Panel: Trauma-Informed Care in Practice

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Trauma Informed Care Policy and Procedure?

Peter Fifield Ed. D MLDAC, LCMHC

Manager of Substance Use Disorder Services

Wentworth-Douglass Hospital

Adjunct Faculty University of New England School of Education

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Organizational Practices

- You need a champion—some one to lead and follow
- Engage patients in planning
  - Patient/Family Advisory Council
- Training of all staff in TIC concepts—talking the talk and walking the walk

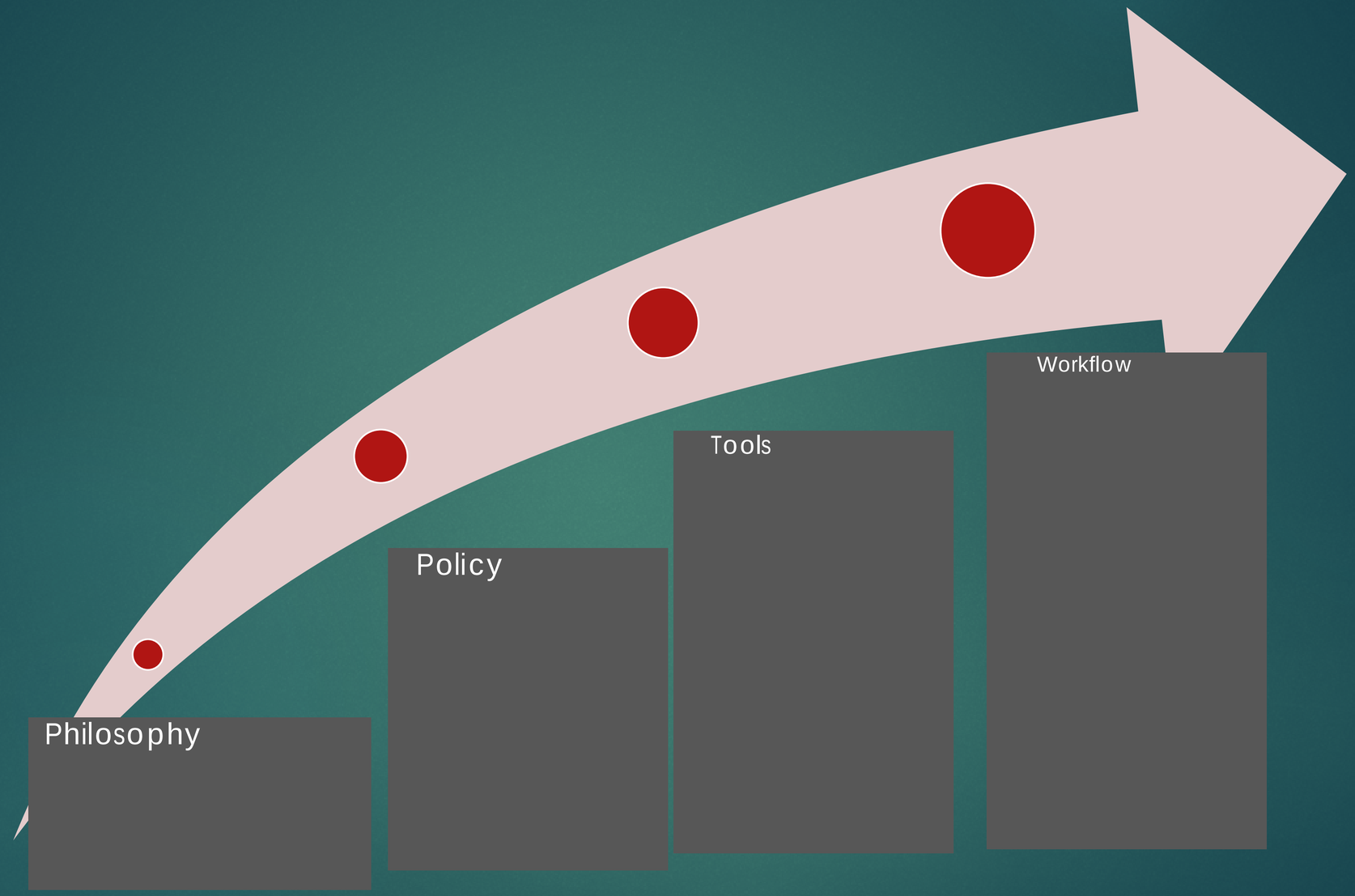
- Creating the environment of safety—full survey of all environmental elements
- Prevent re-traumatization of clients and staff—utmost goal
- Intentional hiring processes—put this in the job description

Clinical Practices

- Involve the patients in the treatment process
- Screen for trauma and assess resilience
- Train staff in TIC treatment approaches
- Create robust community relationships/referrals sources

Trauma Informed Evaluation

- Focus Groups or facilitated discussion
- Interviews
- Self-administered surveys
- Regardless of method chosen
  - Consider environmental and interviewer factors relative to trauma
  - Remind participants participation is voluntary
  - Be transparent when explaining what the purpose is


Workflow
Tools
Policy
Philosophy

Words Matter:

- *Protest any labels that turn people into things. Words are important. If you want to care for something, you call it a 'flower;' if you want to kill something, you call it a 'weed.'"*

http://www.williamwhitepapers.com/blog/2013/07/moral-panics-the-limits-of-science-professional-responsibility.html

Resources

- Menschner, C. & Maul, A. (2016) Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Healthcare Strategies

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LISA DIBRIGIDA, MS, MD

Associate Medical Director, Pediatrics, Child Health Services at Manchester Community Health Center

“Team Pod”- Shared Clinic Space Fosters Consultation & Collaboration

Behavioral Health Integrated Care: The Concord Hospital Pelvic Medicine Experience

Veronica Triaca, M.D.

Director Pelvic Medicine, Continence and
Sexual Health Program at Concord Hospital

NH Citizens Health Initiative Behavioral Health Integration Learning Collaborative

May 1st, 2019

No Disclosures

Objectives

- Review Pelvic Medicine Program at Concord Hospital
- Review Integrated Behavioral Health in the care of the Pelvic Medicine patient

Female Pelvic Medicine and Reconstructive Surgery (FPMRS)

- Pelvic Organ Prolapse
- Urinary Incontinence
- Fecal Incontinence/Defecatory dysfunction
- Overactive bladder
- Pelvic pain/Painful Bladder Syndrome
- Female Sexual Dysfunction
- Post menopausal symptoms
- Vulvovaginal skin disorders
- Recurrent Urinary tract infections
- Pelvic floor muscle dysfunction

FPMRS

- Urologist or Gynecologist who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction.
- Comprehensive management includes diagnostic and therapeutic procedures necessary for the ***total*** care of the patient with these conditions and complications resulting from them

Rationale for the Creation of a Pelvic Medicine Program at Concord Hospital

- Pelvic medicine is a hybrid specialty that lends itself well to coordinated integrated multidisciplinary care
- At least 50% of our pelvic pain patients have a history of trauma
- Improvement in quality of care delivered

Goals

- To develop an integrated and coordinated multidisciplinary program for the treatment of female pelvic disorders
- To assemble a team of care givers with an interest and expertise in pelvic medicine
- To centralize and coordinate care

“Players”

- PRIMARY PLAYERS
  - Urologist(s) Gynecologist(s)
    - Female Pelvic Medicine and Reconstructive Surgery Certification
  - Advanced Provider(s)
  - Physical Therapist(s)
  - Behavioral Therapist(s)
- ADJUNCT SPECIALTIES
  - Colorectal Surgeon
  - Gastroenterologist
  - Nutritionist
  - Sex Therapist
  - Complimentary Medicine

Who are we?

Pelvic Medicine, Continence and Sexual Health

Veronica Triaca, MD

Brian Marks, MD

Joanne Gutt, PA-C

Cathy Yi, MD
Gynecologist

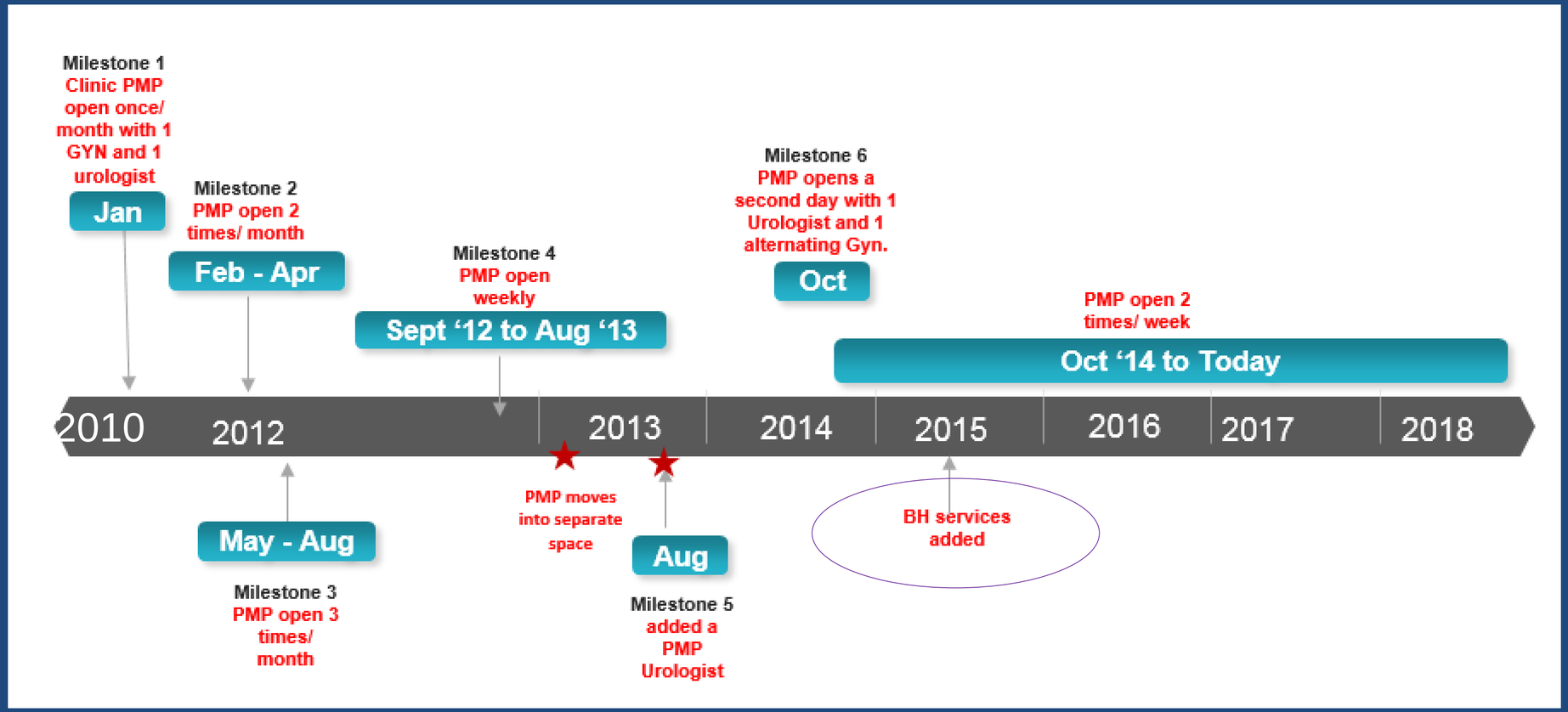
Katherine Cail, APRN

Sheryl Cheney, RPT

Jennifer Savage, LSW

Stacey Lillios, RPT

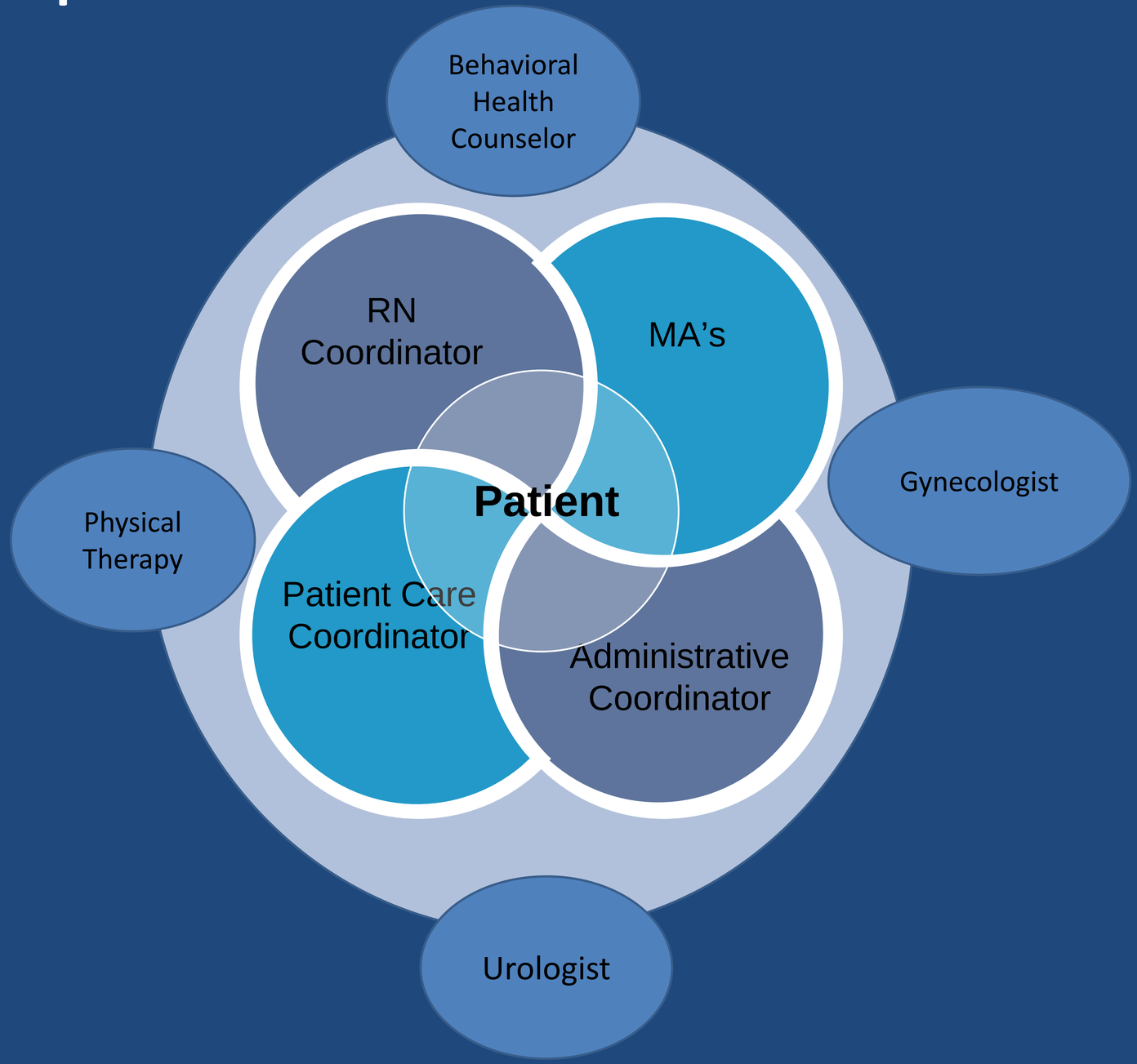
History


Milestone 1
Clinic PMP open once/ month with 1 GYN and 1 urologist
Jan
Milestone 2
PMP open 2 times/ month
Feb - Apr
Milestone 3
PMP open 3 times/ month
May - Aug
Milestone 4
PMP open weekly
Sept '12 to Aug '13
PMP moves into separate space
Milestone 5
added a PMP Urologist
Aug
Milestone 6
PMP opens a second day with 1 Urologist and 1 alternating Gyn.
Oct
BH services added
PMP open 2 times/ week
Oct '14 to Today
2010
2012
2013
2014
2015
2016
2017
2018

Experience to date

- Outpatient Coordination of services
  - Dedicated Clinic Space
  - Thrice Weekly multidisciplinary clinic
  - Dedicated Nurse Practitioner
    - Katie Cail, APRN
  - Present at the clinic
    - GYN, UROLOGIST, NP
    - Dedicated core Physical therapists, Sheryl Cheney, RPT; Stacey Lillios, RPT
    - Dedicated Behavioral Therapist
    - Dedicated Clinical Coordinator, Tracee Sawyer RN
    - Dedicated Administrator, Naomi Marcoux

Patient experience



Reality

- Trauma affects many of my patients
- Being able to address their condition meant to acknowledge and address their history of trauma
- Integrated behavioral care

Case

- 35 y/o female with concerns of incomplete bladder emptying
- Multiple visits to ED for urinary retention
- History of chronic pelvic pain
- PMH/PSH: anxiety, chronic constipation, multiple laparoscopies, hysterectomy

Case

- 62 y/o female with urinary frequency and urgency, urinary incontinence.
- PMH/PSH: bipolar disorder, fecal incontinence, IBS, chronic abdominal and pelvic pain

Urinary Incontinence, Depression and Post-traumatic Stress Disorder in Women Veterans

Bradley *et al* Am J Obstet Gynecol. 2012 Jun; 206(6)

- 968 women mean age 38.7 ± 8.7 years were included.
- 19.7% reported urgency/mixed UI
- 18.9% stress UI
- PTSD (OR [95%CI] = 1.8 [1.0, 3.1]) but not depression (OR [95%CI] = 1.2 [0.73, 2.0]) was associated with urgency/mixed UI.
- Stress UI was not associated with PTSD or depression.

- Conclusion

- In w[illegible]n veterans, urgency/mixed UI was associated with PTSD but not

Corticotropin releasing factor: a mediator of emotional influences on bladder function.

Klausner AP, Steers WD J Urol. 2004 Dec;172-3

- Evidence linking overactive bladder (OAB) and bladder pain with anxiety and depression
- CRF expressed in areas of the central nervous system that control voiding and response to stress.
- CRF is increased during anxiety, depression and pain.
- Epidemiological studies reveal an association between anxiety and voiding disorders.

Bladder dysfunction in sexual abuse survivors.

Davila GW *et al* J Urol 2003, Aug 170(2)

- 58 sexual abuse survivors and 51 controls were included in the statistical analysis.
- Of abuse survivors 72% and of controls 22% reported ever experiencing urinary incontinence symptoms ($p < 0.001$).
- Many symptoms of stress incontinence, urge incontinence and voiding dysfunction were also reported by a greater percent of abuse survivors than controls

Is abuse causally related to urologic symptoms? Results from the Boston Area Community Health (BACH) Survey

Eur Urol. 2007 Aug;52(2):397-406

- Data from the Boston Area Community Health (BACH) survey, a community-based epidemiologic study of many different urologic symptoms and risk factors.
- 5506 adults, aged 30-79 yr (2301 men, 3205 women; 1770 black [African American], 1877 Hispanic, and 1859 white respondents)
- 33% reporting urinary frequency, 12% reporting urgency, and 28% reporting nocturia.
- All three symptoms are positively associated with childhood and adolescent/adult sexual, physical, and emotional abuse ($p<0.05$)

Characterization of a clinical cohort of 87 women with interstitial cystitis/painful bladder Peters KM *et al* Urology. 2008 Apr;71(4):634-40

- 87 women with bladder pain
- 52% reported a history of abuse, often in more than one life stage
- Common comorbidities were pelvic pain (93%), allergies (86%), and sexual dysfunction (72%).

Trauma and posttraumatic stress disorder in women with chronic pelvic pain.

Meltzer-Brody S *et al* Obstet Gynecol. 2007 Apr;109(4):902-8.

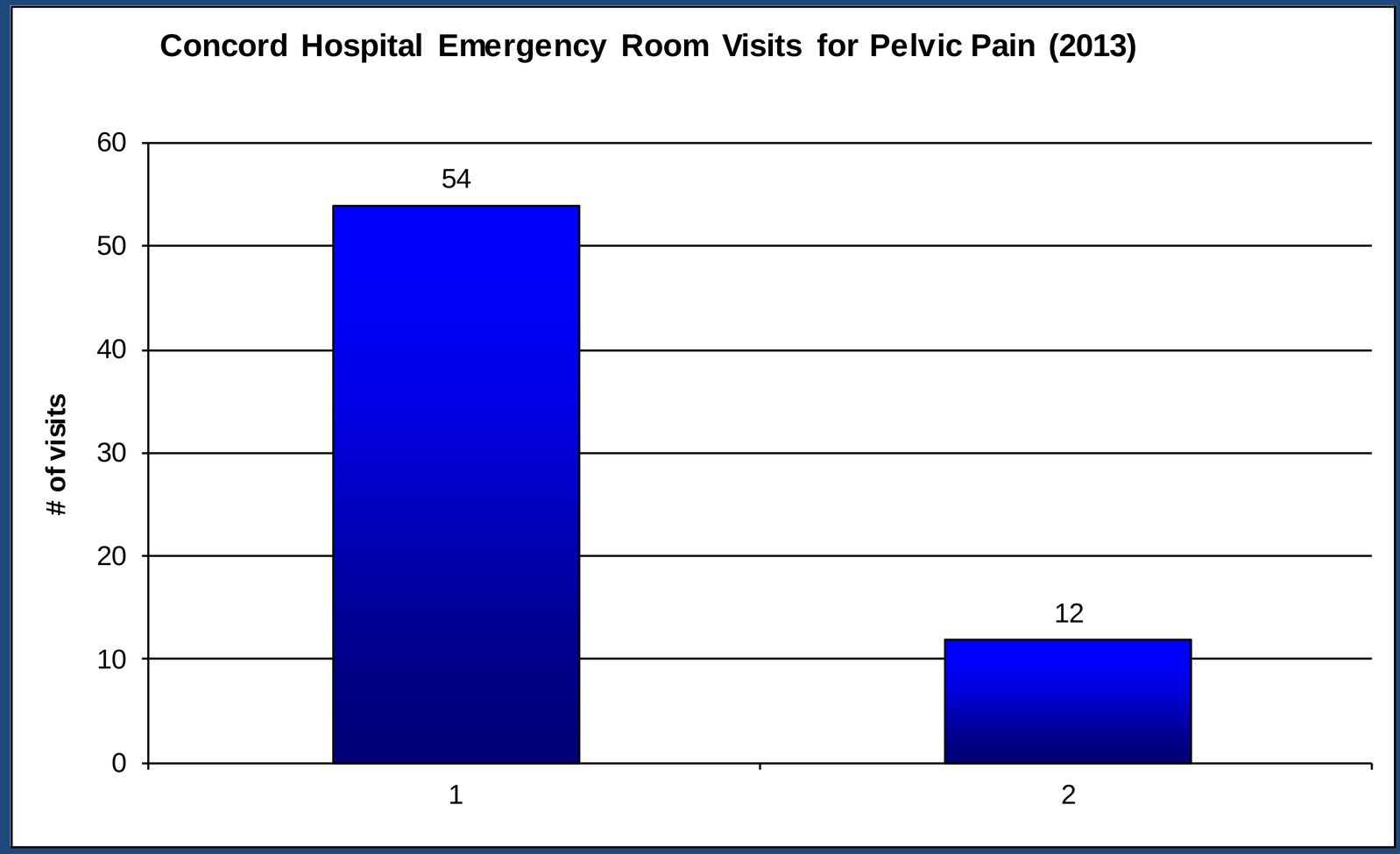
- 713 women seen in a referral-based pelvic pain clinic
- 46.8% reported having either a sexual or physical abuse history.
- 31.3% had a positive screen for PTSD
- trauma history was associated with worse daily physical functioning due to poor health (P<001), more medical symptoms (P<001), more lifetime surgeries (P<001), more days spent in bed (P<001), and more dysfunction due to pain (P<.001).
- PTSD was highly related to most measures of poor health status (P<001)

Pelvic Pain

- Estimated direct medical costs for outpatient visits for chronic pelvic pain for the U.S. population of women aged 18–50 years are $881.5 million per year
- 15% have time lost from paid work
- 45% have reduced work productivity

Obsterics and Gynecology, 1996

Pelvic Medicine Program Impact



118 patients, seen with a diagnosis of pelvic/abdominal pain

Conclusion

- Integrated Behavioral Health is essential for the successful outcome of the Pelvic Medicine patient
- Coordinated and multidisciplinary approach to care is essential for patients with pelvic disorders

Concord Hospital Pelvic Medicine, Continence and Sexual Health Program

https://www.concordhospital.org/services/urology/pelvic-medicine-continence-and-sexual-health/

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