Improving Provider Readiness to Manage Intimate Partner Violence in Family Medicine Resident Continuity Clinics in Chicago

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Outline

• Background about intimate partner violence (IPV) in the United States

• Study Context

• Methods

• Results

• Discussion and Conclusions
Prevalence of IPV in the US

• About 1 in 3 women experience IPV in their lifetime

• 4.8 million incidents of physical or sexual assault annually

• One quarter million hospital visits result from IPV annually
Primary care-based IPV interventions

- Some primary care interventions to screen & refer have demonstrated significant health benefits
  - Reduce very low birthweight and very preterm infants (Kiely 2010)
  - Improve health-related quality of life (Tiwari 2005)
  - Decrease depressive symptoms (Coker 2012, Tiwari 2005)
  - Reduce unprotected sex and pregnancy coercion (Melendez 2003, Miller 2011)
Current Guidelines

• Institute of Medicine
  – Screen women and adolescent girls (2011)

• American College of Obstetrics and Gynecology
  – Screen in pregnancy and postpartum (2012)

• USPSTF
  – Screen women 14 - 46 years and provide appropriate interventions (2013)
Graduate Medical Education Recommendations

• ACGME
  • Managing a suspected victim of abuse is an entrustable physician activity in Family Medicine

• STFM survey
  • 57% of FM programs teach residents to respond to IPV victims (2010)

• AAV
  • Academic training programs must:
Abusive Behaviors in our patient community
Social Determinants of Health Study

28% of patients who responded reported experiencing some form of abuse

In contrast, 17.4% of patients who responded reported having been abused

*Response Rate = 26% (107/406 surveys completed)
Study Purpose & Hypothesis

**Purpose:** to assess and improve the readiness of providers manage patients experiencing IPV

**Hypothesis:** completing a brief, targeted IPV training will improve providers’ readiness to manage IPV in their practice
Study Objectives

1) Improve provider’s self-reported **preparedness** to manage IPV
2) Improve provider’s
   • Self-reported knowledge
   • Actual knowledge about IPV
3) Improve physician understanding of IPV **policies** within the clinic system ("systems issues")
Methods: Study Design

- **Month 1**: Pretest
- **Month 2**: Intervention: IPV Training
- **Month 3**: Create Intervention
- **Month 4**: Post Test (1 month)
- **Month 5**: Post Test (6 month)
Methods: Study Population

• Inclusion
  – All physicians, midwives, nurse practitioners working primarily at 3 FQHC and 1 FMC resident-continuity sites during April 2015

• Exclusion
  – Providers primarily based in other clinic sites,
  – Research team members
  – Providers hired after April 2015
Methods: PREMIS Survey Tool

• **Physician Readiness to Manage Intimate Partner Violence Survey** (2002)
• Developed by CDC and experts in the field
• 15 minute survey
• Comprehensively and reliably measures physician readiness to manage IPV (Cronbachs α ≥ .65)
• Measures training effectiveness
Methods: PREMIS Survey Tool

- 16 questions about “perceived knowledge”:

- 18 questions about “actual knowledge”:

- 12 questions about “preparedness”:

- 13 questions about “screening practices”:
Methods: IPV Training Development

“Pretest Survey”

• Content:
  – PREMIS original CDC survey
  – Demographic information
    • Age, Years in practice, Clinic site, Job title
• Administered to those qualified for study

• Results used to prepare an intervention training tailored to our providers
Methods: IPV Training Development

1. Local community partnership with Sarah’s Inn:
   • Local community organization that supports survivors of IPV
   • Resources, counseling, legal advice, shelter
   • Referral resource for our clinics

2. Collaboration w/ professional IPV educator:
   • Colleen Sutkas:
     • Director of Training & Education at Sarah’s Inn
     • Experience w/ healthcare workers.

3. Training rooted in provider self-assessment
Training Content

- Risk factors for violence
- Signs and symptoms of IPV
- Screening strategies
- Creating a safety plan
- Stages of change for IPV victims
- Legal reporting requirements
- Clinic policy as it applies to audience
- Resources within attendee’s clinics
- Referral resources in the community
Training Implementation

- Three 45-minute trainings were offered:
  - Morning PCC provider monthly meeting
  - Noon FMC provider monthly meeting
  - Weekly resident lecture conference
- Required attendance for its respective providers
  - Excluding those on call, post-call, or absent from work
- Those who were absent were allowed to attend one of the subsequent meetings.
# Results: Participation

## Table 1: Number of Participants Completing Testing & Training by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Pretest (n)</th>
<th>Training (n)</th>
<th>1 month Post-test (n)</th>
<th>6 Month Post-test (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty</td>
<td>16</td>
<td>16</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Residents</td>
<td>25</td>
<td>15</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Fellows</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>APN/FNP</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>CNM</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>37</strong></td>
<td><strong>32</strong></td>
<td><strong>36</strong></td>
</tr>
<tr>
<td>% eligible providers</td>
<td>72%</td>
<td>51%</td>
<td>43%</td>
<td>49%</td>
</tr>
</tbody>
</table>

*Note: total providers invited = 73*
<table>
<thead>
<tr>
<th>Mean Score (SD)</th>
<th>Mean Score</th>
<th>Percent change</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before (Pre)</td>
<td>After (Post)</td>
<td></td>
</tr>
<tr>
<td>Preparation Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre: 1 mo Post</td>
<td>3.48 (±1.34)</td>
<td>4.68 (±1.15)</td>
<td>34%</td>
</tr>
<tr>
<td>Pre: 6 mo Post</td>
<td>3.48 (±1.34)</td>
<td>4.45 (±1.33)</td>
<td>28%</td>
</tr>
<tr>
<td>Perceived Knowledge Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre: 1 mo Post</td>
<td>3.76 (±1.36)</td>
<td>4.81 (±1.20)</td>
<td>28%</td>
</tr>
<tr>
<td>Pre: 6 mo Post</td>
<td>3.76 (±1.36)</td>
<td>4.65 (±1.29)</td>
<td>24%</td>
</tr>
<tr>
<td>Actual Knowledge Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre: 1 mo Post</td>
<td>18.03 (±3.44)</td>
<td>19.55 (±1.86)</td>
<td>8%</td>
</tr>
<tr>
<td>Pre: 6 mo Post</td>
<td>18.03 (±3.44)</td>
<td>19.5 (±2.22)</td>
<td>8%</td>
</tr>
<tr>
<td>Practice Issues Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre: 1 mo Post</td>
<td>16.97 (±6.46)</td>
<td>20.31 (±6.96)</td>
<td>20%</td>
</tr>
<tr>
<td>Pre: 6 mo Post</td>
<td>16.97 (±6.46)</td>
<td>22.37 (±10.23)</td>
<td>32%</td>
</tr>
</tbody>
</table>
Figure 1. Mean scores and 95% CI from PREMIS questionnaire for pre-test, 1 month post-test, and 6 month post-test.
Study Conclusions

- Our study improved provider readiness

- Significant improvement in:
  - **Provider preparedness** at 1 month and 6 months
  - **Provider self-perceived knowledge** at 1 month
  - Improvement in actual knowledge and systems issues
IPV Training in Family Medicine Residency Programs

• **Summary of previous studies**
  • Patient self-reported questionnaires increased IPV identification (Wenzel 2004)
  • Brief IPV training did not change identification or referrals
    • did find female providers identified victims more readily (Saunders 1993)
  • Residents who completed IPV training developed more specific treatment plans (Mandel 1983)
<table>
<thead>
<tr>
<th>Study Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Learner-centered</td>
<td>• No control group</td>
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<tr>
<td>• Interdisciplinary approach</td>
<td>• Not able to assess if the intervention improved</td>
</tr>
<tr>
<td>• Collaboration with faculty and</td>
<td>implementation of screening or victim</td>
</tr>
<tr>
<td>residents</td>
<td>identification</td>
</tr>
<tr>
<td>• Quick, easily reproducible</td>
<td>• Intervention did not alter clinic policy or</td>
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<tr>
<td>intervention for diverse primary</td>
<td>resources available</td>
</tr>
<tr>
<td>care practices</td>
<td>• Provider population (women, early career)</td>
</tr>
<tr>
<td>• Collaboration with community</td>
<td>• Reporting bias</td>
</tr>
<tr>
<td>partners and referral resource</td>
<td>• Confidentiality concerns</td>
</tr>
</tbody>
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Future Direction

• Implementation of screening and policy at clinics
  • focus groups w/ providers and patients
  • studies that examine implementation science

• Larger studies evaluate PREMIS tool and connection with community groups
Acknowledgments

Research team members:

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Amber Alencar MD, MPH (core faculty)
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