Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Congressionally Mandated Report:

Pilot Program on Assisting Veterans Who Experience Intimate Partner Violence or Sexual Assault

May 2024

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EXECUTIVE SUMMARY

Purpose

In response to section 5304 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, the Department of Veterans Affairs (VA), led by Care Management and Social Work Services, conducted a 2-year pilot at 10 VA health care systems to examine the feasibility and advisability of assisting Veterans who have experienced or are experiencing intimate partner violence (IPV) or sexual assault (SA).

Methods

As a framework to explore advisability and feasibility, the pilot explored the demand, acceptability, practicality, implementation, expansion, and adaptations of services to address the experience of IPV or SA. Registered Veterans across 10 pilot sites were included in the data collected. In addition to evaluating feasibility and advisability, efforts were made to increase awareness and outreach to, and promote increased collaboration with, the underserved populations and areas identified in the legislation. *Note: Registered Veterans includes all Veterans and non-Veterans (spouses and significant others) receiving care. Thus, registered Veterans represents a larger group than enrolled Veterans.*

Results

The pilot found it is advisable to offer services to Veterans who have experienced or are experiencing IPV or SA. An average of 11% of registered Veterans in Veterans Health Administration (VHA) care at the pilot sites were screened for the experience of IPV. Of the registered Veterans screened, 87% identified as male. Due to platform limitations screening rates for Veterans identifying as gender diverse could not be captured. When Veterans experiencing IPV or SA were identified, facilities with available services offered acute services and evidence-based interventions.

Program and site efforts across the pilot led to increased engagement in these services for Veterans in rural and other at-risk communities. Lessons learned from these efforts provides information about best practices, challenges, and opportunities to serve Veterans impacted by IPV or SA. It is only feasible for VA to ensure access of Veterans to IPV and SA emergency services, particularly in underserved areas, including services for Native American Veterans if we increase staffing and support for the “hub and spoke” model of service provision. Outreach efforts were increased to Native American and tribal communities, but the pilot did not increase engagement of these Veterans by the close of the pilot, possibly reflecting the time it takes to effectively reach out to historically underserved communities.

We recommend continuing and expanding the pilot program, to include the following:

- Additional evaluation is needed of efforts to reach historically underserved communities and populations and of the provision of services for Veterans experiencing IPV or SA, with a particular emphasis on those in historically underserved areas and communities.

- Increase support to ensure compliance with the national intimate partner violence assistance program's (IPVAP) VHA Directive 1198, to include IPV screening.
- Increase staffing for SA and gender-based violence services and ongoing evaluation of those implementation efforts.
- Develop programming focusing on SA services for Veterans, with particular attention to those who identify as female, LGBTQ+, Native American, and Veterans in historically underserved areas and communities. These populations are at increased risk for experiencing IPV or SA. Both IPV and SA are associated with suicidality and homelessness.

INTRODUCTION

Overview

On January 5, 2021, the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), which includes the Deborah Sampson Act of 2020 (DSA), was enacted into law. Section 5304 of the DSA directs the VA Secretary to carry out a pilot program to assess feasibility and advisability of assisting former members of the Armed Forces who have experienced or are experiencing IPV or SA in accessing benefits from VA and to submit this report.

Section 5304 Pilot Scope

Pursuant to section 5305 of the DSA, "Prevalence of Intimate Partner Violence (IPV) Among Veterans: A Secondary Analysis Study" (Portnoy et al., 2022), addressed demand for Veteran services related to the experience of IPV in the Veteran population. Importantly, section 5304 did not focus on military sexual trauma (MST)-related care provisions, including the required screen for the experience of MST. Issues related to the MST program were addressed in sections 5111, 5301, 5501, and 5503. The focus of this pilot was on expanding services to address the experience of sexual trauma outside the context of the military, with special attention to addressing the unique needs of underserved populations and areas.

Background on IPV and SA

IPV and SA are prevalent, yet preventable, public health issues that may negatively affect the health, safety, and well-being of those impacted by them. According to the Centers for Disease Control and Prevention (CDC), 1-in-3 females and 1-in-4 males experience IPV in their lifetime. Research supports that significant proportions of the public have experienced IPV or SA in their lifetime. While less is known about specific rates of SA in Veteran populations, sexual trauma is found to be more prevalent among military Veterans relative to non-Veteran adults and interpersonal violence is linked to negative physical and mental health outcomes and increased suicide risk in Veteran populations.

The lifetime economic costs of IPV and SA have been estimated to be $3.6 trillion and

$3.1 trillion respectively, when accounting for related medical and mental health services, lost work productivity, and criminal justice costs.

The World Health Organization, the World Health Assembly, the World Psychiatric Association, and the CDC have all identified IPV as a major target for prevention and intervention. The need to train providers and address SA in health care settings is also recognized by the American College of Obstetricians and Gynecologists, American College of Emergency Physicians, the U.S. Department of Justice, and U.S. National Plan to End Gender Based Violence.

VA's Response to IPV and SA

VA implemented IPVAP and MST programs, as outlined in VHA policy (VHA Directive 1198, Intimate Partner Violence Assistance Program, 2019; VHA Directive 1115 (1), Military Sexual Trauma program, amended 2021). The policies require that each VA medical center (VAMC) have coordinators with subject knowledge, that providers are educated, that screenings are conducted, and that Veterans who have experienced IPV and MST are provided services, as needed. VHA Directive 1115 (1) requires universal MST screening for all genders, while VHA Directive 1198 recommends screening for all genders.

The IPVAP is a national VA program that provides oversight, training, and implementation support for services to assist Veterans, their partners, and VA staff impacted by IPV. The IPVAP is informed by a public health model emphasizing prevention and early intervention and is guided by VHA Directive 1198. Services include raising awareness, outreach, training, consultation, and support for VA employees.

VHA Directive 1198 requires providing access to evidence-based Veteran-centric interventions for Veterans who use or are at risk of using IPV. IPVAP has supported national rollouts of Recovering from IPV through Strengths and Empowerment (RISE), an evidenced-based treatment for the recent experience of IPV (Iverson et al., 2022; Doyle et al., 2022) and Strength at Home (SAH), an evidenced-based trauma informed Veteran group that has demonstrated a reduction of violence in relationships (Creech et al., 2023). An SAH-Couples group is also utilized by IPVAP, with a focus on relationship conflict within couples and reducing the risk of IPV.

The pilot extended services to all eligible Veterans impacted by SA occurring outside the context of an intimate relationship (non-IPV) or occurring outside of military service (non-MST).

Environmental Scan

Prior to the initiation of the pilot, VHA completed an environmental scan. Between October 2021 and November 2021, 137 local IPVAPs completed an internal review of their programming available to Veterans who experience IPV or SA. The review identified the following trends:

- Nearly 100% of the sites reported engaging in activities that promote IPV and SA awareness and prevention.
- All sites reported offering IPV and SA education and training in fiscal year (FY) 2021, and most sites identified VA employees as the intended audience with at least some training offered to community partners. Further, sites reported internal and external partners were vital to promoting IPV and SA services and resources.
- Few sites reported screening or using International Classification of Diseases, Tenth Revision (ICD-10) codes to identify Veterans who have experienced SA.
- Most sites reported they did not provide on-site medical care to Veterans who experienced recent SA, but many reported connecting Veterans to acute SA community resources, including Sexual Assault Nurse Examiner (SANE) exams.
- Most sites reported offering several interventions for Veterans who have experienced IPV, including the Relationship Health Safety (RHS) screen (see Appendix C), universal education, safety planning, referrals to the MST Coordinator or the Intimate Partner Violence Assistance Program Coordinator (IPVAP-C), and some individual psychotherapies.
- Sites shared that Veterans in rural locations may face a lack of resources, such as transportation, community resources, and emergency housing, and face several barriers accessing care to include privacy when accessing services. The barriers may be especially salient for underrepresented and at-risk Veterans, such as racial/ethnic minority groups, LGBTQ+, and women, as well as Veterans who are not otherwise eligible for VA health care.
- Sites reported a lack of staff training, resources, and cultural competency issues that impeded Veteran access to services for the experience of SA.

PART 1: PILOT PROGRAM

Site Selection

The national IPVAP initiated a call for applications open to all VAMCs to participate in the pilot. Ten sites were selected to ensure diversity with respect to facility size, region, race and ethnicity of Veterans, and rurality and proximity to tribal communities and Native American populations. The pilot was launched on October 1, 2021, at the following VAMCs and health care systems:

- Jonathan M. Wainwright Memorial VAMC - (Main facility in Walla Walla, Washington)
- VA Pacific Islands Health Care System - (Main facility in Honolulu, Hawaii)
- VA Salt Lake City Healthcare System - (Main facility in Salt Lake, Utah)
- Southern Arizona VA Healthcare System - (Main facility in Tucson, Arizona)
- Cheyenne VA Health Care System - (Main facility in Cheyenne, Wyoming)
- Central Arkansas Veterans Healthcare System - (Main facility in Little Rock, Arkansas)
- VA Chicago Healthcare System - (Main facility in Chicago, Illinois)
- VA Tennessee Valley Healthcare System - (Main facility in Nashville, Tennessee)
- VA North Florida/South Georgia Veterans Health System - (Main facility in Gainesville, Florida)
- VA Finger Lakes Healthcare System - (Main facilities in Bath and Canandaigua, New York)

Pilot Site Review

In October 2021, the 10 pilot sites completed a second environmental scan of their local IPVAPs, identifying relative strengths and growth opportunities. The following additional themes were identified in the second environmental scan:

1. Four of the 10 sites reported having providers who were fully trained to offer RISE, a research-validated early intervention for Veterans who are experiencing IPV (Iverson et al., 2022).

2. Few sites reported providing non-MST, SA-focused services including medical care, screening, community collaboration, or policy development for the recent experience of SA. Most sites reported they did not use ICD-10 codes for SA-related experiences.

Pilot Program Consultation

The VA Central Office (VACO) Megabus Team consisted of three National Program Coordinators on special assignment, under the direction of the Megabus National Program Manager. This team served as the primary project managers of the pilot.

VACO consulted with internal and external subject matter experts (SME) to create a comprehensive plan to respond to the legislative requirements. This included, but was not limited to, the following:

- National MST Office
- IPV Center for Implementation, Research and Evaluation
- SAH Program
- Center of Innovation for Health Equity Research and Promotion
- National Center for Posttraumatic Stress Disorder (PTSD)
- National Center for Health Care Advancement and Partnerships
- VA Human Trafficking Tiger Team
- VHA Assault and Harassment Prevention Program
- Office of Nursing Services
- VA Police Service
- VHA Office of Mental Health and Suicide Prevention (OMHSP)
- Veterans Pro Bono Consortium
- Healing Household 6
- Health Resources Services Administration
- Office of Women's Health
- Women's Health Physician-Harvard Veterans' Family, Caregiver, and Survivor Advisory Committee
- Military Family Network
- Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Suicide Prevention

Throughout the pilot, leadership engaged in consultation with multiple partners to inform all aspects of operations, including the following:

- National Homeless Programs Office
- Office of Minority Veteran Health
- The Office of Tribal Government Relations
- Tribal Housing and Urban Development-VA Supported Housing (HUD-VASH)

- Veterans Benefits Administration (VBA) Office of Outreach, Transition, and Economic Development
- VBA Native American Veteran Program
- National LGBTQ+ Program Office
- Office of Rural Health (ORH)
- National Peer Support Program
- Strong Hearts Native Helpline
- Johns Hopkins School of Nursing
- University of Alabama Birmingham Advanced Forensic Nursing Program

Pilot Structure

Each pilot site received temporary funding to hire a section 5304 Pilot Lead (Megabus Leads) to provide administrative and clinical oversight of pilot operations, in partnership with the local IPVAP-C. Megabus Leads were required to meet specific clinical competencies related to the provision of IPV or SA care. Pilot sites attended five weekly orientation sessions in September 2021 that reviewed the legislation, pilot expectations, the scope of IPVAP, relevant directives, and key program points of contact. Megabus Leads who joined the pilot after the initial start date received an individual orientation. Details regarding the orientation located in Appendix A**.**

Pilot sites were asked to facilitate a manualized treatment for the experience of SA. The Courage Team, under the South Central (SC) Mental Illness Research, Education and Clinical Center (MIRECC), led the implementation and evaluation of the Courage groups for Veterans who have experienced SA.

The Veterans Integrated Service Networks (VISN) 16 SC MIRECC provided clinical training and consultation to the pilot sites to support implementation and sustainment of the intervention during FY 2022-2023. Pilots were also asked to administer an individual protocol focusing on increasing relationship health for Veterans. Finally, pilot sites were asked to develop and launch an innovation project, aligning with the objectives of the § 5304 legislation.

Pilot Site Innovation Projects

Pilot sites referenced their environmental scan to inform the development of innovation projects at each pilot site. These innovations were aligned with pilot objectives: to examine the feasibility and advisability of serving Veterans who have experienced IPV or SA, with particular attention to Veterans in historically underserved areas and tribal communities. Innovations included collaboration with service providers, outreach and education, and raising awareness.

Section 5304 Pilot Sites Innovation Projects

Site Name	Project Focus
Jonathan M. Wainwright Memorial VAMC	Outreach to tribal communities
VA Pacific Islands Health Care System	Outreach to Veterans in rural communities
VA Salt Lake City Healthcare System	Outreach to Veterans in tribal communities
Southern Arizona VA Healthcare System	Outreach to Veterans in tribal communities and Outreach to underserved populations
Cheyenne VA Health Care System	SA services expansion
Central Arkansas Veterans Healthcare System	SANE training
VA Chicago Healthcare System	Outreach to community partners and Veterans in Hispanic communities
VA Tennessee Valley Healthcare System	SA services expansion, in partnership with Vanderbilt University
VA North Florida/South Georgia Veterans Health System	Increase RHS screening for Veterans in rural communities and provide training to rural providers
VA Finger Lakes Healthcare System	Provide outreach to Veterans in rural communities and create SA response kits

Pilot Implementation Support

The pilot developed resources to support outreach efforts, particularly to Veterans in historically underserved areas and communities, and offered focused implementation support for pilot sites.

The section 5304 Data Hub team included a Program Manager, a Social Work Researcher, two Program Coordinators, and a Program Analyst. It established via Memorandum of Understanding (MOU) with VA Portland Health Care System to develop and oversee methods for evaluating and reporting data produced through the Megabus pilot project. The VACO Megabus Team, Data Hub, and SC MIRECC partnered to provide sites with the following supports:

- Weekly consultation for the IPVAP-Cs and Megabus Leads
- Group consultation twice monthly for the IPVAP-Cs and Megabus Leads
- Monthly group consultation for the IPVAP-Cs and Megabus Leads
- Weekly office hours for supervisors of the IPVAP-Cs and Megabus Leads
- Weekly office hours for pilot sites
- The section 5304 National Program Manager completed face-to-face visits with all pilot sites to identify strengths and growth opportunities unique to each site. These visits included meetings with pilot site executive leadership, Megabus staff, and other site clinical staff, including the homeless program, the LGBT+ Veteran Coordinator Program, Women's Health, the police department, the

Veterans Domiciliary, psychiatry, general mental health, the Native American Program Coordinator, Minority Veteran Program staff, and Veterans who were served by the pilot.

- The VISN 16 SC MIRECC developed educational materials to support staff training and Veteran outreach efforts. This included two podcasts, a short whiteboard informational video, a Healthy Relationship Behavior Workbook for Veterans and Clinician Guide, and two series of brochures aimed to support historically underserved populations for Veterans who identify as African American, Hispanic, Native American and Alaska Native, LGBTQ+, and men who have experienced IPV or SA (See Appendix D).
- VACO provided training throughout the pilot, including a 12-month series addressing issues related to inclusion, diversity, equity, and access (IDEA) for Veterans who have experienced IPV or SA (See Appendix B).

PART 2: METHODS

Theoretical Framework

Pilot leadership conceptualized this pilot within a feasibility framework, grounding data collection with respect to demand, acceptability, implementation, practicality, adaptation, and expansion (Bowen et al., 2009; Whitehead et al., 2014).

Demand

Demand assesses to what extent a program, process, or measure is likely to be used. The section 5304 pilot focused on the demand for IPV or SA services across the 10 pilot sites. Demand was captured by positive RHS screens, the number of services offered in RHS-related clinics, the use of RHS note templates, and Veteran encounters utilizing ICD-10 codes linked to IPV, SA, human trafficking, or relationship health.

Acceptability

Acceptability addresses the extent to which a program, process, or measure is judged as suitable, satisfying, or attractive to program deliverers and recipients. The pilot assessed the acceptability of services rendered employing multiple metrics such as questionnaires to pilot site staff and pilot site leadership, feedback from Veterans, and interviews of clinicians administering the Courage Group and the Healthy Relationship Behavior Workbook for Veterans.

Implementation

Implementation includes asking to what extent a program, process, or measure can be successfully delivered to intended participants in some defined, but not fully controlled, context (Bowen et al., 2009). The pilot focused on the tasks identified in the legislation as important to these services and assessed the number of internal and external

trainings implemented to increase awareness of the services and resources available and the number of referrals to clinical services and related resources that occurred. The impact of the screening and treatments offered were also considered.

Practicality

Practicality has been defined as the extent to which an intervention can be delivered when resources, time, and commitment are constrained in some way (Bowen et al., 2009). Factors impacting the ability of pilot sites to fully implement a program to meet the needs of Veterans who are identified as having experienced SA or IPV were explored. Finally, pilot site staff reported labor hours to increase understanding of time requirements for doing this work. To increase the practicality of offering services to Veterans who have experienced IPV or SA, VACO developed resources for pilot sites, including tools with guidance about screening, safe documentation, and program implementation to assist staff with implementing services for individuals experiencing IPV or SA and using IPV behaviors.

Adaptation

Adaptation asks how a program, process, or measure performs when changes are made for a new format or with a different population. Across the pilot sites, we examined several innovations and adaptations to better engage Veterans in underserved populations and areas, with focused efforts to engage Veterans who are Native American and those residing in rural areas. Further, the VACO Megabus Team convened multiple workgroups to examine potential barriers, such as housing instability, transportation, and utilization of peer supports that may impact these engagement efforts.

Expansion

Expansion asks to what extent can a previously tested program, process, approach, or system be expanded to provide a new program or service (Bowen et al., 2009). Early in the pilot, information was gathered related to the mechanisms that already existed for identifying and serving Veterans who have experienced SA outside the context of the military. Based on these findings, this was considered an area of expansion for VA services. Pilot sites developed specific projects to address gaps in this area.

2.1. Data Collection

Throughout this pilot, a realist lens was used in the data collection and analysis methodology. This method focused on collecting data in an iterative fashion to help understand the relationships between “what works for whom, under what circumstances, how, and why” (Ellaway et al., 2020). To this end, the aim was to be sensitive to emergent contextual factors at each site and to remain agile in response to data collection and analysis.

2.2. Participants

For the purposes of data collection, the population of individuals includes registered Veterans at all pilot sites as possible participants. The pilot perceived registered Veterans as a more accurate measure of the sample of “former members of the Armed Forces” to which VHA is reaching out to offer needed care. Registered Veterans are those who are added to the VHA Enrollment System or the Department’s electronic health record (EHR) to receive services at a VA medical facility. Once registered, individuals are evaluated to determine if they are eligible for VA care. If a person is found to be eligible for VA services, they are enrolled and assigned to a specific priority group to receive the complete medical benefits package, including access to specialty services, as defined in 38 C.F.R. § 17.38.

Registered Veterans include all Veterans and non-Veterans (spouses and significant others) receiving care. Thus, registered Veterans represent a larger group than enrolled Veterans. This allows for a more comprehensive look at the demands of offering these services across VA.

2.3. Materials

Materials used in the pilot included a Power Business Intelligence (BI) dashboard, which captured data from October 1, 2021, through September 30, 2023, and an ongoing survey administered to pilot site staff via Qualtrics, from January 1, 2022, through January 30, 2023. Additionally, midterm and final qualitative feedback were requested by email in November 2022 and July 2023, respectively. Field notes from in person interviews at 10 face-to-face pilot site visits were included. Final feedback from clinicians regarding the Healthy Relationship Behavior Workbook for Veterans, the manualized treatment for SA, and the implementation of a program for the experience of IPV was obtained.

2.4. Procedures

The Data Hub created the Intimate Partner Violence Sexual Violence Power Business Intelligence (IPVSV Power BI) dashboard which collected data from October 1, 2021, to October 4, 2023, across 9 of the 10 pilot sites. The IPVSV Power BI dashboard allowed the VACO Megabus Team to monitor the pilot sites' cohorts daily. The VHA Support Service Center (VSSC) Pyramid cube allowed collection of information from all VA health care systems and VAMCs, however data captures lag up to 3 months. The source file for these VSSC reports is derived from the Enrollment Extract File and the Allocation Resource Center workload and cost file.

The Jonathan M. Wainwright Memorial VAMC is the only pilot site using the Oracle Health EHR, and it began doing so in March 2022. The Oracle Health EHR does not recognize the language used for data collection at the other sites. This meant information was not retrievable from the Corporate Data Warehouse (CDW) for that site. The Data Hub consulted with analysts from the Jonathan M. Wainwright Memorial

VAMC several times without any short-term solutions. Any proposed solutions were longer term (1 year or longer), changing Oracle Health to be exportable. The Data Hub managed to get a list of patients from the Oracle Health EHR directly but could not export demographic information. Requests for information through the VA Office of Information and Technology ticket process were placed in attempts to expedite solutions without any immediate solutions to facilitate data to be accessible for FY 2023.

Data collection occurred between October 1, 2022, and September 30, 2023, and included weekly validation of the Power BI, VSSC, and RHS Screening Report Summary Dashboard data. The Data Hub provided ongoing training to sites and quality checks during weekly consultations with each pilot site.

Quantitative data were collected over 7 fiscal quarters (Q) and qualitative data were obtained in November 2022 and July 2023. To inform data collection, the VACO Megabus Team hosted 5 meetings with internal partners related to housing insecurity and 4 roundtable discussions focused on housing insecurity with Megabus Leads and IPVAP-Cs at the 10 pilot sites. Housing, economic, and food insecurities also were tracked using ICD-10 codes. While there is no standardized way to code or operationalize homelessness in medical records, ICD-10 codes have been used to identify those experiencing or at risk of experiencing homelessness. Pilot leadership engaged in ongoing consultation throughout the 2-year pilot. Consultation occurred with the following:

- The national Homeless Programs Office
- The Office of Tribal Health (OTH)
- The Office of Minority Veteran Health
- Tribal HUD-VASH
- The Office of Tribal Government Relations
- SMEs from OMHSP's Diversity, Equity, and Inclusion program
- VBA Outreach, Transition, and Economic Development Office
- VBA Native American Veteran Program Office
- VHA National Chaplain Service
- ORH
- National LGBTQ+ Program Office
- Representatives from VHA's "PRIDE in All Who Served"
- Futures without Violence
- Forensic nursing SME with the University of Alabama at Birmingham
- Two Peer Support specialists

Consultation focused on improving care to Veterans who require emergency housing

and benefits, Veterans from different cultural backgrounds, Veterans who identify as LGBTQ+, or Veterans who live in rural areas. Consultation also focused on increasing Veteran's connection to spiritual care and providing safe, trauma-informed services, and all facets of program implementation.

PART 3: RESULTS

Data Outline

See Appendix F for a full list of the questions asked in each domain of the feasibility study and the sources of these data.

3.1. Demographics

As shown in Table 1 below, the 10 Megabus sites served 1,418,969 registered Veterans as of the end of September 2023. Veterans who were recorded as male accounted for 86% of registered Veterans across the pilot sites, and those who were recorded as female accounted for 14% of all registered Veterans. Approximately 1% of the registered Veterans across the pilot sites self-identified as gender diverse although it is believed this is an underrepresentation. Registered Veterans were on average between 70-79 years of age.

Using registered Veterans enabled the inclusion of 557 Veterans, spouses, partners, Active Duty military members, and persons in the National Guard in the pilot, who might be served by the National IPVAP, who were registered but not enrolled, and who needed IPV or SA services. These VA service users included Active Duty military (0.54% female; 1.08% male) and National Guard (28.01% female; 11.67% male). Additionally, some were spouses or significant others of Veterans (54.57% female; 4.13% male).

A subset of individuals entered the pilot when they had clinical encounters coded using specific health factors or procedure codes. The health factors and codes indicated treatment for or served as an indication that the individual was being evaluated for the experience of IPV or SA. Once a Veteran was included in the pilot, additional program and Veteran-level data were obtained from the CDW and VSSC.

Depending upon the definition used, approximately 22-30% of Veterans served by VHA live in rural areas (Ohl et al, 2018). For the pilot, Veteran residence in the pilot was designated as urban, rural, or highly rural based on the U.S. Census Bureau categories (U.S. Census Bureau, 2020). Of registered Veterans at the 10 pilot sites, 63% resided in urban areas, 33% resided in rural areas, 3% resided in highly rural areas, and 1% resided in the insular islands.

Table 1: Registered Veteran Data at Pilot Sites

Pilot Sites	Complexity Level	Number of Registered (Enrollees, Non-Enrollees and Users as of FY 2023	Number of Veterans in Pilot (FY 2022-FY 2023)	Percentage of Registered Veterans Served by the Pilot	Pilot Veterans' Average Age
VA Finger Lakes Healthcare System	3	70,628	2,132	3.00%	55
VA Salt Lake City Healthcare System	1a	133,796	3,640	2.70%	49
Central Arkansas Veterans Healthcare System	1a	129,443	2,672	2.00%	53
Southern Arizona VA Health Care System	1b	104,617	1,857	1.70%	53
VA Chicago Healthcare System	1b	151,516	2,518	1.60%	51
Cheyenne VA Health Care System	3	60,456	970	1.60%	50
VA Tennessee Valley Healthcare System	1a	265,816	3,873	1.50%	49
VA North Florida/South Georgia Veterans Health System	1a	346,638	3,941	1%	51
VA Pacific Islands Health Care System	3	102,927	992	1%	49
Jonathan M. Wainwright Memorial VAMC	3	53,132	248	0.46%	55
Total	NA	**1,418,969**	**22,843**	**1.60%**	**51**

Note*:* Jonathan M. Wainwright Memorial VAMC data only reflect data up to March 25, 2022. This information came from the VSSC Patients Cube Pyramid as of September 30, 2023

Table 2, below, shows registered Veterans across the 10 pilot sites with respect to race. Not included in the table, 5% of registered Veterans identified as Hispanic or Latino, and 14% were unknown or declined to answer.

Table 2. Sites' Registered (Enrollees, Non-Enrollees, and Users) Race Summary

Pilot Sites Number =1,418,969	Number of Registered Veterans	Native American Alaska Native	Native Hawaiian Pacific Islander	Asian	Black African American	Multiple	White	Unknown Declined
Jonathan M. Wainwright Memorial VAMC	53,132	1.20%	0.45%	0.40%	1.00%	0.90%	79%	17%
Cheyenne VA Health Care System	151,516	1.20%	0.86%	0.89%	6%	1%	73%	17%
VA Finger Lakes Healthcare System	133,796	0.80%	0.90%	0.80%	2%	0.50%	83%	12%
VA Pacific Islands Health Care System	60456	0.70%	0.37%	0.53%	2%	0.70%	75%	21%
VA Chicago Healthcare System	102,927	0.62%	19%	20%	6%	6%	30%	18%
VA Salt Lake City Healthcare System	129,443	0.49%	0.27%	0.23%	18%	0.71%	63%	17%
Central Arkansas Veterans Healthcare System	265,816	0.40%	0.44%	0.40%	13%	0.76%	65%	20%
Southern Arizona VA Health Care System	346,638	0.40%	0.60%	1%	21%	1%	62%	14%
VA Tennessee Valley Healthcare System	70,628	0.30%	0.22%	0.40%	7%	0.50%	79%	12.60%
VA North Florida/South Georgia Veterans Health System	104,617	0.30%	0.60%	0.60%	45%	0.70%	36%	17%
All Pilot Sites	**1,418,969**	**0.60%**	**1.90%**	**2%**	**14%**	**1.10%**	**64%**	**16%**

Note: Source: Pyramid VSSC Patients Cube Pyramid

Pilot Demographics

According to the IPVSV Power BI dashboard, 22,843 or 1.6% of registered Veterans were included in this pilot. The average age of Veterans in the pilot was 51 years old and ranged from 19 to 101 years of age. A higher percentage of Veterans, aged 59 and younger, were in the pilot than in the population of registered Veterans. Male Veterans made up 73% of the pilot, female Veterans made up 27% of the pilot, and 1% self-identified as gender diverse. A chi-square test of independence found a greater percentage of female Veterans served in the pilot cohort than in the population of registered Veterans (27% vs. 14%; chi-square (1) =2897.948, $p < .001$), and conversely, there is a greater likelihood of male Veterans in the population of registered Veterans than in the pilot cohort (87% vs. 73%; chi-square (1) = 2897.9487, $p < .001$).

Most Veterans in the cohort were service connected (80% of females; 81% of males). A small percentage of individuals were Active-Duty military (1% female; 0.04% male) or National Guard (2% female; 0.42% male), and a small percentage were spouses or significant others of Veterans (4% female; 0.14% male).

Table 3. Pilot Census: Race

Pilot Sites Cohort Number =22,843	Native American or Alaskan Native	Native Hawaiian or Other Pacific Islander	Asian	Black or African American	White	Unknown Declined
VA Pacific Islands Health Care System	2.70%	20%	14%	11%	37%	15.30%
Jonathan M. Wainwright Memorial VAMC	2.50%	0.81%	1.60%	2.80%	81%	11.29%
Southern Arizona VA Health Care System	2.30%	1.40%	1.10%	8%	71%	16.20%
VA Salt Lake City Healthcare System	1.60%	1.24%	1.50%	4.90%	83%	7.76%
Cheyenne VA Health Care System	1.50%	0.82%	0.93%	3.80%	79%	13.95%
Central Arkansas Veterans Healthcare System	1.20%	0.60%	0.26%	29%	58%	10.94%
VA North Florida/South Georgia Veterans Health System	1.10%	0.96%	1.70%	30%	56%	10.24%
VA Tennessee Valley Healthcare System	0.93%	0.70%	0.98%	20%	62%	15.39%
VA Chicago Healthcare System	0.70%	0.59%	0.59%	54%	33%	11.12%
VA Finger Lakes Healthcare System	0.70%	0.70%	0.84%	10%	80%	7.76%

All Pilot Sites	**1.30%**	**1.70%**	**2.00%**	**20%**	**64%**	**11.00%**

Note: Source: Power BI. Power BI demographics did not include a 'multiple' category.

A chi-square test of independence found that Veterans in the pilot cohort were more likely to self-identify as Black and African American than registered Veterans (chi-square (1) =583.752, p<0.001); (20% vs. 14%). Similarly, Veterans in the cohort were more likely to self-identify as Native American or Alaskan Native (1.3%) compared to registered Veterans (chi-square (1) =193.131, p<0.001; 1.3% vs. 0.6%). Conversely, Veterans in the pilot cohort were less likely to self-identify as White compared to registered Veterans (chi-square (1) =6.548, p=.011; 64% vs. 64.8%). The pilot cohort and population of registered Veterans did not differ in self-identification as Asian, Native Hawaiian, or Other Pacific Islander.

Ethnicity

A chi-square test of independence found there was a greater likelihood of Veterans identifying as Hispanic or Latino in the pilot cohort than registered Veterans (7.9% vs. 5.2%; chi-square (2) = 1519.284 p < .001).

Sexual Orientation and Self–Identified Gender

In FY 2023, the Sexual Orientation Power BI Dashboard indicated that 7,182 LGBTQ+ Veterans were registered across the 10 pilot sites. Of this population of registered LGBTQ+ Veterans, 481 received services for IPV or SA. This represents just under 7% of the LGBTQ+ Veterans registered at the 10 sites. A chi-square test of independence found there was a greater likelihood of patients identifying as LGBTQ+ in the pilot than registered Veterans (2.11% vs. 0.44%; chi-square (1) = 1355.83, p < .001).

In FY 2023, the Gender Identity Power BI Dashboard 2023 indicated that 7,292 Veterans self-identified during general VA registration as non-binary, transgender, or other gender across the 10 Megabus sites. Of those Veterans, 276 received services for IPV or SA. This represented 4% of all the gender diverse registered Veterans at the 10 sites. A chi-square test of independence found there was a greater likelihood of patients identifying as non-binary, other, and transgender in the cohort, than registered Veterans at the 10 sites (1.2% vs. .44%; chi-square (1) =292.682, p < .001).

Transgender and gender diverse Veterans made up 1% of the pilot cohort, of which 56% identified as transgender female, 22% identify as transgender male, 20% identify as non-binary, and 2% selected the "other" category.

Geographic Reach

A chi-square test of independence found that a greater percentage of registered Veterans than Veterans in the pilot cohort lived in rural areas (rural, highly rural, and insular islands) (37% vs. 29%; chi-square (1) = 636.042, p < .001). Table 4 , on page 18, shows rurality of the Veterans served by the pilot.

Table 4: Veterans in the pilot who reside in Urban/Rural/Highly Rural (URH) Areas.

URH Number=22,843	Highly Rural	Rural	Insular Islands	Urban
VA Finger Lakes Healthcare System	3%	48%	0%	49%
Cheyenne VA Health Care System	2%	28%	0%	70%
Central Arkansas Veterans Healthcare System	2%	44%	0%	54%
VA Salt Lake City Healthcare System	1%	22%	0%	77%
Jonathan M. Wainwright Memorial VAMC	1%	36%	0%	63%
VA Tennessee Valley Healthcare System	1%	39%	0%	60%
VA Chicago Healthcare System	0%	8%	0%	92%
Southern Arizona VA Health Care System	0%	28%	0%	72%
VA Pacific Islands Health Care System	0%	31%	1%	68%
VA North Florida/South Georgia Veterans Health System	0%	34%	0%	66%
All Sites	**0.93%**	**32.05%**	**0.59%**	**66.43%**

Note: Underserved areas such as highly rural, rural, and insular islands are listed first on this table. The ORH categorized “insular islands” as American Samoa, Guam, and the Northern Mariana Islands.

Pilot Growth

Over the 2 years of the pilot, sites worked to identify and engage Veterans who may benefit from services related to IPV and SA more effectively. Given this focus, the pilot assessed growth of the percentage of Veterans overall and in specific groups between FY 2022 and FY 2023.

The size of the cohort grew across the 2 fiscal years of the pilot with 36% of the Veterans in the pilot enrolling in FY 2022 and 64% of the Veterans in the pilot enrolling in FY 2023. This change was significant (FY 2022 (M =1044.00, SD 583.520) and (FY 2023 (M=1655.89, SD 779.372)); t (16) = -1.885, p=.039).

Reported Birth Sex

A chi-square test of independence found the percentage of female Veterans in the pilot increased from FY 2022 to FY 2023 (chi-square (1) = 306.94, $p < .001$,) from 33% in FY 2022 to 36% in FY 2023. Males decreased from 67% in FY 2022 to 64% in FY 2023. At one site, the number of Veterans identifying as female in the pilot increased by 102% from FY 2022 (117) to FY 2023 (236).

Race

Table 5 below outlines engagement of Veterans in specific racial groups during the pilot.

Table 5. Pilot Growth between FY 2022 and FY 2023 by Race

Sites	FY 2022 Native American or Alaska Native	FY 2023 Native American or Alaska Native	FY 2022 Native Hawaiian or Other Pacific Islander	FY 2023 Native Hawaiian or Other Pacific Islander	FY 2022 Asian	FY 2022 Asian	FY 2022 Black or African American	FY 2023 Black or African American	FY 2022 White	FY 2023 White
VA Pacific Islands Health Care System	2%	3%	20%	21%	13%	15%	11%	9%	40%	39%
Southern Arizona VA Health Care System	2%	2%	1%	1%	1%	1%	8%	8%	72%	71%
Central Arkansas Veterans Healthcare System	1%	1%	1%	1%	0%	0%	28%	30%	60%	57%
Cheyenne VA Health Care System	2%	1%	1%	1%	1%	1%	3%	4%	80%	79%
VA Finger Lakes Healthcare System	1%	1%	1%	0%	0%	1%	12%	10%	77%	80%
VA Chicago Healthcare System	1%	1%	1%	1%	1%	1%	49%	52%	38%	34%
VA North Florida/South Georgia	1%	1%	1%	1%	2%	2%	27%	29%	60%	56%

Sites	FY 2022 Native American or Alaska Native	FY 2023 Native American or Alaska Native	FY 2022 Native Hawaiian or Other Pacific Islander	FY 2023 Native Hawaiian or Other Pacific Islander	FY 2022 Asian	FY 2022 Asian	FY 2022 Black or African American	FY 2023 Black or African American	FY 2022 White	FY 2023 White
Veterans Health System										
VA Tennessee Valley Healthcare System	1%	1%	1%	1%	1%	1%	22%	20%	60%	62%
VA Salt Lake City Healthcare System	2%	1%	1%	1%	1%	2%	8%	4%	80%	84%
All Sites	**2%**	**1%**	**2%**	**2%**	**2%**	**2%**	**18%**	**20%**	**65%**	**64%**

Note: For FY 2022 and FY 2023, 11% of pilot participants were either unknown or declined to identify race.

A chi-square test of independence showed the percentage of self-identified Black or African American Veterans in the pilot cohort grew from FY 2022 (18%) to FY 2023 (20%) (Chi-square (1) =13.532, p<0.001). Alternatively, percentages of Native American or Alaska Native Veterans in the cohort decreased from FY 2022 (2.4%) to FY 2023 (.8%) (Chi-square (1) = 101.839, p<0.001), and percentages of Veterans who identify as Native Hawaiian or Other Pacific Islander, Asian, or White remained stable during the same timeframes.

None of the comparison data noted above included Veterans from the Jonathan M. Wainwright Memorial VAMC due to a lack of FY 2023 data.

Native American and Alaska Native

The legislation specifically identified engagement with Native American and Alaska Native Veterans as a goal.

Table 6 shows a decline in enrollment of Veterans identifying as Native American or Alaska Natives served by the pilot during FY 2023 compared to FY 2022. This occurred even though some pilot sites launched innovation projects that specifically addressed engagement of Native American or Alaska Native Veterans.

Table 6. Veterans Identifying as Native American and Alaska Native

Pilot Sites Cohort	Veterans Self-Identified Native American or Alaska Native	FY 2022	FY 2023
Southern Arizona VA Health Care System	59	32	27
VA North Florida/South Georgia Veterans Health System	45	29	16
VA Salt Lake City Healthcare System	61	41	20
VA Tennessee Valley Healthcare System	38	27	11
VA Chicago Healthcare System	15	9	6
VA Pacific Islands Health Care System	28	16	12
Cheyenne VA Health Care System	16	9	7
VA Finger Lakes Healthcare System	14	10	4
Central Arkansas Veterans Healthcare System	32	21	11
All Sites	**308**	**194**	**114**

Note: Source: IPVSV Power BI.

Table 7 highlights the many tribes and Native Hawaiian organizations (Native Hawaiians are not referred to as tribes) outreached during the pilot. Megabus Leads and IPVAP-Cs interacted with members of over 17 tribes and Native Hawaiian organizations during

their outreach events, and more events are planned for FY 2024.

Table 7. Native American and Alaska Native Tribal Affiliations

Pilot Sites	American Indian and Alaska Native tribal affiliations Native Hawaiians and Other Pacific Islanders
VA Pacific Islands Health Care System	Native Hawaiians are not referred to as “tribes” According to the Office of Hawaiian Affairs.
Southern Arizona VA Health Care System	Tohono O’odham Nation
Central Arkansas Veterans Healthcare System	The pilot site made contact for future collaboration with the Miami Tribe from Oklahoma to raise awareness regarding murdered and Indigenous people.
Cheyenne VA Health Care System	Eastern Shoshone and Northern Arapaho (Wind River Indian Reservation); Some Veterans in this cohort identified as Cherokee and Chickasaw.
VA Finger Lakes Healthcare System	NA/Did not engage in tribal contacts during the pilot
VA Chicago Healthcare System	NA/Did not engage in tribal contacts during the pilot
VA North Florida/South Georgia Veterans Health System	NA/Did not engage in tribal contacts during the pilot
VA Tennessee Valley Healthcare System	Lumbee Tribe of North Carolina and Choctaw Indian
VA Salt Lake City Healthcare System	Shoshone, Bannock, Paiute, Goshute, Uinta, Navajo, Ute
Jonathan M. Wainwright Memorial VAMC	Confederated Tribes and Bands of the Yakama Nation

Note: Data obtained from Megabus pilot site staff.

Ethnicity

A chi-square test of independence found that the percentage of Veterans in the pilot who self-identified as Hispanic/Latino grew from FY 2022 (8%) to FY 2023 (9%) (chi-square (1) =6.645, p= .010).

Veterans across Self-Identified Sexual Orientation and Gender

Growth in the percentage of Veterans who identify as LGBTQ+ over 2 fiscal years was not assessed because information from the national dashboard was only available beginning in 2023. The percentage of Veterans who identify as gender diverse in the pilot stayed stable across the 2 fiscal yearss (chi-square (1) =1.438, p=.230; 1.5% vs. 1.3%).

Veterans Living in Rural and Highly Rural Areas

A chi-square test of independence assessed growth in the percentage of Veterans in the pilot who lived in rural areas from FY 2022 to FY 2023. The percent of Veterans in the pilot cohort living in either rural or highly rural areas increased significantly from FY 2022 (31%) to FY 2023 (33%) (Chi-square (1) = 6.518, p = .011). In addition to the increase in Veterans living in rural areas, Veterans who lived in the insular Islands were added to the cohort in FY 2023.

3.2. Demand

RHS Screening

Research confirms Veterans can be routinely screened for the experience of IPV effectively using a brief, validated screen, and the VHA IPVAP made the RHS Screen clinical reminder available to all sites. The reminder is a brief screen for the experience of IPV and was designed to achieve a “no wrong door” approach to care and improve access to care for Veterans who are experiencing IPV.

As shown in Table 8, during the pilot, the 10 sites attempted 294,425 RHS screens and completed 176,687. Between FY 2022 and FY 2023, rates of attempted screens increased across all pilot sites by 27%. We conducted paired samples t-tests to examine the mean change in attempted screens from FY 2022 to FY 2023 across the 10 sites. The average number of attempted screens per site increased by 3,731 from FY 2022 to FY 2023, t (9) =2.52, p=0.02, Cohen’s d=0.80. Similarly, rates of completed screens increased by 27%. We conducted paired samples t-tests to examine the mean change in completed screens from FY 2022 to FY 2023 across the 10 pilot sites. The average number of completed screens per site increased by 8,804 from FY 2022 to FY 2023, t (9) =1.82, p=0.05, Cohen’s d=0.58.

Table 8. Summary of RHS Screening

Project Years	Total	Change FY 2022-2023
Attempted RHS Screens	290,425	27%
Completed RHS Screens	176,687	27%
Environment Not Safe	104,339	26%
Negative Screens	161,490	21%
Primary Positive Screens	5,166	73%
Secondary Positive Screens	954	48%

Note*:* Source: VSSC RHS Screening Report

However, rate of screening varied. Attempted and completed screens increased at one pilot site by 813% and 622%, respectively, while another site reported a decline in attempted and completed screens. Sites that engaged the highest percentage of Veterans in the pilot conducted universal RHS screening; however, even the site with the most robust screening only attempted to screen 28% of their registered Veterans. The average rate of attempted screens at the 10 pilot sites was 11% of their registered Veterans.

From FY 2022 to FY 2023, 3% of the completed initial RHS screens were positive. Of that 3%, 954 were designated as higher risk cases via the secondary risk assessment. Higher risk cases may be at greater risk for negative outcomes, such as severe injury or death.

Importantly, while those who identify as women experience the highest rates of IPV and SA, in this pilot, most screens were completed with male Veterans (87%). Unfortunately, the VSSC dashboard does not capture RHS screening for Veterans who identify as gender diverse and age groupings differed across data capture tools, making it difficult to look at screening across these groups.

On August 2023, a national rollout of the RHS clinical reminder was deployed across the VA system. This change shifted screening from recommended to “required” for all women Veterans, age 47 and younger, consistent with the U.S. Preventive Services Task Force recommendation (2018).

In the pilot, 14% of the Veterans entered the pilot due to screening. Most Veterans (86%) entered the pilot when a relevant ICD-10 code was linked to one of their clinical encounters. Fifty-seven IPV and/or SA-related ICD codes were organized into 10 groups, and the groups were linked to 19,551 Veteran clinical encounters. A relatively generic ICD-10 code, Z63.0 “problems in relationship with spouse or partner,” was used in 66% of these clinical encounters. The second most frequent ICD-10 code (13%) that triggered pilot entry used a personal history of adult physical and sexual abuse code.

Sexual Assault

Since FY 2021, at the 10 Megabus sites, 38 Veterans sought acute medical services for SA. Across VA in the last 2 fiscal years, a total of 344 alleged rapes were coded for services in 74 VAMCs, located in 38 states. This included a medical examination and observation. This does not reflect Veterans who experienced SA and sought out other clinical services, including psychotherapy. Approximately 397 Veterans at the Megabus pilot sites were screened for a manualized treatment for the experience of SA. This represents 2% of the Veterans served by the pilot.

IPV, SA and Mortality by Suicide and Overdose

Beginning in FY 2023 Q2, the Data Hub began reviewing IPVSV Power BI daily for any deaths in the cohort, and this information was shared with sites during weekly consultations. Megabus Leads or IPVAP-Cs then conducted a chart review and consulted with local suicide prevention teams to determine the cause of death. In most cases, no cause of death was determined. Of the identified decedents, 30% had a positive RHS Screen, and 11% had an ICD-10 code related to SA history. Fifteen Veterans served by the pilot died by suicide. In Veterans aged 50 and under, 9% of the Veterans who died did so by accidental overdose. This was the second largest known cause of death for this age cohort, after suicide. Of Veterans who died due to an

accidental overdose, 30% reported they had experienced SA, with one reporting a childhood history of sexual trauma. This is likely an underestimate of the number of these Veterans who experienced SA, due to the low levels of ICD coding for SA found in this pilot. Local pilot staff are now developing internal processes to review IPV-related deaths and are developing a standard operating procedure (SOP) for death notifications.

3.3. Acceptability

Sites were asked about the advisability and feasibility of offering IPV and SA services at the end of the pilot. They reported offering IPV and SA services was advisable and that given the significant numbers of Veterans impacted by sexual violence and the negative impacts of this trauma, it is not only advisable, but ethical and necessary. While several sites felt this care was feasible, they expressed the need for staffing to address the increase in positive screens and to meet the variability of need for acute and lifetime referrals. Staff would also be needed to continue relationship building with internal and external local and national partners, especially with rural communities who may not be as familiar with VA resources.

Pilot sites also described the following needs to further enhance current IPV and SA programming:

- Ongoing training and support from VACO.
- Ongoing coordination at the VISN level of services across programs and sites.
- Consistent and sufficient staffing.
- Ongoing funding of the program.
- Continued support for telehealth/virtual treatment modalities, including support resources and devices and improved connectivity in very rural areas.
- Transportation support of Veterans to the medical centers and community resources.
- Ongoing and broad outreach and relationship building to the Native American and rural communities to repair their inherent distrust of Government and external agencies.
- Identification of supports and resources in rural communities and the VA resources needed to supplement those services.
- Cultural awareness training.
- Administrative support.
- Private and safe spaces at all sites of care (either virtually or in person).
- Assistance with navigating systemic processes, such as contracting, MOUs, information technology, and/or purchasing.
- Increased publicity/awareness campaigns.

- Increased coding of Veteran's ethnic, gender, and sexual identities, to help ensure Veterans get access to relevant resources and supports.
- Increased care for partners and children.
- Program evaluation tools and support.
- Consideration of alternative care models to the hub and spoke model for care.

Veteran Advisory Committee (VAC)

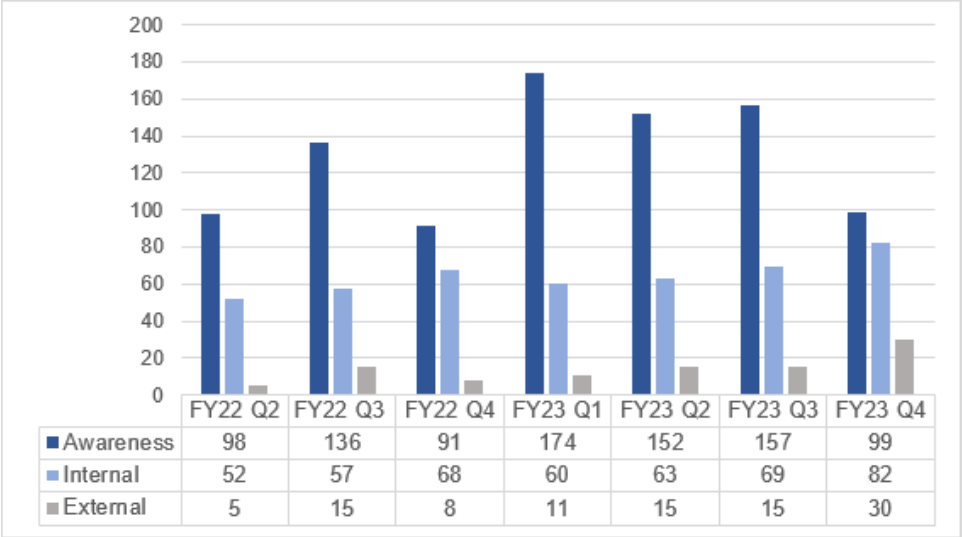
A VAC at one of the sites, consisting of six Veterans receiving IPV or SA services, met weekly to inform local pilot operations. Five of the VAC members attended a focus group to discuss access to services at their facility for Veterans experiencing non-military-related SA. The sample included 3 Navy Veterans, 1 Army Veteran, and 1 Air Force Veteran ranging in age from 32 to 60 years of age. Three Veterans identified as White, one identified as Native American, and two identified as Hispanic. Three Veterans identified as cisgender females, and two identified as cisgender males. One identified as LGBTQ+ and noted that she served before the enactment of P.L. 111-321, Don't Ask, Don't Tell Repeal Act of 2010. Three Veterans identified as survivors of SA. The following themes emerged from the discussion: the desire to have consistent access to the same providers and follow-up points of contact to build safety for disclosing traumas; the desire for providers to all demonstrate sensitivity and appropriate responses versus judgement and invalidating responses; and lastly, they identified a desire for an "advocate" who could help direct them where they need to go and talk them through processes.

3.4. Implementation

The section 5304 pilot focused on increased awareness of and referrals to the facilities for services related to IPV and SA. The 10 pilot sites engaged in 1,457 activities to increase collaboration across the sites and with relevant community partners, including 907 awareness or outreach activities, 451 internal VHA trainings, and 99 external trainings. The quarters that coincided with awareness months, such as Sexual Assault Awareness Month (SAAM) and Domestic Violence Awareness Month, and with pilot innovation project implementation contained more awareness/outreach activities than the quarters that did not. In contrast, rates of internal trainings increased in FY 2023 Q4, which coincided with the new mandate for the use of the RHS screening. External trainings increased steadily over the span of the pilot.

Consistent with the focus of the pilot, there was a significant increase in the number of external training events from FY 2022 (M=7.00, SD=6.272) to FY 2023 (M=17.75, SD=8.382)(t (6) = - 2.054, p = .043) and awareness/outreach events from FY 2022 (M=81.25, SD=57.662) to FY 2023 (M=145.50, SD=32.399) (t (6) = - 1.943, p = .050). There was not a significant increase in internal training events between FY 2022 (M=44.25, SD=30.248) and FY 2023 (M=68.50, SD=9.747) (t (6) = - 1.526, p = .089).

Figure (1) Number of IPV and SA Activities Completed across the Pilot



	FY22 Q2	FY22 Q3	FY22 Q4	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4
Awareness	98	136	91	174	152	157	99
Internal	52	57	68	60	63	69	82
External	5	15	8	11	15	15	30

Note: Data collected via site survey.

Focus of the Activities

Pilot sites tracked their activities from FY 2022 Q2 to FY 2023 Q4 in relation to four topics: IPV, SA, serving underserved areas, and serving underserved populations. Slightly more than half (53%) of the training events focused on IPV, and 47% focused on SA. FY 2023 Q3 had the most training events, according to Figure 1 above.

Given the pilot's focus on increasing training related to SA experience, it is notable that sites significantly increased the number of SA-focused activities, such as awareness, training, and outreach events they participated in over the course of the pilot (independent sample t-test FY 2022 (M = 105.25, SD = 73.054) and FY 2023 (M = 188.00, SD = 12.302) (t (6) = -2.234, p = .033).

Attendance

84,732 people attended activities offered by sites during this pilot. An independent samples t-test was conducted to assess change across FY 2022 and FY 2023. Attendance at awareness/outreach activities increased between FY 2022 (M = 2524.75 SD = 1884.433) and FY 2023 (M = 10082.50, SD = 4653.785) (t (6) = -3.011 p = .012). Attendance at internal training/education activities also increased significantly between FY 2022 (M = 1611.25 SD = 1102.744) and FY 2023 (M = 4456.25, SD = 2490.893) (t (6) = - 2.089 p = .041). External training/education activities were less attended than other categories and there was not significant growth between FY 2022 (M = 233.25 SD = 267.116) and FY 2023 (M = 541.25, SD = 225.546) (t (6) = - 1.762 p = .064). From FY 2023 Q2 forward, 6,935 self-identified Veterans and 77,797 non-Veterans participated in training events.

Serving Underserved Areas and Populations

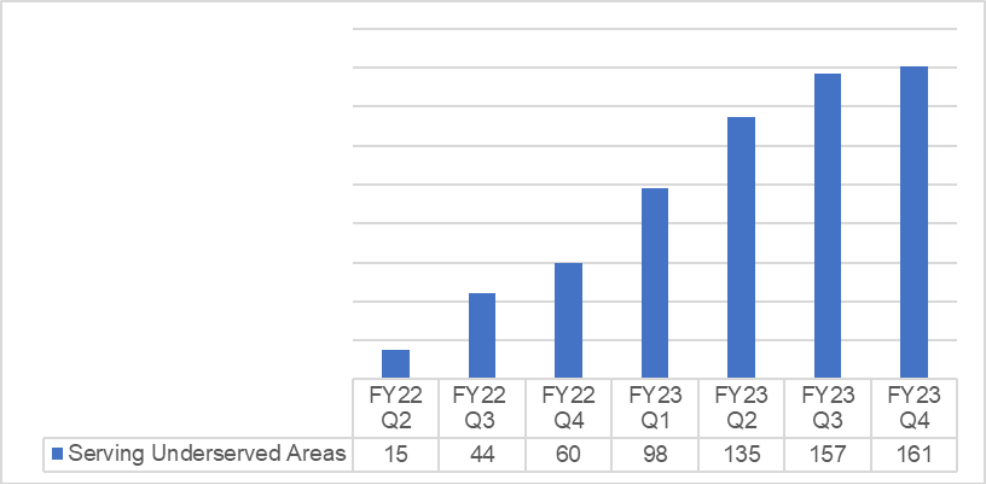
Geographic Reach

Geographic areas were designated into one of these groups based on the following U.S. Census definitions:

- Urban: an area with a population greater than 50,000 people
- Rural: an area with a population between 2,500 and 50,000 people
- Highly Rural: an area with a population less than 2,500 people.

Serving Underserved Areas

Figure (2). Number of Activities Completed in Rural and Highly Rural Areas over FY 2022 and FY 2023



Note: Data collected via site survey.

Most training and outreach activities in rural and highly rural areas (82%) occurred in FY 2023 (Figure 2). Four sites had innovation projects directly addressing rural engagement; these sites displayed the greatest progress in reaching rural and highly rural areas. Independent sample t-tests indicated there was significant growth in the number of activities targeting rural (FY 2022 (M = 70.75, SD = 48.644); FY 2023 (M = 149.50, SD = 19.227); (t (6) = - 3.011 p = .024) and highly rural (FY 2022 (M = 39.75, SD = 27.645; FY 2023 (M = 99.50, SD = 12.557); t (6) = - .3936 p = .004) areas. There was not statistically significant growth in activities targeting urban areas (FY 2022 (M = 118.00, SD = 80.759); FY 2023 (M = 224.50, SD = 81.509); t (6) = -1.856 p = .056).

Additionally, in rural areas, 85% of external training/education was in person during FY 2023, while few were in person in FY 2022. Highly rural areas experienced a similar increase from 0% in-person activities in FY 2022 to 83% in-person activities in FY 2023. Pilot sites focused outreach the most on rural and highly rural areas. Pilot sites shared factors impacting the rate of in-person activities in rural and highly rural areas could

include seasonal weather challenges, Coronavirus 2019 (COVID-19)-related restrictions, and geographical distance.

Between FY 2022 Q2 and FY 2023 Q4, there was a 167% percentage increase in activities focusing on underserved populations. Within the 136 activities focused on underserved populations in FY 2023 Q4, pilot sites reported 80% (109) of these activities focused on Native American Veterans or Native Hawaiians and Other Pacific Islander Veterans, including the Indigenous people of the Hawaiian Islands, American Samoa, Guam, and Saipan: Hawaiians, Samoan, Chamorro, and Carolinian. Some site innovation projects targeted increasing community engagement with partners who were connected to underserved populations:

- VA Salt Lake City Healthcare System contacted Native American shelters and attended a Powwow in Cedar City in mid-June 2023. They are in contact with the Ute Tribe Reservation in Northeastern Utah.
- Jonathan M. Wainwright Memorial VAMC is building a relationship with Umatilla Yellowhawk Clinic for a partnership.
- VA Pacific Islands Health Care System Megabus Lead and IPVAP-C conducted field assessments with American Samoa, Guam, and Saipan and identified SANE, counseling, and IPV resources for Veterans and their partners in the rural areas.
- Southern Arizona VA Health Care System conducted outreach events with the Tohono O'odham Nation and Pascua Yaqui. Further collaborations continued with the VA Native American Advocate Program Coordinator and the University of Arizona OASIS Clinic Sexual Assault Program.
- The Cheyenne VA Health Care System hosted a Medicine Wheel Event in partnership with Sioux from South Dakota. Medicine Wheel, or sacred hoops, are stone structures built by certain Indigenous peoples of the Americas for astronomical, ritual, healing, and teaching purposes.

Community Collaboration

IPVAP-Cs and Megabus Leads provided information to Veterans at their sites, including those not enrolled in the pilot, and connected them to 1,755 VA and community-based resources from January 1, 2022, to September 30, 2023. Over half of those Veterans (66%) received information about services offered by a community resource, which included 51 different community partners. External resource referrals were most often made to IPV shelters, Veterans Service Organizations, Veteran benefit organizations, SA crisis centers, the court system, and community housing programs.

Information on Resources

Megabus Leads and IPVAP-Cs conducted training and outreach events throughout the pilot at which resources and referrals were provided. The types of internal resource materials provided spanned over 25 different VA offices or programs. Mental health, MST Coordinator, women's health, and maternity care program information was

provided at a greater frequency than information about other programs and offices.

Manualized Treatment for IPV

Fifteen clinicians at nine pilot sites delivered the RISE intervention, a research-validated IPV intervention that is delivered individually and focuses on psychoeducation and self-efficacy (Iverson et al., 2022) during the pilot. Eleven clinicians were either IPVAP-Cs or Megabus Leads, and four were other clinicians. During the first year, 28 Veterans completed the course of treatment, and 48 Veterans completed the treatment in the second year. Most Veterans attended an average of five sessions; attending a minimum of three sessions is considered successful completion.

Between the first and second year of the pilot there was an increase in the percentage of women participating in treatment (53.8% to 64.1%) and a reduction in participation of men (42.4% to 34.4%) and LGB individuals (8.6% to 2.1%), while there was no change in participation rates of non-binary individuals (1.7%). White individuals receiving the treatment remained consistent, and those identifying as Black fell 8% (28.1% to 20.1%). There were increases in West Asian, Middle Eastern, or North African Veterans (0% to 1.5%) and Native Hawaiian or Pacific Islander Veterans (0% to 0.67%). Veterans identifying as Hispanic also had an increase (2.9% to 6.9%).

Housing Assistance

Research confirms the experience of IPV or SA can impact all aspects of health and well-being, including housing security, and almost 20% of women Veterans. The recent U.S. Department of Housing and Urban Development's "Annual Homelessness Assessment Report (AHAR)" to Congress indicated that homelessness in Veteran populations increased by 7% between 2022 and 2023 (Sousa et al., 2023). Since October 1, 2021, 10% of the pilot Veterans (N=2,276) experienced homelessness. Veterans served by the pilot spent an average of 128 days homeless. Of this sample, 51% identified as White, 35% identified as Black or African American, 2% identified as American Indian or Alaska Native, 2% identified as Native Hawaiian or Other Pacific Islander,1% identified as Asian, and 9% were unknown or declined to answer. Males made up 71% of this sample, and 29% were females. No data were available for Veterans who identify as gender diverse.

The Supportive Services for Veteran Families Program considers Veterans fleeing from an IPV relationship eligible for a rapid re-housing plan. In the last 2 years, Veterans served by the pilot completed 94,356 patient visits that involved referrals for housing, food, or financial assistance. The average age of the sample was 51. Since FY 2021, coding for housing insecurity in the pilot increased by 34%. The VACO Megabus Team hosted trainings by the national Homeless Programs Office, Tribal HUD VASH, VBA's Outreach, Transition, and Economic Development Office, Legal Services for Veterans Program, and VBA's Native American Veteran Program Office to provide education to the 10 pilot sites regarding housing insecurity and other social drivers of health associated with IPV and SA.

Tribal HUD-VASH is a small demonstration program established in 2016 and modeled

after HUD-VASH. The program was designed to assist Veterans in tribal communities who cannot use traditional vouchers. They can serve Veterans who identify as American Indian and Alaska Native and who are homeless or at risk of homelessness, as “homelessness” can present differently for Veterans in tribal communities. Tribal HUD-VASH is currently working with 29 tribes to support Veterans with their housing needs. Defining homelessness can be complicated with this population, as Tribal HUD-VASH staff noted Veterans in their community will often report they are not homeless despite leaving their homes following an experience of IPV or SA, because they are staying with friends or family. As a result, consultants highlighted that some Veterans who identify as Native American may never meet the traditional definition of homelessness, despite their need.

Consultation with staff from the VA Pacific Islands Health Care System highlighted issues related to access and quality of resources in their communities. Staff noted few options for emergency housing, and shelters often lack sufficient funding and resources and have high staff turnover, which can impact feelings of safety. Staff also noted that Veterans often report they will “take care of their own.” During a focus group with the 10 pilot sites, clinical staff expressed concerns about exposing kids to disruptions, custody issues if they go to emergency housing, and an inability to achieve quality sleep. Sites remarked on the limited availability for male and LGBTQ+ options for emergency housing following the experience of IPV or SA and that options are not ideal, as residents in shelters often must share rooms with someone else, they often choose a more unsafe situation rather than a communal environment and would much rather stay with individual people.

3.5. Practicality

The pilot attempted to both assess and improve the practicality of offering IPV and SA services to Veterans. One of the ways the pilot worked to increase the practicality of offering these services was to develop a series of social media and educational tools to assist the IPVAP-Cs and Megabus Leads in increasing awareness, especially in historically underserved areas and communities.

The pilot produced brochures designed for Veterans who identify as Native American/Alaska Native, LGBTQ+, Black/African American, Hispanic Americans, and male. IPV brochures were distributed to the 10 pilot sites beginning in December 2022. In May 2023, IPV and SA podcasts were released to the 10 pilot sites. In July 2023, SA focused brochures were released. The SA-focused training was not released until September 27, 2023. These products provided education to Veterans and community partners about VA services and benefits tailored for these underserved populations.

Collectively, Megabus sites distributed 89,722 brochures during their outreach events and reported they received positive feedback about the content. An independent sample t-test showed that distribution of brochures increased significantly from FY 2022 ($M = 979.14$, $SD = 2128.774$) to FY 2023 ($M = 2114.72$, $SD = 2022.499$); $t(56) = -2.083$, $p = .021$. In addition to the brochures being shared at events, three sites shared digital

copies with employees via email blasts and through their local SharePoint. Only two pilot sites reported they used the other social media and educational tools developed throughout the pilot, including podcasts and Talent Management System trainings. Most pilot sites reported lack of time and competing priorities limited their ability to share these tools; however, they are considering opportunities, like SAAM, for future dissemination.

Table 9 below describes the percentage of each type of brochure distributed throughout the pilot out of the 89,722 total brochures.

Table 9. VA Local and National Brochures Distribution

Brochure Type	Percentage of the Total
Locally and nationally produced brochures - Courage brochure	17%
Locally and nationally produced brochures - Strength at Home brochure	15%
Locally and nationally produced brochures - Local SA brochure	11%
Locally and nationally produced brochures - National IPVAP Brochure	9%
Locally and nationally produced brochures - National MST Brochure	4%
Locally and nationally produced brochures-Warrior to Soul Mate brochure	3%
Megabus population specific brochures - Men	5%
Megabus population specific brochures - Native American/Alaskan Native	3%
Megabus population specific brochures - LGBTQ+	4%
Megabus population specific brochures - African American	3%
Megabus population specific brochures - Hispanic American	3%
Megabus population specific brochures - Healthy Relationship Behavior Workbook for Veterans	0%

Note: Data are from the Qualtrics Survey. The Courage brochure was distributed to over 14,000 Veterans and community partners over the 10 Megabus sites. Courage focuses on Veterans who have experienced SA developed by Foley, D. and Sherman, M, 1995.

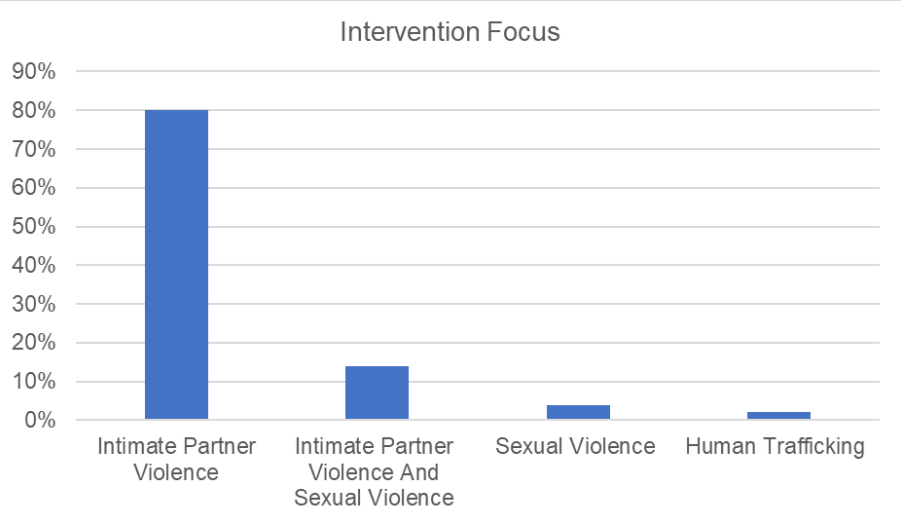
Time spent on Program Tasks across the Pilot Sites

The pilot explored the number of hours spent on program-related activities by clinical staff and others who supported the program. The Data Hub tracked this labor related information between March 2023 to May 2023. Pilot sites reported 1,575 program activity hours during that time span. The activities were designated as clinical (52%) and administrative/supportive activities (48%). Clinical activities included groups and individual treatments that were in-person or provided by telehealth. Administrative activities included documentation, travel, contacting Veterans between sessions to offer follow-up support, and other non-billable activities.

Clinical Activities

As shown in Figure 3 below, between March 2023 and May 2023, the Data Hub tracked information about the time spent offering specific types of clinical interventions. Most interventions offered in the pilot (77%) were for Veterans either using or experiencing IPV. The remaining interventions addressed 7% of Veterans who received treatment for the experience of sexual violence,13% of Veterans who received combined treatment for the use or experience of IPV and sexual violence, and the remaining 3% of the interventions were related to human trafficking.

Figure (3): Intervention Focus



Note: Pilot sites tracked labor hours from March 2023 to May 2023. IPV interventions focused on interventions for the use and experience of IPV.

In FY 2023 Q4, sites tracked time spent on IPV or SA related interventions. This included questions about time spent offering crisis counseling, safety planning, RHS screening, and SA screening. Sites reported providers time shifted toward offering more interventions for the experience of IPV in FY 2023, as compared to FY 2022. This increase in time spent on interventions for the experience of IPV was also supported in the data gathered about the use of RISE over the span of the pilot.

Figure (4): Time spent offering clinical interventions in FY 2023 Q4

Intervention Type	Number of Hours
Crisis Counseling and Safety Planning	417
Conducting Individual RISE sessions	196
RHS Screening	173
Conducting Relational Health group interventions (SAH Couples, Warrior/Soulmate, or SAH)	147
Conducting the Courage Group	142

SA Screening	53
Total hours	**1,273**

Note: Hours were reported in sites surveys in FY 2023 Q4. The Jonathan M. Wainwright Memorial VAMC did not have an IPVAP-C or Megabus lead at the time these data were reported.

As shown in Figure 4 on Page 44, sites spent the most time offering crisis counseling and safety planning. Following time spent offering crisis counseling, sites spent time offering the RISE intervention, completing RHS screenings, and conducting relational health and Courage groups. The least amount of time was spent assessing SA. IPVAP-Cs and Megabus Leads conducted 87% of the clinical interventions offered during the pilot.

Administrative Activities

In FY 2023 Q4, sites were asked to track time spent on administrative tasks. Sites reported spending 1,636 hours preparing for and doing outreach, conducting education, offering trainings/presentations, offering office hours, and taking consultation calls related to IPVAP and Megabus, 623 hours on correspondence or reports, 592 hours travelling from their workstations to other destinations (e.g., community based outpatient clinics (CBOC), community agencies), 409 hours in department and work team meetings or huddles, 317 hours in committee meetings or focus group participation, 138 hours in resource investigations, 129 hours in strategic planning and program development activities, 150 hours meeting with leadership and/or their supervisors, 247 hours tracking data and reporting it, 107 hours in a VA Town Hall or community meeting, 40 hours in SOP development/writing, 75 hours working with interns and trainees, 405 hours in professional development, and 370 hours completing tasks such as help desk/technical support, materials procurement, printing and mailing items, and clinic development tasks. Administrative tasks were completed by the IPVAP-Cs and Megabus Leads 92% of the time.

Barriers to Implementing Megabus Services

The pilot also explored specific barriers that might impact the practicality of implementing the Megabus services. In November 2023, Megabus Leads and IPVAP-Cs completed questionnaires exploring barriers to implementation. Identified themes included the importance of leadership support, the value of using a virtual network to connect with internal and external partners, the challenges of engagement with partners in rural communities, the impact of insufficient resources, and implementation authority. For example, pilot staff at two sites noted they would not be able to obtain training in the newly developed protocol focusing upon IPV prevention because of a lack of bandwidth, describing they were already offering two to three other manualized treatments for the experience and use of IPV and SA. Multiple staff at different pilot sites noted during consultation that they were aware of their vulnerability to burn out as they pushed to offer back-to-back treatments to Veterans with complex needs. Staff noted the pressure to do so as they frequently were the only clinical staff providing these interventions at their sites.

Pilot staff also described several barriers to providing services to underserved populations and areas including distance, lack of resources, and lack of trust between the community and the VA health care system.

3.6. Expansion

Manualized Treatment for SA

One of the main areas for expansion undertaken by pilot sites was to explore the feasibility of addressing the needs of Veterans who have experienced SA outside the context of the military. The Courage Group protocol was identified as a skills-based psychotherapy group that sites could implement to meet this goal. In the group, Veterans received education about the effects of sexual violence and learned cognitive and behavioral coping skills to improve their functioning. During the pilot, the Courage Group team provided a total of 125 hours of training and consultation to the 10 pilot sites. They trained 97 clinicians to deliver the protocol, and 67% of the trained clinicians (n=65) continued offering the program.

Of the 391 Veterans screened to participate in the intervention, just over a quarter (28%) of the Veterans were from rural areas, 77% identified as female, 21% identified as male, and 32% identified as a person of color. Of those screened, 308 (79%) went on to participate or are currently participating in group.

Of the Veterans who then participated in a Courage Group (n=308), 83% were female, 16% were male, and 27% identified as a person of color. Veterans of color receiving treatment included 29% Black, 1% American Indian or Alaska Native, <1% Native Hawaiian or Pacific Islander, and <1% Asian. Approximately 4% of those receiving treatment identified as Hispanic. Of note, not everyone disclosed race and ethnicity.

Exit interviews were conducted with 19 clinicians who described factors that influenced successful delivery of the protocol, including the following:

- Creating and following a local implementation plan.
- Sharing responsibility among trained facilitators for completing administrative tasks, such as tracking referrals, screening Veterans, and delivering the group.
- Building clinical partnerships across different VA clinics or other VA sites, such as intensive outpatient settings.
- Using mass media to raise awareness about the group to Veterans.
- Securing leadership support.

The most common barriers to implementing the Courage Group included:

- Understaffing or frequent staff turnover.
- Lack of available providers and co-facilitators.
- Technological issues, including user error and challenges with using virtual platforms (Cisco and WebEx, for example).

Healthy Relationship Behavior Workbook for Veterans

To promote healthy relationships, a Healthy Relationship Behavior Workbook for Veterans was developed for Veterans, disseminated to the pilot sites and used by clinicians with a small sample of Veterans (number=21). Veteran participants ranged from 30-102 years of age, (M_{age} = 51).

Black/African American or Latino participants made up 14% of those receiving the workbook. Females, including 1 transgender female, made up 55% of the sample. When asked about the impact of using the Veteran workbook on their relationships, many Veterans reflected that learning relationship skills may support the development of healthier new relationships.

Veteran Focus Group

Cheyenne VA Health Care System held a focus group of five Veterans to elicit feedback regarding the pilot and to ask questions about Veterans' access to services for SA, military and non-military related. Three themes emerged: the need for consistency in treatment providers, the importance of provider knowledge and attitudes, and having a point of contact or SA advocate who can help navigate the resources.

3.7. Adaptation

Sexual Assault Response Services

Four pilot sites focused on developing programming for the experience of SA including Veteran outreach, case management, staff consultation, and medical services for the experience of SA. Themes from this work included the importance of engaging with internal and external partners in the delivery of SA-related care, including VHA nursing, Veterans, and community partners.

One pilot site launched an interdisciplinary team They found it to be an effective tool for staffing the needs of patients with complex clinical, housing, and financial needs.

One pilot site focused on staff training, launched a Veteran Advisory Council (VAC), and developed a model of champions for SA care provision. This site found the use of the VAC and their champions to be particularly helpful in expanding their IPV and SA services, reflecting that relying on one staff to care for all Veterans impacted by IPV and SA is unsustainable.

One pilot site focused on collaboration with community partners. They developed agreements with five local hospitals to allow for a warm hand off for Veterans presenting to their emergency room for care following an SA. They also launched an interdisciplinary SA Response and Prevention Project Team that included the following:

- Social Work leadership

- Nursing
- VA Police
- Privacy Office
- Contracting
- Women Veteran's Program Manager
- Emergency Department and Urgent Care Center leadership
- Quality and Patient Safety
- Workplace Violence Prevention
- the MST Coordinator
- Mental Health leadership

The Project Team met monthly and focused on policy and MOU development. As of August 31, 2023, this Team had drafted seven MOUs with community partners to support Veterans who have experienced SA. Currently, the Megabus Lead is not alerted to all incidents of SA but is now receiving referrals, which did not happen prior to the pilot. During FY 2022-23, there were three SA referrals to the Megabus Lead, who facilitated transportation or directed Veterans to an SA forensic examination facility.

One pilot site focused on training SANEs. The site was able to train 4 of the 10 they intended to train. They described challenges identifying nurses to participate in the training, noting nurses are already experiencing significant workload issues. This site completed its first SANE exam in FY 2023. The site noted some delays developing a Sexual Assault Response Team (SART) and described challenges with navigating contracting and purchasing.

PART 4: DISCUSSION

The pilot demonstrated there is a demand for IPV and SA related services across VA. When Veterans screen positive, they are receiving services for the experience of IPV or SA, and the percentage of Veterans being screened for these experiences is relatively low. This pilot reviewed the current state of IPV and SA services in a cohort of Veterans that, in comparison to registered Veterans, had a higher representation of women, were more likely to identify as Native American or Alaska Native, Black or African American, Hispanic, or LGBTQ+ and appeared to be younger.

Across the timespan of the pilot, the pilot increased the number of Asian, Black or African American, Hispanic, White, female, and rural Veterans served for the experience of IPV or SA. The pilot did not demonstrate statistically significant growth in the percentage of Veterans identifying as Native American, Native Hawaiian, or Other Pacific Islander, including Hawaiians, Samoan, Chamorro, and Carolinian, or Hispanic across the 2 years of the pilot. Due to lack of data during FY 2022, the pilot was not able to assess growth of the number of Veterans identifying as LGBTQ+.

The initial environmental scan revealed two sites offered specific services for Veterans who identified as Native American, and multiple sites reported they were collaborating with their local LGBTQ+ Veteran Care Coordinators. While the pilot created products to assist with outreach and training, and outreach activities increased in number and attendance over the span of the pilot, the impact of pilot site efforts may take time to actualize. By the conclusion of the pilot, sites were still only screening an average of 11% of their registered Veteran population.

Across the span of the pilot, the reach of the RISE and Courage interventions increased, providing greater opportunities for Veterans to access interventions targeting IPV and SA experiences. RISE is an evidence-based treatment for the experience of IPV that has been found through a randomized clinical trial to increase Veteran's self-efficacy and reduce symptoms of depression (Iverson et al., 2022). Courage is a promising practice that provides education about the effects of sexual violence and teaches cognitive and behavioral coping skills to improve Veteran functioning following the experience of SA. Courage was shown through this pilot to fill an important gap in the clinical services at facilities, and clinicians reported the group offered a safe space for Veterans to connect with peers and discuss their shared experiences. Some clinicians noted it offered an important opportunity to engage Veterans in other types of care, such as evidence-based treatments for trauma. These clinical interventions were primarily offered by IPVAP-Cs and Megabus Leads, and as screening increases, it will be imperative that more clinical staff are engaged in this work, using a hub and spoke model of care like suicide prevention.

Awareness

Raising awareness is foundational, not only to inform staff about how to connect Veterans to needed care, but also to provide critical psychoeducation for Veterans regarding IPV and SA. People experiencing violence in their relationships may not characterize their experiences as harmful, and awareness efforts may assist Veterans in taking the first step to getting help. At least 10 Veterans who provided direct feedback to VACO expressed lack of awareness as a barrier.

Staffing

Prior to the pilot, the national IPVAP has implemented a full range of services for Veterans who have experienced IPV, which often includes SA. As indicated in the practicality section above, demand for services may exceed available time, and the demand will likely increase over the next fiscal year as RHS screening increases.

Pilot sites with two or more staff were better positioned to address demand, and the loss of staff often had a dramatic impact. For example, one site had three staff members for the first 8 months of the pilot. That Megabus Lead functioned as an SA response advocate and engaged in raising awareness in their large rural community. When a staff member left in April 2023, the Megabus Lead had to assist with more clinical work and advocacy, and raising awareness efforts ceased.

Within 4 months, the number of completed RHS screens dropped by 50%. Another site lost one employee in March 2023 and another in July 2023. This had been a high performing site where they had some of the highest screening rates in the pilot. By the end of FY 2023, RHS screening decreased by 77%, and the site was no longer engaging in IPV or SAraising awareness activities, conducting staff trainings, or participating in any externally focused events.

One strategy to increase a site's ability to reliably support Veterans' IPV and SA needs is the hub and spoke model. The education and competency of multiple staff helps ensure the loss of one staff member does not impact the entire program. The additional trained staff may enable the program to be more fully supported. Ensuring multiple staff are trained may be particularly helpful to increase outreach to Veterans in rural communities.

RHS Screening

Screening is the foundational element of the IPVAP. If Veterans experiencing or using IPV are not identified, they cannot be served. Factors impacting RHS screening include lack of time, training, and provider hesitancy. Research shows successful screening implementation includes the support of site leadership, primary care, women's health, and social work, and emphasizes the utility of engaging in targeted implementation strategies. While the recent national roll out of RHS screening for all Veterans, who identify as women 47 years of age or younger, is a step forward in ensuring Veterans are identified and offered services to address their relational health needs. All genders and ages of Veterans experience IPV. In fact, during the pilot, around 95% of the Veterans who completed the initial screen were not women of childbearing age. Even more critically, 499 male Veterans and 153 female Veterans in high-risk situations were not women of childbearing age (the number of female Veterans not in the childbearing age range in this grouping starts at age 45 rather than 47, as indicated in the national mandate).

While global screening would increase VHA's ability to identify all Veterans who are experiencing IPV, regardless of age and gender, the recent mandate to screen women of childbearing age is helping to increase screening. Prior to the launch of the new clinical reminder, two pilot sites had completed almost no RHS screens. These sites are now not only screening women Veterans but also Veterans of all genders. In less than 1 month (October 4-27, 2023), 16 high-risk cases were identified at these 2 sites that otherwise would not have been identified. These are Veterans at higher risk of being seriously harmed or killed due to IPV.

With weekly consultation from the VACO Megabus Team and the Data Hub, some sites experienced growth in their RHS screening rates; others continued to struggle to implement screening. Pilot data underscores low RHS screening rates at most of the pilot sites. While 2 sites were screening all genders before the launch of the pilot, 2 sites reported screening less than 60 Veterans each in FY 2021. For the pilot site with the most robust screening, the greatest percentage of Veterans with IPV or SA experiences were served. However, even at this site, only 2.5% of all registered Veterans were

treated for IPV and/or SA experience. Currently, there is no standardized screening tool used for non-IPV-related SA.

Interviews with staff in the VA Pacific Islands Health Care System highlighted how culture intersects with provider reluctance to administer RHS screening. Staff reported the difficulty they have determining where the line is between respecting privacy and connecting Veterans with help and that some rural communities may not readily accept help from anyone outside their community. Visits to sites serving Veterans in rural areas highlighted the impact of having culturally diverse staff from the communities they are serving. Staff described their experience of African American patients being more reluctant to report IPV or SA, and how patient perception of safety and cultural inclusivity may reduce a Veteran's engagement, noting several of the communities they serve remain racially segregated.

Age and staff perception can impact screening rates. One site attempted to launch RHS screening at a rural CBOC and believe they were unsuccessful because this community has high numbers of Veterans over the age of 80, and described staff perceptions that IPV or SA would not be relevant to Veterans in this age group.

The pilot confirms local leadership support impacts screening levels. Staff at a site with one of the highest rates of screening described the medical center director's expectation that all social workers are conducting screening and that nurses completing RHS screening are also important to their success. Sites without local leadership support were much less successful implementing screening.

IPV impacts everyone experiencing and using it and can be potentially life threatening, therefore, the national IPVAP recommends universal screening for Veterans of all ages and genders. As identified in the pilot, several Veterans in high-risk IPV situations would not have been identified if only women 47 years and under were screened. A requirement to screen all Veterans is currently not part of national policy.

Patient Identification

Most Veterans in the pilot were identified through ICD-10 codes rather than screening. While screening can lead to earlier prevention, detection, and intervention, ICD-10 codes can identify those currently receiving services for current or past IPV or SA. The "problems in the relationship with spouse or partner" code was reportedly used by some providers to increase privacy and safety for Veterans experiencing IPV because it was considered a safer way to code. ICD-10 codes may be included on insurance explanations of benefits that are mailed to the home and then are seen by potentially abusive partners. In fact, 2 sites used this code in 20-22% of the encounters that lead to inclusion in the pilot. A lack of coding inhibits the identification of base rates, impeding the assessment of actual Veteran and facility needs. It also can lead to Veterans at risk of not being offered important resources and their care providers to not fully understand their care needs and challenges.

Employing reliable coding practices requires ongoing staff training regarding proper coding and safe documentation. Coding practices during the pilot highlighted that staff were most likely to use a generic code referring to “relationship distress.” One site described how they were reluctant to use ICD-10 codes documenting the experience of violence due to concerns about patient safety, as the person using violence may be able to access the EHR of the Veteran. Providers are encouraged to be sensitive about documentation and engage in safety planning in the event their medical record has been accessed (Lutgendorf, 2019). The VACO Megabus Team consulted with a community-based organization which recommended employing a section of the EHR that can house sensitive information to increase patient privacy. This recommendation was made by Miller et al. (2015), as well. While the national IPVAP documentation toolkit recommends the same safety practices, ensuring ongoing staff training is challenging.

Another coding challenge was the limitations of the EHR most sites were using, which may not include the Veteran’s race, ethnicity, LGBTQ+ status, and/or gender identity, as this information often relies upon self-reporting and clinicians asking questions about sexual orientation and gender identity (Webermann et al., 2022). This led to challenges in identifying RHS screening rates for Veterans in vulnerable populations, such as Veterans of color and LGBTQ+ Veterans. Similarly, the Social Institutions and Gender Index were not available until December 2021 via self-report through a website or at registration. This process inhibited collection of gender identity for those Veterans who were screened.

The site using VHA’s new EHR, could not utilize this system during the pilot. This site had designated pilot staff with whom the Megabus Data Hub were able to collaborate to manually identify patients who had been screened. After the departure of these two staff, it became even more challenging to accurately capture workload in the EHR.

Availability of interventions

Once identified that a Veteran is experiencing or using IPV, they must be informed about and referred to desired resources. Awareness of both internal and external resources are needed to support Veterans with positive screens. Clinical services for the experience of both IPV and SA were the least developed aspects of the programs at the beginning of the pilot, and a majority of the crisis and clinical interventions offered are done so by the IPVAP-Cs and Megabus Leads. As Veterans needing these services are identified more regularly, these interventions will need to be offered by other clinical staff to meet demand.

IPV, SA, and Mortality

The CDC’s National Violent Death Reporting System (NVDRS) found that between 2018 and 2020, there were 8,061 reported homicides related to spouse or intimate partner relationships in the U.S. population. The NVDRS indicates that 406 homicide victims were current or former military members. Additionally, the 2023 National Veteran Suicide Prevention Annual Report identified relationship problems (33.7%) were one of the top four factors leading to suicide deaths among Veteran VHA users between 2019-

2021 (2023). Findings support the value of combining suicide and lethality risk assessments and assessing for access to weapons when engaged in both suicide and IPV-related safety planning (VA Suicide Prevention, 2023).

Coordination of IPV and SA services

Having strong, regular partnerships with services that address problems related to IPV, such as homelessness, substance abuse, LGBTQ+ services, working closely with Veteran Care Coordinators, and having an on-site IPVAP CBOC presence are identified best practices. One site described being embedded in their homeless program has allowed them to quickly identify Veterans at risk for IPV and/or SA and coordinate care, riding with their homeless program staff to meet Veterans where they are and eliminating transportation as a barrier to accessing care. Another site joined their local coordinated outreach team, facilitating the IPVAP's ability to raise awareness, and this site experienced a 479% increase in screening during the pilot. Multiple sites reported close collaboration with their local LGBTQ+ Veteran clinics, noting some of their partners were preparing to launch SA programming tailored to serve LGBTQ+ Veterans. One site described a close partnership with law enforcement, and their police department is part of a "Veterans Mental Evaluation Team." This team provides a coordinated response with social work to Veterans in crisis.

4.1. Access for Underserved

There are many reasons Veterans experiencing IPV or SA do not seek care, including individual, organizational, socio-cultural, and structural issues as well as concerns about increased risk to self or loved ones, privacy, shame, the judgment of others, and a lack of awareness about available resources and IPV itself. Organizational barriers include provider bias, limited resources or challenges accessing the resources as they are provided, and the impact of the COVID-19 pandemic on provider capacity. Cultural norms that stigmatize formal help seeking for the experience of IPV and SA and language barriers may also impact access. Systems issues, include a sometimes unwelcoming or unreceptive environment, social and geographic isolation, and policies that limit access to services.

Veterans who identify as female, LGBTQ+, Native American, and who reside in rural areas experience the highest rates of IPV or SA. This pilot experienced mixed success with respect to Veteran engagement and highlights the need for tailored outreach to diverse communities. "One size does not fit all" when providing care for Veterans who have experienced IPV or SA. The pilot primarily improved engagement of Veterans who identified as Asian, Black or African American, White, female, and rural Veterans. Of note, the pilot initially included a higher percentage of Veterans identifying as female, Black, Native American, Hispanic or Latino, LGBTQ+, and gender diverse compared to the general population served at the 10 pilot sites. As described earlier, it is possible that the additional impact of the increased outreach to Veterans in Native American, Hispanic, and rural communities may be seen in the future, given most of these activities occurred near the end of the pilot.

Serving Veterans who identify as Native American

This pilot focused upon the feasibility and advisability of providing SA and IPV services to Veterans, with a specific focus on Native American Veterans and other underrepresented groups in health care. The pilot was able to increase representation among Veterans living in rural areas, and with those who identify as Black or African American but did not increase engagement with Veterans who identify as Native American and Alaska Native.

Efforts to increase representation included focused consultations, provision of awareness materials, specialized education for Veterans in historically underserved communities, staff education, and ongoing consultation with partners focused upon IDEA principles. Equitable delivery of behavioral interventions is critical. Research shows that sexual violence is often perceived as a gender-specific problem, which dismisses the needs of all survivors. The history, systemic inequities, cultural values, and experiences of marginalization among specific racial and ethnic groups might explain differences in treatment engagement. Pilot sites noted the need to build relationships with underserved communities for them to feel safe enough to engage in treatment. Many sites have started collaborating with agencies and community leaders as initial steps in relationship building with some success. However, they shared that engaging with underserved populations is not a “one size fits all” process and staff need regular training on culturally competent care. The importance of sensitivity and patience when engaging with Veterans in tribal, Hawaiian, Samoan, Chamorro, and Carolinian communities were noted by multiple pilot sites.

Consultation with the OTH underscored the importance of considering culture in all interactions Veterans who have experienced IPV and SA. They described how VHA providers and leadership should be informed about historical factors that impact native Veterans’ experiences of safety and trust in VHA health care. They shared how it is critical to work toward establishing trust at local VHA medical centers and clinics. They reflected how members of tribal communities may be reluctant to disclose traumatic experiences to non-native providers and noted native women may not feel permitted to discuss SA and IPV with others. They described the importance of always considering culture in every patient encounter and highlighted the importance of workplace diversity to have tribal staff available. Finally, they shared how important it is to minimize staff turnover, so Veterans do not have to repeat painful narratives to multiple staff.

The VACO Megabus Team consulted with two Veteran Peer Support Specialists on increasing access to IPV and SA-related care for Veterans. One of the peers reflected "it's hard for Veterans to get to entry points to access benefits....” They described how if they have experienced discrimination, heterosexism, racism, or traumatic events during their military service, they “may generalize this to the VA. They [Veterans] have experienced doctors who won’t treat them.”

Finally, being able to identify vulnerable populations by asking about ethnic, tribal, gender identity, LGBTQ+ membership, and improving Veteran engagement in services is foundational to providing culturally inclusive care. Providers must offer culturally

sensitive care and tailor the resources they offer.

Serving Veterans in Underserved Areas

Engaging with Veterans in rural communities is necessary to increase access to care. According to research, Veterans are more likely to reside in rural communities than the public, and statistically rural areas generally have higher rates of poverty, elder residents, poorer health, and limited access to health care, education, employment, housing, and transportation options. Research confirms that for rural Veterans, access is the biggest barrier to treatment engagement. Increasing engagement with Veterans in rural areas was a focus of pilot efforts, and engagement during the pilot did increase in a statistically significant way. However, the pilot sample still underrepresented Veterans in rural communities, as compared with the broader population of registered Veterans.

Pilot sites reported lessons learned in their attempts to engage both staff and Veterans in rural communities. One site noted that telehealth has been helpful to increasing access to Veterans in rural communities. While telehealth implementation is one strategy (Day et al., 2021; Fletcher et al., 2021), there are concerns with using telehealth exclusively with rural populations due to broadband issues and less access to appropriate digital tools (Kim et al., 2020). Almost 30% of Veterans living in rural areas served by VA do not have internet access. One site emphasized that Veterans may not have good internet, and older Veterans may prefer being seen at the clinic. Also, staff at rural clinics are often used to being under resourced or may miss opportunities for intervention because they lack the knowledge about IPV and SA. One pilot site expressed the importance of building relationships and trust with Veterans in rural communities. Another unique challenge reported about rural areas is that Veterans may not want to disclose since privacy may be a challenge in smaller communities.

Pilot activities in the Pacific Islands highlighted some of the challenges of providing culturally competent care in more remote areas. The Pacific Islands are comprised of Hawaii and three U.S. Territories, including the Indigenous people of the Hawaiian Islands, American Samoa, Guam, and Saipan, each with distinct racial and ethnic groups, cultural histories, values, and beliefs. Local pilot staff described how Veterans in the Pacific Islands identify with “a warrior culture” and enlist in the military to increase economic opportunities, contributing to higher rates of military service. Additionally, not all areas have access to health care and may need to ferry or fly to other islands to get treatment. Other barriers to care include lack of awareness and trust in VA or community partners and lack of culturally relevant options, including language barriers. For example, the site highlighted “there is no word for ‘trauma’ in Hawaiian and Samoan.” Consultation with the OTH underscored the absence of trust in government in many Indigenous communities.

Serving Veterans who identify as LGBTQ+

LGBTQ+ Veterans may have increased risk for life-time experiences of violence. While Veterans in general have higher rates of Adverse Childhood Experiences, research shows LGBTQ+ Veterans may have even higher risk and be more likely to experience IPV and/or SA during military service. Within the pilot, LGBTQ+ individuals made up

almost 4% of the Veterans served. The VHA LGBTQ+ Health Program has been expanding the ability to identify and provide services and support to LGBTQ+ Veterans. LGBTQ+ Veteran Care Coordinators engage in awareness and education events to build an affirming environment and trust.

Three pilot sites had clinics that provided specialized health care for Veterans who are gender diverse and questioning their gender identity. At one pilot site, the Megabus Lead worked with this clinic at their site to offer events in Fall 2023, focusing on the intersection of IPV and LGBTQ+ Veterans. Another pilot site's ongoing collaboration with their LGBTQ+ Veteran Care Coordinator (VCC) can be seen as a necessary practice for IPVAP and Megabus to connect with this vulnerable population. Having VCCs for other historically underserved Veteran populations could help bridge the barriers and help build trust.

4.2. Serving Veterans who have experienced SA

According to VHA policies, including VHA Directive 5019.02 (1), Sexual Assaults and Other Defined Public Safety, updated in 2022; VHA Directive 1101.14, Emergency Medicine, updated in 2023; and VHA Directive 1101.13, Urgent Care, March 20, 2023, VHA must be prepared for and provide emergency care for Veterans who present for treatment following an SA. Treatments include procedures to evaluate, support, and treat patients of reported SA, such as screening for injuries, preserving evidence, performing or referring for forensic examination, preferably by a SANE, if desired by the patient, and ensuring access to prophylaxis for sexually transmitted disease and pregnancy, when clinically indicated.

Follow-up care may include screening and treatment of sexually transmitted diseases, treatment of injuries, or access to law enforcement and patient services. Acceptable procedures must consider regional law enforcement requirements. If the forensic examination is being performed in a VA medical facility, the forensic provider must first obtain informed consent and be trained in conducting forensic evidentiary examinations. Of note, SANEs are considered important resources for those who experience SA and are trained to protect the integrity of evidence needed in cases of SA and provide trauma-informed care.

Institutional culture and awareness impacted the small numbers of Veterans who presented for urgent SA-focused care at three pilot sites. The pilot impact on SA awareness was limited as SA-focused products were not released until July 2023, and the SA staff training launched September 2023. Despite this barrier, targeted SA treatment was utilized by Veterans of different races, ethnicities, and genders.

According to research, males may not acknowledge they have experienced sexual violence and seek help due to perceived or actual discrimination and a belief that only women are experiencers. Institutional and provider bias directing staff to screen those identifying as women only, may impact rates of referrals and a failure to identify men who have experienced SA. At one site, a RISE facilitator noted the clinician at their site providing RISE was in the Women's Health clinic which may send the message to male experiencers that they are an anomaly, or their experience of violence is less valid than

a female's. Promotion of services should be gender inclusive, and both Veterans and staff need increased education about men's experiences of SA.

The perceptions of Veterans, staff, and community partners regarding where it is appropriate to seek SA care may also be an important factor impacting utilization of SA-related services. When asked what VA could do to improve access for Veterans who have experienced IPV and SA, Veterans described embarrassment when they were not believed, as well as a feeling of helplessness.

One Veteran shared how he had 10 primary care doctors in 2 years, highlighting how he did not have adequate time with his providers to build a sense of safety and trust to disclose his sexual trauma. Another site highlighted how Veterans and community partners are not socialized to see VHA as a place where Veterans can receive care for the recent experience of SA. As VHA has not traditionally provided SA-related care for the recent experience of SA, this speaks to the need to increase services for Veterans who have experienced SA and for additional efforts to raise awareness about SA-related care in VHA, particularly when there are limited or no community-based resources.

Cultural change takes time. Consistency and persistence are needed to build working relationships, raise awareness, and work effectively with Veterans who have experienced SA. At a face-to-face site meeting, a Veteran shared that one of the most important elements of her experience working with the local pilot staff was the time and attention her therapist spent with her. She noted the therapist showed patience and saw her as a person who mattered. During another face-to-face site meeting, a VHA provider reflected that the availability of the local pilot staff allowed them to build trust and confidence in the services they were offering to their patients. This provider highlighted how in years past, she and other staff did not ask patients about their experiences of IPV and SA because there were no resources to offer the Veterans.

4.3. Community Care

Connecting with community services including transportation, rape crisis, and other emergency services can be challenging, particularly for historically underserved areas. For example, VA's Veterans Transportation Program offers community partnerships to support the transportation or travel reimbursement of qualifying Veterans to VA medical appointments and approved non-VA partners. However, not all states and territories have access to these services.

Additionally, transportation services are typically in a multi-person van and during normal business hours, which creates barriers for individuals seeking services for SA or IPV-related care. Ride share options may be limited, especially in rural areas or after hours and be costly upfront, even for those who will be reimbursed. Feedback on the mid-term questionnaire administered to site staff regarding barriers to care highlighted challenges with transportation as a main barrier to accessing care for IPV and SA. VA transportation resources and formal partnerships with community transportation resources should be considered.

Further, during two face-to-face site meetings, frontline staff noted there was no rape crisis facility accessible for Veterans in their area. One psychiatrist working in a rural community described how rural their catchment area is, noting that despite the increased risk for IPV experience for Veterans in rural communities, psychiatric and family crisis services in the community are generally unavailable.

Community partners are impacted by time constraints, funding, resources, and space availability. At one site meeting, a Veteran shared they had to wait 6 months for a community care appointment. Finally, community care settings may benefit from education about military culture, identifying Veterans needing these services, and understanding how VHA can enhance services for Veterans they encounter. To address this, one pilot site had an on-site regular presence with an urban partner serving Hispanic communities, and another built a partnership with a local University to increase referrals to SANE providers.

4.4. Program Implementation

Sites with coordinators who had training and experience in program development, implementation, and evaluation had the most success. Additionally, pilot data indicate weekly consultation may have been helpful in increasing the reach to some historically underserved groups. As staff from the Courage Team noted, working with individual sites to identify and address potential health care disparities using the Health Equity Implementation Framework may be helpful (Woodward et al., 2019, 2021). This framework offers guidance on how to assess and understand the nature of health care disparities within integrated health care systems like VA. Further, the Health Resource and Services Administration's (HRSA) "2023-2025 Strategy to Address Intimate Partner Violence" may be a useful approach to guiding future efforts. HRSA's most recent plan includes strengthening "workforce capacity" and emphasizing prevention. HRSA's three-phased approach emphasizes the value of increasing awareness, implementation, and evaluation in year 2025.

LIMITATIONS

The findings in this pilot should be interpreted in the context of the following limitations. First, Veterans are not socialized to go to VA for medical treatment for the experience of SA. While the pilot collected some SA information, many Veterans may have been taken to other health care facilities, did not seek services at VA, or had concerns about what they could expect from VA. Since IPV screening is not required for all Veterans, they may not be comfortable answering questions related to IPV as it is not a standard part of their health care experience and shame is a common emotion linked to the experience and use of IPV. Also, effective screening for IPV and SA requires the use of trauma informed approaches and not all staff are trained. These factors can lead to an underreporting of experiences of IPV and SA.

While many clinicians felt the Courage intervention filled a gap in service delivery, additional efforts to evaluate the clinical impact of this intervention and ensure the program materials are representative across diverse groups of Veterans is needed.

The Healthy Relationship Behavior Workbook for Veterans was only used with a small sample of Veterans and requires additional evaluation.

KEY FINDINGS AND CONCLUSIONS

To ensure Veterans who have experienced or are experiencing IPV or SA have access to benefits:

- It is advisable for VA to ensure Veterans experiencing IPV or SA have access to emergency services including treatment and follow-up care, particularly in underserved areas, including services for Native American Veterans.
- It is not feasible for VA to ensure access of Veterans to IPV and SA emergency services, particularly in underserved areas, including services for Native American Veterans, without increased staffing and support for the “hub and spoke” model of service provision.
- It is advisable to conduct universal RHS and SA screening for Veterans of all genders and ages, given the intersectionality of IPV, SA, and suicide.
- It is not feasible for VA to provide care for all enrolled Veterans screening positive for IPV without increased staffing.
- It is advisable for VA to assist registered Veterans who have experienced or are experiencing IPV or SA to access benefits from VA, including access to medical treatment centers, housing assistance, and so forth.
- It is advisable to provide SA services for Veterans, including clinical, case management, and advocacy services for Veterans who have experienced SA outside of military service, with particular attention to those who identify as female, LGBTQ+, Native American, and those in rural areas.
- It is not feasible to provide SA services for Veterans, with particular attention to those who identify as female, LGBTQ+, Native American, and those in rural areas, without increased staffing and employing a “hub and spoke” model of care.
- It is advisable for VA to require annual training for staff on IPV and SA screening, coding, safe documentation, and trauma informed care.
- It is advisable for VA to increase messaging about IPV and SA-related programming to Veterans.
- It is advisable for VA to support collaboration between IPVAP, suicide prevention, homeless, and MST programs to provide a coordinated, holistic response to Veterans experiencing IPV and/or SA.
- It is advisable to further evaluate the impact of specific efforts to reach underserved areas and populations.
- It is advisable to continue to track the reach of the IPVAP and Megabus programs featured in the pilot and ensure that all Veterans in need of these services are identified and offered evidence-based care.

- It is advisable to embrace a hub and spoke model of care that engages all VA clinical staff in IPV and SA response, mirroring VA's approach to suicide prevention.

In conclusion, VA recommends continuing and expanding this pilot program if the above-mentioned elements are addressed.

Department of Veteran Affairs
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Appendices

Appendix A: Topics in the orientation training for the Pilot Site IPVAP-Cs and Megabus Leads

VHA IPVAP-C will receive training to advance knowledge about:

- Dynamics of IPV and SA, including safety concerns, legal protections, and the need for the provision of confidential services.
- Eligibility of Veterans for services and benefits from VA which are relevant to recovery from IPV and/or SA including emergency housing, mental health care, other health care and disability benefits.
- Local community resources addressing IPV and/or SA.
- Considerations for underserved populations including Native American Veterans.

Community based IPV and SA providers will receive training about:

- Identifying Veterans who have been victims of or who are currently experiencing IPV or SA.
- Coordinating with local VHA service providers.
- Connecting Veterans with appropriate housing, mental health, medical, and other financial assistance or benefits from VA.

Considerations and available services for underserved populations include the Native American Veteran Community IPV/SA Advocates Guide upon publication. Pilot site coordinator will receive the same training package offered to VHA IPVAP-Cs and will also receive training related to:

- Administrative oversight of pilot program.
- Clinical intervention for SA (including the Courage group protocol).
- Reporting, data collection and management.
- Record keeping.
- Consultation requirements.
- Eight required elements of pilot site implementation.

Appendix B: Megabus Project Trainings for IPVAP-C and Megabus Leads

- VBA Comprehensive Benefits Briefing
- HUD-VASH and VAWA: VHA Homeless Programs Office (HPO)
- Guidance for Using Appropriated Funds for the Care of Homeless Veterans during a Declared Public Health Emergency (COVID-19) Overview
- Human Trafficking in the Native American/Alaskan Native Population
- Native Americans and Alaskan Native Impacted by IPV
- The Impact of Racism on Veterans Who Are Experiencing IPV and Sexual Assault
- Increasing Effectiveness with Veterans of Color Impacted by IPV and Sexual Assault
- Pride in all who Served
- Trauma Informed Care for Veterans who have Experienced Sexual Assault
- Sexual Assault in Tribal Communities

Appendix C: RHS Screen

In the past 12 months, how often did a current or former intimate partner(s)

- Scream or curse at you.
- Insult or talk down to you.
- Threaten you with harm.
- Physically hurt you.
- Force or pressure you to have sexual contact against your will or when you are unable to say no.

The Veteran can select the following: never, rarely, sometimes, often, or frequently for any of the queries above.

If never is answered to all of the above questions, general education and information are provided. If anything else is answered, the secondary screen is administered with the following questions:

- Has the IPV behavior increased in frequency/severity in the past six months?
- Has your partner ever choked or strangled you?
- Do you believe your partner may kill you?
- If yes is answered to any of the secondary screen questions, a warm handoff is immediately offered to a licensed IPV clinician to assess for immediate risk, offer safety planning, and provide additional resources/support.

Appendix D: Educational materials developed by the SC MIRREC.

Podcasts: Four introductory podcasts, two about IPV and two about SA, were created: Part 1: Basic Information and Part 2: Resources. Transcripts of the podcasts are available to ensure accessibility. Each podcast is less than 10 minutes.

Sexual Assault Whiteboard Video: The Sexual Assault Whiteboard Video is an animated 2-minute video designed to educate Veterans about SA and increase their access to care for SA.

Clinician Sexual Assault Training: The purpose of this recorded, knowledge-based, eLearning program is to allow clinicians to gain the knowledge, skills, and resources to enable them to recognize and address SA and related issues, including human trafficking, particularly when working with historically marginalized and underserved Veteran populations such as Native American/Alaska Native, African American, Hispanic, LGBTQ+, or men.

Healthy Relationship Behavior Workbook for Veterans: The Healthy Relationship Behavior Workbook for Veterans was developed to provide education to Veterans regarding healthy, unhealthy, and at-risk relationship behaviors and key concepts to improve their healthy relationship behaviors and improve communication in their daily lives. Topics covered in the workbook include sex and intimacy, providing support, communicating, spending time with others, conflict resolution, privacy, and responsibility and choice.

Healthy Relationship Workbook Clinician Guide: A clinician guide was created to accompany the Healthy Relationship Behavior Workbook for Veterans. The guide contains background information about the foundational concepts in the Veteran Workbook, steps on how clinicians could use the Veteran Workbook in clinical settings, and references for additional resources for clinicians. A 2-hour live virtual training was offered to clinicians to prepare them for the Veteran Workbook pilot.

IPV and SA Brochures: A series of educational brochures were created about IPV and SA to facilitate equity for historically marginalized and underserved populations: African American, Hispanic American, Native American/Alaska Native, LGBTQ+ and men (underserved in the realm of IPV or SA). The brochures included information on healthy behaviors, at-risk behaviors, unhealthy behaviors, understanding IPV or SA, statistics about IPV or SA specific to Veterans in the group, possible negative impacts of IPV or SA, tips for safety and VA and community resources.

Appendix E. Midterm and Final Feedback Questions

Midterm feedback on innovation projects:

- How has your Megabus experience been with administering the Megabus Pilot?
- What has your experience been like with providing trainings to community partners and internal VA staff?
- What do you find most helpful in providing trainings?
- What has your experience been like connecting with community partners regarding Veterans in underserved areas and populations?
- Describe any challenges you have experienced regarding staffing, administrative support, or other areas while working on the pilot?
- What, if any, additional information would you like to share?

Section 5304 Pilot Site Exit Interviews-SME Questionnaire

- What have you learned about serving Veterans impacted by sexual assault?
- Is it feasible for VA to provide services to Veterans who have experienced IPV and sexual assault? Why or why not?
- Is it advisable for VA to provide these services? Why or why not?
- What have you learned about providing IPV/SA services to Veterans in rural communities?
- What have you learned about providing IPV/SA services to Veterans in historically underserved populations? Native American Veterans?
- Can you share some of your “successes” during the pilot?
- What have been some of your challenges?
- What supports will you need to sustain the work you have begun in the Megabus pilot?

Section 5304 Pilot Site Exit Interviews-Leadership Questionnaire

1. Is it feasible for VA to provide services to Veterans who have experienced IPV and sexual assault? Why or why not?
2. Is it advisable for VA to provide these services? Why or why not?
3. What has your site learned about providing IPV/SA services to Veterans in rural communities?
4. What has your site learned about providing IPV/SA services to Veterans in historically underserved populations? Native American Veterans?
5. What have been some of your site’s implementation “successes” during the pilot?
6. What have been some of your site’s implementation challenges?
7. What supports will your site need to further implement and sustain the work you

have begun in the Megabus pilot?

8. Other comments?

Appendix F. Data Analyses

Data captured in each domain of the feasibility study and the sources of that data

Area of Focus	Question	Data Source
Demographics		
	# of registered Veterans per site	VSSC Patients Cube Pyramid
	# of registered Veterans per site by racial group	VSSC Patients Cube Pyramid
	# of registered Veterans per site by ethnic categories of Hispanic or Latino, not Hispanic, or unknown/declined.	VSSC Patients Cube Pyramid
	# of registered Veterans in the pilot	IPVSV Power BI
	# of registered Veterans in the pilot by racial group	IPVSV Power BI
	# of registered Veterans in the pilot who identified as Hispanic or Latino, not Hispanic, or unknown/declined.	IPVSV Power BI
	% growth in engagement between FY 2022 and FY 2023 by racial group and across site	IPVSV Power BI
	# of Veterans in the pilot who identify as Native American and Alaska Native	IPVSV Power BI
	The specific Native American and Alaska Native Tribal Affiliations and Native Hawaiian/Other Pacific Islander groups	VACO consultation notes
	% of pilot group for ethnic groups	IPVSV Power BI
	Numbers of Hispanic or Latino Veterans in the pilot across FY 2022 and then FY 2023	IPVSV Power BI
	% of the pilot who identify as gender diverse	IPVSV Power BI
	% of Veterans in the pilot who live in urban, rural and highly rural locations	IPVSV Power BI
	Compare to demographics of full Veteran population	CUBE and Power BI
Demand		
	# of RHS screens	VSSC
	Growth in screening	VSSC
	Gender and Age demographics of the Veterans who completed screens	VSSC
	Percentage of Veterans in the pilot based on ICD-codes	VSSC
	Mortality data	Chart review

Area of Focus	Question	Data Source
	Number/% of Veterans who experienced multiple traumas	coded when a vet has a relevant HF in combination with a relevant ICD-10 code
Acceptability		
	SME feedback about the advisability of offering IPV and SA services	Surveys
	Leadership feedback about the advisability of offering IPV and SA services	Surveys
	Identified needs to further implement IPV and SA programming	Surveys
	VAC feedback	Focus group
Implementation		
	# and of external awareness activities	Qualtrics
	# of internal trainings	Qualtrics
	# of external trainings	Qualtrics
	Attendance at the activities	Qualtrics
	Veteran attendance at events/Geographic reach of the outreach	Qualtrics
	Focus of the training events	Qualtrics
	# of activities focusing on underserved populations	Qualtrics
	Types of external resources shared with Veterans	Qualtrics
	Types of internal resources shared with Veterans	Qualtrics
	Referrals to financial resources	Qualtrics
	Information on housing instability, including information from the 3 housing insecurity roundtable discussions	ICD-9 codes Notes from qualitative discussions
	Referrals to interventions, such as RISE, safety planning, PTSD treatment, etc.	Qualtrics
	Types of interventions offered	Qualtrics
	RISE program data	RISE provider survey
Practicality		
	Brochures distributed	Qualtrics
	Other feedback on social media and training tools	Questions to coordinators/Megabus

Area of Focus	Question	Data Source
		Leads
	Time spent in clinical activities	Qualtrics
	Barriers to implementation	Coordinator/lead and leadership feedback
Expansion		
	Courage program data	MIRREC report
	Healthy Relationship Behavior Workbook for Veterans feedback	MIRREC report
	Veteran focus group	Focus group results
	Feedback on SART teams	VACO consultation notes and face to face site field notes
Adaptation		
	SA Response Services projects	VACO consultation notes and face to face site field notes