Original Publication

OPEN ACCESS

Addressing Interpersonal Violence as a Health Policy Question Using Interprofessional Community Educators

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Citation: Clithero A, Albright D, Bissell E, et al. Addressing interpersonal violence as a health policy question using interprofessional community educators. *MedEdPORTAL*. 2016;12:10516.

https://doi.org/10.15766/mep_2374-8265.10516

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Abstract

Introduction: The health effects of intimate partner violence (IPV) not only include physical injury, but can also manifest as posttraumatic stress disorder, anxiety, and others. US medical students report receiving inadequate training about IPV. This case-based tutorial for third-year medical students examines: (1) a clinical encounter with a patient experiencing several complex challenges including IPV and homelessness; (2) the implications of existing policy on the delivery of health care services; and (3) the impact of policies on patient choices. **Methods:** This case is completed during a family medicine clerkship. The 2-hour case review moves between small- and large-group sessions led by community interprofessional experts at a local family advocacy center. Optimal group size is three to four students and one or two experts per group. The large-group session should be led by a dynamic moderator who is familiar with the Socratic method of teaching to elicit a variety of responses to ad hoc challenge questions. Materials provided include student resources, student case, facilitator guide, moderator guide, and sample brochure of IPV documentation policies. **Results:** To date, over 200 students have participated in this session. During the most recent iteration the average response to the question, “As a result of the FAC experience, I feel more empowered to care for persons experiencing IPV,” was 4.1 out of 5 (5 = *strongly agree*). **Discussion:** Public health, health policy, and clinical topics can be effectively taught by an interprofessional team of community experts and lead to improved student understanding of the importance of health policy to both individual and population health outcomes.

Keywords

Interprofessional Education, Intimate Partner Violence, Interprofessional Relations, Health Policy, Community-Based Education

Educational Objectives

By the end of this session, learners will be able to:

1. Apply critical thinking and analysis to evaluate policy implications on patient care and health care practice.
2. Understand the incidence and prevalence of intimate partner violence (IPV), sexual assault, and stalking, as well as associated health conditions among patients.
3. Compare and contrast how health care policy differences might impact the care of IPV patients versus non-IPV patients.
4. Identify appropriate care plans for IPV patients.
5. Synthesize current literature on IPV and articulate policy implications.

Introduction

The Center for Disease Control defines intimate partner violence (IPV) as “physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.”¹ The prevalence of IPV in New Mexico is significant and has lasting physical and psychological

Appendices

- A. Suggested Student Resources.docx
- B. IPV Moderator Guide.docx
- C. IPV Facilitator Guide.docx
- D. Sample Domestic Violence Brochure.pdf
- E. IPV Student Case.docx

All appendices are peer reviewed as integral parts of the Original Publication.

effects on the victims. A New Mexico Department of Health report on the health of the state noted that as of 2010,

1 in 4 (24%) New Mexican adults, and 1 in 3 adult females (32%) will be victims of domestic violence in their lifetime. One-third of domestic violence cases reported to law enforcement resulted in injury to the victim; and 18% of the total homicides in New Mexico were related to domestic violence.²

Health effects not only include immediate physical injuries but also can manifest as posttraumatic stress disorder, anxiety, sleeplessness, gastrointestinal disturbances, and headaches, among others.³ In addition, children who witness household violence are at risk for poor health outcomes as a result of their adverse childhood experiences.⁴

US medical students report receiving inadequate training about IPV. The Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ) annually surveys all graduating students from Liaison Committee on Medical Education–accredited US medical schools. In the 2012 GQ, 17% of the 12,618 respondents believed instruction in the area of family and domestic violence was relatively inadequate.⁵ Combining this statistic with data in a 2008 AAMC report⁶ indicating that health policy content is perceived as boring, irrelevant, presented too theoretically, and having little or no context gave us the idea to address the two in combination. Following a study on IPV screening, Pagels, Kindratt, Reyna, Lam, Silver, and Gimpel recommended that residents and attending physicians in internal medicine, emergency medicine, family medicine, and obstetrics/gynecology also needed IPV training.⁷ In practice, all specialties will encounter IPV within their patient populations and communities and should therefore receive training on appropriate screening, documentation, and resources.

In 2008, we introduced health policy and advocacy into the University of New Mexico family medicine clerkship. Initially, the curriculum consisted primarily of didactic lectures and a few practical assignments.⁸ We brought community stakeholders into the classroom to discuss the interface of policy, health care, and IPV. We assembled a panel of interprofessional community stakeholders including a defense attorney, a prosecutor, a judge, the director of a local domestic violence shelter, an IPV victim, members of local law enforcement, and family medicine and emergency medicine physicians. The panel responded to questions asked by the students, and each experience was different for each rotating cohort of students. The goal of this activity was to illustrate how policies could help or constrain the students' work. The activity provided students with an opportunity to consider policies and practices related to IPV. At times, the conversation was somewhat out of control and not as professional or constructive as we had hoped. Panel facilitators often varied, and their responses frequently veered into less relevant topical areas. Feedback from learners and instructors suggested a need to revise the curriculum to improve the linkage between health care practice and health policy.

In response, we made three changes. First, one of the course instructors recognized that this learning experience would be more effective if students were first able to visit a local resource. The panel activity was moved from a classroom on campus to an offsite location, the Albuquerque Family Advocacy Center (FAC). The FAC uses a colocated service delivery model where citizens can seek multiple different but related family violence services. In this one-stop-shopping model, victims and families can receive medical exams, speak to a victim advocate, file a police report, obtain a restraining order, speak to police without filing a report, receive emergency shelter, obtain civil legal attorney information, and access the crime victims compensation fund all at the same location. As a community-based organization for victims of IPV, the FAC is an ideal site for our activity.⁹ Many communities, but not all, have organizations that offer a colocated service delivery model like the Albuquerque FAC. Nearly all communities, however, will have at least one community-based setting offering services to IPV victims. In our experience, students engage and learn better when instruction occurs within the community where services are delivered.

Second, we revised the panel to improve the representation of health care practice and health policy professionals. As part of the curriculum change, we restructured the panel to include community and medical experts who had experience working collaboratively in the health policy environment. The scope

of professional backgrounds for panel participants may need to be expanded or narrowed to ensure relevance to alternative service settings chosen for the assignment. At our site, the panel consisted of the following members:

- Family, emergency, and public health physicians.
- A hospital chief medical officer.
- The city director of the Office of Diversity and Human Rights.
- A sexual assault nurse examiner.
- A member of the New Mexico legislature.
- A sociologist.
- A victim rights advocate.
- A local law-enforcement officer.

In the session, the experts share their real-life experience with the challenging role of balancing individual and population health issues. The panel facilitators who regularly provide trauma support to victims (i.e., sexual assault nurse examiner and victim rights advocate) facilitate difficult conversations that may be triggering for some students.

Third, we made changes to the curricular activity. We created a clinical case to illustrate a patient who comes to the emergency department for common complaints (i.e., headache, medication refill). We kept the medical issues relatively simple but added several layers of complexity, including IPV, homelessness, and other concerns. The case weaves in corresponding health policy questions at every step of the patient's care. The case is discussed in small groups of three to four students and guided by the expert panel members.

This builds on current MedEdPORTAL publications by adding a unique case on both health policy and IPV to the existing literature. A search of MedEdPORTAL using *violence* as the keyword returned several evaluation tools for sensitive-topic communication^{10,11} and interviewing skills with simulated or standardized patients.¹²⁻¹⁵ A second search for health policy case-based publications returned no results.

Methods

The family medicine clerkship recurs every 8 weeks, with 14 hours of health policy and health system education embedded within it. Each block has an average of 16 students who attend didactic sessions on health insurance, health care finance, international health systems, and health advocacy. They are also required to write and present a health policy brief at the end of the clerkship. The FAC site visit occurs during the first week of the clerkship after a 1-hour introduction to health policy. The additional curricular material gives students a broader understanding but is not required to meet the stated objectives.

Prior to visiting the FAC, students are randomly assigned to groups of two to three. Each group reads one assigned article, reviews two websites (described in Appendix A), and submits one written question for the moderator to review in advance of the session. The moderator prepares written responses to all questions in case any are not addressed during the site-visit session. Following the session, all questions and responses are distributed to the students to ensure all questions have been addressed. Both the moderator and the facilitators are given their tailored guides, Appendices B and C, respectively, to review prior to the site-visit session.

Both the moderator (one of the course instructors) and the facilitators should be familiar with applicable state and local laws regarding IPV and sexual assault, as well as understanding how these laws impact the practice of medicine in their jurisdiction. Some organizations may see patients in different jurisdictions, including municipal, county, state, tribal, and federal. It is important to recognize that each of the jurisdictions may have very different legal requirements. An important requirement that varies between jurisdictions is on mandatory reporting versus mandatory documentation of IPV.

Facilitators—the licensed health care providers, in particular—should already be aware of the mandatory reporting requirements in their area of practice, since all states have laws regarding mandatory reporting

of both child and elder abuse. In addition, it is recommended that facilitators be aware of any specific legal requirements (if any) for the following:

- Mandatory reporting of
 - IPV,
 - Sexual assault for adult victims,
 - Suspected child abuse and neglect, and/or
 - Elder abuse/incapacitated adult.
- Mandatory documentation.
- Ages of consent for treatment of minors for reproductive health, mental health, substance use, and so on.
- Specific organizational policies that govern the evaluation and treatment of victims of violence.

In New Mexico, state law specifies mandatory documentation requirements, but there is no mandatory reporting requirement for IPV. A sample brochure (Appendix D) put together by the New Mexico Domestic Violence Leadership Commission details the mandatory documentation requirements in New Mexico—legislation spearheaded by two of our facilitators. This brochure can and should be adapted to any local setting in order to inform students about existing law and to open up the discussion about mandatory reporting versus nonmandatory reporting. Resources for finding applicable information in different states are described in the last section of the facilitator guide (Appendix C).

Appendix B includes detailed instructions for running the site-visit session, which follows this outline:

- Facilitator introductions, FAC history, IPV overview (20 minutes).
- Tour of the FAC (15 minutes).
- Break (5 minutes).
- Review of case objectives (5 minutes).
- Case Section 1: Your Patient—Clinical (20 minutes).
 - Read case as a group (5 minutes).
 - Small-group discussions (5 minutes).
 - Large-group discussion (10 minutes).
- Case Section 2: Social and Family History (25-30 minutes).
 - Read case as a group (5 minutes).
 - Small-group discussions (20 minutes) or large-group discussion (25 minutes).
- Case Section 3: Policy and Advocacy (35 minutes).
 - Small-group discussions (20 minutes).
 - Large-group discussion (15 minutes).

Upon arrival at the FAC, the moderator provides an overview of IPV (Appendix B) and the services offered at the FAC. The moderator then introduces the facilitators who work at the FAC, such as a sexual assault nurse examiner and a police officer, and invites them to describe their training, roles, legal processes, and the community resources they use for both victims and offenders. The students then tour the facility with FAC employees. Following a short break after the tour, students reassemble in a room set up with tables for groups of three to four students, and each group is joined by one or two facilitators. The ideal ratio is three students to one facilitator.

The moderator then reviews the case objectives and hands out the first section of the student case (Appendix E). The case is divided into multiple sections in order to gradually introduce policy issues with the new information. Increasing case complexity in each section allows students to build confidence. Students should receive a brochure on the reporting laws of the jurisdiction (such as Appendix D), which will enable them to assume more of a leadership role within the small-group discussions, where facilitators provide guidance. Each section should be kept to the time limit in order to be respectful of the facilitators' time.

At the time limit, the moderator begins the large-group discussion by randomly calling upon students to share their answers using report-back and Socratic methods. Key to this portion is a moderator who can interject a variety of what-if questions to stimulate discussion. For example, the patient in the case is a homeless female victimized by her husband, so the moderator might ask, “What if this was a male victimized by a female? Or another male? What policies would then be enacted?” Similarly, the question “Why does it matter where your patient lives?” can be followed up with “Is it legal to live in your car?” or “Since she has children, would you call social services? What about child protective services?” This approach illustrates the extraordinary complexity of health care, IPV, and the federal, state, and local laws and policies that govern care. The what-if technique usually generates a lively and interactive discussion by encouraging students to explore complexities beyond the immediate answers from experts.

Results

To date, over 200 medical students have toured the FAC and participated in this session. Students evaluate the family medicine clerkship at its completion. While prior evaluations did not include sufficient questions for testing the efficacy of the course changes, student feedback on the FAC experience has been uniformly positive since these changes were implemented. In 2014, we added the question “As a result of the FAC experience, I feel more empowered to care for persons experiencing IPV.” Based on a 5-point Likert scale (1 = *Strongly Disagree*, 5 = *Strongly Agree*), the mean response to the FAC experience question between 2014 and 2016 was 4.15 ($SD = 0.80$, $N = 195$).

Within the course evaluation, students have the opportunity to provide written comments about the FAC experience. During the same evaluation period, these comments have fallen into five categories:

1. Praise for the experience: Almost all students providing comments offered some form of praise to describe the experience. Multiple students indicated that the FAC activity was their “favorite experience of the block.” One was impressed by the engagement of the panel in the activity and wrote, “The panel was engaged, energetic, and bursting with information.”
2. Exposure to interprofessional knowledge: Comments highlighted an appreciation of the inclusion of interprofessional knowledge about IPV. One participant wrote, “Multiple perspectives from different professionals illustrated the issues with great detail.” Another described the experience by writing, “really enjoyed the site visit and getting to talk to and listen to different viewpoints from different professions.”
3. Exposure to nonmedical interventions: Comments captured student feedback about how the FAC experience provided them with exposure to interventions outside of the medical environment. A participant described the FAC experience as “great to visit a place full of action and see a little more about what really goes on. [There was a] woman in the lobby [when we were there] seeking help, so it was real life.” Another linked exposure to an intervention outside of the medical environment to the effectiveness of the session by commenting, “Very effective session to be able to see the setting in which IPV is investigated and support offered.”
4. Expectations for clinical practice improvements: Multiple students wrote that the experience improved their confidence about caring for patients with IPV, with one noting, “I feel far more equipped to refer and screen patients regarding IPV.” Another indicated that he or she had already used the information gained from the FAC experience to “care for a patient while on rotation.”
5. Timing of the educational experience: Students indicated they would like to see community resources introduced earlier in their education. Their reasons for early introduction were twofold: (1) to reduce feelings of powerlessness when confronting patients with social service needs and (2) so students can learn how to network with others who can assist in caring for patient needs outside of the clinical realm.

We have also observed some creative outcomes related to participation in the FAC experience. During the family medicine clerkship, students undertake projects that are of interest to them and of importance to the community. Several students selected projects based on their FAC experience. Sample projects created and implemented following this session include (1) conducting a violence workshop at an immigrant and refugee clinic, (2) developing in-person and web-based training materials for emergency medical service providers (e.g., first responders, EMTs, and paramedics) on mandatory documentation procedures, and (3) updating materials and training for clinical preceptors on available IPV resources.

Discussion

The case session and format give students an increased understanding of health policies that affect patient choices, care delivery, and community responses to IPV, which may enable them to navigate the health system more efficiently. One concern posed by medical school deans is the lack of faculty expertise and interest in teaching health policy.¹⁶ Health professional schools interested in including a health policy component in their curriculum can use this curriculum to make the link between health policies and clinical care. The target audience can potentially include any student learner. We chose third-year family medicine clerkship students for two reasons: (1) a health policy curriculum is already embedded and (2) to encourage students to consider family medicine as a specialty. The American Association of Family Physicians definition of a family medicine specialist states, “these specialists, because of their background and interactions with the family, are best qualified to serve as each patient’s advocate in all health-related matters.”¹⁷ Students’ knowledge of health policy and the availability of local resources may improve both their clinical practice and their job satisfaction when treating patients with complicated social service needs.

Challenges and Recommendations

We encountered a number of challenges in implementing the curriculum. The main challenges were the following:

Time constraints. The discussions were generally so lively that 2 hours was quite often not enough time. We have decided to not expand beyond the 2-hour limits, in part because the facilitators are volunteers and we do not want to lose participant energy. Instead, we have time limitations for each section that are strictly adhered to. To overcome this challenge, the moderator must be able to manage time and limit lengthy answers. In addition, we created the curriculum objectives to coincide with emerging competencies for identifying IPV victims, resources available, and the impact of policy on care. Our curriculum is detailed and complex. We do not expect that all users would deploy this curriculum exactly as written. We encourage teachers to select the objectives that they can meet within their given time constraints and capacity.

Volunteer facilitator mix. Facilitators need to be enthusiastic and collaborative, be able to facilitate student discussions, and have some knowledge of IPV whether it is from a policy, clinical, or community perspective. Facilitators should be comfortable with the Socratic method to help learners draw connections between health policy and clinical application. We suggest having a pool of facilitators in case one or more facilitators cannot attend. Our facilitators receive the session dates 1 year in advance and attend according to their availability. There are eight consistent facilitators who, when not available, are replaced by one of three alternates. We like to have a varied list of facilitators from different content areas. Not all facilitators know all topics. This makeup is not required, but we find that it adds dimension to the conversation. We do suggest having a lawyer or legal professional as one of the facilitators, if possible, to guide any legal discussions. It is also important to have people on the facilitator team who understand trauma to help students who may have triggers to the subject matter.

Community-based location. It may be a challenge to identify a community organization that can host a large gathering for 2.5 hours, including time for an employee to give a tour of the organizational resources. This is critical as the case and discussion are considerably more relevant when conducted off campus and in the community. It makes the issues real and provides an opportunity for students to experience a care setting beyond the exam room.

Addressing local policies. The nuances of health policy are often taught from a federal level (e.g., the Affordable Care Act, Emergency Medical Treatment and Active Labor Act, etc.) and can seem abstract to students who just want to care for the patient. It is important to design the case in a way that recognizes that many policies have health implications and all health and community service professionals work within policy constraints. This curriculum requires consideration of local hospital policies (e.g., prohibitions on free drug samples, not giving patients money out of your wallet), city policies (city ordinances against sleeping in one's car), and shelter policies (90-day-stay maximum or male only, female only, family only, as well as hours of operation). All guide the decisions available for both patients and caregivers.

Future Directions

We have identified areas for continued improvement. Community resource identification has been added earlier in the curriculum and is emphasized in subsequent years, while a specific focus on IPV resources will remain in the third year. In addition, a few students expressed a lack of concrete skills to medically manage this population. Therefore, future sessions will include an emphasis on the RESPECT model,¹⁸ which is a model for building trust in patient-provider communication, as well as experiences and lessons the clinicians have learned. For example, one question that is typically raised is "What do I do if a suspected abuser is in the exam room? How do I get the patient alone?" Sample responses have included "Tell the patient you need a urine sample, walk them to the bathroom, and enter with them."

In future offerings, we would like to determine whether or not students make referrals to the FAC. We also hope to expand our case offerings to address considerations for LGBTQ, intellectually and developmentally disabled, and elderly populations.

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Disclosures

None to report.

Funding/Support

None to report.

Prior Presentations

Society of Teachers of Family Medicine Conference on Medical Education; Orlando, FL; April 2015.

The Network Towards Unity for Health Annual Conference; Fortaleza, Brazil; November 2014.

Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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Received: June 29, 2016 | Accepted: November 29, 2016 | Published: December 9, 2016