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Building the Capacity of PCPs to Eliminate Stigma Through a Research-Informed Training Mode

Abstract

We intentionally centered the voices of historically excluded patient populations in the design of a national primary care practitioner (PCP) training intervention. We sought out patient counter-narratives on HIV/PrEP and COVID vaccine screenings to co-exist with a structured literature review. Doing so allowed our training efforts to understand, disrupt, and reshape systems of power. After our team published a scoping review protocol on both screenings, we identified themes from key informant interviews (n=9) with minoritized patients and PCPs using the Socio-Ecological Model as a theoretical guide for our analysis. Reporting on our research process is beyond the scope of this commentary. Instead, we focus in this paper on what we learned from our research to inform our nine-part PCP training series. Major findings were that PCPs are largely unaware and/or unfamiliar with patient experiences and perceptions of screening; PCPs attend to individual-based, institutional-based, and policy-based facilitators to screening (i.e. overlooking interpersonal-based and community-based facilitators); and patients and PCPs align on the community-based barriers to screening. We developed and implemented a research-informed PCP training series. PCP trainings must be theory-informed and evidence-informed so that learners have the opportunity to become structurally competent in their aims to eliminate stigma.

HIV and COVID-19 are highly stigmatized and disproportionately impact the same patient populations. The Two in One Model was designed as a national research-informed training effort for primary care practitioners (PCPs) to eliminate stigma by routinizing screening for HIV testing and COVID vaccines in the primary care setting.

The Dimensionality and R4P Health Equity Framework offered the equity-based action required to design a training series to address the historical conditions that cause disparate HIV and COVID outcomes among minoritized populations. [1] We conducted HIV (n=49) and COVID (n=19) scoping reviews on screening practices where we used the Socio-Ecological Model [2] to organize our findings-turned-training themes while Critical Race Theory [3] and Queer Theory [4] informed the key informant interviews (n=9) that we conducted to contextualize the training content. Lastly, we relied on a design-based research approach [5] by continuously consulting our National Advisory Board with proposed training content.

We curated a committee of experts to serve as our National Advisory Board who represented specific content knowledge and a range of perspective as patients, residents, clinicians, and government leaders. They also represented a range of racial, sexual, and gender identities. We acknowledge the fullness, complexity and within-group differences of minoritized groups by stating this stance on our website. We also believe it is necessary to name and dismantle colonialism as a way to push back against who gets to create knowledge. As such, our training series includes Black women, patients and community organizers as thought leaders, change agents, and subject matter experts on HIV and COVID-19 prevention who can inform medical education and clinical practice. When creating the program mark/logo, we intentionally used the vibrant colors from the LBGTQIA+ flag. We used this mark on all PowerPoint slides and the recorded videos that branded the program.

Since we started our research with patient and PCP stories, we were able to uncover early on in the project period that there existed a gap in the PCP-patient relationship. We learned that while PCPs focused squarely on the structural factors that affect clinical screening, patients reported the importance of their relationship with PCPs on their screening behaviors. Yet, most notably, we learned that PCPs were largely unaware of their patients' experience with racism and the level of responsibility placed on patients for deciding if and when to seek care, how to navigate the healthcare system, and what to disclose in exam rooms while experiencing the toll of racism at every turn. We knew there needed to be a specific competency that PCPs could learn to address this phenomenon – and thus the call for culturally responsive communication (CRC) emerged. CRC is the skill that cuts across all modules despite varied training content.

In this commentary, we focus on the research-informed messaging we shared in our PCP training webinar series. We hosted a nine-part research-informed live lecture training series designed for PCPs to build their capacity to eliminate stigma in the primary care setting. From January 2023-November 2023, we were able to reach over 3,000 learners through our live CME-bearing training series. We invited all of the virtual speakers to record never-before-seen content for a self-paced asynchronous online course version of the same training. On March 1, 2024, we debuted 5 of the 9 online standalone modules. The remaining 4 modules debuted on May 1, 2024.

We extended what we learned from our scoping reviews to include 60-minute key informant interviews using the Socio-Ecological Model (SEM) as a theoretical guide.[6-7] We conducted nine semi-structured interviews with six patients who identified as minoritized and three PCPs. Below is how we organized and translated our qualitative themes using the SEM into training content for PCPs to support patient screening needs.

Individual-level Factors

PCPs feel largely attuned to their responsibility to self-educate on the enduring impact of racism and heterosexism. They also reported being hyper aware of stigmatizing patient HIV attitudes. However, they admitted that acting on their awareness is circumvented by feelings of burnout. PCP burnout is well-documented for the impact it has on clinician well-being but it also affects the PCP-clinician relationship.[8]

- Patients told us that they experienced racialized discrimination at every turn as they navigated the healthcare system and life beyond clinical settings. While advocating for their right to health is noble, this ongoing fight is not only unfair but it remains exhausting. Patients reported feeling drained by the perceived pressure to remain open-minded with clinicians who exhibit profiling behaviors.
- When it came to preparing a training, we focused on the need for PCPs to practice culturally responsive communication (CRC). Not only does our call for CRC advise clinicians to consider the role of patient culture on screening but it also reminds clinicians to interrogate their own cultural beliefs for how assumptions shape clinical discussions.[9] This training also introduced PCPs to the culture of racism given the maldistribution of power.

Interpersonal-level Factors

- Patients reported that having a PCP of a similar race was just as important as them being involved in supportive patient networks. In both instances, a sense of solidarity, belonging and safety becomes evident.
- Interestingly, PCPs rarely discussed their patient relationships. There was a minimal mention of being friendly. The extent of their interactions were limited to performing patient histories. While the purpose of these interviews were not to make generalizations, this omission is glaring for the role of power imbalances.
- When it came to preparing a training, we focused on the need for PCPs to share power and decision-making authority with patients. This session included a patient advocate who manages living with HIV as well as a community-engaged practitioner. It is important for screening conversations to consider the needs of patients across the lifespan who want multiple prevention and treatment options which requires clinicians to be up-to-date on HIV prevention tools.

Institutional-level Factors

- PCPs noted that while they intend to screen patients for HIV exposure and PrEP candidacy, remembering to do so when managing the care of clinically complex patients and time being limited makes it challenging to standardize screenings. PCPs focused on how access to patient records and following clinical policies/procedures may help when they do have time to host these conversations. Patients emphasized that having access to a PCP, a positive environment, and material at appropriate health literacy level is what matters most.

- Patients pointed out how not having access to their electronic health record, the stigma of other emergent infections and the fact that some clinicians test them for HIV without their knowledge are what make them less inclined to seek out screening services.

- When it came to preparing a training, we focused on the need to apply a health justice approach. This session shifted priorities away from patient education alone to also addressing the social determinants of health. The population health impact model tells us that a focus must be on structural inequities if we want to eliminate health disparities and restore trust amongst marginalized communities.[10] A health justice approach to screening conversations facilitates patient power and autonomy in the clinical setting when patients perceive not having control over the conditions in which they live.

Community-level Factors

- Patients re-emphasized the impact that family, social media, church, friends and clinicians have on their sense of knowledge and self-efficacy to protect themselves against HIV.
- PCPs and patients, alike, described the negative impact of myths and stigma on HIV prevention efforts.
- When it came to preparing a training, we focused on the need for PCPs to reframe how we talk about HIV. PCPs can rely on motivational interviewing, or goal-affirming and open-ended questioning, to challenge stigmatizing narratives within the clinical encounter. Doing so may encourage patients to share their health seeking behaviors and contexts that may expose them to HIV.

Public Policy-related Factors

- PCPs focused their discussions on the role of the health department in addressing Mpox and state auto-populated immunization records. Patients had much to say on the role of public health attitudes amidst mandates.
- We addressed the factors identified by PCPs and patients in a published set of policy recommendations to expand and integrate existing HIV and PrEP/PEP screening guidelines more seamlessly in clinical care.[11]
- When it came to preparing a training, we focused on the need for PCPs to understand state-level HIV opt-out screening policies. We secured a government official that supported our recommendation to expand CDC's HIV clinical testing guidelines. We emphasized that automatically testing for HIV must not preclude screening conversations. Doing so would promote patient mistrust and infringe on a patient's right to refusal.

Conclusion and Next Steps

Our training efforts were designed to curate credible resources in one setting for PCPs to access and receive the support they need to address sociocultural factors weighing in on screening practices. Given the reach of our live series, we have designed a self-paced CME-bearing online course to reach an even broader audience. Each online module includes a welcome video, speaker video content with embedded quiz questions, required readings, supplemental readings and resources such as our patient care toolkit and policy white papers, as well as a retrospective pre/posttest. The total time learners spend in each module is estimated at 60 minutes.

This online training series is designed for clinicians in training (MDs, DOs, PAs, NPs, RNs, PharmDs) and in practice (i.e. students) to value routinizing HIV, PrEP/PEP and COVID vaccine screenings for all their patients. But this content is also applicable to the work of researchers, non-clinician faculty, and scholars who write about and design interventions and policies that impact population health. Eligible clinicians can claim up to 1.0 AMA PRA Category 1 Credit and others can download a certificate of completion.

The application of our conceptual framework resulted in the development of three policy white papers and four clinician vignettes that reached 75,000 clinicians (which we embedded in our training module). Since our original monthly nine-part live webinar reached 3,000 learners, we are confident that our recently debuted asynchronous, self-paced CME-bearing online course will reach an even broader audience. We only assessed reach in our live training and will assess impact in our new online modules. We have presented this training model as six peer-reviewed national conference presentations as well as invited keynote presentations for Meharry Medical College, the American Medical Student Association and the National Medical Association. The research that informed our training series is published as two open-access scoping review protocols[6, 12] and the National Advisory Board that vetted all our training content is also presented as a model. [13]

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About the Author

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