

A Novel Trauma-Informed Care Training for Internal Medicine Residents

JIA LIU, MD

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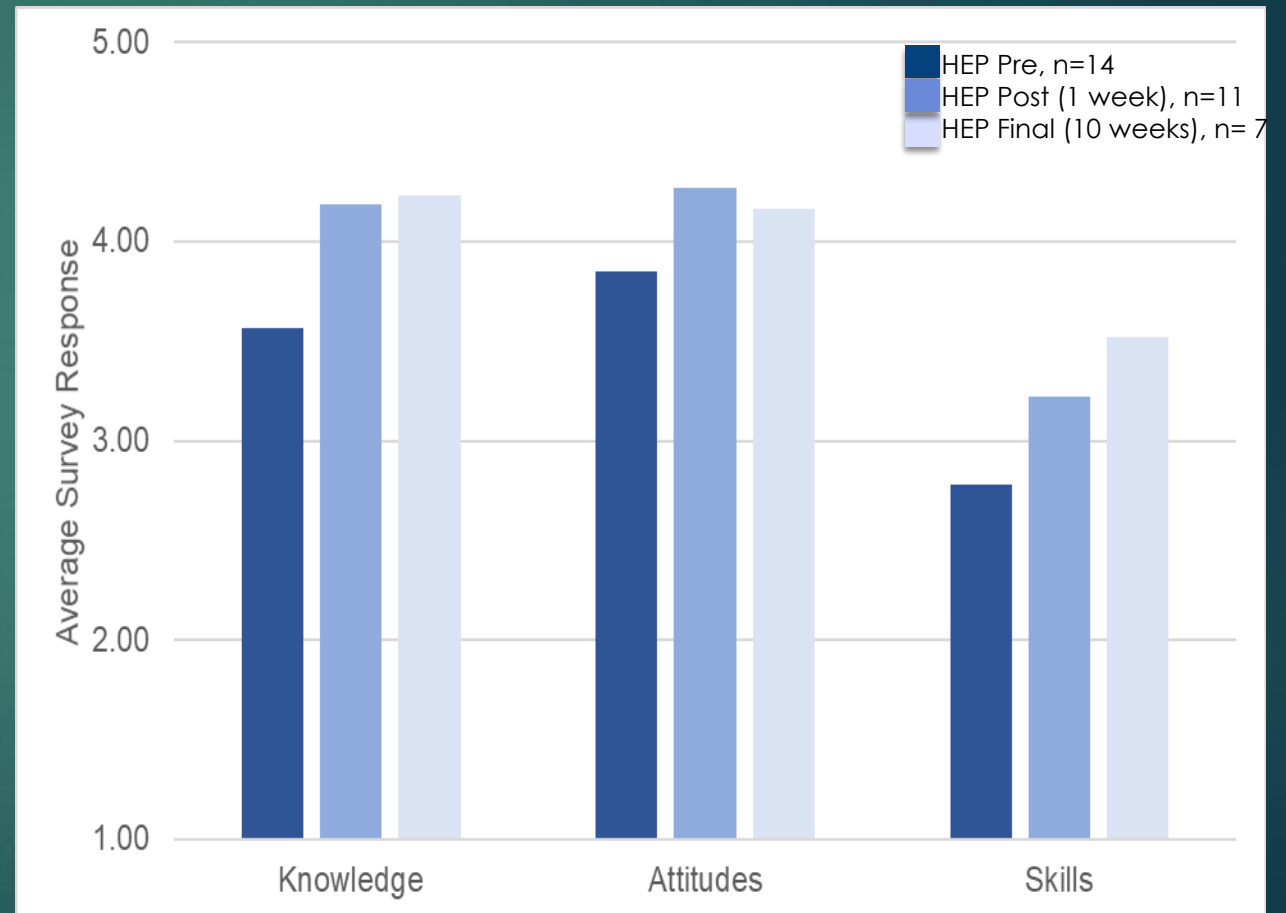
Background

- ▶ Traumatic events in childhood are linked with adverse medical outcomes and an increased prevalence of many chronic medical conditions in adulthood (1.)
- ▶ A lack of formal training in providing care for patients with a history of trauma coupled with the strong emotional reactions that can manifest can create conflict and reduce physician's ability to deliver effective and optimal medical care (2.)
- ▶ Teaching Internal Medicine residents about the impact of prior trauma can help foster better communication between patients and providers and help avoid re-traumatization in vulnerable patients.

Background

A Pilot study done in a prior year was comprised of a 3-hour training led by a psychologist delivered to residents in Health Equity Pathway (HEP)

Figure 1: Mean Likert scale responses before and after a Trauma-Informed Care Workshop for Internal Medicine residents categorized by their knowledge, attitudes, and skills



Background

Goals of my project:

1. Develop a clinically relevant TIC training focused on reducing provider distress around caring for patients with a history of trauma
2. Increasing awareness of ways to reduce re-traumatization.
3. Make a training that was adaptable and deliverable to all levels of GME (PGY 1-3), and eventually, also UME and CME.

Learning objectives

- × Understand ACEs as an important public health problem
- × Recognize ways that ACEs might adversely affect a person's health and lead to adverse health outcomes
- × Develop a framework to recognize the impact of trauma in patients and be sensitive to ways of avoiding retraumatization
- × Raise awareness to think about ways to advocate for decreasing the prevalence and impact of ACEs

Structure:

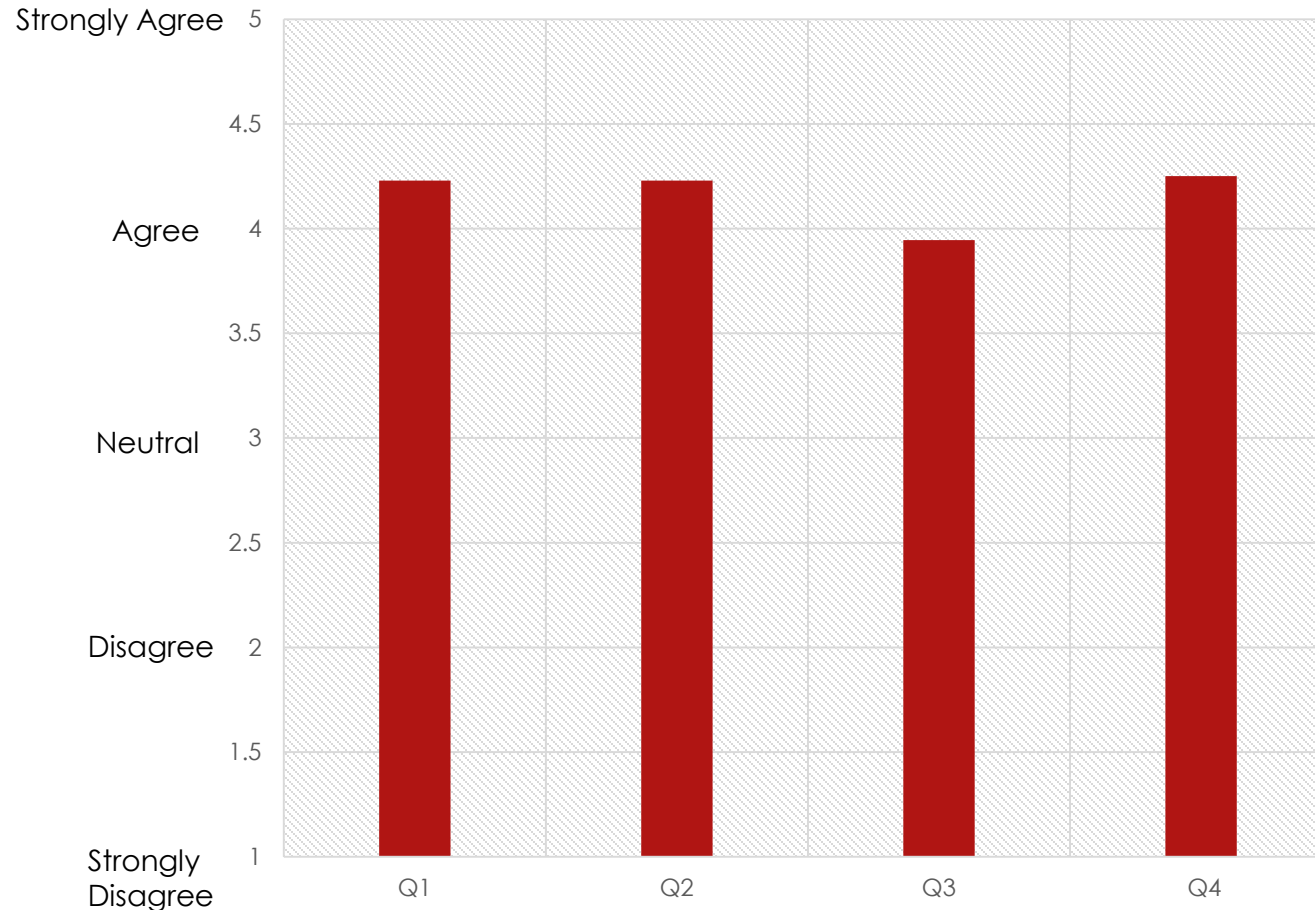
- ▶ 1- hour lecture from an MD (i.e. developed and put together by myself) how trauma manifests in chronic medical conditions:
 - ▶ ACE's study
 - ▶ Chronic/heightened activation of the stress response
 - ▶ Brain remodeling/Epigenetics
- ▶ 1- hour lecture from clinical psychologist focusing on work done at Denver Health and recognizing a provider's own histories of trauma
- ▶ 1- hour discussion section with clinical case scenarios

Audience:

PGY1 internal medicine residents (who have not selected a pathway yet) and PGY-2 and PGY-3 residents in the Health Equity Pathway

Results:

Figure 2: Average of Likert Responses (n: 44)



Question 1: I feel that this session has helped me recognize signs and symptoms of trauma, even if my patient does not disclose them to me.

Question 2: I feel that this session has reshaped my thinking about why patients who have experienced trauma may interact with the healthcare system in often less than optimal ways.

Question 3: I feel that being able to recognize how my own experiences of trauma helps me understand why certain patient interactions might be more challenging for me

Question 4: I feel that this session has increased my awareness of issues that need to be addressed to improve the overall health of the population I care for.

Results: Open-ended Questions:

How might you utilize one thing that you learned during this session to change your practice?

- ▶ Verbage I use during encounters with "difficult" patients
- ▶ I will try to reframe conversations with my patients to explain how our prior experiences can shape our health in the long term
- ▶ Try to coordinate always having my patients see me.
- ▶ Using pathophysiology in discussion of psychosomatic symptoms
- ▶ Being mindful of trauma
- ▶ Keep in mind the effect of trauma - especially in my most difficult patients that I know have had trauma to improve empathy. Use tips from the third lecture to make these patients feel as comfortable as possible in our interactions
- ▶ Understand that an ace of 4 is highly correlated with many diseases. Start using ace survey
- ▶ Go to use to work in the small details of my patient interactions that help foster a positive experience such as how Introduce myself, ask their preferred name, go about the exam, engage them in the visit process
- ▶ I will attempt to recognize signs of trauma when a patient may not disclose this. I'll also try to create a safe space where a patient can talk about this and where I can talk with them about how I can make them feel comfortable in a healthcare situation.
- ▶ Taking time after each visit to consider how my patients life my be affected by trauma- especially for those who are less focal and seem more amenable to my solutions. Acknowledging when trauma has a more subtle presentation.
- ▶ Being more understanding
- ▶ Slow down during pt encounters. Create good relationship w pt
- ▶ Place more emphasis on patient goals and shared decision making
- ▶ Taking a step back before each perceived challenging encounter and being cognizant of how implicit bias, ACE, or other previous traumas may have impacted patient's life/care.
- ▶ Being aware of the prevalence of trauma
- ▶ Utilize motivational interviewing to reduce shame/guilt that traumatized patients experience
- ▶ When I'm getting frustrated, take a moment to reset, try to understand the patient more, and make them a more active member of their treatment
- ▶ Focus more on involving patients in heir care overall

Discussion/Limitations

Difficult to assess efficacy of this training in any kind of longitudinal fashion:

- ▶ Difficult to achieve significant levels of post-intervention survey participation several weeks after the training
- ▶ We did not attempt to assess for patient feelings on efficacy and there are many challenges in attempting to do something like this (to assess if this intervention truly reduces feelings of re-traumatization)

Future Directions

- ▶ Expanding the training to target the entire internal medicine residency class early on in their training
- ▶ Expanding this training to different levels of learners (CME, UME) and multidisciplinary healthcare providers

References:

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1. Green BL KS, Frank L, Glennie M, Subramanian A, Fritts-Wilson M, Neptune D, & Chung J. Primary care providers' experiences with trauma patients: A qualitative study. *Psychological Trauma: Theory, Research, PRactice, and Policy.* 2011;3(1):37-41