



Improving Communication between Primary Care Providers and their Trauma Patients

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Abstract

Our NIMH-funded study is adapting and testing the *Risking Connection* (RC) curriculum, a theory-based approach for helping service providers work with patients who may be trauma survivors, with a focus on growth-promoting and healing relationships. We are adapting it for primary care providers (PCPs) as continuing medical education training. The adaptation has included reduction in the length of the original curriculum to a 6-hour training over one to two sessions, and modifications that were informed by the expert team's experiences and the input of PCPs and patients. After having evaluated initial feasibility and acceptability of the curriculum in the primary care setting through focus groups and pilot trainings, we are now conducting a randomized trial of the training intervention. Four groups of PCPs are randomized to training or wait-list (delay) conditions. The primary outcomes are based on audio taped visits to the PCPs by *standardized patients*, and consist of changes in dialogue codes of independent raters in areas that link theoretically with the RC training. Secondary outcomes include the short-term impact on a subset of PCPs' actual patients.

Introduction

- ◆ Trauma and interpersonal violence can compromise mental health functioning.
- ◆ Trauma is associated with increased medical morbidity, decreased preventive care, and increased costs to the health care system.
- ◆ Rates of trauma and trauma-related mental health problems are high in primary care settings and low-income populations are at highest risk

The proposed research, funded by an NIH grant to Georgetown University, addresses trauma-related mental and physical health problems that present in the primary care setting. Our strategy is to **adapt and test the *Risking Connection* training curriculum** (Saakvitne et al.; Sidran Institute) for primary care providers (PCPs). The curriculum helps them understand and work with patients who may have a trauma and mental health history, with a focus on settings that serve low-income and minority patients. The training is **relationship-focused, with the goal of helping providers understand the patient's perspective and appreciate how significant past trauma might affect one's relationships with providers and others. It teaches RICH relationship qualities that foster respect, information, connection, and hope, among those with trauma histories.** While the training targets work with trauma survivors, it is likely to be beneficial and applicable to all patient-provider interactions.

Aims

- ◆ Adapt an existing manual and training curriculum (Risking Connection) for training PCPs on working effectively with trauma survivors
- ◆ Evaluate acceptability of the adapted curriculum and associated training materials
- ◆ Conduct a randomized controlled trial of the adapted curriculum with PCPs in our partnership safety-net primary care settings

Development Phase

- ◆ Developed draft slide set and participant guide to conduct the initial pilot training
- ◆ Conducted focus groups with primary care providers
- ◆ Conducted focus groups with patients
- ◆ Met with consultant about adaptations to curriculum
- ◆ Conducted pilot training session, debriefed participants and received further feedback
- ◆ Applied for and received Continuing Medical Education credits for training sessions
- ◆ Finalized training design and materials
 - ✧ Training slides
 - ✧ Participant Guide
 - ✧ Trainer Guide
 - ✧ Manual
 - ✧ Training aids (posters, pocket cards, etc.)
- ◆ Finalized outcome measures
- ◆ Developed 3 SP cases for randomized trial
- ◆ Trained six actors to provide SP encounters

Example SP

Ynez is a 35 - 50 year old female complaining of lower abdomino-pelvic pain. She is visiting the doctor today for a follow up to a previous visit during which a pelvic examination was completed, along with lab tests (pap smear). The pain was evaluated during a prior examination and no specific medical problems were found from the examination or the lab work.

She reports that she has had this abdominal pain off and on for "several years," and that it is the same pain for which she has been seen before. On further questioning, Ynez says that this pain began while she was serving in the military and that "those damn doctors could never find anything wrong." As she talks about her military service, you can see that her nostrils flare and she stiffens.

Ynez was an Army mechanic, private, 2nd class, when she was younger(32-36) (approx. 10 – 15 years ago). She was not deployed overseas and spent all four years at an Army base in Texas. When she entered the service, she did not have any children, nor was she married. Her unit was mostly male and she was raped during a party on base by a fellow NCO, but she never reported it for fear of retribution. She did visit the Rape Crisis Center twice after the rape but didn't press charges. She married upon leaving the service (approx. 20 – 30 years) but now is divorced due to irreconcilable differences. Ynez got her GED while in the Army.

She reports that her period has always been irregular, with a heavy flow for the first five days and lasting a total of eight. The onset of her last menstrual period was 5 days prior to today. Ynez reports that the abdominal pain is worse than it has been before for about two weeks but couldn't get an appointment any sooner. On a scale from 1 – 10, pain was a 3 but now it's a 7. Pain is dull and achy. Goes on all the time. She reports no recent treatment for infections. She reports that when she began to hurt she started using a heating pad on her abdomen but nothing has helped. She has been taking 2 Advil every eight hours for the last week and tried an over-the-counter treatment for a yeast infection, Monistat. Nothing has helped. If asked, "can you point to where it hurts?" she points to the general area across the pelvis.

Extensive Hx and Sx provided to SP

Door Note given to provider before encounter

Trial Phase

Curriculum: 6-hr training in two 3-hr sessions
Comparing immediate to delayed conditions
3 SP visits per provider (3 cases)
Pre, post, follow-up (Immediate condition)
Pre, pre, post (Delayed condition)

Delivery method

- ◆ Less than 30% lecture
- ◆ Balance is discovery, case-based, small group activities, symbolic interaction, and experiential learning exercises
- ◆ Models daily activities experienced in practice

Curriculum Topics

- ◆ Trauma as a subjective experience
- ◆ Developmental characteristics of trauma
- ◆ How trauma affects individuals
- ◆ Realms impacted by trauma
- ◆ Survivors' relational styles as obstacles to care
- ◆ Core principles of *Risking Connection*
- ◆ RICH Relationships as intervention

Outcome measures

- ◆ Pre- and post-training questionnaires filled out by the providers
- ◆ Standardized patient (SP) visits before and after training
 - ✧ Recordings of visits scored by Roter's RIAS system at Johns Hopkins, which specializes in research on doctor-patient relationships
 - ✧ SPs fill out rating forms following the visits
- ◆ Anonymous questionnaires that patients fill out about their providers after a visit.

Sites and Trainers

- ◆ 2 community sites and 2 residency training sites
- ◆ 2 trainers, one with adult education and curriculum design expertise (an RC trainer), one psychologist with graduate teaching and physician training experience
- ◆ Trainers crossed with sites
- ◆ All sites serve low-income mostly uninsured minority patients

Preliminary Results

- ◆ Two sites trained (one residency, one community)
- ◆ 15 providers trained
- ◆ Staff trained along with providers
- ◆ 207 patients responded to questionnaires
 - ✧ 86% women
 - ✧ 28% African American; 72% Latino
 - ✧ 73% with trauma exposure
 - ✧ ~ 25% with PTSD sx
- ◆ After training, patients gave their providers significantly higher ratings in the areas of guidance, collaboration, and understanding their problems
- ◆ SP encounter dialogue undergoing RIAS analysis

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