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Stepped collaborative care for trauma: giant leaps for health equity

Rachel Rivero, Lisa M Kodadek

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Mortality rates after injury are low due to advances in trauma care, but survival is not sufficient: trauma leads to more disability worldwide than any other disease.[1] In the year after injury, between 20% and 44.4% of patients screen positive for post-traumatic stress disorder (PTSD) and over 40% of patients are unable to return to work.[2–4] The goal of a trauma system is to facilitate recovery after injury, including optimal long-term functional outcomes and reintegration into society. However, patients recovering from injury face significant barriers to receiving optimal postdischarge healthcare. Only 28% of level 1 and 2 trauma centers in the USA routinely screen for PTSD[5] and less than 10% of patients receive treatment for PTSD after injury.[3] Patients belonging to minority populations are disproportionately affected by care transition disruption and experience adverse healthcare disparities after trauma.[6]

Dr Abu[7] and colleagues offer an innovative, stepped collaborative care intervention which has differentially reduced PTSD symptoms at 6 months after injury in self-reported racial and ethnic minority populations. Their work demonstrates the development of a successful model for achieving more equitable health outcomes after injury. These findings result from secondary analysis of data from a stepped wedge, cluster randomized trial conducted at 25 trauma centers. Injured patients at risk for PTSD were randomized to enhanced usual care or the intervention, which included proactive care management, cognitive–behavioral therapy, and psychopharmacology for PTSD.

The authors demonstrate how multidisciplinary care can be used to mitigate health disparities in trauma by incorporating shared decision-making and individual treatment preferences. The collaborative approach highlights the importance of engagement from all healthcare providers, including nurses, social workers, and physicians. Effective care strategies must incorporate patient-centered care and tailored elements to directly address baseline healthcare inequities and social determinants of health. Furthermore, care must account for patients' individual past experiences, their own interpretation of trauma, and culturally specific ways of healing.

All patients included in this study had very high rates of baseline PTSD and prior trauma. Although we often think of trauma as an acute disease, the reality is that it may be recurrent and chronic, particularly when associated behavioral health risk factors are not addressed. Among non-white/Hispanic patients, 14.3% had baseline PTSD and almost 40% had suffered five or more prior injuries; they also reported significantly lower frequencies of preinjury mental health service utilization compared with white/non-Hispanic patients. For some, the collaborative care intervention may have represented the first opportunity to receive appropriate healthcare for PTSD associated with prior injury.

Dr Abu and colleagues should be commended for taking important steps to care for adverse sequelae associated with traumatic injury. For underserved populations, these first steps represent giant leaps for health equity.

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ORCID iD

Lisa M Kodadek http://orcid.org/0000-0001-6433-9159

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Yale School of Medicine, New Haven, Connecticut, USA

Correspondence to
Dr Lisa M Kodadek; lisa.kodadek@yale.edu