Healing healthcare: Applying the principles of trauma-informed care

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Objectives

Understand	Understand the impact of trauma on the healthcare workforce.
Consider	Consider ways in which toxic stress impacts trainees and healthcare workers.
Develop	Develop a new vision for applying trauma-informed principles in the healthcare environment.

Can you leave here today with one idea for ~~changing your practice~~ **change**?

Photo by Jimmy Chang on Unsplash

Trauma is experienced by an individual

"…an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Consider effects of structural inequity/stigma on physiology and behavior… individual perception no longer a requisite.

Substance Abuse and Mental Health Services Administration (SAMHSA.gov)

Sciolla, AF, unpublished communication

Trauma is ~~experienced by an individual~~

"…an event, series of events, or set of circumstances ~~experienced by an individual as~~ that becomes physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Substance Abuse and Mental Health Services Administration (SAMHSA.gov)

Trauma Examples

Can be a single event, more often multiple events over time

Structural violence: social structures harm/disadvantage individuals including experiences of systemic oppression, ‘isms’, poverty

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Interpersonal violence/violations by authority figure can be most damaging

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Natural Disasters/Climate Change/Wildfires/Wars

Collective, historical, generational

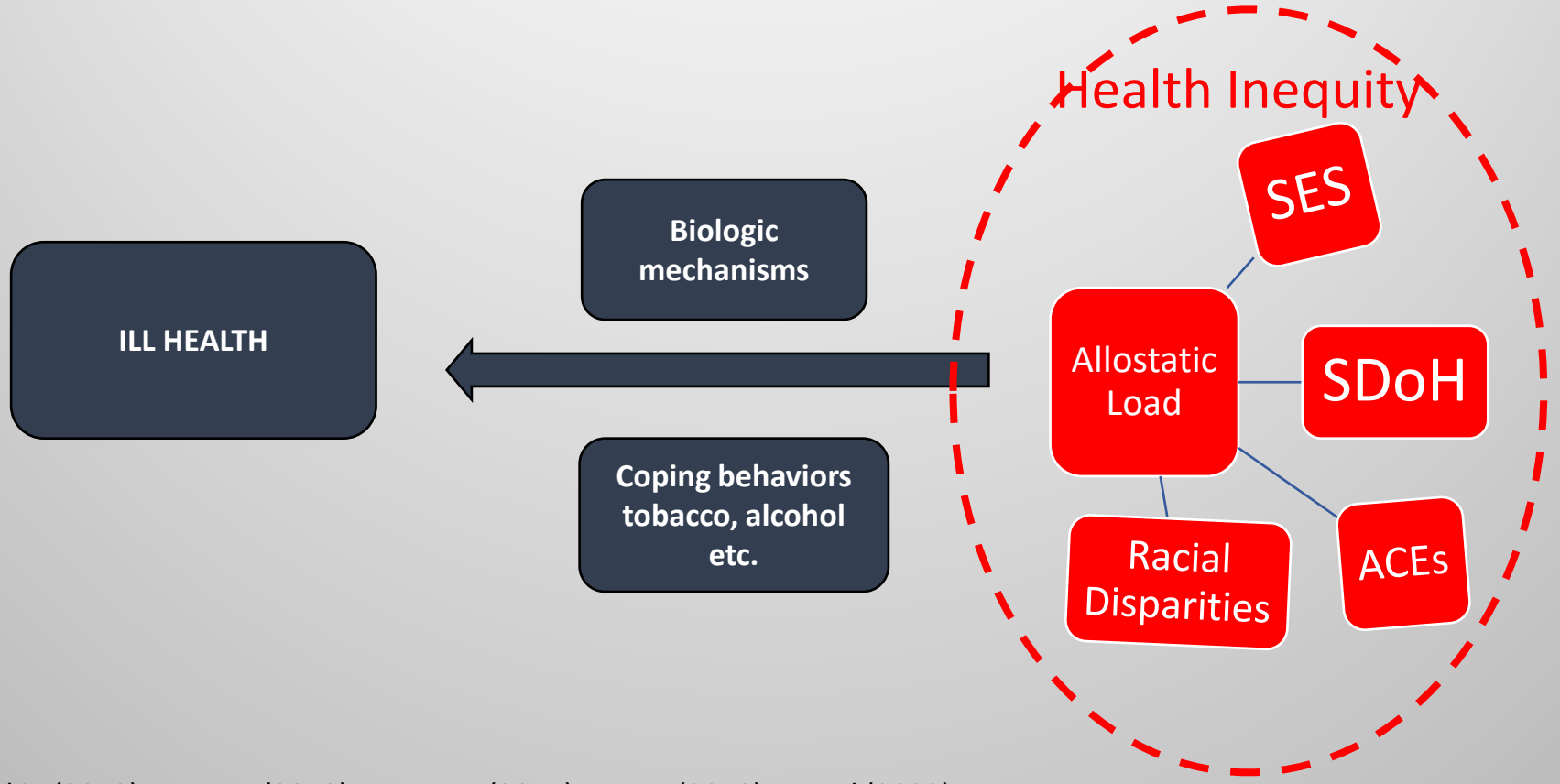
Trauma and Ill Health: Complex Interplay

Allostasis and Allostatic Load

"Allostasis" = highly integrated balance of the central nervous system (CNS), endocrine/metabolic, and immune systems which mediate the response to stress.

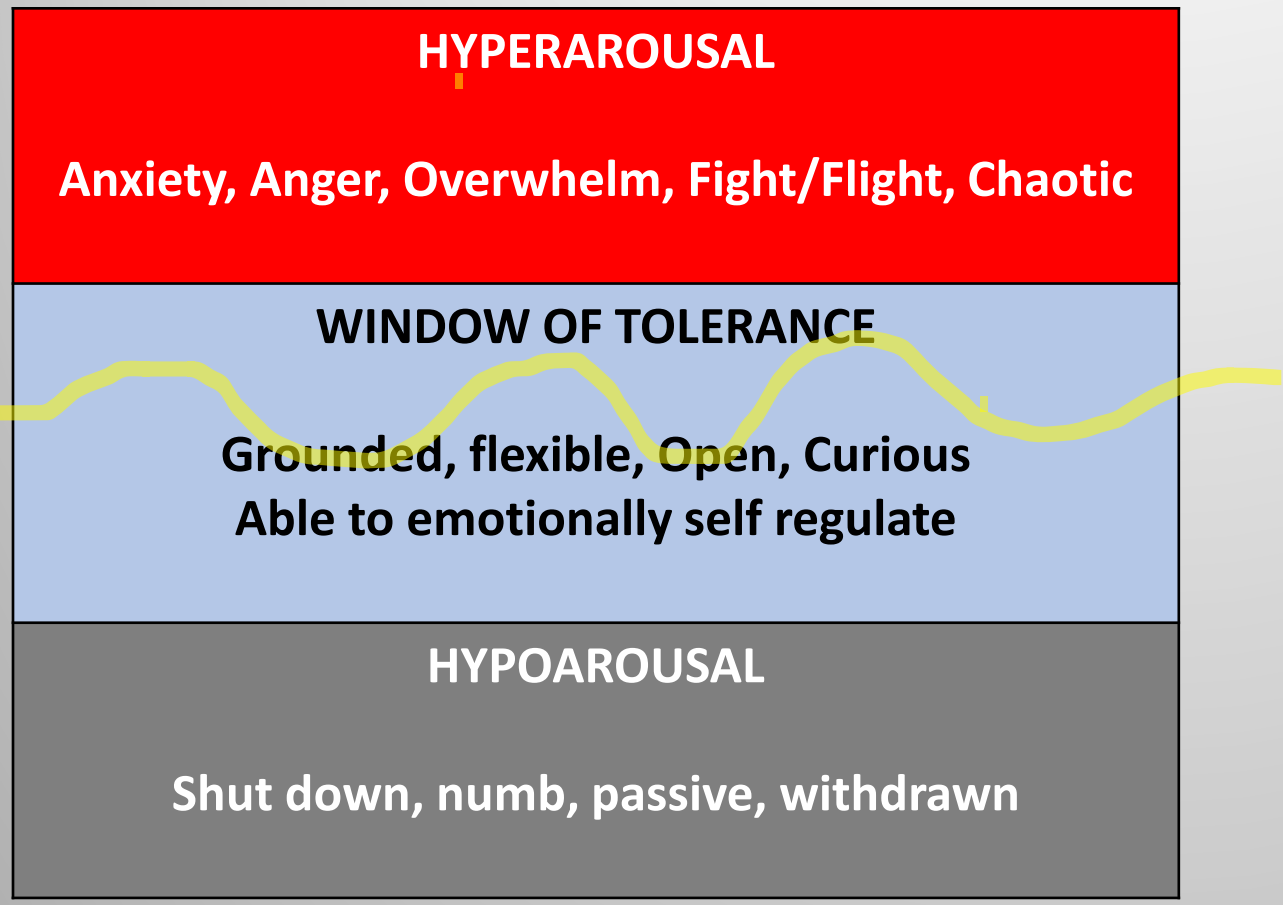
Measurement: biomarkers cortisol, epinephrine, CRP.
Clinical measurements: lipids, A1c, BP, HR, BMI, skinfold.

Allostatic Load: Associations/Mechanisms



Beckie (2012), Danese (2012), McEwen (2017), Juster (2010), Dowd (2009)

Window of Tolerance



Autonomic sensitivity: Sympathetic hyperarousal & parasympathetic hypoarousal are extremes.

Dysfunctional behaviors such as substance use, self-harm are efforts to regulate the ANS which is regularly triggered into extreme states by reminders of original trauma.

Corrigan (2011)

Trauma-informed Care/Systems (4Rs)

- **Realizes** the widespread impact of trauma and understands potential paths for recovery;
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively **Resist** re-traumatization.

Hopper (2009), Gerber (2020), Kelly (2015), Substance Abuse and Mental health Services Administration (SAMHSA). Definitions. SAMHSA News. 2014;22(2).

© *UnMasked* by Megan Gerber *Fall 2021 Intima: A Journal of Narrative Medicine*

2020

Collective Occupational Trauma

An already worn workforce has been forced to wrestle constant & intense levels of suffering. Grief, loss, & fear of illness, morbidity & mortality are shared with patients, their families, colleagues & society.

Increases in physical and emotional violence against health care workers – trend accelerated during pandemic.

Chronic & recurrent waves of pandemic-related illness, exhaustion & depersonalization have kept HCW on high alert.

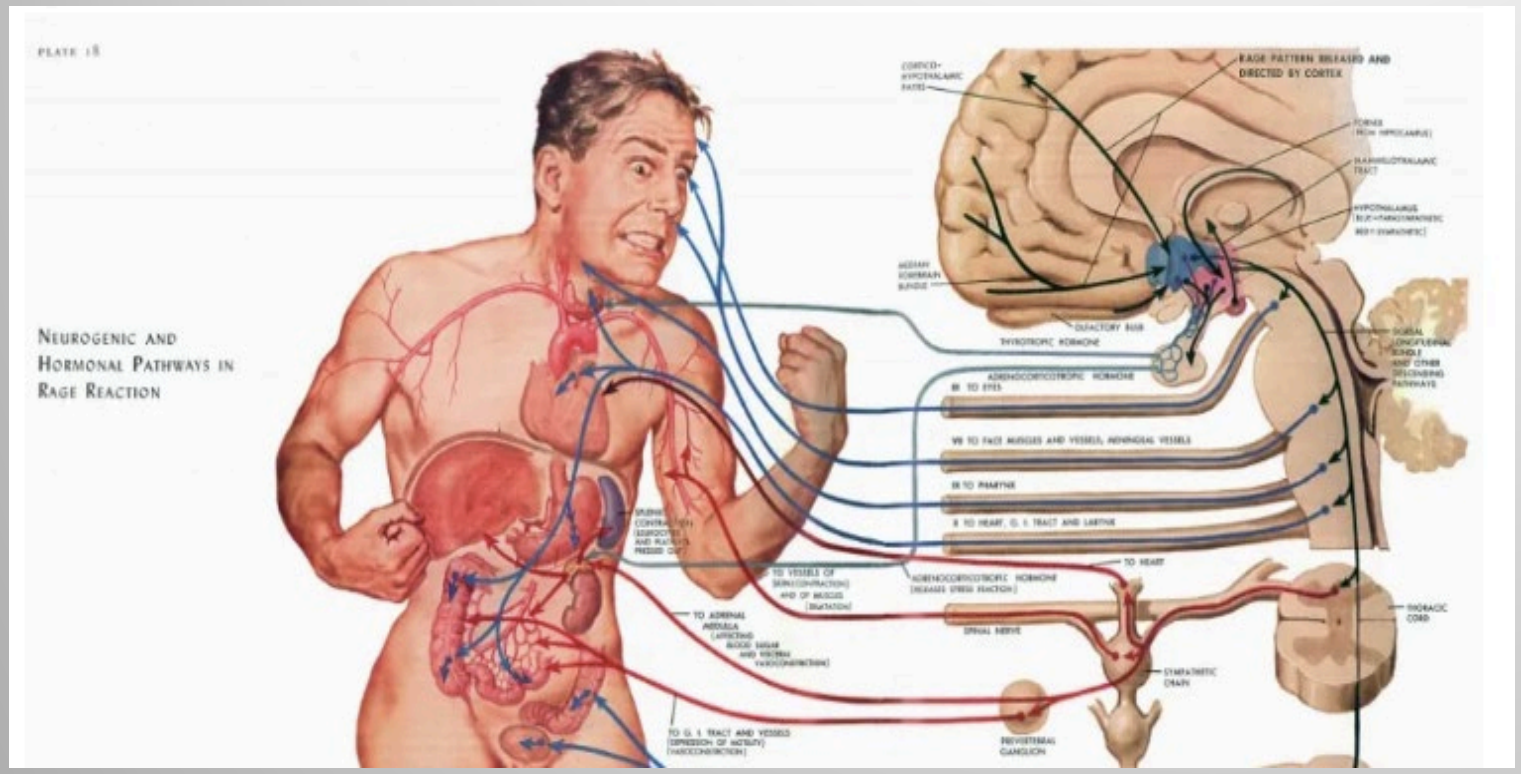
Staff sick calls, absences, coverage challenges, plummeting retention rates, early retirements.

75% of the interprofessional workforce is mentally/physically exhausted (UK study)

Added intense social narrative of cultural, social and racial injustice

Dyer (2021), Fink-Samnick E.

Trauma in Medicine - amplifiers



- Critical illness/injury/death
- Microaggressions/bias
- Shaming/bullying
- Culture of training
- Legacy of structural racism
  - Race-based measurement
  - 70 kg man
  - Representation (Netter drawings, White skin)
  - Portraits in medical schools

Microaggressions

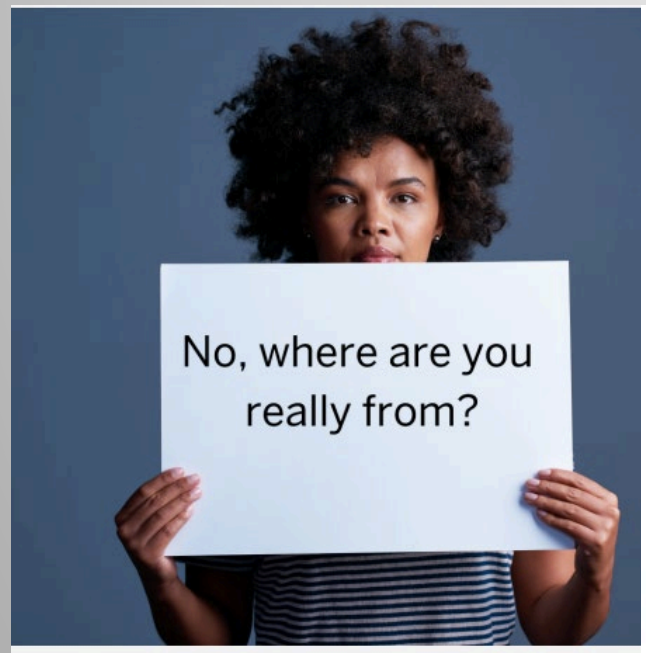
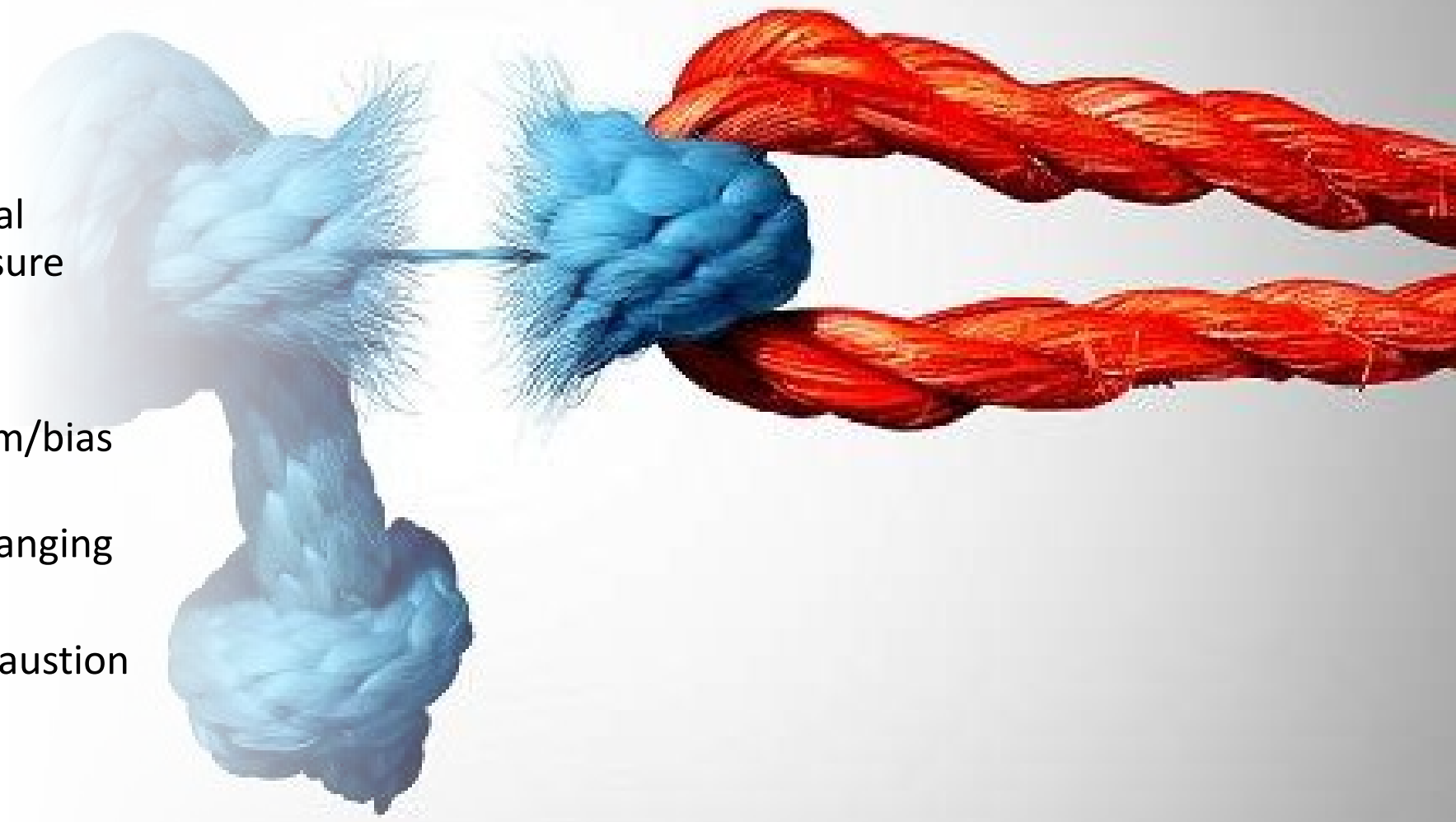


Photo credits: Miller et al, Am College Emerg Physicians, ACEP Now, Kiyun Kim, "Racial Microaggressions" (2013) www.adl.org/education-outreach

What does this mean?

- We may enter professional school with trauma exposure
  - ACEs, structural racism/violence
- We may experience racism/bias during training
  - Medical culture is changing slowly
- Rates of burnout and exhaustion were high pre-pandemic
- And then came COVID



COVID and the healthcare environment

OUR PATIENTS

- Increases in interpersonal violence (IPV, elder/child abuse),
- Structural racism, ageism, poverty
- COVID itself is traumatic
- Worsening mental health, SUD among patients
- “Politicization” (polarization) of health measures/public health

US (WORKFORCE)

- Widespread staffing shortages
- Clinician/HCW death and disability
- PTSD, depression, suicide, burnout, moral fatigue
- Redeployments, early retirements
- Fewer resources for our patients (corporatization of behavioral healthcare) –
- Financial strain

Neria (2008), Galea (2020), McGuire (2021), Gerber (2020), Han (2020), van Gelder (2020), Kuehn (2020), Marvaldi (2021)

COVID: a syndemic

A “syndemic” is defined as a synergistic interaction between **socioecological and biological factors**, resulting in adverse health outcomes.

Infection with SARS-CoV-2 is interacting with non-communicable diseases within social groups according to patterns of inequality.

A syndemic is characterized by biological and social interactions between conditions and states that increase a person’s susceptibility to harm or worsen their health outcomes.

Vulnerability of older citizens, minoritized persons and key workers who are commonly poorly paid.

Yadav, https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_WPV_HS_Survey_Report_FINAL.pdf

COVID-related financial trends

- Multi million year-to-date operating loss
- Medical staff RVU shortfall due, in part, to no show rate
  - Team is advised they may have to start double-booking
  - Each clinician is held accountable for their no-show rate
    - Patients on Medicaid plans have higher no-show rates
  - Clinic SW left, position swapped for RN
  - Minimal on-site behavioral health

Ms. C – new patient visit

- Ms. C is a 30-year-old Black woman seen as a new patient establishing primary care at our practice. She came with her 3 yo son, A. They arrived late and “she argued with the staff.”
- She is taking naltrexone for alcohol use disorder which was started in 12/2021 6 weeks after the birth of her 2nd child, G. She shared a challenging childhood and wants a better life for her children. ACE score = 9.
- SH: Former partner was abusive, and she is sole parent. She works 4 days a week doing data entry and relies on family members for care of the children. Several family members died of COVID.
- PE: Guarded. Hopeful, forward thinking, positive/caring interaction with A. during visit.

Ms. C – Urgent visit

- Ms. C. returned for an urgent visit 2 months later with c/o malodorous vaginal discharge after unprotected intercourse.
- She experienced a relapse and used cocaine and is now in the [day treatment] program. She had pregnancy testing last week and feels pregnancy is unlikely as she has Nexplanon.
- She feels her discharge is due to BV which she has had before.
- As we spoke, she told me she had multiple sexual contacts in order to pay for drugs.
- Testing: +gonorrhea, +BV

Ms. C – Care coordination

- We scheduled Ms. C for follow-up for a “test of cure.”
- She does not attend her appointment.
- Referred to Managed MCD Case Management.
- We called her, rescheduled.
- We receive notification she is in detox, then discharged.
- She does not attend two more appointments…..
- She was discharged from the practice.

Moral Injury (Distress)

- “psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations.”
- “describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control. **Moral injury is the consequence of the ever-present double binds in health care: Do we take care of our patient, the hospital, the insurer, the EMR, the health care system, or our productivity metrics first?”**

Dean W, Talbot S, Dean A. Reframing Clinician Distress: Moral Injury Not Burnout. Fed Pract. 2019 Sep;36(9):400-402.
Litz et al. Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. Clin Psychol Rev. 2009 Dec;29(8):695-706. Epub 2009 Jul 29.

COVID, trauma and us

Compassion Fatigue	Vicarious traumatization	Secondary Traumatic Stress
Diminished capacity of a health professional when experiencing the distress at knowing about or witnessing the suffering of their patients and clients.	Describes the undesirable outcomes of working directly with traumatized populations and presents as **negative transformative processes experienced by the health professionals when exposed to traumatized patients.** This process arises out of the empathetic nature and engagement of the health professional with the distressed patient	Stress response resulting from **witnessing or knowing** about the trauma experienced by significant others. It has been defined as the destructive emotional distress resultant of an encounter with a traumatized and suffering patient or who has suffered primary or direct trauma **More recently, it is being recognized as driven by fear that arises from a threat to one's personal safety.**

Nimmo, 2013

Study of HCW Trauma and MH NYC (n=889)

Probable PTSD	Secondary Traumatic Stress	Burnout	Compassion Satisfaction
Female Gender **2.14 (1.10-4.15)**	COVID Obsession **3.84 (2.44-6.03)**	Age 45-54 **0.38 (0.21-0.69)**	Death of COVID patient **1.63 (1.09-2.44)**
Prior BH Condition **2.01 (1.00-4.04)**	Probable PTSD **6.72 (3.27-13.81)**	Prior BH Condition **2.48 (1.28-4.81)**	Secondary Traumatic Stress **0.67 (0.47-0.96)**
COVID Obsession **3.93 (2.35-6.56)**	Burnout **3.92 (2.57-5.98)**	Probable PTSD **3.88 (2.11-7.11)**	Burnout **0.11 (0.07-0.96)**
Secondary Traumatic Stress **6.58 (3.19-13.57)**		Secondary Traumatic Stress **4.12 (2.68-6.32)**	
Burnout **4.03 (2.15-7.56)**			

Yu et. al. Healthcare worker trauma and related mental health outcomes during the COVID-19 outbreak in New York City. PLoS One. 2022 Apr 29;17(4):e0267315.

The healthcare macro-environment: enhancing toxic stress

- "The US hospital financial model largely relies on providing lucrative, highly reimbursable services – joint replacements, cardiac procedures, and the like. **These services receive priority over meeting the broader health needs of the population**.
- Although COVID patients might require more of some resources from a hospital and its staff, reimbursements for the types of intensive care they receive offer lower margins than elective procedures."
- Changing the environment for patients and staff is still possible.
- Educating future healthcare leaders, changing culture.

https://hbr.org/2021/06/preparing-hospitals-for-the-next-pandemic

What can be done?

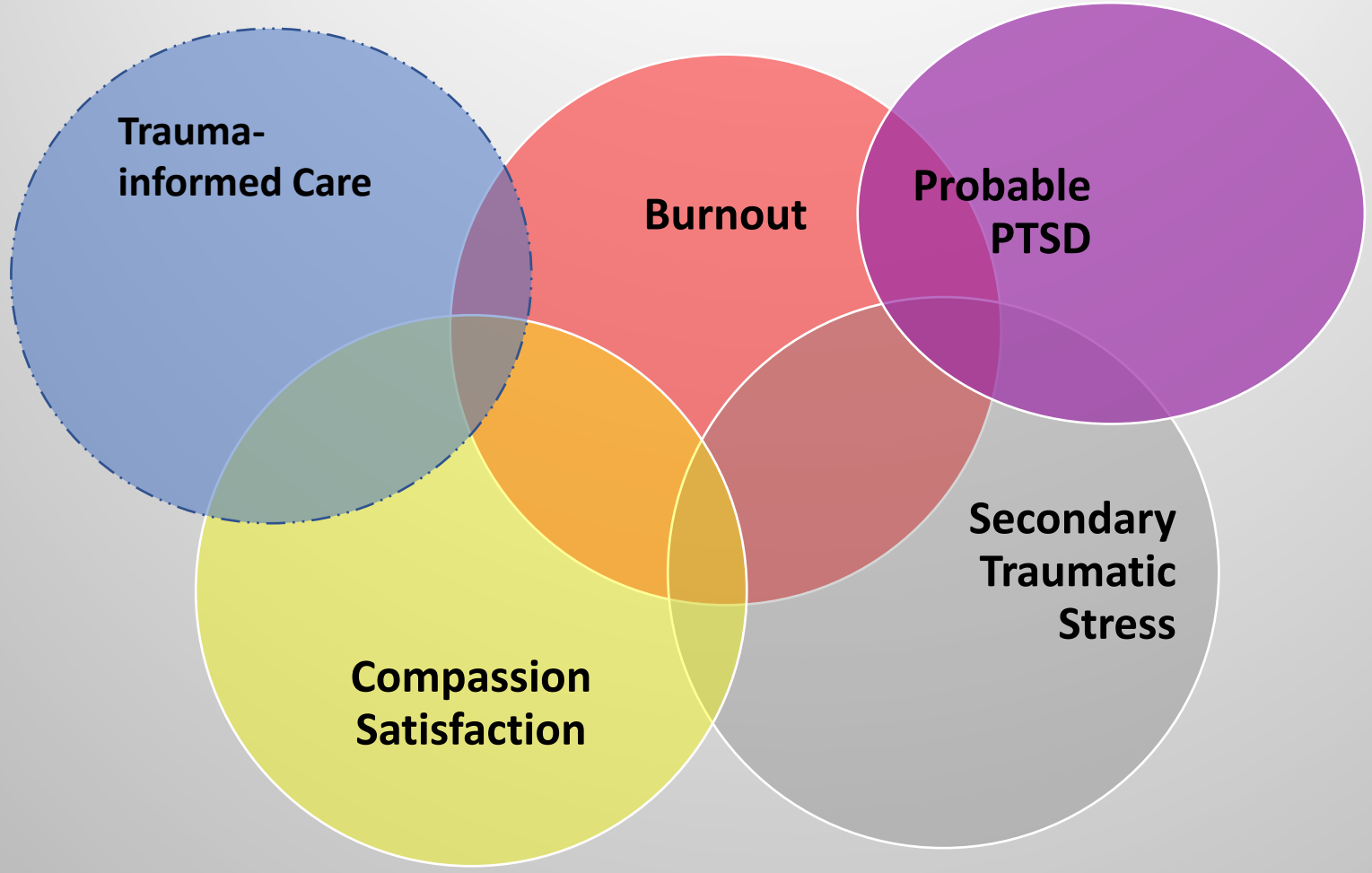
Trauma-informed Leadership

Realizes	HCW through the nature of the work, societal stresses and syndemics experience trauma along with patients/clients.
Recognizes	Conditions like burnout have roots in traumatic stress & that the work environment/policies/economic pressures can worsen/exacerbate this.
Responds	To foster healing environments to not only retain but foster posttraumatic growth and compassion satisfaction in HCW.
Resists	Retraumatizing HCW through policies and pressures that pit clinicians against patients.

Trauma-informed leadership

Safety: Feeling unsafe in the workplace is correlated with burnout & compassion fatigue	Adequate protocols and policies to work with “difficult patient behaviors”, adequate PPE, emotional safety.
Trustworthiness/ Transparency	Autonomy, varying caseloads, allowing true participation of employees in decision-making, place trust in staff, accept a realistic view of services, “explain the why” to staff.
Peer Support	Professional Development, Balint Groups, self-care activities at work.
Collaboration/ Mutuality	Adapting practice style/modifying expectations/recognizing limitations, diversifying workforce.
Empowerment/ Choice	Motivate through positive methods, not fear-based; trauma-informed leaders accept different ways of doing the work, validate knowledge of staff, incorporate staff ideas, support autonomy, shared decision-making.
Cultural, historical and gender issues	Inclusive environment, respect SO/GI, pronouns, policies to support all employees/families.

Hacer TY (2020), Wolotira (2022), Woolhouse (2012), https://traumainformedoregon.org/wp-content/uploads/2020/08/Research-Notes-Behaviors-and-Actions-of-Trauma-Informed-Leaders.pdf



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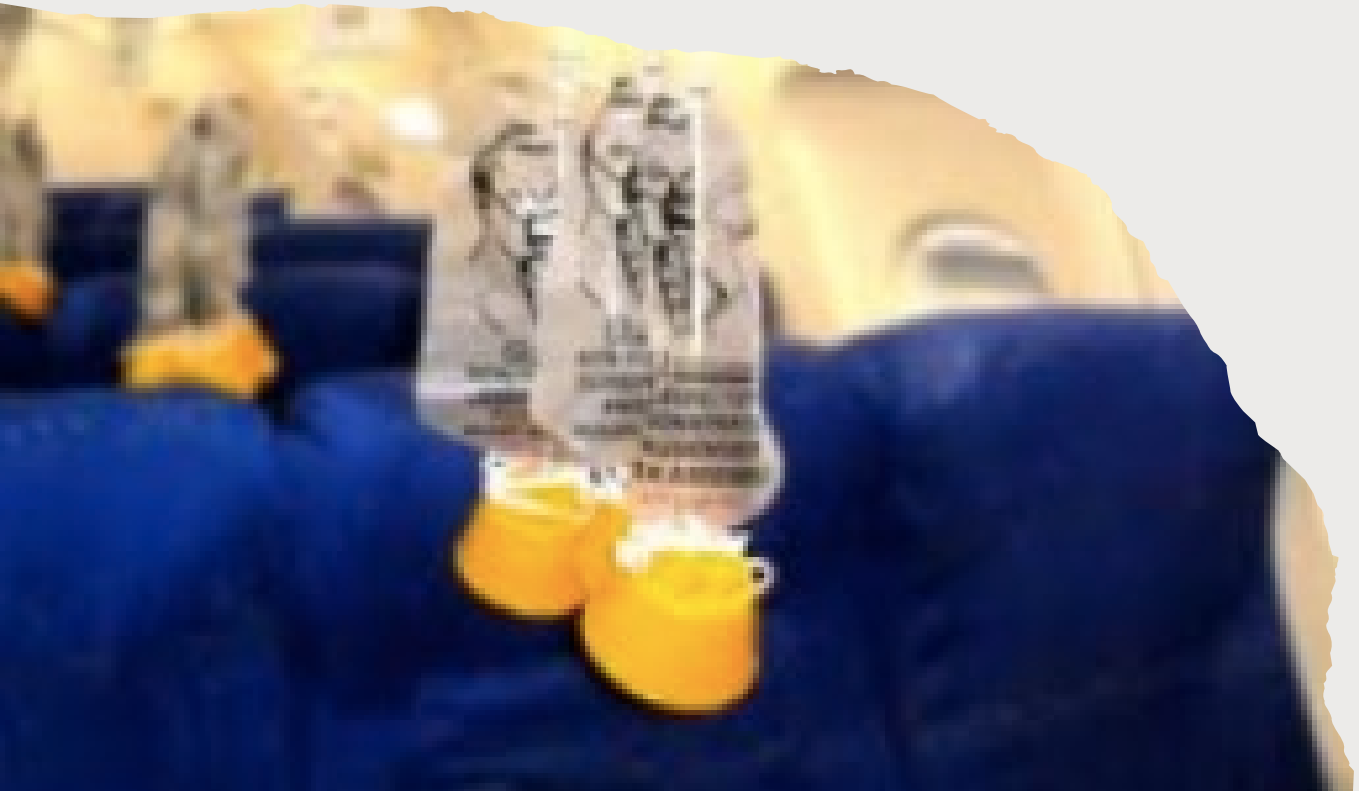
Resources for Clinicians



- National Center for PTSD, Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak: https://www.ptsd.va.gov/covid/COVID19ManagingStressHCW032020.pdf
- ACP Emotional Support Hub: https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment/im-emotional-support-hub

Health Professions Education

- National Collaborative on Trauma-informed Healthcare Education and Research: Competencies for Undergraduate Medical Education: https://tihcer.weebly.com/tic-competencies.html

- Albany Medical College
  - 1st year curricular thread beginning with Intro to Medicine in Week 1
  - Interdisciplinary Problem-based learning
  - Trauma-informed communication and physical exam

Thank you!

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