA IPVAP as well as the duties and perceived challenges of the IPVAP coordinators and VISN champions.⁸⁰ To evaluate the national status of the IPVAP implementation and identify barriers to compliance, the OIG conducted a national survey of IPVAP coordinators, VISN lead coordinators, and VISN champions as well as virtual interviews of select IPVAP coordinators and VISN champions.⁸¹

VHA defines IPV as violent behavior by a current or former intimate partner that includes physical and sexual violence, psychologically aggressive or coercive acts, and stalking.⁸² The prevalence of IPV among veterans and active duty service members varies across studies with

⁷⁹ VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016. Network homeless coordinators are responsible for ensuring VISN medical centers use resources properly to prevent homelessness and support housing stability; ensuring adequate orientation and training of homeless program staff; and monitoring service delivery, outcomes, and satisfaction. VHA Directive 1162.08, *Healthcare for Homeless Veterans Outreach Services*, February 18, 2022. Special populations include IPVAP, women veterans, and post-9/11 Military2VA case management.

⁸⁰ VHA Directive 1198.

⁸¹ VHA Directive 1198; VA Care Management and Social Work, *Intimate Partner Violence Assistance Program, Operating Guide National Intimate Partner Violence Assistance Program*.

⁸² VHA Directive 1198.

rates estimated between 14 and 58 percent.⁸³ Male veterans and active duty service members are up to three times more likely to perpetrate IPV than civilians.⁸⁴ The COVID-19 pandemic has resulted in a “marked increase in IPV incidence” due to multiple factors including financial, occupational, and home instability; mandatory lockdowns with remote work and school orders causing families to remain in the household for prolonged periods of time; and social distancing measures that may have contributed to victims’ isolation and inability to access supportive resources.⁸⁵

In January 2019, VHA established an IPVAP directive and considered a medical facility “out of compliance” if a designated IPVAP coordinator or implementation of “the full scope of services” was not in place as of January 24, 2019.⁸⁶ The Office of Care Management and Social Work Services, within the VHA Office of Patient Care Services, is responsible for “implementation, management, administration and evaluation of the IPVAP.”⁸⁷ The National IPVAP Program Manager, who reports to the National Director of Social Work, provides “Oversight of the implementation, maintenance, and reporting requirements to support all components of IPVAP to include, but not limited to, promoting education and training, raising awareness, implementing screening, enhancing safety, and providing intervention.”⁸⁸

The OIG found that the majority of IPVAP coordinators’ and VISN champions’ open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity. Based on analyses of survey and interview data, the OIG found over half of the facilities did not have a local IPVAP protocol, as required.⁸⁹ The majority of IPVAP coordinators reported over half of their time was dedicated to the role, although both the IPVAP coordinator serving the facility with the most patients and the one serving the least

⁸³ Amy D. Marshall, Jillian Panuzio, and Casey T. Taft, “Intimate Partner Violence among Military Veterans and Active Duty Servicemen,” *Clinical Psychology Review* 25, (2005): 862-876. Jennifer M. Gierisch et al., *Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches*, VA-ESP Project #09-010, August 2013.

⁸⁴ Marshall et al., “Intimate Partner Violence among Military Veterans and Active Duty Servicemen.”

⁸⁵ “COVID-19 and its impact on intimate partner violence.” PennState Social Science Research Institute, accessed March 7, 2022, <https://covid19.ssri.psu.edu/articles/covid-19-and-its-impact-intimate-partner-violence>. Rossi et al., “Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19,” *Journal of General Internal Medicine* 35, no. 9, (September 2020): 2728-2731, accessed March 7, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7325833/>.

⁸⁶ VHA Directive 1198. VHA Directive 1198 supports the execution of critical recommendations as delineated in the VHA, *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program*. “VHA Directive 1198, Intimate Partner Violence Assistance Program (January 24, 2019), *Frequently Asked Questions (FAQs)*, February 2019.

⁸⁷ VA Care Management and Social Work, Intimate VA Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*.

⁸⁸ VHA Directive 1198.

⁸⁹ VHA Directive 1198.

patients reported a dedicated time between zero and 25 percent. Given the absence of an apparent logical relationship between the IPVAP coordinators' dedicated time and the patient population size, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of population needs and IPVAP coordinator role demands.

Almost half of the IPVAP coordinators described inadequate resources to fulfill their responsibilities. The majority of IPVAP coordinators reported providing training at fewer than half of new employee orientation sessions and to fewer than half of IPV screeners. Fourteen percent of IPVAP coordinators reported that their facilities did not implement routine IPV screening. Over 90 percent of IPVAP coordinators reported establishing and maintaining community partnerships. Although IPVAP coordinators are identified as responsible for program evaluation, the OIG found that VHA did not establish standardized program evaluation methods or standardized measures.

To ensure robust monitoring and oversight, the OIG would expect use of the standardized instrument for routine screenings nationally with identified benchmark metrics to establish baseline measures. Standardization of program evaluation procedures could facilitate ongoing performance improvement processes that ultimately determine the implementation of appropriate interventions.

In interviews, VISN champions identified the need for clearer expectations of the responsibilities of the VISN champion and VISN lead coordinator roles, a full time IPVAP coordinator, the clinical reminder and screening being mandatory, and a designated VISN IPVAP coordinator. Interviewed VISN champions suggested establishing a dedicated VISN champion position and clear role responsibilities would be desirable IPVAP improvements.

The OIG concluded that clearer role expectations would likely support more effective leadership at the VISN level. Similarly, the OIG made recommendations to clarify elements of IPVAP that would promote standardization of service delivery and evaluation of critical outcomes across the system in an effort to support informed performance improvement initiatives.

Recommendations 1–7

1. The Under Secretary for Health ensures that Intimate Partner Violence Assistance Program protocols are developed at all medical centers consistent with the national requirement.
2. The Under Secretary for Health evaluates the sufficiency of current guidance and operational status regarding Intimate Partner Violence Assistance Program coordinators' dedicated time and population needs, and takes action as warranted.
3. The Under Secretary for Health determines the appropriate guidance for dedicated administrative staff support in consideration of the Intimate Partner Violence Assistance Program coordinators' responsibilities, and takes action as warranted.
4. The Under Secretary for Health considers the establishment of standardized Intimate Partner Violence staff training content and format as well as the evaluation of training efficacy, and takes action as warranted.
5. The Under Secretary for Health develops intimate partner violence screening requirements based on the current guidance and patient population needs, and takes action as warranted.
6. The Under Secretary for Health expedites standardized program evaluation processes with oversight and reporting responsibilities to ensure identification of implementation and program deficiencies and monitoring of corrective action and performance improvement plans.
7. The Under Secretary for Health evaluates the current guidance and operational status related to the roles and oversight functions of the Veterans Integrated Service Network Intimate Partner Violence Assistance Program champions and lead coordinators and clarifies expectations and requirements.

Appendix A: Facility and VISN Locations That Did Not Submit Surveys

VISN	Facility IPVAP Coordinators
1	VA Connecticut Health Care System*
2	Bath VA Medical Center, New York
4	Wilmington VA Medical Center, Delaware†
5	Washington DC VA Medical Center
7	Central Alabama Veterans Health Care System, Tuskegee

Source: *OIG analysis of IPVAP coordinator survey data.*

*The *OIG* sent surveys to three VA Connecticut Health Care System IPVAP coordinators, two IPVAP coordinators responded that they were no longer in the role and one IPVAP coordinator was on extended leave at the time the survey was deployed.

†At the time of the *OIG* survey deployment, the Chief of Social Work informed the *OIG* that the IPVAP coordinator position was vacated and hiring for the position was in process.

VISN	VISN Champions
2	VA Health Care Upstate New York, Albany
8	VA Sunshine Healthcare Network, St. Petersburg, Florida
10	VA Healthcare System, Cincinnati, Ohio
17	VA Heart of Texas Health Care Network, Arlington

Source: *OIG analysis of VISN champion survey data.*

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: August 25, 2022

From: Under Secretary for Health

Subj: OIG Draft Report, Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance (Project Number 2021-00797-HI-1133) (VIEWS 08170980)

To: Office of the Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report, Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance.
2. The Veterans Health Administration (VHA) concurred with recommendations 1, 2 and 4-7. VHA concurred in principle with recommendation 3. VHA's comments to the recommendations are attached.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov

(Original signed by:)

Shereef Elnahal, M.D., MBA.

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Recommendation 1. The Under Secretary for Health ensures that Intimate Partner Violence Assistance Program protocols are developed at all medical centers consistent with the national requirement.

VHA Comments: Concur. The National Intimate Partner Violence Assistance Program (IPVAP) will revise VHA Directive 1198 to include guidance that all VA medical centers must establish a standard operating procedure (SOP) that outlines implementation of the IPVAP in accordance with VHA Directive 1198. The National IPVAP will monitor medical center compliance through the annual IPVAP Program Implementation Evaluation (PIE) process. Medical centers that do not have an IPVAP SOP in place will be required to develop an action plan to meet this requirement within 60 days of notification.

Status: In progress

Target Completion Date: April 2023

Recommendation 2. The Under Secretary for Health evaluates the sufficiency of current guidance and operational status regarding Intimate Partner Violence Assistance Program coordinators' dedicated time and population needs, and takes action as warranted.

VHA Comments: Concur. IPVAP will revise VHA Directive 1198 to include guidance that all VA medical centers must have a minimum of a 1.0 full-time employee equivalent (FTEE) dedicated as the IPVAP Coordinator (IPVAP-C) to meet the needs of Veterans, partners and staff who are experiencing or using IPV. IPVAP will monitor medical center compliance through the annual IPVAP PIE process. Medical centers that do not have a minimum 1.0 FTEE dedicated as the IPVAP-C will be required to provide certification that IPVAP programming is successfully implemented as outlined in VHA Directive 1198.

Status: In progress

Target Completion Date: April 2023

Recommendation 3. The Under Secretary for Health determines the appropriate guidance for dedicated administrative staff support in consideration of the Intimate Partner Violence Assistance Program coordinators' responsibilities, and takes action as warranted.

VHA Comments: Concur in principle. IPVAP will revise VHA Directive 1198 to clarify administrative task responsibilities for IPVAP-Cs and reinforce that performing certain administrative tasks are part of IPVAP-C duties. IPVAP will encourage use of existing service line administrative support resources to assist IPVAP-Cs with completing administrative tasks. IPVAP will provide training for IPVAP-Cs and their supervisors on labor mapping processes to ensure that IPVAP-C workload is accurately captured. Providing guidance on sound labor mapping processes will allow medical centers to

accurately capture the division of administrative and clinical duties for IPVAP-Cs. IPVAP will monitor medical center compliance with review of labor mapping through the annual IPVAP PIE process.

Status: In progress

Target Completion Date: April 2023

Recommendation 4. The Under Secretary for Health considers the establishment of standardized Intimate Partner Violence staff training content and format as well as the evaluation of training efficacy, and takes action as warranted.

VHA Comments: Concur. The IPVAP Leadership Council Development and Education Committee currently creates and facilitates comprehensive training opportunities for VHA staff including but not limited to:

1. Standardized Talent Management System training focused on the IPVAP including information on how to seek assistance if experiencing or using IPV.
2. Monthly New IPVAP Coordinator training calls.
3. Quarterly IPVAP Education calls.
4. Quarterly Medical center based IPVAP Supervisor training calls.
5. Strength at Home regional trainings and implementation calls.
6. Recovering from IPV through Strengths and Empowerment trainings.
7. Weekly IPVAP “office hours” calls focused on various IPVAP training topics.

IPVAP will revise VHA Directive 1198 to ensure that staff designated as IPVAP-Cs receive standardized mandatory program orientation and training within 90 days of onboarding. IPVAP will also clarify policy regarding inclusion of general IPVAP training in New Employee Orientation at the medical center level. IPVAP will monitor medical center compliance with IPVAP training requirements through the annual IPVAP PIE process.

Status: In progress

Target Completion Date: April 2023

Recommendation 5. The Under Secretary for Health develops intimate partner violence screening requirements based on the current guidance and patient population needs, and takes action as warranted.

VHA Comments: Concur. IPVAP will revise VHA Directive 1198 to include guidance that VA medical centers must initiate IPV screening for at-risk Veteran populations to include men and women across diverse settings. IPVAP will monitor medical center compliance through the annual IPVAP PIE process and VHA Support Service Center Capital Assets data analysis. Medical centers identified as non-compliant with screening at risk Veteran populations will be required to submit an action plan to address the screening requirement as outlined in VHA Directive 1198.

Status: In progress

Target Completion Date: April 2023

Recommendation 6. The Under Secretary for Health expedites standardized program evaluation processes with oversight and reporting responsibilities to ensure identification of implementation and program deficiencies and monitoring of corrective action and performance improvement plans.

VHA Comments: Concur. IPVAP currently facilitates the annual IPVAP PIE to assess the state of IPVAP at the medical center level and to identify areas of non-compliance with VHA Directive 1198. If deficiencies are identified, the National IPVAP will consult with regional and local leadership to develop plans for resolving program deficiencies. The National IPVAP establishes reasonable timelines for completion of corrective actions and monitor progress.

Status: In progress

Target Completion Date: April 2023

Recommendation 7. The Under Secretary for Health evaluates the current guidance and operational status related to the roles and oversight functions of the Veterans Integrated Service Network Intimate Partner Violence Assistance Program champions and lead coordinators and clarifies expectations and requirements.

VHA Comments: Concur. IPVAP will clarify VHA Directive 1198 on the role, expectations and requirements of Veterans Integrated Service Network (VISN) IPVAP Points of Contact. The directive will require all VISNs to designate an IPVAP VISN Lead.

Status: In progress

Target Completion Date: April 2023

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OIG Contact and Staff Acknowledgments

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