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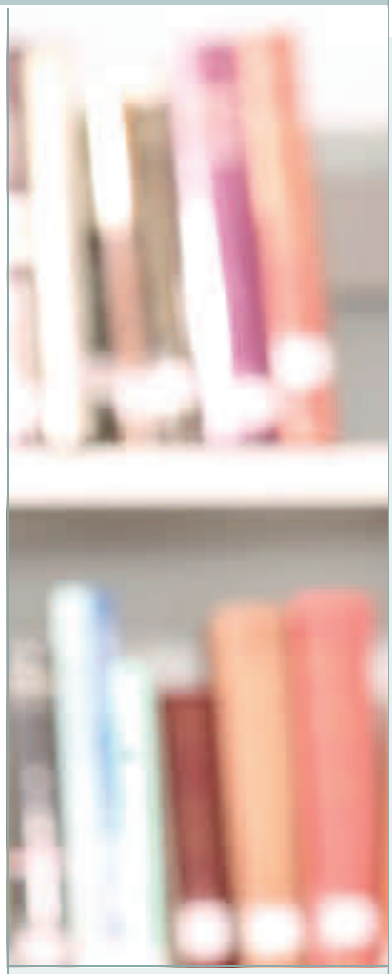
Insights

INTO RISK MANAGEMENT



@RISK: TRAUMA INFORMED HEALTHCARE

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This article is an enduring activity approved for *AMA PRA 1 Credit(s)™* and category 1 credit in Risk Management Study. *(See link on p. 3)*

Those of us who work in healthcare are intimately familiar with trauma. Medical trauma appears on our doorstep as the car accident survivor presenting with a fractured pelvis or serious burn, the soccer player describing the neurosymptoms of a head injury or the young man in pain resulting from an industrial accident hemothorax.

But, what of the other trauma—the one that is less visible, excruciatingly painful and always present in healthcare settings—psychological trauma. There is hardly a patient or visitor who crosses the threshold of a healthcare facility who does not carry with them a reservoir of trauma. Add the impact of natural and human-engineered disasters, terrorism, military conflict and hardly an individual remains unaffected. Ironically, missing from this select list of trauma etiology is the reason that brings the individual to our healthcare setting. Whether a patient or visitor, it is safe to assume that worry, fear and pain cross our threshold with them.

Neglecting to address trauma can have huge implications not only for the effectiveness of mental health treatment, but in addressing the medical needs of patients as well. Trauma informed care (TIC) is a concept that aims to engage people with histories of trauma, recognize the presence of trauma symptoms, and acknowledge the role that trauma has played in their lives.

This edition of *Insights* is intended as an introduction into this important and very real concept in an effort to raise awareness, as well as provide some resources and tools for managing patients who have, in some way, experienced significant trauma in their lives.

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SPECIAL POINTS OF INTEREST

- For further reading on *Trauma Informed Care,* see page 6 for references used in the writing of this newsletter
- See page 3 for the Survey Monkey CME link for this edition
- See page 6 for the 2017 *@Risk Live Lecture Series* schedule

Psychological trauma, simply put, can be defined as any adverse experience that affects a person's ability to function. Having individuals in our healthcare system who have experienced trauma has always been true.

To demonstrate the large number of people impacted by trauma in their lives, consider these statistics:

- **About 7 or 8 out of every 100 people (or 7-8% of the population)** will have PTSD at some point in their lives. About 8 million adults have PTSD during a given year. This is only a small portion of those who have gone through a trauma.
- **An estimated 26.2% of Americans** ages 18 and older or about one in four adults suffer from a diagnosable mental disorder in a given year.
- **An estimated 1.7 individuals** receive hospice care each year.
- **Approximately 2,600,000 individuals** die annually, leaving millions of individuals to adjust to their loss.
- **In 2015 the U.S. had the highest one-year percentage increase** in traffic deaths in half a century. Data indicates that 38,300 people were killed on U.S. roads and roughly 4.4 million sustained injuries that resulted in medical consultations.
- **Nearly 1 in 5 women (18.3%)** and 1 in 71 men (1.4%) in the United States have been raped at some time in their lives.
- **Approximately 1 in 10 Americans aged 60+** have experienced some form of elder abuse. Some estimates range as high as 5 million elders who are abused each year.
- **The American criminal justice system** holds more than 2.3 million people in state, federal and military prisons and jails, juvenile correctional facilities and immigration detention facilities. There are another 850,000 people on parole and a staggering — and growing — 3.9 million people on probation.
- **Approximately 3 million children** per year have a substantiated maltreatment report and many, many more children who are abused or neglected go unreported.
- **More than 2.7 million children** have a parent who is incarcerated and approximately 10 million have experienced parental incarceration at some point in their young lives.
- **Nearly 11 million children** under the age of 18 are being raised in a household with at least one parent suffering with alcoholism. Countless others are affected by parents who are impaired by other psychoactive substances.
- **Every day, 306 people in America** are shot in murders, assaults, suicides & suicide attempts, unintentional shootings, and police intervention. Every day, 90 people die from gun violence: 31 are murdered. 56 kill themselves.
- **Over 48 million Americans** live in food insecure households, including 32.8 million adults and 15.3 million children.
- **46.7 million people (14.8 percent)** in America live in poverty.

As many traumatic events erode the dignity and safety of the individual, they often influence a survivor's attitude toward medical care and the provider of that care. Many healthcare procedures, especially those which involve a patient to be alone with a provider, placed in a physically vulnerable position, or touched in intimate areas may be re-triggering for traumatized patients. Depending on the nature of their trauma, many individuals may be reluctant to trust providers with critical information or may avoid the healthcare system altogether.

The concept termed ***trauma informed care (TIC)*** has invited evolutionary change in a variety of settings including schools, prisons, and social service agencies. This shift in culture has resulted in improved care to individuals who have histories of traumatic life events or toxic stress. According to the Substance Abuse and Mental Health Services Administration, a program, organization or system that is trauma informed:

- ◊ realizes the universal impact of trauma
- ◊ recognizes the signs and symptoms of trauma in individuals involved with the system
- ◊ integrates knowledge about trauma into policies, procedures and practice and seeks to actively resist re-traumatization.

Although the concept of trauma informed care can take many forms as it is applied to healthcare, studies suggest that TIC in our delivery system consists of two major domains: universal trauma precautions and trauma-specific care (Raja et.al. 2015).

UNIVERSAL TRAUMA PRECAUTIONS ~ *A CULTURE SHIFT*

Employing **universal trauma precautions** assumes that every individual receiving services in that system has a history of trauma. With this foundational culture shift in place, the stage is set for the provider to establish trust and rapport with survivors of traumatic life events, encourage patients with undisclosed trauma histories to reveal their vulnerabilities, and creates a more therapeutic environment for the small percentage of individuals who have escaped life trauma.

Awareness is the first step. If a patient presents with challenging behaviors, an enlightened provider views the behavior through the lens of trauma. Brain science informs that disregulated behaviors, emotion dyscontrol and cognitive interruptions are hallmark trauma reactions. In a trauma-sensitive culture a patient raising her voice, a parent forgetting their child's birthdate or a visitor pushing past a provider, trauma would be considered as a root cause of the behavior. Trauma research provides the back story behind many patient behaviors that challenge our healthcare system. Armed with nuanced knowledge and interpersonal skills especially de-escalation skills, healthcare providers can vastly improve the patient experience for all populations.

"Trauma is personal. It does not disappear if it is not validated..."

Once the patient has revealed a history of trauma or toxic stress, **specific strategies** can be utilized to support the needs of the patient. These techniques may involve targeted screening to determine the health effects of the trauma, interdisciplinary collaboration, and provider education concerning the risks and prevention for vicarious traumatization.

According to author and trauma survivor Danielle Bernock: "Trauma is personal. It does not disappear if it is not validated. When it is ignored or invalidated, the silent screams continue internally heard only by the one held captive. When someone enters the pain and hears the screams, healing can begin."

A shift in culture to become more trauma informed will set the stage for maximum healing to take place. If healthcare environments recoil from validating damaging trauma experiences, the toxicity of trauma will corrode the very potential of healing.

To earn CME credit for reading information on Trauma Informed Care in this issue, go to:

https://www.surveymonkey.com/r/V67MXZS

SPECIFIC SUGGESTIONS FOR IMPLEMENTING **TRAUMA INFORMED CARE** IN PATIENT CARE

Principle of Trauma-Informed Care (TIC)	Specific Suggestions for Practice
Patient-centered communication and care	◊ Ask every patient what can be done to make them more comfortable while in the hospital or during the appointment. ◊ Prior to physical examination, present a brief summary of what parts of the body will be involved, allow the patient to ask questions, and let the patient know there will also be time available to ask questions afterward. ◊ In the outpatient setting, give the option of shifting an item of clothing out of the way rather than putting on a gown when an entire area does not need to be visualized. ◊ Patients who are anxious in the supine position may feel more comfortable if offered a pillow for their back. ◊ If feasible, offer the option of a mirror to see procedures or examinations that are out of the patient's visual field. ◊ If patient nonverbal behavior indicates a moderate to high level of anxiety, conduct further anxiety assessment and offer patient ways to "signal" distress either verbally or via by raising their hand (e.g., signaling anxiety during a Papanicolaou smear).
Understanding the health effects of trauma	◊ Understand that maladaptive coping (e.g., smoking, substance abuse, overeating, and high-risk sexual behavior) may be related to trauma history. ◊ Understand that the maladaptive coping behaviors have adverse health effects. ◊ Engage with patients in a collaborative, non-judgmental fashion when discussing health behavior change.
Inter-professional collaboration	◊ Maintain a list of referral sources across disciplines for patients who disclose a trauma history. ◊ Keep referral and educational material on trauma readily available to all patients in the waiting room. *(See page 6 for resources)* ◊ Engage in inter-professional collaboration to ensure continuity of care.
Understanding your own history and reactions	◊ Reflect on your own trauma history (if applicable) and how it may influence patient interactions. ◊ Learn the signs of professional burnout and vicarious traumatization and prioritize good self-care. *(See page 5 for additional information)*
Screening	◊ Examine your specialty, setting, and level of long-term interaction with patients. ◊ Decide if you will screen for current trauma (e.g., current domestic violence) or a history of traumatic events. Consider if screenings will be face-to-face or self-report. Use a framing statement prior to the trauma screen. ◊ Provide all staff with communication skills training about how to discuss a positive trauma screening with a patient. *(See page 6 for resources)*

Raja, Sheela; Hasnain, Memoona; Hoersch, Michelle, et al: Trauma Informed Care in Medicine: Current Knowledge and Future Research; Family & Community Health; Jan. 1, 2015; *Reprinted with permission from Wolters Kluwer Health, Inc.*

EXPERIENCING DIFFICULTIES*

Pair an adverse outcome with a difficult physician-patient relationship and you have a recipe for malpractice litigation. Across the Harvard-based CRICO-insured settings, cases involving a difficult physician-patient relationship represent 117 cases worth more than $31 million in losses from January 2004 through February 2008.

One out of six patients is deemed "difficult" by his or her physician according to some estimates. In the U.S., that label could apply to tens of millions of patients, many of who are coping with an unresolved illness, scared, undereducated (or over informed) …and sometimes demanding of both your time and patience. If those traits compromise your ability to provide adequate care—and consequently the patient suffers real harm —the aggrieved patient's decision to file a lawsuit is unencumbered by compassion for the physician.

Whatever behaviors annoy them, physicians, nurses and office staff cannot wish patients away because they are unlikeable or hard to deal with: *they are duty bound to find ways to make the patient relationship tolerable, and the health care encounters appropriate and safe, or appropriately transfer their care*. Any provider or clinician who understands that the problem is serious and the consequences of ignoring it are potentially tragic, can contact **Lifespan Risk Management** for real-time help and advice.

Sometimes it can be the provider who makes the relationship difficult. Frustration over an elusive diagnosis, irritation at a patient's bad habits, time pressures, personal distractions, substance abuse, and myriad other factors can offset clinical competence. And while a "bad day" may pass for the provider, the patients he or she alienated may not forget those encounters. Chronic friction with patients may signal the need for peer or leadership intervention and help. Consider talking with a trusted colleague, department Chief or Manager, or utilizing the services of Coastline EAP or the APOLLO program.

**Experiencing Difficulties; By Jock Hoffman, CRICO: https://www.rmf.harvard.edu/Clinician-Resources/Article/2009/SPS-Experiencing-Difficulties*

RESEARCH INDICATES THAT THE RATE OF POST-TRAUMATIC STRESS IS TWICE AS HIGH FOR HEALTHCARE WORKERS THAN FOR THE GENERAL PUBLIC.

A critical element in the creation of a trauma informed culture is a psychologically well-nurtured healthcare provider. The extreme stress experienced firsthand by those of us working in medical settings, along with the second hand trauma that we absorb from our patients and their loved ones requires our vigilant attention. While vicarious traumatization and professional burnout are two distinct entities, they share some risk factors and symptoms in common. Be cognizant of the distinct, yet often subtle signs that require more than the usual self-care.

Healthcare is truly a team sport which requires us to care for ourselves and each other. Remain vigilant to the following signs and symptoms in yourself and your colleagues.

- ◊ *Increased negativity about or at work*
- ◊ *Difficulty managing your emotions*
- ◊ *Difficulty accepting or feeling okay about yourself*
- ◊ *Difficulty making good decisions*
- ◊ *Problems managing the boundaries between yourself and others*
- ◊ *Relationship problems*
- ◊ *Physical problems*
- ◊ *Difficulty feeling connected to what is going on around you or within you*
- ◊ *Loss of meaning or hope*

Remember, prevention is key. The help of a trusted colleague, behavioral health specialist or employee assistance provider is close at hand.

***The 2017 curriculum for the *@Risk Live Lecture Series* is a program of Risk CME certified presentations** that tackle interesting and complex issues in professional liability and risk mitigation. To enhance the learning experience, attendees are encouraged to actively participate in these dynamic, innovative sessions through role playing, panel discussions and more.

We hope to see you there!

FY 2017 *@Risk Live Lecture Series
Presented by Lifespan Risk Services, Inc. - Loss Prevention
Rhode Island Hospital - George Auditorium

De-escalation and Self-Protection in the Medical Setting*	Medical Ethics	Transgender Issues in Healthcare	Informed Consent
01/19/2017 12 - 1pm	02/1/2017 12 - 1pm	03/16/2017 12 - 1pm	04/14/2017 12 - 1pm
05/18/2017 12 - 1pm	06/16/2017 12 - 1pm		

***The presentation(s) on *De-escalation and Self-Protection in the Medical Setting* correlate with the focus of this Insights Newsletter edition, *Trauma Induced Care*.**

SOURCES USED IN THE DEVELOPMENT OF THIS EDITION INCLUDED:

V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine*, 14, no. 4 (1998): 245-258.

J. P. Shonkoff, A. S. Garner, and the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *Pediatrics*, 129, (2012b): 232–246.

Public Health Management Corporation (2013). *Findings from the Philadelphia Urban ACE Survey*. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836.

Trauma-Informed Approach and Trauma-Specific Interventions online at http://www/samhsa.gov/nctic/trauma-interventions.

S. Raja, M. Hasnain, M. Hoersch, S. Gove-Yin, C. Rajagopalan. "Trauma Informed Care in Medicine." Family Community Health, 38, no. 3 (2015): 216-226.

RESOURCES FOR EDUCATIONAL MATERIAL ON TRAUMA AND SKILLS TRAINING:

American Psychological Association:
http://www.apa.org/

American Academy of Child and Adolescent Psychiatry:
http://www.aacap.org/

American Psychiatric Association:
https://www.psychiatry.org/

Substance Abuse and Mental Health Services Administration:
https://www.samhsa.gov/

American Academy of Pediatrics:
https://www.aap.org/en-us/Pages/Default.aspx

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