Healing healthcare: Applying the principles of trauma-informed care

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# Objectives

<table>
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<tr>
<th>Understand</th>
<th>Understand the impact of trauma on the healthcare workforce.</th>
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<tbody>
<tr>
<td>Consider</td>
<td>Consider ways in which toxic stress impacts trainees and healthcare workers.</td>
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<tr>
<td>Develop</td>
<td>Develop a new vision for applying trauma-informed principles in the healthcare environment.</td>
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Can you leave here today with one idea for changing your practice—change?
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)
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

Interpersonal violence/violations by authority figure can be most damaging

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.

Prolonged activation through chronic stress, repeated traumatic exposures

“Wear and Tear” on body

Allostatic Load: cumulative physiologic consequences (ex CVD, Metabolic disorders)

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

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Allostatic Load: Associations/Mechanisms

Window of Tolerance

HYPERAROUSAL
Anxiety, Anger, Overwhelm, Fight/Flight, Chaotic

HYPOAROUSAL
Shut down, numb, passive, withdrawn

WINDOW OF TOLERANCE
Grounded, flexible, Open, Curious
Able to emotionally self regulate

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.

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

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

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.

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

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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?**”


### COVID, trauma and us

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<tr>
<th>Compassion Fatigue</th>
<th>Vicarious traumatization</th>
<th>Secondary Traumatic Stress</th>
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<tr>
<td>Diminished capacity of a health professional when experiencing the distress at knowing about or witnessing the suffering of their patients and clients.</td>
<td>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.</td>
<td>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.</td>
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Nimmo, 2013
## Study of HCW Trauma and MH NYC (n=889)

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

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

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<th>Safety: Feeling unsafe in the workplace is correlated with burnout &amp; compassion fatigue</th>
<th>Adequate protocols and policies to work with “difficult patient behaviors”, adequate PPE, emotional safety.</th>
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<td>Trustworthiness/ Transparency</td>
<td>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.</td>
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<tr>
<td>Peer Support</td>
<td>Professional Development, Balint Groups, self-care activities at work.</td>
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<td>Collaboration/ Mutuality</td>
<td>Adapting practice style/modifying expectations/recognizing limitations, diversifying workforce.</td>
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<td>Empowerment/ Choice</td>
<td>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.</td>
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<td>Cultural, historical and gender issues</td>
<td>Inclusive environment, respect SO/GI, pronouns, policies to support all employees/families.</td>
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Resources for Clinicians


• 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

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Thank you!
References


Fink-Samnick E. Collective Occupational Trauma, Health Care Quality, and Trauma-Informed Leadership: Intersections and Implications. Prof Case Manag. 2022 May-Jun 01;27(3):107-123


