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Session:  Prevalence, Implications and Efforts to Address Stranger harassment on VA Grounds

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Molly: And as we are at the top of the hour now I would like to introduce our speakers. Speaking first we have Dr. Becky Yano, she is the director of the VA HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy, and also an Adjunct Professor of Health Policy & Management at the UCLA Fielding School of Public Health. Joining her today is Dr. Ruth Klap, Program Manager for VA Women’s Health Research Consortium of the Greater Los Angeles Health Care System at the West Los Angeles Medical Center campus. So I’d like to thank our presenters for joining us today, and at this time, Dr. Yano, I’m turning it over to you.

Dr. Elizabeth (Becky) Yano: Thank you so much. Today we have the pleasure of talking to you about a difficult subject and one that has had very limited research to-date. And so we’ll be talking today about the prevalence, implications, and efforts to address stranger harassment on VA grounds.

First, I want to acknowledge and provide disclosures, this work was funded by VA HSR&D Service, under the Women Veterans’ Healthcare CREATE Initiative, with follow-up evaluation and expert panels supported by VA Women’s Health Services. This has also been supported by and presented to the national End Harassment workgroup, which is supported by the Undersecretary for Health and a wide array of VA program offices. And the views expressed here do not necessarily reflect the position or policy of the VA or the U.S. Government.

So for the overview of today’s talk, I’ll be talking about the prevalence of stranger harassment of women Veterans on VA grounds, based on a population-based random sample of routine users at VA primary care, and discussing some of the implications of exposure to harassment on VA grounds. And then Dr. Klap will be talking about efforts to better understand and address stranger harassment through focus groups and key stakeholder interviews.

Just by way of background it’s important to remember in terms of women in the military, that they represent 15% of active duty and 20%, or more now, of new recruits. And there has been a longstanding equalization of the hardships and risks of military service, with 71% having 1 or more combat exposures, even before the changes in the law and regulation around allowing women to be in combat roles. There is also a much greater risk of military sexual harassment and assault for women compared to men, with estimates ranging from 15 to 32% of women in the military. When it comes to women Veterans in the VA, women Veterans continue to be the fastest growing segment of new users of the VA Health Care System, with over half of women Veterans coming back from Iraq and Afghanistan having enrolled in VA care. The VA numbers, absolute numbers have also doubled in the past decade with an expectation of 10% of the user population being women by 2018. This is changing the face of VA care. At the same time, their numerical minority has also challenged the VA with historical gaps in safety and privacy for women, with VA providers with little or no exposure to women as patients, and a greater mental health burden that women Veterans who use the VA have, compared to male Veterans.

The VA has thought to keep pace with these changes in new realities. Military sexual trauma screening is universal in the VA and there is an MST coordinator at every VA Medical Center. There are also regional MST support teams that support VA facilities in this area. VA is also focused on comprehensive one-stop shopping primary care models for women that integrate gender specific and mental health care in the same setting. And also, there’s been a VA handbook and policy regarding designated women’s health providers and to ensure that all women’s care is delivered in safe, secure health care environments, with an eye to privacy and dignity.

There are concerns nonetheless, and some anecdote that military culture tolerating harassment may linger in the VA. So our objectives in this work were to examine the extent to which women Veterans experience negative interactions with male Veterans on VA grounds, and to explore the types of incidents that have been reported, and to analyze the characteristics associated with such experiences.

So as I mentioned earlier, this is part of a baseline patient survey in a 12 VA cluster randomized trial. We randomly sampled women Veterans with 3 or more VA primary care and or women’s health clinic visits in the prior year, in the VA that means they’re basically routine primary care users, we used computer assisted telephone interviewing with trained interviewers through a non-VA survey research firm, and the field period for these particular data are between January and March 2015. We now have data from 2016 and 2017 as well. The response rate was 47% for a sample size of 1395. Now the main variable for this particular analysis was the following: in the last 12 months have you experience inappropriate or unwanted comments or behavior towards you from male Veterans at your VA? With the response options being always, often, sometimes, or never, which we dichotomized to always/sometimes versus never. The text responses from the open-ended questions included: to help us understand your experiences, please briefly describe or give an example of when you experienced unwanted comments or behavior from male Veterans at the VA. We then included other variables in our analyses including demographic and health characteristics, history of combat exposure and trauma, results of screeners for posttraumatic stress disorder, military sexual trauma, anxiety, depression, preferences for care, and the extent to which women Veterans reported the harassment experiences to anyone at the VA.

We adjusted our results for the sample design and nonresponse using sample frame demographics to get to the population of routine primary care users among women Veterans seen in the VA. Our quantitative analyses basically examined bivariate relationships using chi-square tests, and then multiple logistic regression to adjust for our other covariates. We then did an open-ended analysis of the incident descriptions by using qualitative methods with independent thematic coding by two coders, with discussion to reach a consensus as well as comparison of themes to the existing literature on harassment, and then compiled frequencies of code occurrences.

The prevalence of negative interactions when visiting the VA in the past 12 months, oops, excuse me, I apologize that the part of this screen is not showing here, but it’s 24.4% of women Veterans report having 1 or more negative interactions with male Veterans when visiting the VA.

This variation was substantial across VA site. You can see across the 12 participating VA Medical Centers that were spanned 4 different VA networks and 9 states, that the prevalence ranged from 10% to 42% across these sites.

To give you an idea of the frequency of the mentioned behaviors as well as the nature of them, the most common were catcalls, flirting, or ‘you’re too pretty to be a Veteran’. You can see in blue here something we actually were not expecting, which was denigration of women Veteran status, you know, ‘you’re not a Veteran’, ‘you don’t belong at VA’. Others were propositions and sexual innuendos and reference to women’s body parts. Another 44 mentioned rude and derogatory and snide and slur comments. Some were nonverbal gestures and staring, as well as persistent unwanted requests and attention. Down to 14 women that described actual touching, groping, hugging, and kissing. Some angry and abusive reactions if the comments were not answered, some defensiveness as well as some following, cornering, and stalking. And a fraction that heard very significant resentful comments about women Veterans getting special treatment.

Just to give you an idea of some of the verbatim descriptions, ‘in the parking lot the catcalling starts right away, the women’s clinic is a long way and I am bombarded by sexual attention, it is very threatening.’ ‘Getting hit on when I’m there just to see a doctor, that’s not what I’m there for.’ ‘They try to get in my business and it gets old, it’s unwanted.’ ‘Other Veterans tend to express disbelief that I am a Veteran, ask if I am sure, say too attractive to be a Marine, say why am I there since I didn’t see any action.’ And ‘they still think that they are still in the military and they can treat us that way. Being in the military service with men feels exactly like going to the VA with the other Veterans.’ And lastly, ‘I am getting verbally harassed 88 to 95% of the time, that’s one of the main reasons I don’t go to or like the VA. And they also tell female Veterans to go outside the VA.’ This last one is of particular importance also because in prior work, when you ask women Veterans about their decisions to use or not use the VA, many of them rely on their social networks with other female Veterans. We also asked whether or not they reported the harassment to someone at the VA and as you can see over half did not report to anyone. And those that did were more likely to report to VA staff than they were to VA providers.

When we examined the independent factors and the odds of experiencing harassment, based on demographic and health factors, what we see is that those women who were 65 and older were less likely to be harassed. Those with a college degree had 2 times the odds of being harassed as those with less education. Those with histories of trauma exposure were nearly 3 times as likely to experience harassment. And those who had positive screens for military sexual trauma were over 3 times, had a 3 times greater odds of experiencing harassment than those that were not screened positive.

We also looked at the influence of the experience of harassment in terms of utilization and experience of care. And here we see that women Veterans who have reported harassment in the past year were much more likely to delay and miss care, were much more likely to delay and miss care specifically due to their concern about negative interactions with male Veterans. They were also less likely to agree with feeling welcome as a woman at the VA, and much more likely to prefer women-only care, such as clinics and waiting rooms as being important to them.

Now by the 12-month phase, because we had these data for baseline, we then asked very specific questions about each type of harassment experience. We were able to thematically identify from the baseline data. So at 12-months we noted that each woman Veteran was able to, that 21% of women Veterans experienced catcalls and whistles specifically; about almost 15% said that they had heard the ‘don’t belong at the VA, you’re not a Veteran’ comments denigrating their service; the personal slurs and rude comments are about 14.5%; the followed, bothered, cornered was around 13%; and sexual comments around 1 in 10 or 11%; and the touching, brushing up, and actual assaults on VA grounds were about 4%.

We also asked then related to these data at 12 months follow-up in 2016, that of those who reported any such experience, 27% said that it had happened in the past year, and 6% greater than a year ago. So together that means the prevalence may actually be closer to 1/3 of women Veteran primary care users who routinely come to the VA for such care. If we add those numbers up from the prior chart, about 58% have had this happen to them once or twice, 26% say some visits, 12% say most visits, and about 59% were said they were harassed by male Veterans, and 22% said they were harassed by VA employees.

So by way of conclusion, we found that the majority of women Veterans did feel welcome at VA and did not report negative interactions. However, 1 in 4 on average were harassed on their way to see their VA doctor. Many reported delaying and missing care as a result, some as a direct result of those harassment experiences. Harassment is often sexual and personal in nature as well, with the second most common theme being women not deserving VA care or not being seen as Veterans. Not surprisingly, harassment experiences were also linked to not feeling welcome at the VA.

It is also of concern that our women Veterans with trauma histories had almost 3 times greater odds of experiencing and reporting harassment, so greater attention is needed regarding the safety and security of common areas and clinical environments. We didn’t speak to this in detail, but many noted that these harassing experiences occurred in the canteen and near the elevators, and then other common aggregated areas. There is also a preference for women only clinics and waiting areas, and that presents challenges for mixed gender areas, especially in terms of who polices that behavior, as well as new waiting room policy that prohibits women-only waiting rooms. So some challenges ahead.

The implications of this work is really that all VA patients must be able to see their doctors in a safe and dignified environment. And there is concern that public harassment may have become a social norm, though I think it’s not necessarily arguable that all healthcare settings should be harassment free, and that male Veterans may be no more comfortable with the behavior of their peers than women Veterans are. So change is needed.

This also came from a partnered research initiative that ensured the findings got to the highest levels of VA within months of these analyses. And so some of the initial work was to look at non-VA evidence-based programs to see whether or not they could be tailored to the VA based on Veteran and key stakeholder input. The other issue with partnered research is with these early reports that meant that more information could get to the leaders on many levels of the VA earlier than you would normally see in a traditional research enterprise, where you would wait to find the paper get published and then disseminate the paper. But clearly more information was needed to develop evidence based program elements to address harassment in the VA. So VA Women’s Health Services took the initial lead, as they were our primary partners in this CREATE initiative, and they facilitated discussion groups with Veterans, which Dr. Klap and Dr. Potter oversaw. They reviewed existing harassment reduction programs and conducted key stakeholder interviews.

So with that, I’m going to hand it over to Dr. Klap.

Molly: Thank you Dr. Yano. So Dr. Klap, we now have your screen.

Dr. Ruth Klap: Hi. Okay great. So I’m going to describe some of the work that Becky just described, where we were getting ready for an expert panel and looked at the background. And first off, I want to point out that public harassment is not just something that happens to VA, national studies show that 2/3 of all women report public harassment. It’s referred to street harassment or stranger harassment as well in the literature. And in general, it’s an under-researched topic, but it’s clear from the literature that the problem exists and that it is a significant problem. You can find more information about public harassment outside the VA at the website listed here.

And I also want to talk about the impact of harassment on women in general. Studies outside the VA show that women often avoid places where the harassment occurred. They make adjustments in their demeanor or appearance. There’s stories of women change what they wear in order to avoid harassment. And there’s a number of negative psychological and emotional consequences: fear, anger, distrust, depression, stress, sleep disorders, they all have justification, shame, and reduced self-esteem have all been attributed to harassment in the literature.

So we looked for some evidence based interventions that could be useful in addressing harassment in the VA setting. We found some online programs and some street activism programs that specifically dealt with public harassment. There’s also some films out there that try to sensitize men to the issue. There is a number of public transportation campaigns, and there’s also women-only transportation where, you know, subway cars are actually reserved for women. And there are some apps out there that either help women with responses to the harassment or try and help them identify places that aren’t safe because they could be harassed.

So for the most part, these programs have not been evaluated or haven’t been shown to be as successful. There’s more evaluation work done in the transportation field. There is a general sense that formal surveillance by police or security personnel, electronic surveillance using cameras, and social norms campaigns, and grassroots campaigns may be effective in the transportation. But for the most part, the views about effectiveness comes from expert opinions and anecdotal information, or process evaluation. There haven’t really been comprehensive evaluations yet.

So we also looked at interventions that have been launched at university campuses to deal with sexual assault, and there is a number of bystander intervention programs that have been evaluated and shown to be effective. And there is one program that was developed by the Prevention and Innovations Center at the University of New Hampshire that includes bystander in-person prevention program and a bystander social marketing campaign. And this program has actually been adapted and evaluated within the military. They found that soldiers who saw the campaign images were less likely to report that sexual assault and stalking were the responsibility of someone else.

So we conducted some discussion groups with male and female Veterans. And we asked about their experiences with harassment at VA, and what they thought VA should do about it. And we also specifically asked them what they thought about the idea of a bystander [inaudible 19:25] program and whether they thought it would be appropriate for VA. So, and we conducted separate groups with men and women Veterans, and we recruited using the flyers on the screen. In total we conducted 15 groups between May and July of 2016. The groups were conducted in West Los Angeles, Iowa City, Hines and Chicago, and Jamaica Plains in Boston. And we offered a $50 incentive for anyone who participated. So 95 people participated across all the groups. The groups ranged in size from 1 to 9, so we did a couple of interviews when we didn’t have enough people to form a group, and the average group size was 6 to 8. So the mean age of the participants was 54, 45% were women, 30% were non-white, and 70% were service-connected, and 83% had seen a mental health provider in the past year.

So we found that the majority of women Veterans experience or witness harassment at the VA. And one woman told us, in public men respect boundaries more than they do inside the VA. And someone else said, in VA men are more comfortable, they will get away with it, there is no real consequences like being arrested or cited. And then someone else said, VA is the same environment as the military but just a different setting, men stick together, even if it’s wrong, and even if they are VA police they are former military and they stick together. So for the most part the women Veterans felt helpless when faced with harassment at VA.

So we also asked them how they thought the VA should deal with harassment. And the men and women Veterans unanimously stated there needs to be a staff initiative, they wanted a system-wide statement or program to handle harassment. And there was a lot of talk that zero tolerance was necessary. They wanted protocols and procedures to address public harassment that are known by all VA employees. They wanted the VA employees to be trained to intervene and they thought that the training should be ongoing.

We also asked specifically, what do you think of the idea of a bystander intervention? And they pointed out that the problem’s currently not being addressed by VA staff and they didn’t think it should be up to the Veterans to solve this. They didn’t really think it was their responsibility. People said, I’m sick and I’m here to get my care. There was talk about, I’m here for my recovery, that’s my primary concern. They also talked about personal safety, they said some Veterans are really unpredictable and they were concerned that some Veterans were armed, and some of the men were concerned about retaliation or being labeled as a snitch.

So we also did, I think a slide, sorry, okay, we did key stakeholder interviews as well. And the key stakeholders had a perception that the VA is very different from other medical settings. People said they’d never been to a hospital where people are allowed to just hang out at the front door, they doubt that in private sector you can behave that way in a doctor’s office and expect to be able to go back there for your care. And even as residents rotated among multiple hospitals we were like, what’s up with the patients of the VA that they think they can do this to us?

There was a general consensus that there is a negative impact on the staff, based on the harassment that goes on. The staff talked about helplessness, trauma, concerns about the attire, increased sick leave, self or attention problems and composure breaks. And many of the women staff described monitoring what they wore in VA settings. When we asked the staff what to do in the case of harassment, they said that they generally weren’t, they were aware of policies to deal with harassment of staff, or harassment of Veterans by staff, but most knew of no formal policies or practices for dealing with harassment by Veterans. And they talked about a number of barriers to intervening, they’ve simply, most people said they just didn’t know what to do under what authority. And they talked about the difficulty with the logistics, a lot of the harassment takes place in public spaces and they generally didn’t know the identity of the perpetrator.

So we identified three groups of harassers; they seem to fall into these three categories. There were the individuals who seemed to be unaware of what they were doing, there were generational or cultural factors seemed to be at play, they would refer to women as honey or dearie, they might tell women to smile. So you got the sense that these people didn’t intend to be demeaning and they were often surprised that their comments were hurtful. And it seems like this group might benefit from an educational campaign. The second group were individuals with dementia, mental health, or other cognitive problems, and this group also didn’t seem to be necessarily acting with intent, but it seems like this group might need to be managed more clinically. And there was a final group of individuals who seemed to be acting with malice or intent. Someone said, if you know anything about the folks who are perpetrators, they’re going to try smaller stuff first, they’re going to see how far they can push the envelope.

So it’s important, based on the work with the discussion groups and the interviews, I want to say it’s important that VA leadership communicates its stand on harassment on VA grounds. Policies and procedures for how staff should deal with Veterans who harass other Veterans are needed, and preferably policies with teeth and that can be enforced. We need policies to deal with people who won’t stop acting when they’re harassed. And finally, policies are needed regarding what Veterans should do when they’re harassed. Who should they tell and what should be done?

So I want to thank everyone for calling in. And I’d also like to ask if you’re aware of any programs or polices that address harassment at your VA or in the VA to let me know. And also, if you’re aware of any programs within or outside the VA that you think might be appropriate for the VA setting, to let me know. The work we did, the groups, the interviews, and the discussion groups took place over a year and a half ago, so we’re hoping that maybe things have changed. Thank you.

Molly: Thank you both very much. We will open it up for audience Q&A now. Ruth, would you mind advancing it to the slide with your contact information? Wonderful, thank you so much. I’m sorry, go ahead.

Dr. Ruth Klap: Sorry, and that slide’s up now.

Molly: Okay perfect. Sorry, I might have a delay on my end. So for our attendees that joined us after the top of the hour, to submit your question or comment just go to the GoToWebinar control panel on the right hand side of your screen, go down towards the bottom and click the arrow next to the word questions, that will expand the dialogue box and you can then submit your questions or comments there, and we will get to them in the order that they are received.

The first question, oh I’m sorry, the first comment is: thank you for this excellent presentation, this is a much-needed topic that needs to be researched further and absolutely implementations need to be put in place. So thank you to that commenter.

The first question: Much like in the general public, it seems that when a woman is harassed at the VA the onus falls on her to follow through with all of the offices to make sure that actions are taken and the Veteran who did the harassment is being reprimanded. Will there be any attempt to try and put more of the onus on the system itself, or the harasser, rather than having the complainant have to relive the experience?

Dr. Elizabeth Yano: I can give a whirl on that one. Currently VA has put forward, starting on August 1st, a national culture campaign to improve the awareness and knowledge of these issues among all VA employees. There is also a workgroup focused on developing training modules that would be done in addition to that kind of social marketing kind of effort. I think what’s more difficult is that there are not policies or procedures in for what a woman Veteran should, in fact, do. So I think that in some cases you can see that women Veterans may at least tell staff, but then it’s critical for the staff to have an idea of what they should indeed do next. And I think that that’s where some of the complexity of this comes in.

For the key stakeholder interviews that Dr. Klap led, it was clear that there are roles for disruptive behavior committees, there are roles and education needed for VA police, for VA clinicians, and for frontline clerks. There’s concerns in some places where providers don’t feel like they can take this on either, and other providers who feel like they don’t want their clerks to handle it and they need to know right away. So there is just huge variability in peoples personal sense and professional standing in the VA what they think their, kind of, job position can and can’t do in this arena. You know, you noticed in the 12-month data we asked specifically whether or not any harassment was occurring, to the best of women Veteran’s knowledge, from VA employees, and in that particular arena there are indeed laws and regulations for that. And so, you know, the expert panel definitely came up with recommendations on targeting that area for which regulations in law exist, and strategies and approaches exist for it. I have heard some discussion around concerns about, you know, say this happened at a Kaiser, the Kaiser would simply not deliver services to that Veteran anymore, or that patient anymore, and in the VA, you know, there’s varying notions of where the lines really are in terms of caring for, you know, a mentally ill Veteran, caring for all Veterans, and balancing how they manage this, especially since identifying perpetrators and alike is an ongoing concern. So I’d say for now, the VA’s quite aware of this, the end harassment workgroup was in fact charged by the Under Secretary for Health, actually it was charged when Dr. Shulkin was still the Under Secretary for Health, so there is awareness now in the highest levels of VA and VHA, and I think that the workgroups underway still have a lot of work to do. I know that’s not a definitive answer, but this is the direction things are going in, so we’re very interested in anything, any other progress people have heard of that have been helpful in this kind of arena.

Molly: Thank you for that reply, that kind of begins to answer the next question, so we’ll see if you have anything you want to add to that. Has this data, I’m sorry, I got another one to come in, has this data been presented to anyone at higher levels in the VA? And if so what was the response?

Dr. Elizabeth Yano: So yes, even at the expert panel there were representatives from the Undersecretary of Secretary levels and a host of national program offices. So people are definitely aware. And right now the, to the best of my knowledge, the response has been to continue to develop the Culture Campaign and the training and education programs. There are several pilots going on around the country, including some from the study sites that participated in this study, because these data were presented to the intervention sites as formative data to act upon, and some of those include things like Sister Assister Program that I believe came out of Wisconsin, but I think it is being launched also at the Jesse Brown VA, where they have women Veterans who basically provide, you know, door-to-door companionship through the VA. There is, we are working actually on something somewhat related on a trauma sensitive environmental checklist to get [inaudible 33:22] and when we already have to do environmental checklists for joint commission, kind of, quality of improvement, but this is one with an eye to what’s the experience of someone getting to the women’s health clinic or getting to gynecology, or even getting to general primary care, do you have to walk through a waiting room that’s set up like a gauntlet? Do you have to walk through an area near the canteen where the homeless program might be spilling over, where we may have some more Veterans with some mental health problems and concerns? And changing the viewpoint of the folks who do facilities management and environmental QI, if you will, to think about the patient flow. In some places they’ve changed the entryway to the women’s health clinic because they found doors that are a little bit closer that reduce the, you know, walking through common areas that might expose women to some of these concerns. But women’s health services and the work groups are tracking what these innovations are like at the different VAs that are trying them. So we’re hoping to gather more information from that as well as pilot test other interventions locally and elsewhere. Ruth, do you want to add anything to that?

Dr. Ruth Klap: No, that was pretty complete.

Molly: Thank you. During the focus groups did you find even more reticence by the female Veterans to report their harassment, given the closeness of the Armed Forces? It sounds it’s based on, kind of, the sense.

Dr. Ruth Klap: Can you repeat?

Molly: Is there even more reticence by harassed female Veterans to report the incidents, given the brother-ship of the Armed Forces and the closeness within the battalions?

Dr. Ruth Klap: It seemed to be more that they didn’t know what to report. It was interesting, you got a sense that they wanted the VA to do something about it, but there was a line where, but they wanted the male Veterans to get their care, so it didn’t seem like they wanted male Veterans to be asked to leave or anything, they just wanted, like, safety.

Molly: Thank you. I am a Vet and I was harassed by a VA full-time employee, and the EEO officer said she wanted to do whatever was necessary to keep me from going to the local newspaper. That is not leadership nor method to create a safe environment. Thank you, that commenter.

Dr. Elizabeth Yano: I would like to say that, you know, we’ve been providing feedback on these data also now to the sites that were originally control sites. Meaning they did not get feedback from the patient or the provider surveys, this was a trial of what’s called evidence-based quality improvement as an approach to improve the comprehensiveness of women’s health care and tailor packed to the needs of women Veterans. It’s been used in many trials for many different kinds of roll outs of evidence based programs. And for one of the sites, that we reported their site-specific data to recently, had someone from their Disruptive Behavior Office, their EEO office, their Minority Veterans Office, their Veteran Experience Office, the Women Veteran Program Manager, the Women’s Health Medical Director, and someone from leadership. It was quite extraordinary, I didn’t even capture all of the people that were on the phone listening to these results. But I thought it reflected a both dynamic and multidisciplinary and multi-office approach to considering these results and thinking about what they would do about them as a facility. And, but there’s no precedent for how to even respond to these results. And so I spoke to another site to feedback their information and it went only to the Women Veteran Program Manager, and in all honesty I’m not sure it’s going to go a lot farther. So, every site is so different when it comes to addressing something like this, and these are new data that break new ground. I mean I wish it was good news, new ground, but it’s something that obviously needs multidisciplinary, multilevel action. And, you know, needs some support and evidence. So, if there’s ever anything that requires clinical, managerial, and research partnerships, I think it’s this area.

Molly: Thank you for that reply. The next questioner writes, is there anything we can start doing today as a staff to improve the culture?

Dr. Elizabeth Yano: That’s a great question. You know it would be really great, we probably should have organized this to have some of our women Veteran program managers who participated in this initiative, who are launching their own pilots. Some of them have taken this on as personal mission and talk very much about, you know, what were some of the terms, Ruth? Like, you know, my name’s not hey baby. You know, putting buttons on that kind of repeat the message about respect. There’s certainly posters that are getting plastered all over, or such is the plan. And I think that many people take it like one Veteran at a time, you know, to engage people. But that, you know, many of these folks are also very busy themselves and so they’re doing this out of the belief in trying to change the culture one person at a time. But insofar as this may be more pervasive in some places than others, you know, you would really want to make sure that many people had information and training, and even group opportunities to, you know, perhaps roleplay what you would say to someone when you observe some of this behavior. Just to get people more comfortable with what to do. Ideally you’d have a whole structure and policy and protocol in place that everyone understood so it was very clear how you respond. But I don’t think we’re there yet.

Molly: Thank you. Ruth had posed a question asking people to write in if they knew of any programs or implementations that were being done at their facilities, or any VA facilities, and one person writes in, the Hampton VA recently handed out fliers titled: Compliment/ Harassment, Know the Difference. I thought the handout was great until I hear a male staff, who is also a Veteran, state that one of the examples listed as not okay, which was staring or leering at someone, was simply a symptom of PTSD and should be excused. I could provide at least a dozen examples of harassment by male staff at this facility. Thank you for this training, I hope the issue will continue to be addressed.

Dr. Elizabeth Yano: I think that’s a great example of the complexity of handling this in our settings. And the conflict it raises for patients, for staff, and for providers. And I, you know, think it is a subject we need to keep tackling, both through research, which is what we know the best, but from people’s front-line experiences in care. Because I think we’ve learned a lot from talking to Veterans, and providers, and staff members, and VA police, and facility directors, and chiefs of staff and alike, on what the barriers and facilitators are to changing behavior, to responding, even the barriers to different policies. And so, but what we have heard is a consistent message of an intent and desire to move forward. Because we, for the first time actually, as we’ve been analyzing these data, included the same question I just reported data on for patients, but I included it in our primary care and women’s health provider and staff survey. We are just now analyzing those results, but whenever we present these data to groups of providers and staff in the VA, people find it very salient, very quickly. Because apparently many staff are harassed on a routine basis. What was interesting is that some of it is what you might consider sexual harassment and, you know, being asked on a date, will you marry me, things that definitely adversely affect the doctor patient encounter. And doctors are a little uncomfortable with where the lines are, because they’re trying not to damage that doctor/patient relationship, although in reality, it’s been affected by the behavior, but also a lot of concerns around patients who are getting their opioids not renewed. So we weren’t really expecting that issue to come forward when we talked about unwanted or behavior. But there is a lot our providers and staff go through to take care of our Veteran patients. And so we’ll be bringing those data forward as soon as we’re done with analysis as well.

Molly: Thank you. We have some more questions and comments coming in. Great presentation, and thank you, I am wondering when the survey/pilot was conducted, what year?

Dr. Elizabeth Yano: The baseline survey of patients was done in 2015, and then we did a 12-month and a 24-month follow-up with the same questions in all 3 years. For the provider and staff version, those data were just collected in the last 6 months.

Molly: Thank you. The next comment came in after the discussion about relaying this information to leadership. Institutional culture only changes when the top-level leadership dictates the change. Cultural change is top driven and it cannot be driven by lower or middle level staff.

Dr. Elizabeth Yano: Yeah, I can tell you from a research perspective and evidence based QI we found that top down and bottom up is often the most effective. I agree that it’s very hard to do it bottom up only, but it’s also pretty hard to do it top down only. So our own work has demonstrated that culture change works best when it’s both directions. But I hear you.

Molly: Thank you. It is clear that the change needs to be done VA wide and staff wide, has there been any discussion about also offering materials to the female Veterans when they come in for care, reminding them that it is not okay to go through this and that there are avenues for them to take against harassment?

Dr. Elizabeth Yano: I think there has been some discussion about that, especially after Dr. Klap’s discussion groups with the women Veterans and male Veterans and the concerns around whether or not male Veterans want to participate in bystander roles. I think the key would be before you do that you have to know what it is you’re telling them to do, and who you’re having them go to. And that I think is what probably needs to get worked out. You know probably, in all honesty, on a site-by-site basis at first, because not all sites have the same kind of staffing along the way. And so, you know, I’m an epidemiologist by training so we get trained that you don’t screen until you know you can treat, and so in some ways I think that processes for engaging and activating women Veteran patients’ needs to be done hand in hand with activating and engaging the facility leadership and staff and alike so that there is a kind of a system of response ready to receive that complaint and that concern. Otherwise I would at least personally get a little concerned about unintended consequences along the way. So that’s at least some thoughts. I don’t know, Ruth, if you have anything to add to that?

Dr. Ruth Klap: So a number of the Veterans suggested mailing out educational materials in the registration thing that was just defining harassment and letting people know what it was. And we did like, you know, pass that information along, but I agree with Becky, it’s hard to deal with the rules and regulations at this point.

Molly: Thank you both for those responses. While we wait for any further questions or comments to come in I would like to give each of you the opportunity to make any concluding comments you’d like to. We’ll just go in order of speakers, Dr. Klap or Dr. Yano, would you like to make any concluding comments?

Dr. Elizabeth Yano: Sure. Well I really appreciate everyone’s time and listening to these results today. You know, manuscripts and alike are all in process but we wanted to make sure that frontline staff were aware that other researchers who have interest in this area might be interested in collaboration as we move forward to solve some of these thornier issues. I also want to just thank all of the Women’s Health Medical Directors, the Women Veteran Program Managers, the Women’s Health Practice Based Research Network Site Leads, and others who participated in this 12 VA/4 VISN effort. None of this work, while we centrally collected the data, they are ones that helped put all this stuff into context and many of them, as I said before, have moved forward on pilots to improve the safety and security of their VAs and we really look to them for some of the innovations, because they know their patients and their setting the best. And I think that, I’m hoping that in the future some of their work will be the focus of Cyberseminars coming forward, to spread ideas for how we can tackle some of these thornier issues. Ruth?

Dr. Ruth Klap: Sure. I’d like to thank everyone that Becky thanked as well, especially the PBRN site leads that helped us arrange the visits. And I also just want to point out that I think if we were to go back and do discussion groups and interviews now, the situation would be very different. I don’t think that people would tell us this problem is solved, but I do think that there would be a lot more people aware of the problem and, you know, trying various types of solutions, because I know of various programs or interventions that have been implemented throughout the VA.

Molly: Excellent. Well thank you both so much for coming on and lending your expertise to the field, we, especially for this important topic, we really do appreciate it. And of course, thank you to all of our attendees for joining us today. I am going to close out the meeting momentarily. For our attendees, please hold on just a second while a feedback survey populates on your screen, it’s just a few questions but we look very closely at your responses and it helps us to improve individual presentations as well as the program as a whole. So thank you once again to everyone, and this does conclude today’s HSR&D Cyberseminar presentation. Thank you Ruth, thank you Becky.

[ END OF AUDIO ]