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Medicaid Enrollees May Not Be Screened for Intimate Partner Violence Because of Challenges Reported by Primary Care Clinicians

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REPORT HIGHLIGHTS

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Why OIG Did This Review

- Intimate partner violence (IPV)—which includes physical, sexual, and psychological abuse perpetrated by a spouse or partner—is a significant health problem that affects millions of Americans.
- The U.S. Preventive Services Task Force (USPSTF) and the Women's Preventive Services Initiative (WPSI) recommend that clinicians screen certain women for IPV and provide, or refer those who screen positive to, support resources. The 41 States with Medicaid expansion programs must cover the IPV screening and referral services recommended by USPSTF and WPSI.
- This study analyzed survey responses from 1,186 primary care clinicians who served patients enrolled in Medicaid to identify clinicians' screening and referral practices and the challenges they face related to providing IPV screening and referral services, as well as incentives that could improve these practices. Our findings are based on completed surveys from 4 percent of the clinicians who met our inclusion criteria and cannot be generalized to all primary care clinicians who serve Medicaid enrollees.

What OIG Found

Responding primary care clinicians who serve Medicaid enrollees reported a range of challenges to IPV screening.

The most frequently reported challenge was time constraints. Other barriers include concerns about patient privacy and safety, and inadequate training.

Among primary care clinicians who screened patients for IPV, there are additional challenges that hindered their ability to make referrals.

These additional challenges included limitations with IPV support resources for patients who screen positive.

Conclusion

Despite the widespread impact of IPV, clinicians may face limitations in their ability to screen and refer their patients for this significant health risk. Primary care clinicians who responded to the survey reported that changes to how IPV screening and referral services are reimbursed; better resources to help patients; and additional training and guidance may increase the likelihood that IPV screening and referral services are delivered to Medicaid enrollees. The results of this evaluation highlight challenges that hinder some primary care clinicians' ability to perform IPV screening and make referrals as well as the incentives that may help them to overcome these challenges. Clinicians play a critical role in IPV screening and making referrals. Therefore, policymakers may consider the challenges and incentives the clinicians reported to OIG to plan steps so that primary care clinicians may more easily prioritize providing these critical services to their patients.

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BACKGROUND

OBJECTIVE

To identify challenges faced by primary care clinicians who serve patients enrolled in Medicaid related to providing intimate partner violence (IPV) screening and referral services, as well as incentives that could improve these practices.

IPV Is a Significant Public Health Problem

IPV—which includes physical, sexual, and psychological abuse perpetrated by a spouse or partner—is a serious, preventable public health problem that affects millions of Americans.[1, 2] In the U.S., 41 percent of women and 26 percent of men have experienced physical violence, sexual violence, and/or stalking by an intimate partner and reported an IPV-related impact during their lifetime.[3] In addition to injury and death, IPV can have long-term health consequences, including depression, post-traumatic stress disorder, and chronic medical conditions. IPV also is associated with increased risks of prenatal complications, as well as physical and mental health disorders for children exposed to it.

Clinical Recommendations for IPV Screening and Referral Services

Primary care clinicians play a critical role in screening patients for IPV and referring patients who screen positive for IPV to support resources.[4] They are well-positioned to identify IPV during a patient visit, either by asking relevant questions or identifying signs and symptoms of violence.[5] When patients screen positive for IPV, these clinicians also can connect patients to essential support resources.

The U.S. Preventive Services Task Force (USPSTF) and the Women's Preventive Services Initiative (WPSI) have clinical recommendations related to IPV screening and

[1] Centers for Disease Control and Prevention (CDC), *Fast Facts: Preventing Intimate Partner Violence*, https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Accessed on June 21, 2023.

[2] IPV also is referred to as relationship violence or domestic violence. It also can include stalking, reproductive coercion, isolation, and the threat of violence, abuse, or both.

[3] CDC, loc. cit.

[4] For this evaluation, we focused on primary care clincians who served adult patients, including general practitioners; family medicine physicians; internal medicine physicians; obstetrics and gynecology physicians; geriatric medicine physicians; preventive medicine physicians; and nurse practitioners.

[5] Peter F. Cronholm, et al., "Intimate Partner Violence," *American Family Physician*, Vol. 83(10), 2011.

referral services. USPSTF—an independent panel of experts in prevention and evidence-based medicine—has a Grade B recommendation that clinicians should screen women of reproductive age for IPV and provide, or refer women who screen positive to, ongoing support resources.[6] A USPSTF Grade B recommendation means there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.[7] In addition, WPSI—a national coalition of professional organizations and patient representatives—recommends that clinicians screen adolescents and all women (regardless of age) for IPV at least annually and, when needed, provide or refer patients to initial intervention services.[8] This recommendation is part of a set of guidelines for clinicians that WPSI established "to complement, build upon, and fill gaps" in existing national and Federal guidelines for preventive health services.

USPSTF Recommendation
Clinicians should screen women of reproductive age for IPV and provide or refer women who screen positive to ongoing support resources.

WPSI Recommendation
Clinicians should screen adolescents and all women for IPV at least annually and, when needed, provide or refer patients to initial interventions.

Medicaid Coverage of IPV Screening and Referral Services

The 41 States (including Washington, D.C.) with Medicaid expansion programs must cover certain preventive health services, without any patient cost-sharing.[9] These covered preventive health services must include the IPV screening and referral services recommended by USPSTF and WPSI. States with traditional Medicaid programs are not required to cover IPV screening and referral services. However, all States may receive a 1 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid expenditures on preventive services with an USPSTF Grade A and Grade B recommendation—provided that the State Medicaid program covers these services for enrollees without cost-sharing.[10]

[6] USPSTF, *Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening*, October 2018, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening. Accessed on June 22, 2023.

[7] USPSTF, *Understanding How the U.S. Preventive Services Task Force Works*, February 2023, https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/inline-files/understanding-how%20the%20tf-works-2022-update_2.pdf. Accessed on June 21, 2023.

[8] WPSI, *Interpersonal and Domestic Violence*, https://www.womenspreventivehealth.org/recommendations/interpersonal-and-domestic-violence/. Accessed on June 21, 2023.

[9] Section 2713 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010). Beneficiaries who are eligible for Medicaid under a State's Medicaid expansion program must enroll in an Alternative Benefit Plan (42 C.F.R. § 440.305(b)), which includes coverage for certain preventive care services as required under section 2713 of the Public Health Service Act (42 C.F.R. § 440.347(a)(9); 45 C.F.R. § 156.115(a)(4); 45 C.F.R. § 147.130(a)(1)).

[10] Section 4106 of the Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010).

Billing for IPV screening and referral services. When IPV screening and referral services are covered by Medicaid, there are no national, uniform procedure codes for clinicians to use that specifically identify that IPV screening and/or referral services were provided.[11] Instead, WPSI advises clinicians to use procedure codes for general preventive screening; brief counseling; or the appropriate evaluation and management service to receive reimbursement for IPV screening and referral services.[12] The lack of specific procedure codes for IPV screening and/or referral services impedes the implementation of clinical quality measures aimed at improving clinicians' delivery of IPV-related services.[13] Notably, there are national, uniform procedure codes that clinicians can use to specifically bill for other preventive screening services covered by Medicaid, such as screening for depression.

How Primary Care Clinicians Can Screen for IPV

Clinicians can use a variety of approaches to screen patients for IPV, ranging from self-administered questionnaire-style assessment tools to informal conversations during an annual wellness visit. For example, some clinicians may ask all patients to complete a pre-visit intake form with IPV-related questions. Depending on how the patient responds to the intake questions, the clinician then may ask further screening questions during the visit. Other clinicians may use questions embedded in their electronic health record (EHR) system and may be prompted by this system to ask questions during the visit. Some clinicians may ask their patients a single general safety question (e.g., "Do you feel safe at home?").

How Primary Care Clinicians Can Make Referrals to IPV Support Resources

How a clinician refers patients who screen positive to IPV support resources can vary depending on the resources available. For example, clinicians can provide patients with contact information for IPV support resources (e.g., telephone numbers for a hotline or local IPV agencies); offer patients the use of a phone to call a resource; call a resource together with the patient; directly connect the patient with a trained professional in the moment who is either onsite or remote (this is sometimes referred to as a "warm referral"); or offer the patient a followup visit. A Federally funded IPV support resource is the National Domestic Violence Hotline, which is a free helpline

[11] In this report, the term "national, uniform procedure codes" refers to Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) Level II codes. It does not include procedure codes created by States for their specific Medicaid programs.

[12] WPSI, *Women's Preventive Services Initiative (WPSI) 2023-2024 Coding Guide*, https://www.womenspreventivehealth.org/wp-content/uploads/WPSI_CodingGuide_2023-2024-FINAL.pdf. Accessed on February 26, 2024.

[13] According to CMS staff, when there is a lack of a specific procedure code to bill for a service, then programs reporting to CMS have to submit information from other sources (such as medical record reviews or electronic health records). This results in fewer States reporting information to CMS. With fewer States responding, the ability to calculate a measure is compromised.

funded by the Administration on Children, Youth and Families that provides callers with safety-planning services and connections to local support resources.

Related OIG Work

A 2022 OIG report focused on the special challenges that the COVID-19 pandemic posed for the National Domestic Violence Hotline, which included difficulties connecting callers to resources that were operating at a limited capacity.[14] OIG has not performed an overall assessment of the National Domestic Violence Hotline and its effectiveness as an IPV support resource.

Methodology

We surveyed primary care clinicians who served adult patients (18 years or older) enrolled in Medicaid in 2021. From January to February 2023, we sent an online, anonymous survey to 27,738 clinicians who met our inclusion criteria and received completed surveys from 1,186 of these clinicians (4 percent). The Detailed Methodology provides a description of the data sources and criteria we used to identify clinicians. Our survey was voluntary, and respondents were not compensated for their time.

On the survey, we defined an "IPV screening" as the clinician, or a member of their staff, asking questions about IPV or personal safety as part of routine preventive screening practices. These questions could be asked verbally or in writing (e.g., on an intake form or on an electronic device) during a pre-visit check-in or pre-visit screening, or during the visit. We defined "referring a patient to IPV support resources" as the clinician, or a member of their staff, directly promoting a patient's contact with or knowledge of a support resource related to IPV, personal safety, or social services when that patient has disclosed or screened positive for IPV. The survey contained closed-ended (i.e., multiple choice) questions about the challenges that hinder clinicians' ability to provide IPV screening and referral services and changes that would incentivize clinicians to increase these practices. The survey also contained questions about clinicians' IPV screening and referral practices and their locations. In addition, we completed 26 followup interviews with survey respondents who provided their contact information and indicated that they were willing to participate in an interview. The Detailed Methodology provides a description of our analysis of survey and interview responses.

Limitations

We collected self-reported data from primary care clinicians and did not independently verify the accuracy of clinicians' survey responses. Clinicians were able to select multiple response choices for the challenge and incentive questions but did not have the option to write in responses or provide further details about their

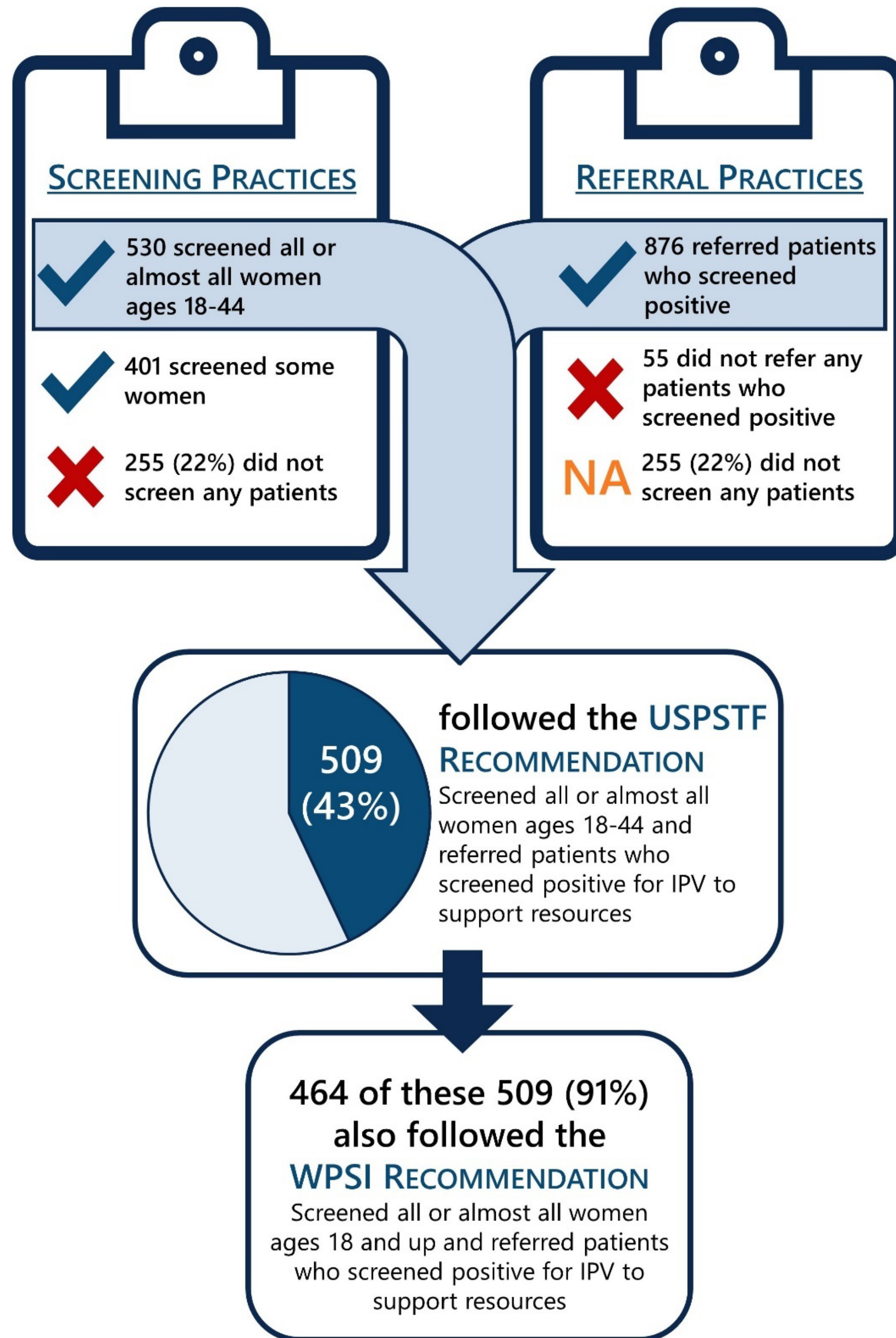
[14] OIG, *National Snapshot of Trends in the National Domestic Violence Hotline's Contact Data Before and During the COVID-19 Pandemic* (A-09-21-06000) April 27, 2022.

response choices. In addition, our findings are based on completed surveys from 1,186 clinicians who serve Medicaid enrollees and cannot be generalized to all clinicians who serve Medicaid enrollees due to our survey's low response rate. In addition, because our survey was voluntary and clinicians were not compensated for their time completing it, there is potential for response bias such that clinicians with an interest in IPV screening (who may be more inclined to screen their patients in alignment with USPSTF and WPSI clinical recommendations) may have been more likely to respond to our survey.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

IPV SCREENING AND REFERRAL PRACTICES OF THE 1,186 PRIMARY CARE CLINICIANS WHO COMPLETED THE OIG SURVEY



Source: OIG analysis of 1,186 primary care clinicians' responses to IPV survey administered from January to February 2023. Questions regarding referral practices were asked only of the 931 respondents who indicated that they screened patients for IPV.

How Clinicians Screened

72% screened patients themselves

37% reported that their staff screened patients

24% reported that patients self-screened

90% reported that they ensure patients are alone when they screen

Source: OIG analysis of responses from 931 primary care clinicians who completed the OIG survey and indicated that they screen patients for IPV. Respondents could select more than one screening method.

How Clinicians Made Referrals

81% offered followup visits with patients to further discuss IPV

77% referred to local IPV hotlines or other hotlines

75% referred to IPV-specific social service organizations or shelters

75% referred to social service organizations or shelters (i.e., not IPV specific)

62% referred to the National Domestic Violence Hotline

53% referred to a remote or onsite trained professional to evaluate, assist, or further refer patients

39% referred to legal aid

Source: OIG analysis of responses from 876 primary care clinicians who completed the OIG survey and indicated that they screened patients for IPV and referred those with a positive screen to support services. Respondents could select more than one referral method.

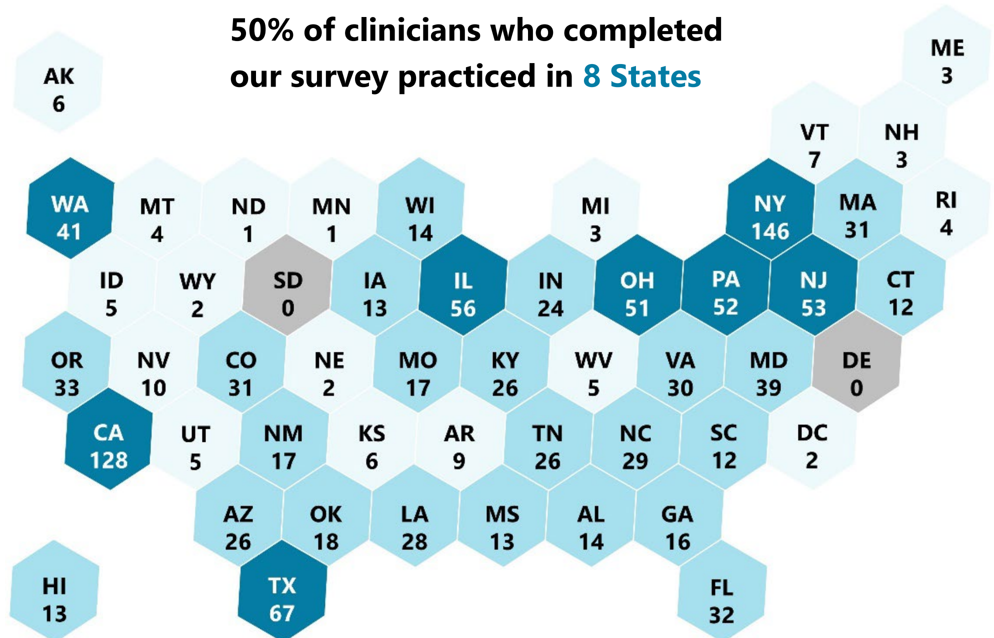
Where Clinicians Practiced

42% practiced in urban locations

33% practiced in suburban locations

25% practiced in rural locations

50% of clinicians who completed our survey practiced in 8 States



Source: OIG analysis of 1,186 primary care clinicians' responses to IPV survey administered from January to February 2023.

FINDINGS

Primary care clinicians who serve Medicaid enrollees reported a range of challenges to IPV screening—most frequently reporting time constraints

"[W]e screen for alcohol and depression at annual visits. There's a new recommendation we should be screening for anxiety. There's IPV. ***There's just too many competing things."***
– Primary care clinician

Of the 1,186 clinicians who completed our survey, 692 (58 percent) indicated that time constraints (i.e., insufficient time or too many competing priorities) during patient visits hindered their ability to screen for IPV. Time constraints were clinicians' most frequently cited challenge regardless of whether their IPV screening practices followed the USPSTF clinical recommendation.

Among the 26 clinicians we spoke to during followup interviews, many described having a very short amount of time—sometimes as short as 15 minutes—to complete a patient visit. In addition to addressing patient health concerns, clinicians must complete certain health screenings during a patient visit, which leaves little to no time to screen for IPV. Some clinicians also raised the concern that the short timeframe of a visit does not allow for building rapport with a patient, which they believe could impact whether a patient feels comfortable discussing or disclosing IPV.

According to clinicians who were challenged by time constraints, changes to how IPV screenings are reimbursed would increase screening practices

"...[I]t's not a coincidence the screen[ings] we do are definitely reimbursed*—the depression and alcohol screenings."*
– Primary care clinician

Most of the clinicians who identified time constraints as a challenge to IPV screening reported that changes related to the way IPV screenings are reimbursed would increase their likelihood of performing these screenings. Specifically, among the 692 clinicians who reported time constraints as a challenge, 502 (73 percent) reported that at least 1 of the following incentives would increase their likelihood to screen:

- increased reimbursement for time spent screening for IPV,
- creation of procedure codes to bill specifically for time spent screening for IPV, and
- implementation of clinical quality measures to provide incentive payments for routinely screening patients for IPV.

"You're challenged by how much time you have in the visit. *You have 15-30 minutes [so] you cover as much as [you] can....* ***I'm in there 30 minutes, and I'm getting paid $17 [for that visit] so it's hard to financially survive and get done what we need."***
– Primary care clinician

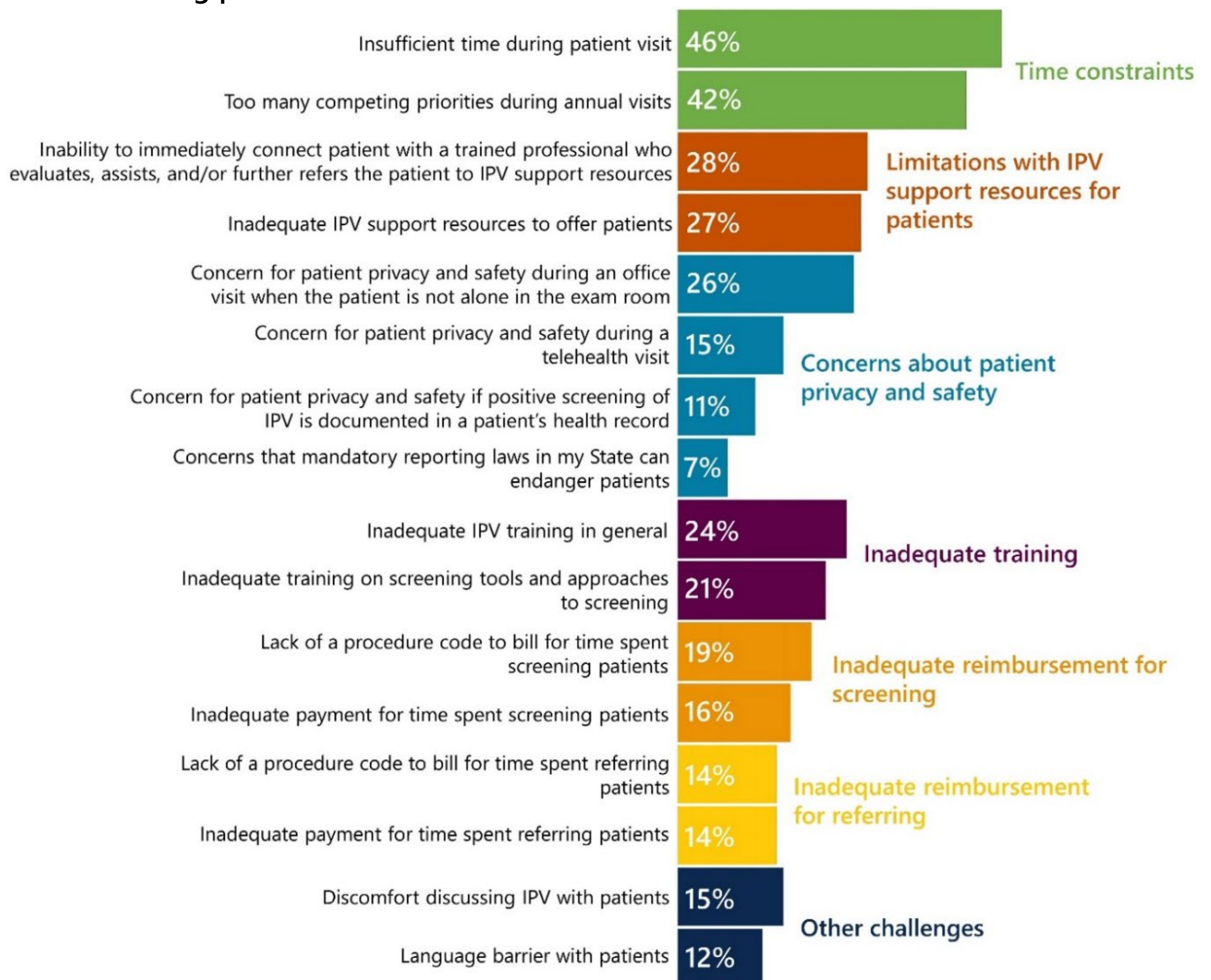
Some clinicians we spoke with stated that receiving reimbursement specifically for IPV screening would justify their decision to use valuable time during a patient visit to screen for IPV. One clinician indicated that certain screenings—such as screenings for depression and alcohol—are prioritized above IPV screening because clinicians

receive reimbursement for administering them. Another clinician noted that a procedure code associated with IPV screening would enable clinicians to allocate time to determine whether a patient has experienced IPV. Appendix A shows the percentage of clinicians who reported that each incentive would increase their likelihood of performing IPV screenings.

Primary care clinicians also reported a range of other challenges to IPV screening

In addition to time constraints, clinicians reported a range of other challenges that hindered their IPV screening practices, including limitations with IPV support resources for patients who screen positive; concerns about patient privacy and safety; and inadequate training, as shown in Exhibit 1.

Exhibit 1: Primary care clinicians reported a range of challenges that hindered their IPV screening practices



Source: OIG analysis of 1,186 primary care clinicians' responses to IPV survey administered from January to February 2023. Clinicians could select more than one screening challenge.

Clinicians reported that limitations with IPV support resources for patients who screen positive hindered their IPV screening practices. Among the 1,186 clinicians who completed our survey, 434 (37 percent) reported they are hindered in their screening practices by at least 1 of 2 challenges related to limitations with IPV support resources for patients who screen positive. Some clinicians we interviewed noted that their inability to aid and effectively deliver help to a patient who screened positive for IPV discouraged them from performing screenings.

"The knowledge that if I screen, I can't do anything about IPV—most of the time makes screening a daunting task."
– Primary care clinician

Many of the 434 clinicians who reported limitations with IPV support resources as a screening challenge also highlighted screening incentives related to (1) having access to better or more immediate IPV support resources and/or (2) enhancements to their EHR systems. For example, 78 percent (340 of 434) of these clinicians indicated that having immediate access to a trained professional—either onsite or by phone or telehealth—who could evaluate, assist, and further refer patients who screen positive for IPV (in what is sometimes referred to as a "warm referral")[15] would increase their likelihood of performing IPV screening. As another example, 69 percent (301 of 434) of clinicians who reported limitations with IPV support resources as a screening challenge indicated that embedding screening and best practice alerts and/or contact information of IPV support resources into their EHR system would increase their likelihood of performing IPV screening.

A third of clinicians reported that a challenge related to patient safety and privacy hindered their IPV screening practices. Of the 1,186 clinicians who completed our survey, 407 (34 percent) indicated that at least 1 challenge related to patient safety and privacy hindered their ability to screen for IPV. One clinician we interviewed noted that patients may not be able to answer questions honestly with others—such as potential abusers—present at the appointment. Other clinicians discussed the discomfort and fear that patients experience from a lack of privacy during the visit. Among the 407 clinicians who reported challenges related to patient safety and privacy, 30 percent reported that better privacy protections within EHR systems would increase their likelihood to screen.

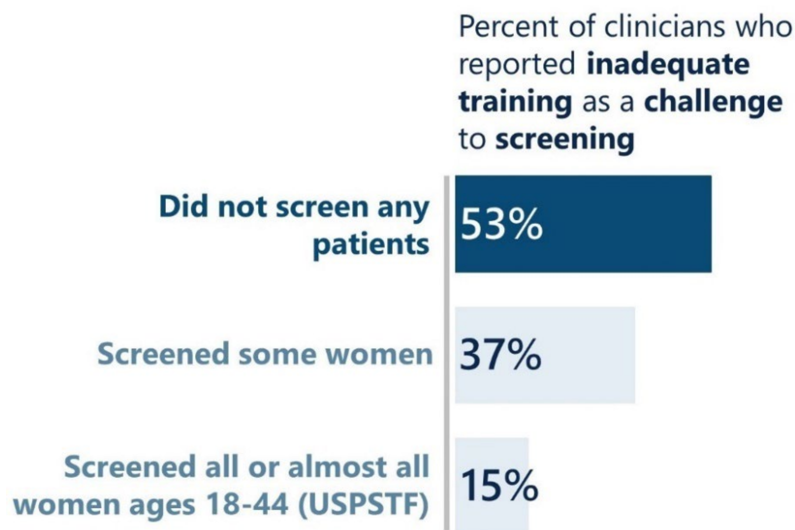
"We had several classes about care of vulnerable populations. ***But [training on how to screen patients for IPV] was all just rolled in.*** *There was no, 'Okay, we're spending half of today on IPV screening.'* ***It was all just rolled in."***
– Primary care clinician

Clinicians who never screened patients for IPV reported inadequate training as a challenge more frequently than clinicians who did screen. Overall, 30 percent (361 of 1,186) of the clinicians who completed our survey indicated that inadequate training—on IPV-specific screening tools/methods and/or on IPV in general—was a challenge to screening patients for IPV. However,

[15] From our interviews with clinicians, we understand that this kind of "warm referral," even when accessed by phone or telehealth, is different from accessing staff of an external hotline. Rather, it would be with a trained professional who is directly connected to or within the practice. For instance, clinicians could hand off their patient to a nurse in the practice who takes the lead on making referrals to IPV support resources.

compared to clinicians whose screening practices followed the USPSTF clinical recommendation, clinicians who did not screen any patients for IPV more frequently reported inadequate training as a challenge, as shown in Exhibit 2. During followup interviews, some clinicians discussed the lack of IPV-specific training in their careers. Commonly, these clinicians explained that they had not received any IPV-specific training in the recent past, if at all. Some clinicians remarked that the topic of IPV may have come up during their medical school training, but that coverage of the topic was minimal.

Exhibit 2: Inadequate training was more often reported as a challenge to IPV screening among primary care clinicians who never screened



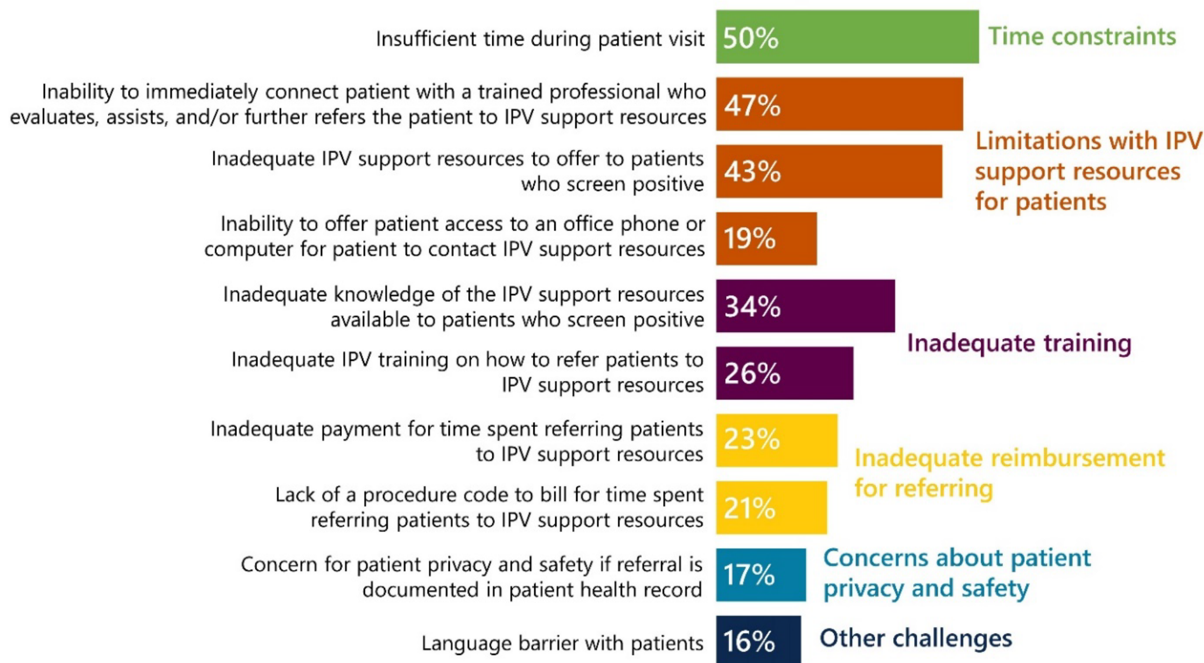
Source: OIG analysis of 1,186 primary care clinicians' responses to IPV survey administered from January to February 2023.

Notably, among the 361 clinicians who reported that inadequate training was a challenge to screening patients for IPV, 79 percent reported that guidance on effective IPV screening tools/approaches, guidance on appropriate IPV support resources for patients who screen positive, or increased opportunities for IPV-related training would increase their likelihood to screen.

Among primary care clinicians who screened patients for IPV, most reported at least one challenge that hindered their ability to make referrals

Of the 931 clinicians who indicated that they screened patients for IPV, 792 (85 percent) reported that at least 1 challenge hindered their ability to refer patients who screened positive to IPV support resources. The referral challenges that these clinicians cited spanned a wide range of issues, as shown in Exhibit 3.

Exhibit 3: Primary care clinicians reported a range of challenges that hindered their IPV referral practices



Source: OIG analysis of 931 primary care clinicians' responses to IPV survey administered from January to February 2023. Questions regarding referral challenges were asked only of respondents who indicated that they screened for IPV. Clinicians could select more than one referral challenge.

Half of all clinicians who screened for IPV cited insufficient time as a challenge to making referrals. During followup interviews, some clinicians expressed that the time needed to obtain necessary information and determine a course of action for making referrals exceeds the limited amount of time available for a patient visit. According to one clinician, *"One of the things that happens when someone screens in as having high needs [...] that visit balloons into a two-hour visit. That's appropriate, but the clinic is not set up for that."* Among the 468 clinicians who cited time constraints as a referral challenge, 331 (71 percent) reported that compensation-related incentives—including creation of procedure codes to bill for time spent referring, increased reimbursement for time spent referring, or implementation of clinical quality measures to provide incentive payments for referring—would increase their likelihood to refer patients to IPV support resources. Appendix B shows the percentage of clinicians who reported that each incentive would increase their likelihood of making referrals.

*"If someone can't get to them [immediately], that time will pass....**It's that golden hour. Someone needs to be able to contact them and make a plan** that they agree is safe."*
– Primary care clinician

If a person is ready and able to seek help—including planning to leave an abuser—that opportunity may be lost if IPV support resources are not immediately available. Clinicians frequently reported challenges to making referrals that are related to limitations with IPV support resources for patients who screen positive. Some

clinicians we interviewed described areas with few available resources. For example, one clinician who works in a city of more than 60,000 people remarked that there is no shelter for people experiencing IPV. Among the 931 clinicians who screened patients for IPV, 690 (74 percent) reported that incentives related to better or more immediate IPV support resources would increase their likelihood of making referrals. Specifically, these incentives included:

- having IPV support resources that better meet the needs of patients who screen positive;
- availability of an office phone or computer for patients to contact an IPV support resource; and
- having immediate access (onsite and/or by phone/telehealth) to a trained professional to evaluate, assist, and/or further refer patients for support resources (in what is sometimes referred to as a "warm referral").[16]

Clinicians also reported that enhancements to their EHR systems would increase their likelihood of making referrals. Of the 550 clinicians who reported that their referral practices were hindered by limitations with IPV support resources, 63 percent indicated that their referral practices would increase if contact information for IPV support resources were embedded in their EHR systems. Furthermore, while just 161 clinicians indicated that concerns for patient safety and privacy hindered their referral practices, the majority (64 percent) of these clinicians stated that their referral practices would increase if they had the ability to mask a referral to IPV support resources in the patient's EHR (e.g., documenting a referral so that it's not apparent it's for IPV support resources).

[16] As noted above, we understand from our interviews with clinicians that this immediate access to a trained professional, even when accessed by phone or telehealth, is different from accessing staff of an external hotline. This trained professional would be someone directly connected to or within the practice.

CONCLUSION

IPV is a significant public health problem. Forty-one percent of women in the U.S. have experienced physical violence, sexual violence, and/or stalking by an intimate partner and reported an IPV-related impact during their lifetime. These impacts include death, injury, long-term health consequences, prenatal complications, the need for help from law enforcement, and missed workdays. Beginning in January 2013, the USPSTF has recommended that clinicians conduct preventive screenings of women of reproductive age for IPV and provide, or refer women who screen positive to, support resources. Meanwhile, a body of academic research has sought to identify barriers that clinicians encounter while attempting to provide IPV screening and referral services.[17] More recently, the COVID-19 pandemic shone a bright light on this issue as fears of a surge in IPV accompanied stay-at-home orders.

Despite the widespread impact of IPV, clinicians may be limited in their ability to screen and refer their patients for this significant health risk. While the primary care clinicians who responded to OIG's survey represent a small fraction of those we contacted, their decision to respond voluntarily on this topic suggests they may be a group that is engaged with the issue of IPV. Yet, these clinicians frequently reported challenges to screening and referring their patients, including challenges related to time and limitations with IPV support resources. Additionally, less than half of them followed the USPSTF's recommendation.

The clinicians who responded to our survey provided insights into incentives that may increase their likelihood of performing IPV screenings and referrals. Many clinicians reported that changes to how screening and referral services are compensated would increase their likelihood of screening (Appendix A). Changes to compensation that clinicians identified as likely incentives included increased reimbursement amounts for time spent screening for IPV. Clinicians also reported that improvements to the accessibility and quality of IPV support resources would increase their likelihood of referring patients to IPV support services (Appendix B). Among other improvements, clinicians reported that access to trained professionals who help coordinate support services for patients who screen positive for IPV could increase IPV screening and referrals. These trained professionals would be accessible by phone or telehealth to evaluate, assist, and further refer any patient who screens positive for IPV. Finally, our findings indicate that (1) issuing guidance to clinicians on effective IPV screening tools and approaches and/or (2) increased opportunities for IPV-related training could

[17] Lisa Colarossi, et al., "Barriers to Screening for Intimate Partner Violence: A Mixed-Methods Study of Providers in Family Planning Clinics," *Perspectives on Sexual and Reproductive Health*, Vol. 42(4), 2010, pp. 236-243; Shelia Sprague, et al., "Barriers to Screening for Intimate Partner Violence," *Women & Health*, Vol. 52, 2012, pp. 587-605; Karin Rhodes, et al., "Challenges and Opportunities for Studying Routine Screening for Abuse," *JAMA*, Vol. 320(16), 2018, pp. 1645-1647; Susan Levine, et al., "Health Care Industry Insights: Why the Use of Preventive Services Is Still Low," *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, Vol. 16, 2019, pp.1-6.

increase the likelihood that clinicians screen for IPV—particularly clinicians who did not screen any patients.

OIG conducted this evaluation to spotlight the challenges that hinder primary care clinicians' ability to perform IPV screenings and make referrals, as well as the incentives that may help to overcome these challenges. Because these clinicians play a critical role in IPV screening and making referrals to IPV support resources, we urge policymakers to consider the challenges and incentives the clinicians reported to OIG and plan steps to position all primary care clinicians to more easily prioritize providing these critical services to their patients.

DETAILED METHODOLOGY

Data Sources and Criteria Used to Identify Survey Respondents

From January to February 2023, we sent surveys to 27,738 primary care clinicians who met our inclusion criteria, which included having a National Provider Identifier (NPI) that:

- was designated as an individual (and not an organization) in the Provider Enrollment, Chain, and Ownership System (PECOS) or the National Plan and Provider Enumeration System (NPPES);
- had a specialty code in PECOS indicating primary care[18] and/or had a taxonomy code in NPPES indicating primary care;[19, 20]
- had at least one unique and deliverable email address listed in PECOS or NPPES;[21] and
- appeared as the servicing provider NPI (or, if the servicing provider NPI was missing, appeared as the billing provider NPI) on a Medicaid fee-for-service claim or managed care encounter record extracted from the Transformed Medicaid Statistical Information System (T-MSIS) in September 2022 that met the following parameters:
    - it was submitted by a State or the District of Columbia (we did not include claims and/or encounter records submitted by U.S. territories);
    - it was an outpatient, non-denied, non-voided, final action claim or encounter record with a date of service in calendar year 2021;
    - it was a claim or encounter record for service rendered to an adult enrollee (i.e., with a date of birth before January 1, 2004); and

[18] If the NPI had an active primary specialty code in PECOS, we ensured it was for one of the following specialties: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Geriatric Medicine, Nurse Practitioner, or Preventive Medicine. If the NPI did not have an active primary specialty code in PECOS, then we ensured it had an active specialty code for at least one of those specialties and no other active specialty codes besides those specialties.

[19] We ensured that the NPI had any one of the following taxonomy code values or any combination of these values (and no other values): 208D00000X, 207Q00000X, 207QA0000X, 207QA0505X, 207QG0300X, 207R00000X, 207RA0000X, 207RG0300X, 207V00000X, 207VG0400X, 207VM0101X, 207VX0000X, 2083P0901X, 363L00000X, 363LA2200X, 363LC1500X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP1700X, 363LP2300X, and 363LW0102X.

[20] If an NPI appeared in both PECOS and NPPES, we ensured that it had both a specialty code(s) in PECOS indicating primary care and a taxonomy code(s) in NPPES indicating primary care. If an NPI only appeared in NPPES, then we ensured it had a taxonomy code in NPPES indicating primary care.

[21] In addition, we did not include email addresses that did not contain an "@" symbol and a period.

- it had an evaluation and management (E&M) services procedure code that described a routine preventive care visit.[22]

Data Analysis

We analyzed survey responses from 1,186 clinicians who completed[23] the online survey and confirmed in their survey responses that they are practicing primary care clinicians. Questions regarding referral practices, referral methods, challenges that hinder referrals, and the incentives that could increase the likelihood of performing referral services were asked only of the 931 respondents who indicated that they screened for IPV. In addition, we summarized responses from 26 followup interviews with respondents.[24]

IPV Screening and Referral Practices

We designated clinicians as having practices that followed the USPSTF recommendation if they indicated that they screened all or almost all adult female patients between ages 18 and 44 and indicated that they referred any patients who screened positive for IPV to support resources. We designated clinicians as having practices that followed the WPSI recommendation if they indicated that they screened all or almost all adult female patients (regardless of age) and indicated that they referred any patients who screened positive for IPV to support resources.[25] We also summarized the percentage of clinicians who used certain screening methods and referral sources.[26] Finally, to identify where clinicians practiced, we summarized responses related to the location of the majority of their practice.

Challenges and Incentives for Improving IPV Screening and Referral Practices

We summarized clinicians' survey responses to questions regarding (1) the challenges that hinder their ability to screen patients for IPV and make referrals for patients who screen positive and (2) the incentives that would increase their likelihood of providing

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[22] Specifically, we identified service lines containing the following E&M procedure codes: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99415, 99416, 99417, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99441, 99442, 99443, 99497, 99498, and 99499. **The five-character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FAR/DFARS apply.**

[23] For a survey to be considered "completed," a clinician had to disclose their IPV screening and referral practices.

[24] We completed followup interviews with 26 of the 198 survey respondents who provided their contact information and indicated that they were willing to participate in an interview.

[25] The WPSI recommendation states that clinicians should refer patients "when needed." We determined that a clinician followed this recommendation if they reported that they referred any patient who screened positive for IPV.

[26] Clinicians could select more than one screening and referral method on the survey.

these services. For both screening and referral services, we determined the challenges and incentives that clinicians most frequently reported. We used this analysis to develop questions for our followup interviews that focused on obtaining additional details about the challenges and incentives that clinicians frequently reported.

APPENDICES

Appendix A: Percentage of Primary Care Clinician Respondents Who Reported Incentives That Would Increase Likelihood of Screening for IPV

Screening Incentive	Percentage of Clinician Respondents
Incentives Related to Compensation for Screening Services	
Creation of procedure codes to bill specifically for time spent screening patients for IPV	45%
Increased reimbursement for time spent screening patients for IPV	40%
Implementation of clinical quality measures to provide incentive payments for routinely screening patients for IPV	33%
Incentives Related to Compensation for Referral Services	
Creation of procedure codes to bill specifically for time spent referring patients who screen positive to IPV support resources	31%
Increased reimbursement for time spent referring patients who screen positive to IPV support resources	30%
Incentives Related to Better or More Immediate Access to IPV Support Resources	
Immediate access, either by phone or telehealth, to a trained professional who evaluates, assists, and/or further refers the patient to IPV support resources	40%
IPV support resources that better meet the needs of patients who screen positive for IPV	36%
Immediate access to an onsite trained professional who evaluates, assists, and/or further refers the patient to IPV support resources	31%
Incentives Related to Training or Guidance	
Guidance on effective IPV screening tools and approaches to screening	33%
Guidance on appropriate IPV support resources for referring patients who screen positive	32%
Increased opportunities for IPV-related training	27%
Incentives Related to Enhancing Electronic Health Record Systems	
IPV screening and best practice alerts embedded in my practice's EHR system(s)	40%
Contact information of IPV support resources for referring patients embedded in my practice's EHR system(s)	34%
Better patient privacy protections in EHR systems	14%

Source: OIG analysis of 1,186 clinicians' responses to IPV survey administered from January to February 2023. Clinicians could select more than one screening incentive.

Appendix B: Percentage of Primary Care Clinician Respondents Who Reported Incentives That Would Increase Likelihood of Making Referrals to IPV Support Resources

Referral Incentive	Percentage of Clinician Respondents
Incentives Related to Better or More Immediate Access to IPV Support Resources	
Immediate access, either by phone or telehealth, to a trained professional who evaluates, assists, and/or further refers the patient to IPV support resources	54%
IPV support resources that better meet the needs of patients who screen positive for IPV	52%
Immediate access to an onsite trained professional who evaluates, assists, and/or further refers the patient to IPV support resources	41%
Availability of office phone or computer for patients to contact an IPV support resource	20%
Incentives Related to Training or Guidance	
Guidance on appropriate IPV support resources for referring patients who screen positive	44%
Increased opportunities for free IPV-related training	32%
Increased opportunities for paid IPV-related training	22%
Incentives Related to Compensation for Referrals Services	
Creation of procedure codes to bill specifically for time spent referring patients who screen positive to IPV support resources	40%
Increased reimbursement for time spent referring patients who screen positive to IPV support resources	39%
Implementation of clinical quality measures to provide incentive payments for referring patients who screen positive for IPV to support resources	32%
Incentives Related to Enhancing Electronic Health Record Systems	
Contact information of IPV support resources for referring patients embedded in my practice's EHR system(s)	50%
Ability to mask a referral to IPV support resources documented in a patient's EHR to protect patient privacy and safety	32%

Source: OIG analysis of 931 primary care clinicians' responses to IPV survey administered from January to February 2023. Questions regarding referral incentives were asked only of respondents who indicated that they screened for IPV. Clinicians could select more than one referral incentive.

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