NH CITIZENS HEALTH INITIATIVE

TRAUMA-INFORMED INTEGRATED CARE

NH Behavioral Health Integration Learning Collaborative

May 1, 2019

WELCOME

JEANNE RYER, MSc, EdD
Director, NH Citizens Health Initiative

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Jeanne Ryer, MSc, EdD,** Director, NH Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire

New Staff

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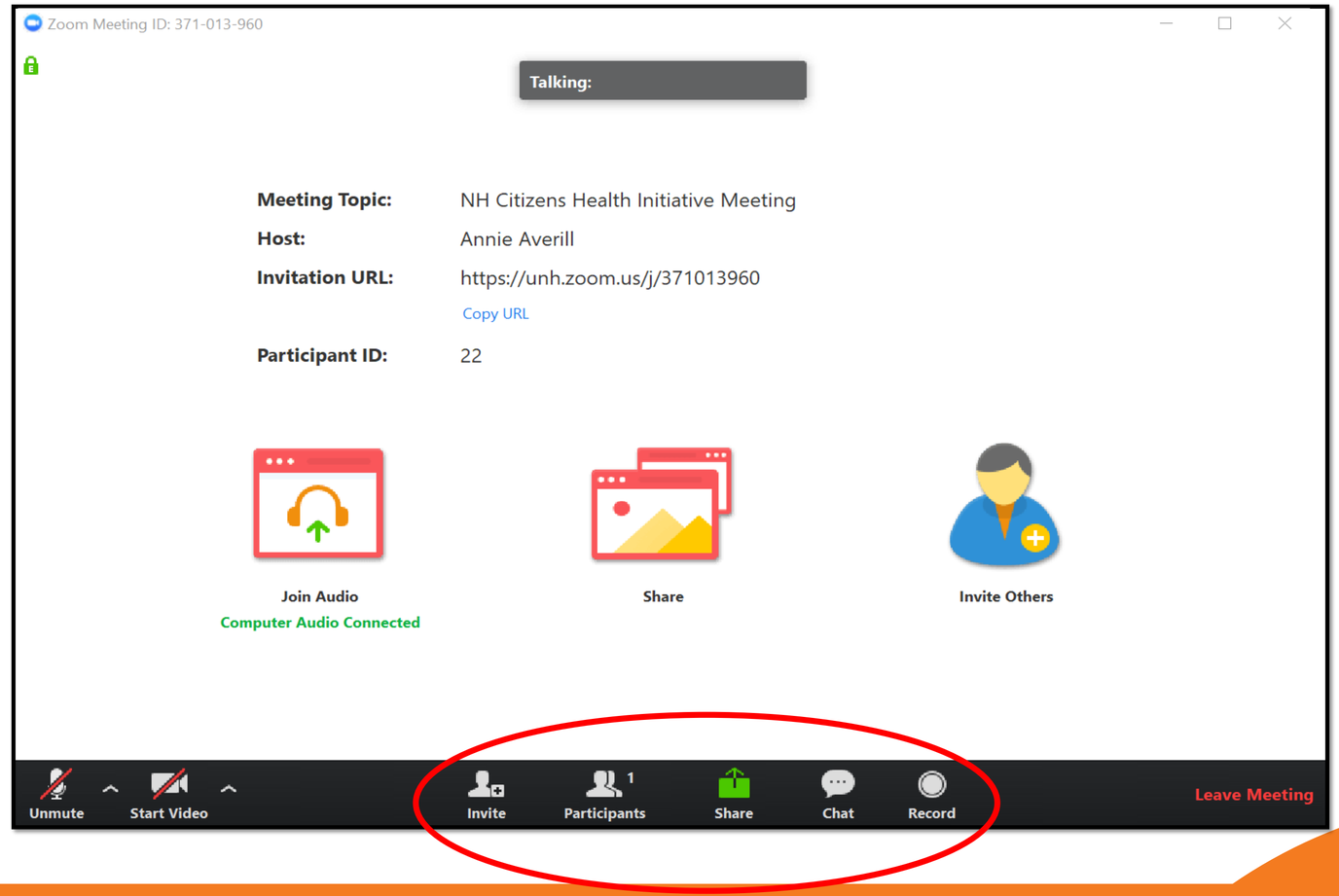
ZOOM REMINDER

Use the chat box if you have any questions



AGENDA

Welcome Jeanne Ryer, MSc, EdD, NH Citizens Health Initiative
Introduction to Trauma-Informed Integrated Care Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative
Brain Break Felicity Bernard & Michael Skinner
Evidence-Based Practices for Children Who Have Experienced Trauma Becky Parton, MSW, LICSW, Dartmouth Trauma Interventions Research Center
Networking Break
Personal Perspective on Trauma and the Impact on Receiving Health Care Michael Skinner, The Surviving Spirit and the National Center for Trauma Informed Care
Brain Break Felicity Bernard & Michael Skinner
Panel: Trauma-Informed Care in Practice Moderator: Jan Thomas, ADRN, NH Citizens Health Initiative Lisa DiBrigida, MS, MD, Manchester Community Health Center Peter Fifield, Ed.D, MLADC, LCMHC, Behavioral Health Department Veronica Triaca, MD, Concord Hospital Center for Urologic Care
Closing Remarks & Next Steps Jeanne Ryer, MSc, EdD, NH Citizens Health Initiative

PLANNING DISCLOSURES

The following individuals have responded that they have nothing to disclose:

- **Planner: Kelsi West**, ***BS****, Research Associate,* NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Frederick Kelsey**, **MD, FACP**, *Interim Medical Director,* Mid State Health Center
- **Planner: Marcy Doyle, DNP, MS, MHS, CNL, RN** , *Quality and Clinical Improvement Director,* NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Annie Averill, BA,** *Research Associate,* NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Laura Remick, MEd, CHES**, *Education and Workforce Coordinator*, North Country Health Consortium
- **Planner: Jill Gregoire, RN, MSN**, *Lead Nurse Reviewer*, North Country Health Consortium

LEARNING OBJECTIVES

After participating in this activity, learners will be able to:

Describe the epidemiology of trauma.

Review the biologic pathways by which trauma compromises physical & mental health.

Discuss available trauma screens and evidence-based interventions.

Identify key considerations to prepare clinic staff for responding to trauma.

Introduction to Trauma-Informed Integrated Care

FELICITY BERNARD, LCMHC, MA
Project Director, NH Citizens Health Initiative

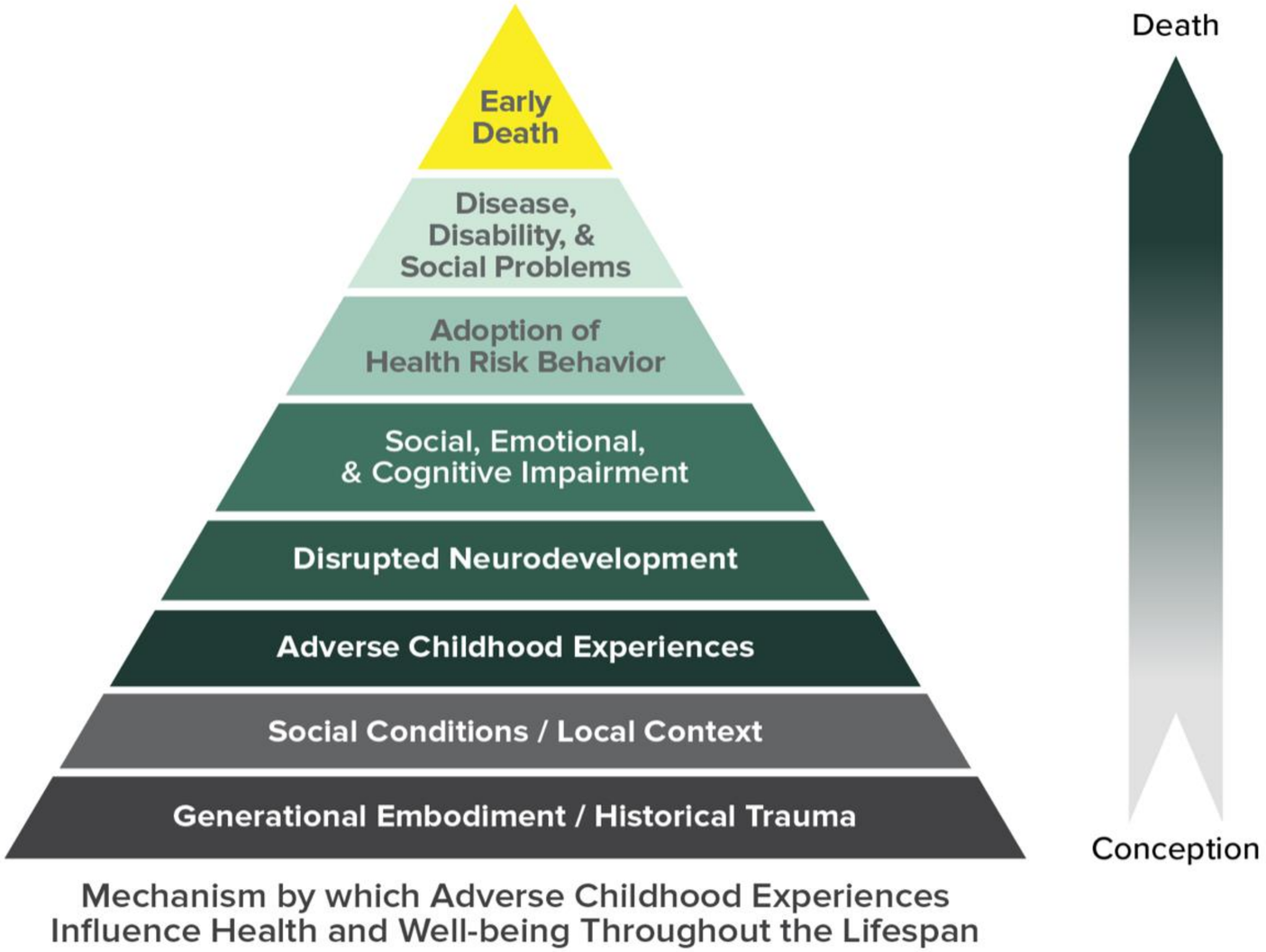
PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Planner & Presenter: Felicity Bernard, LCMHC, MA** Project Director, NH Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire

Creating a Safe Space

Trauma-Informed Integrated care



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Adverse Childhood Experiences

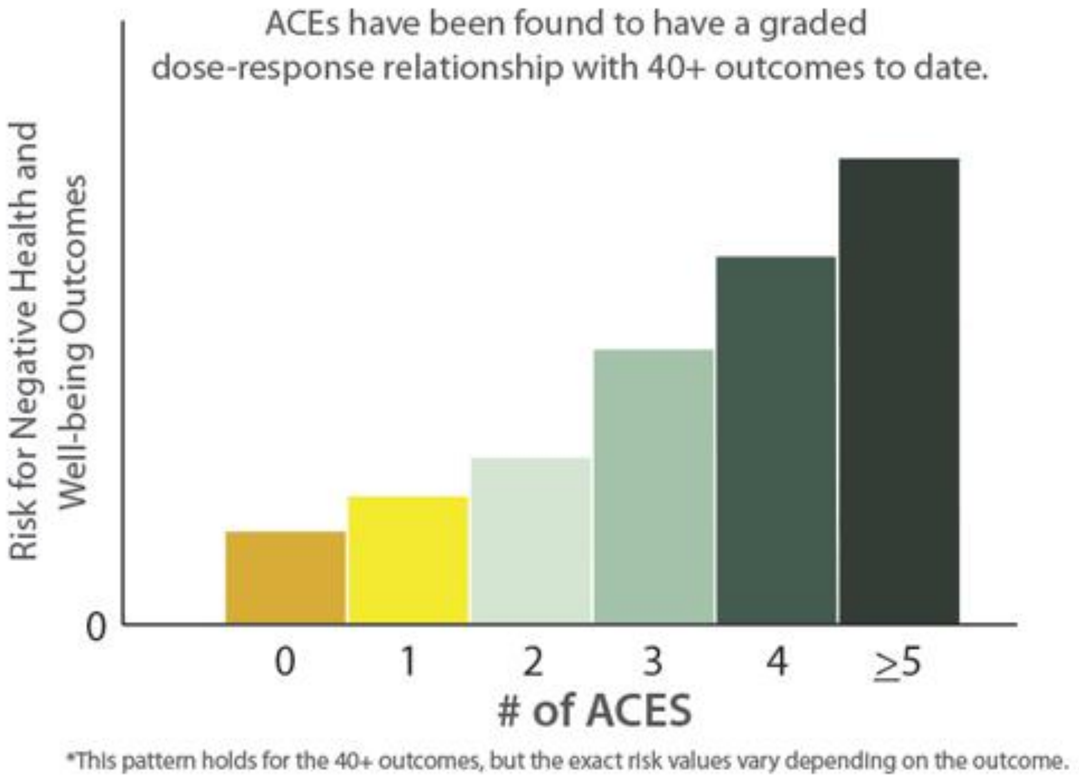
(Source: Centers for Disease Control (CDC) ACEs Pyramid)

ACES can have lasting effects on….

Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

Behaviors (smoking, alcoholism, drug use)

Life Potential (graduation rates, academic achievement, lost time from work)



Source: Centers for Disease Control (CDC)

Examples of Increased Risk

ACE Score Of 4 or More

Suicide **1,220%**

Depression **460%**

Chronic pulmonary lung disease **390%**

Hepatitis **240%**

Significantly higher rates of heart disease and diabetes

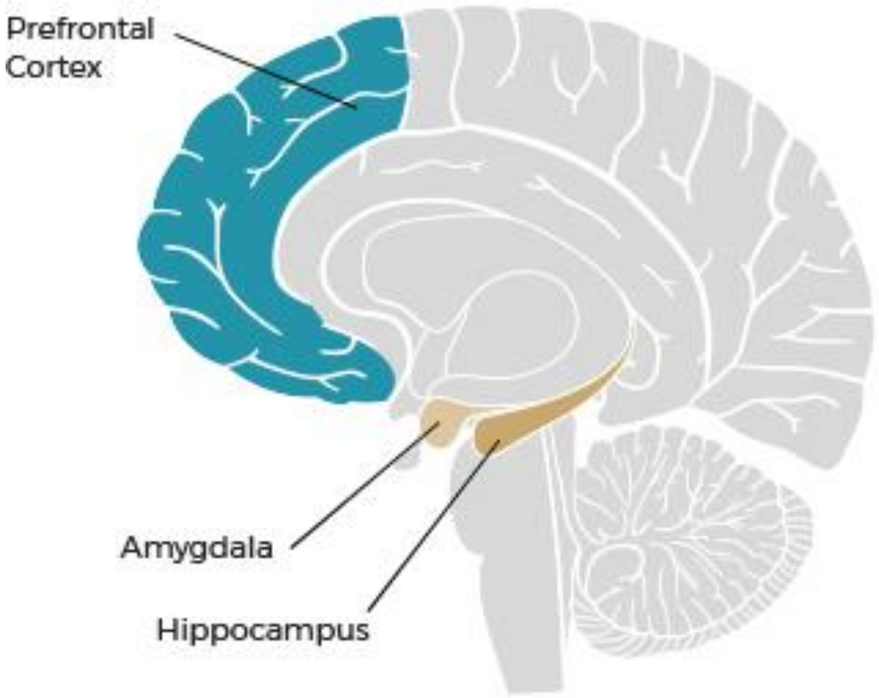
ACE Score Of 6 or More

Likelihood of becoming an IV drug user **4,600%**

Die, on average, 20 years earlier than those with low scores

Source: Felitti, V. J., et al, 1998

Trauma on the Brain



Amygdala

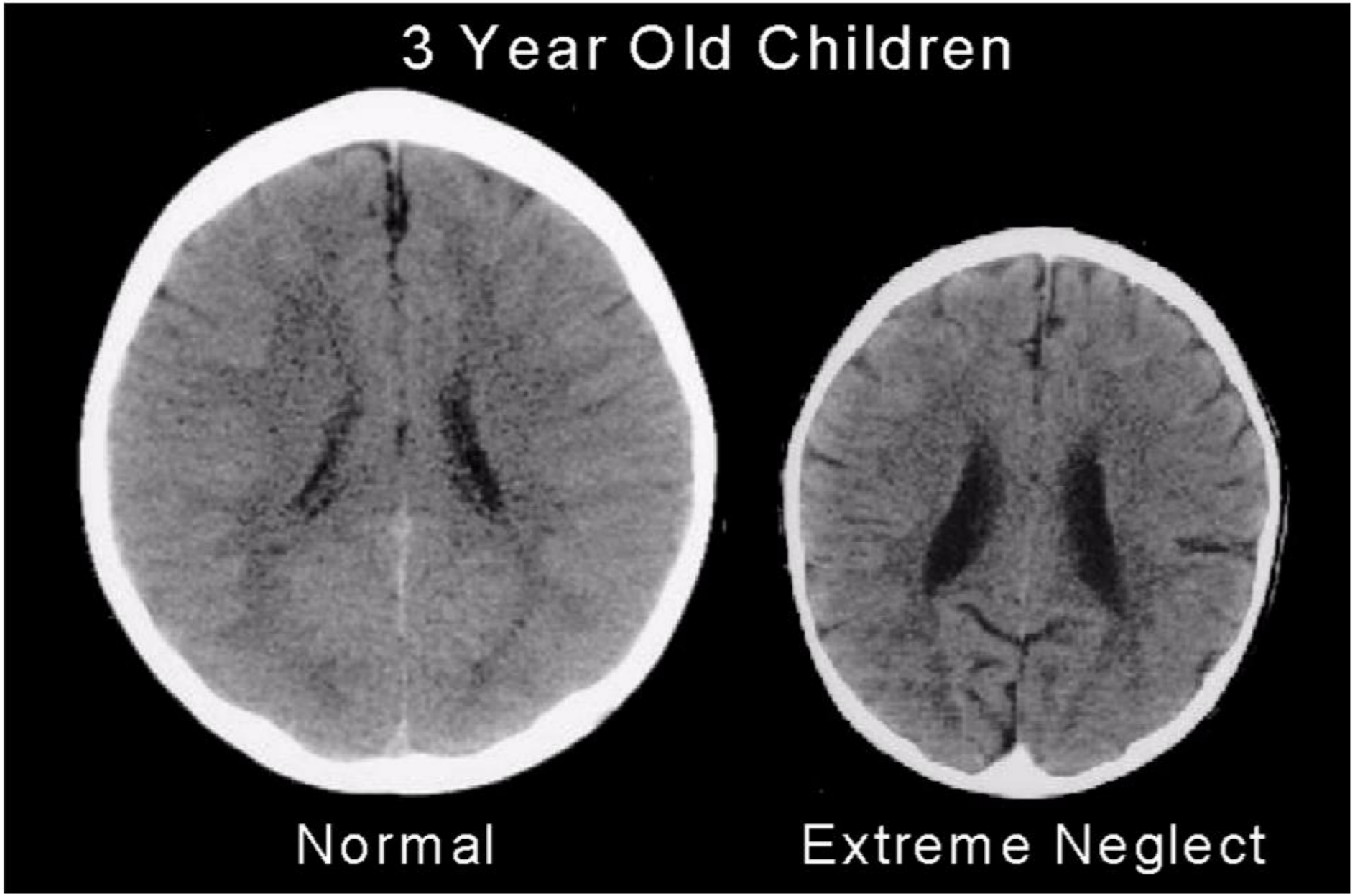
- Acute stress response: Flight/Fight/Freeze
- Promotes survival by quickly acting when danger is perceived

Hippocampus

- “Time stamp” function
- Necessary to put danger in a spatial context
- Involved in emotions, learning and memory formation
- Cortisol receptors – size decreased associated with anxiety, depression and impaired learning and memory

Prefrontal Cortex

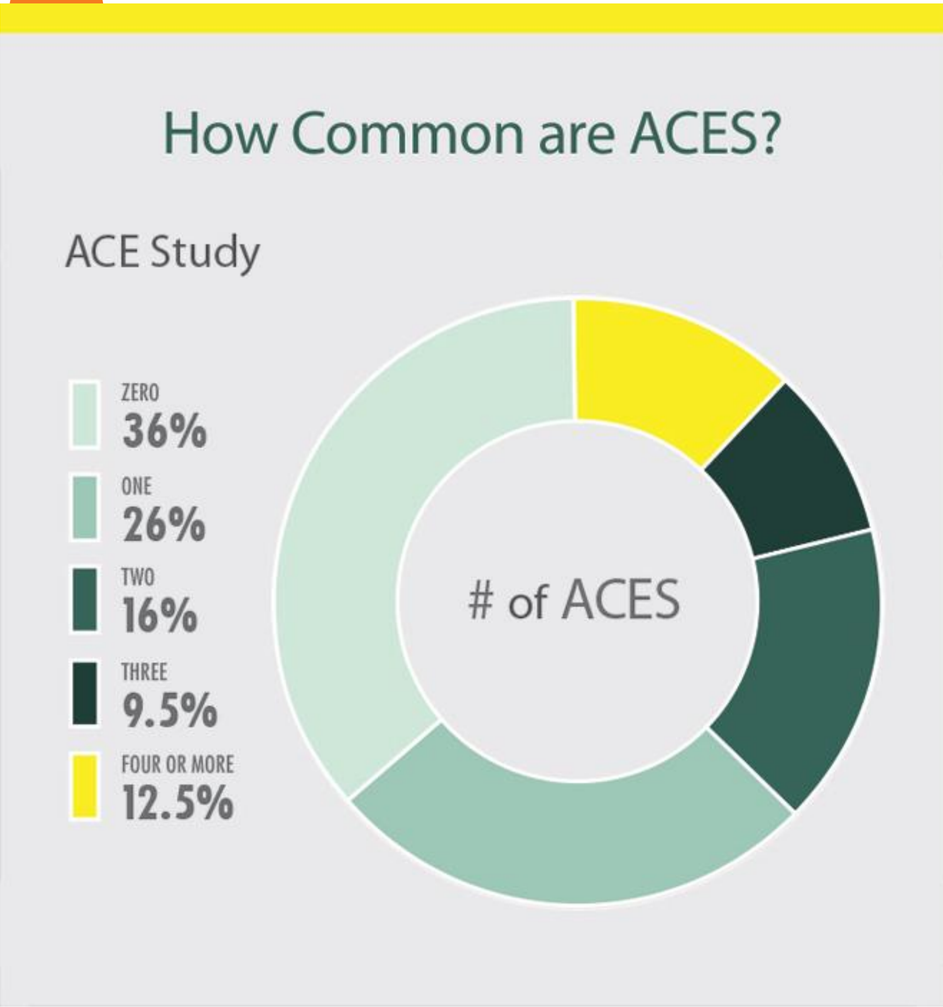
- Asks “Have I ever experienced this before? What is the best thing to do? What might the consequences be?”
- Connected with the amygdala and exerts inhibitory control over stress responses and emotional reactivity



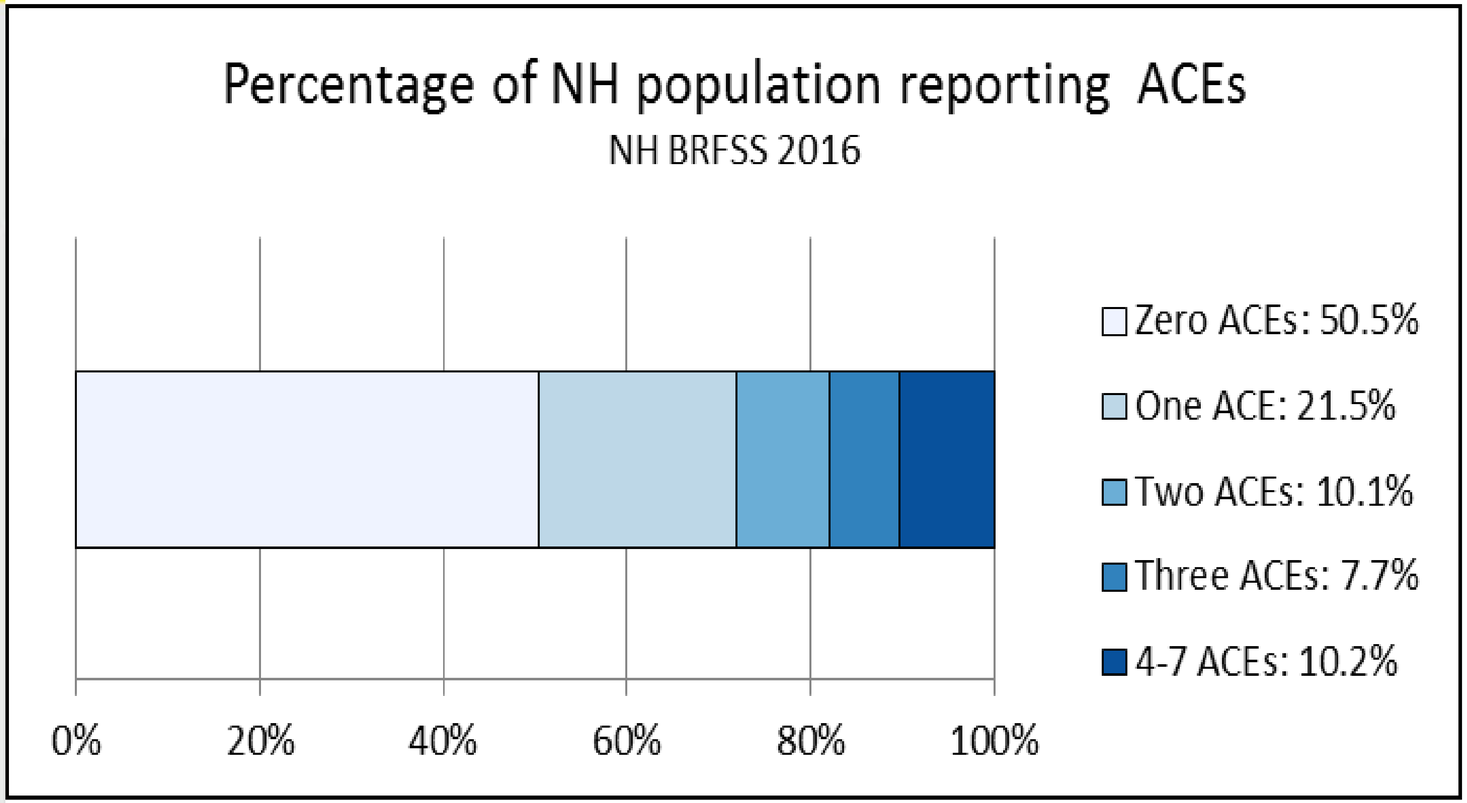
Source: Perry, B. D. (2002).

SCOPE

Prevalence



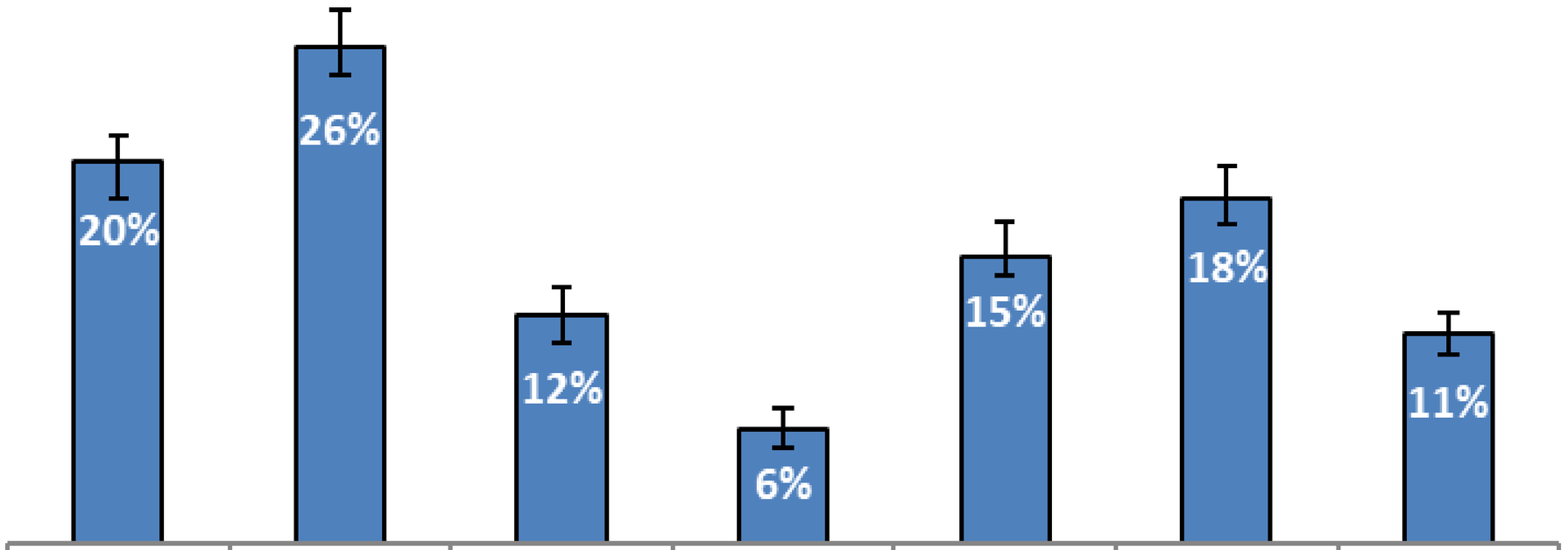
Source: Centers for Disease Control and Prevention, Kaiser Permanente, 2016.



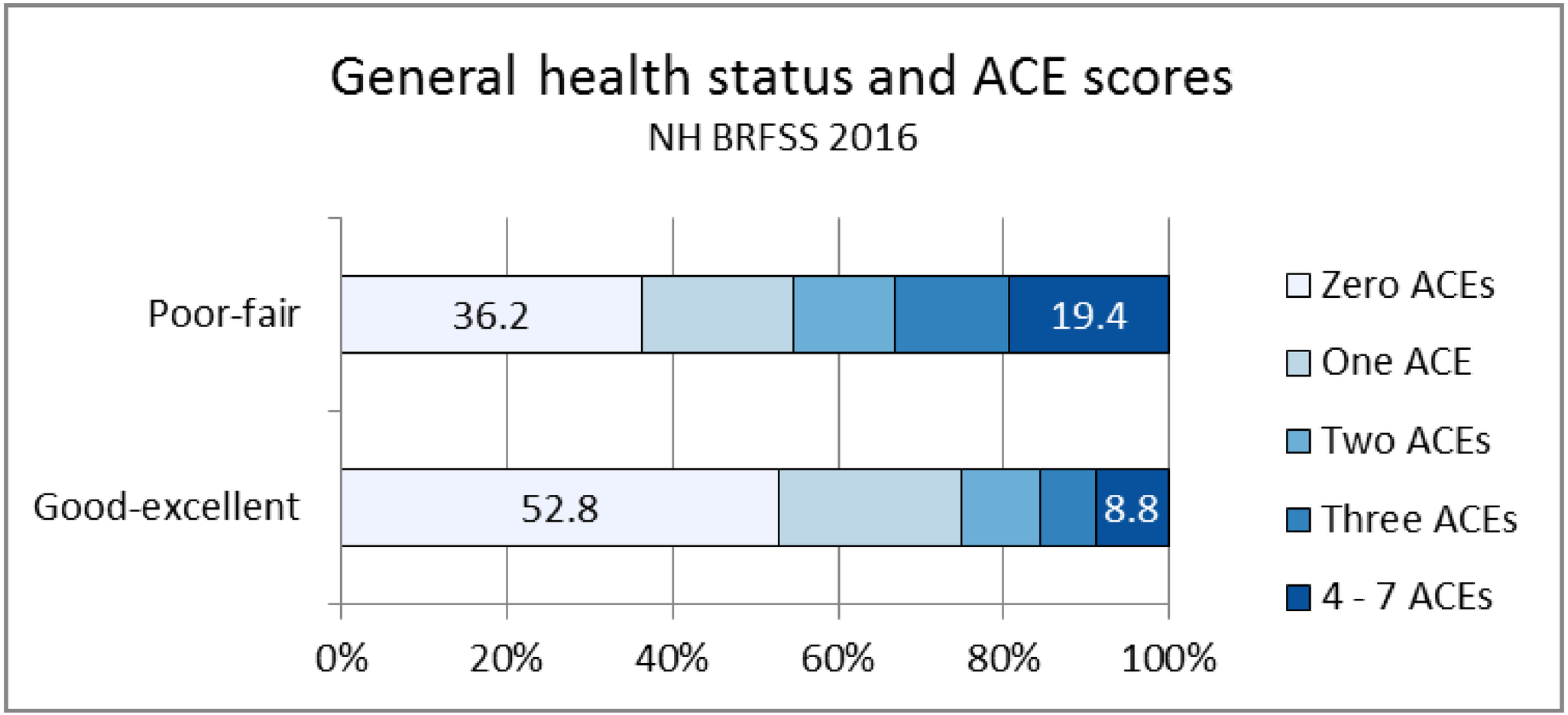
Source: NH Behavioral Risk Factor Surveillance System (BRFSS)

Prevalence of ACEs: total percentage reporting each ACE

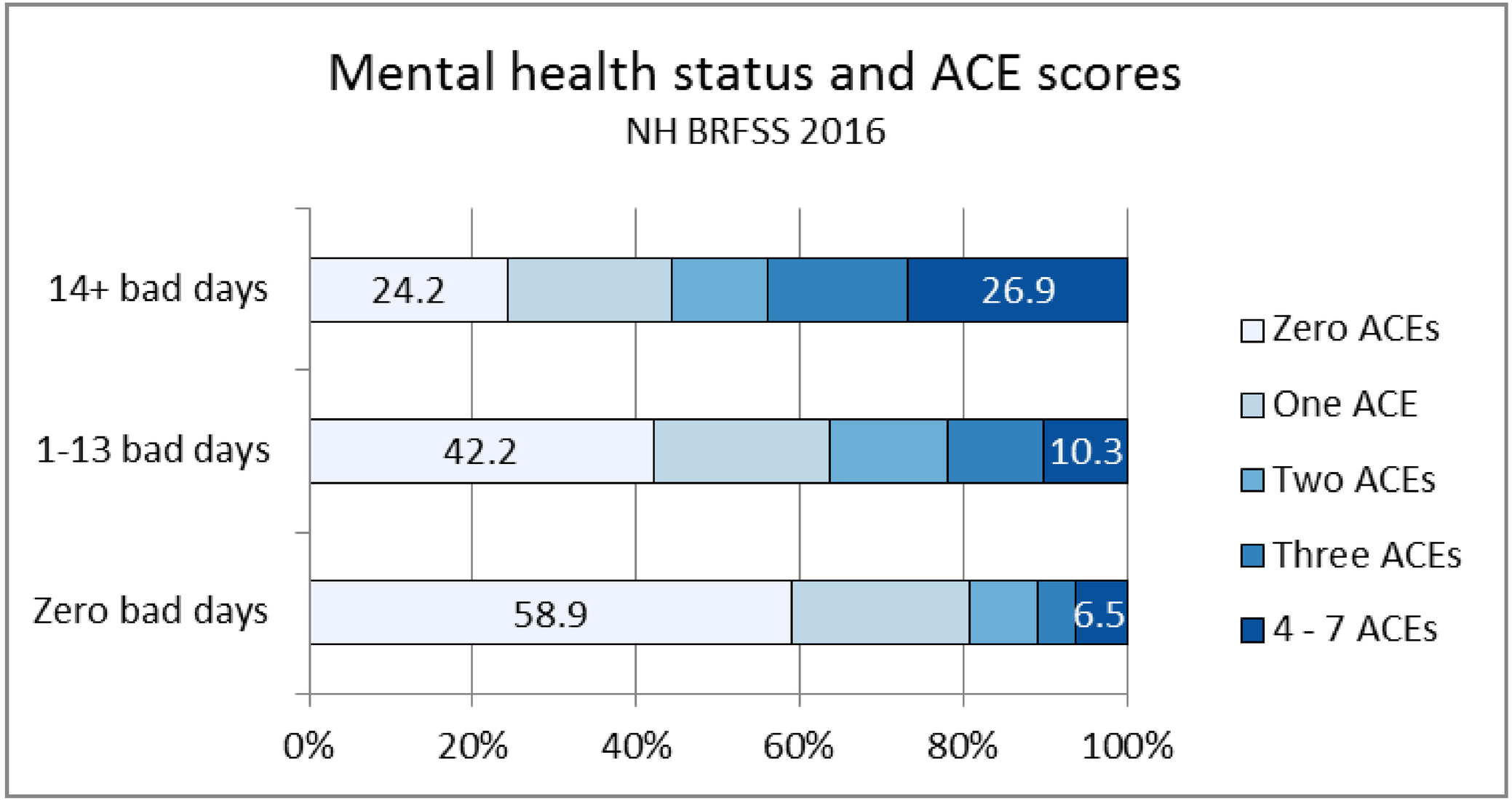
NH BRFS 2016



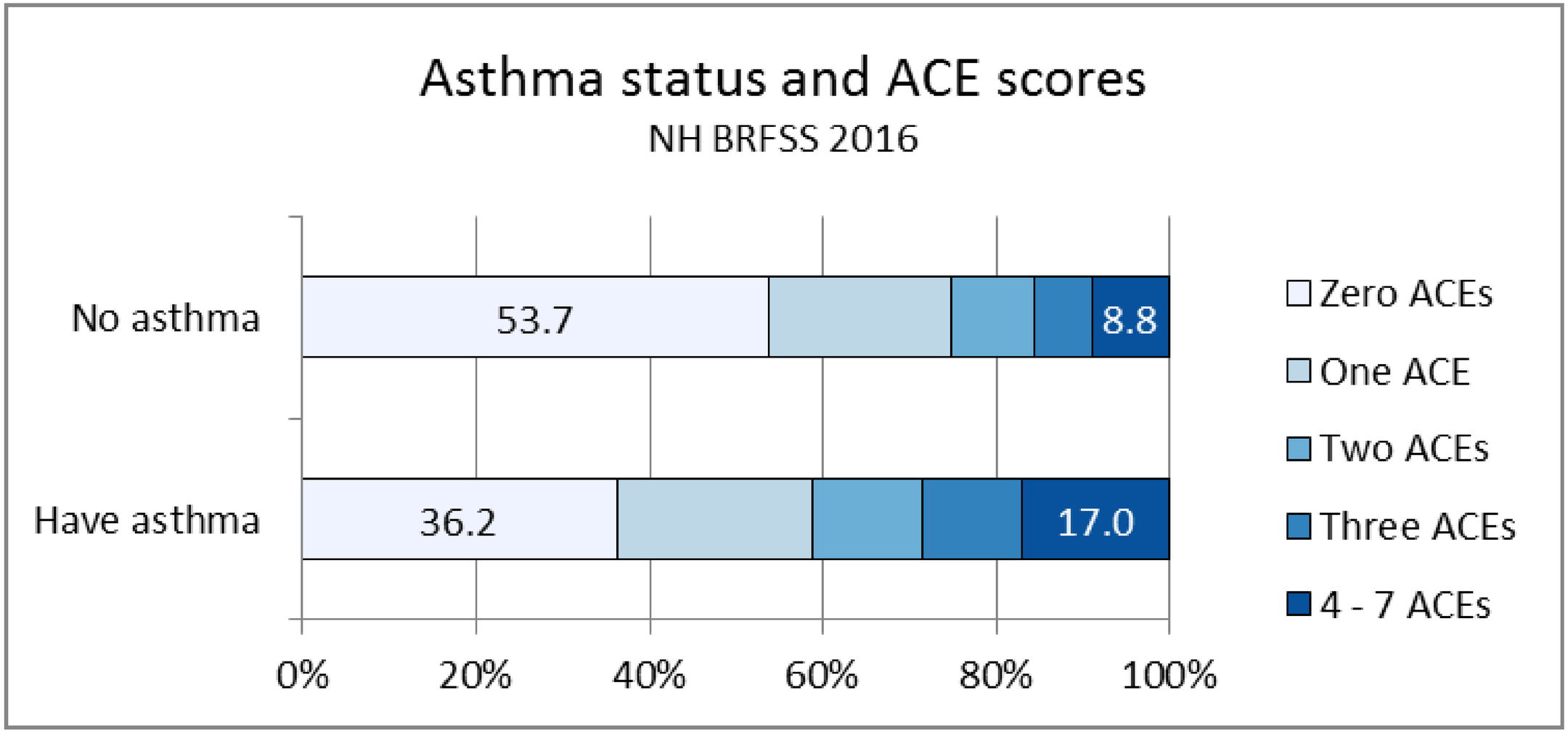
General Health



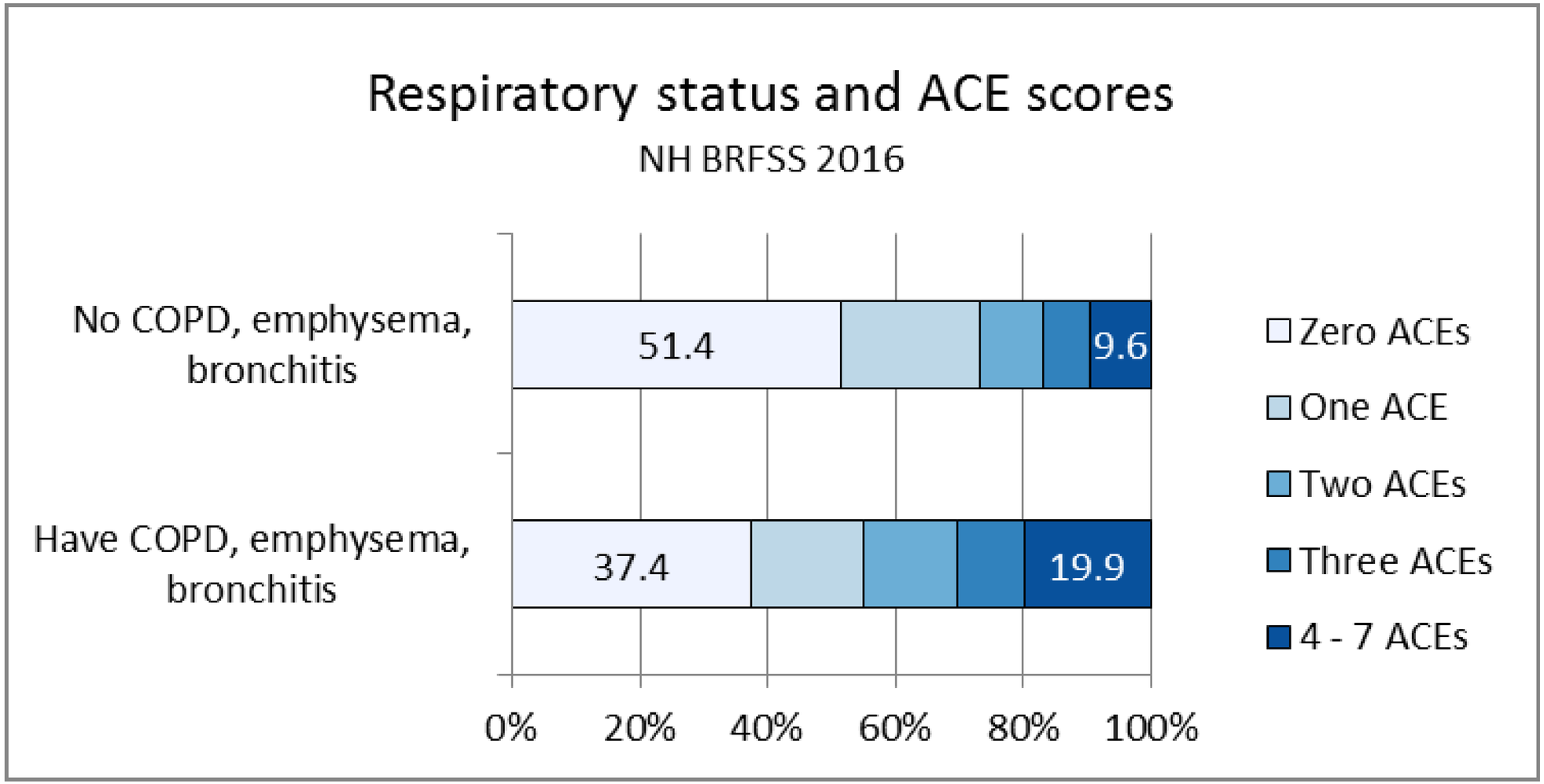
Mental Health



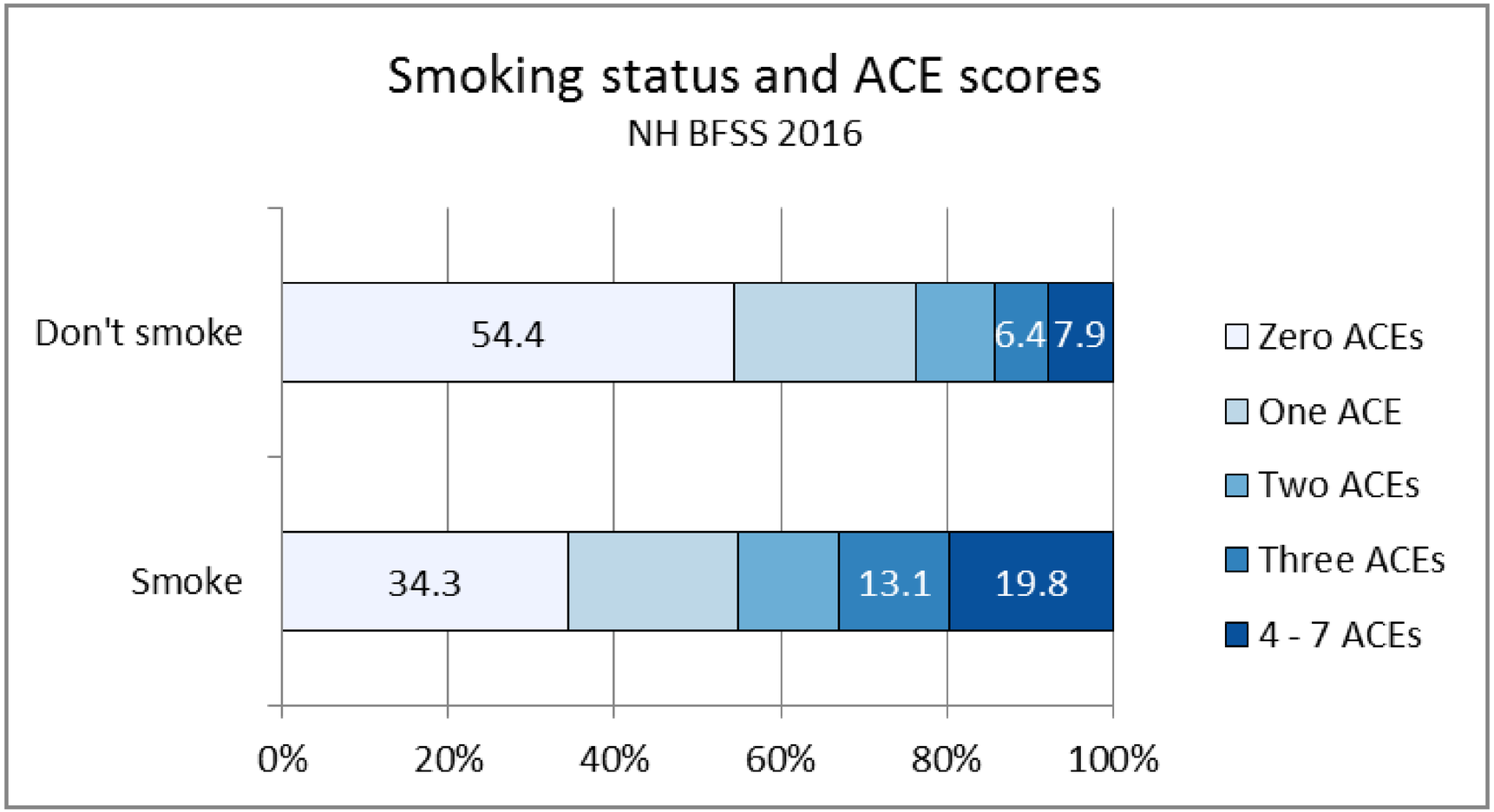
Asthma



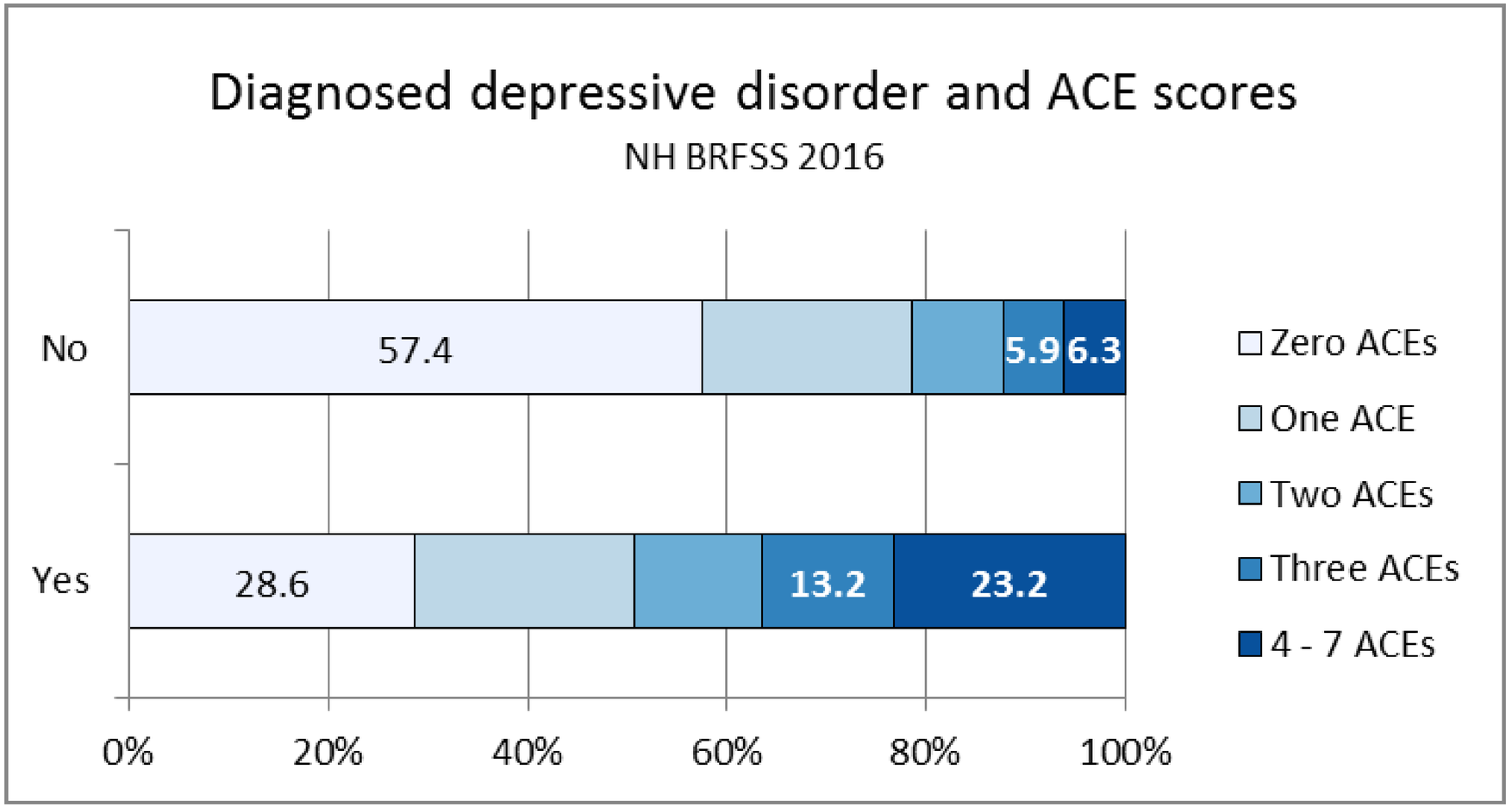
COPD, Emphysema, Bronchitis

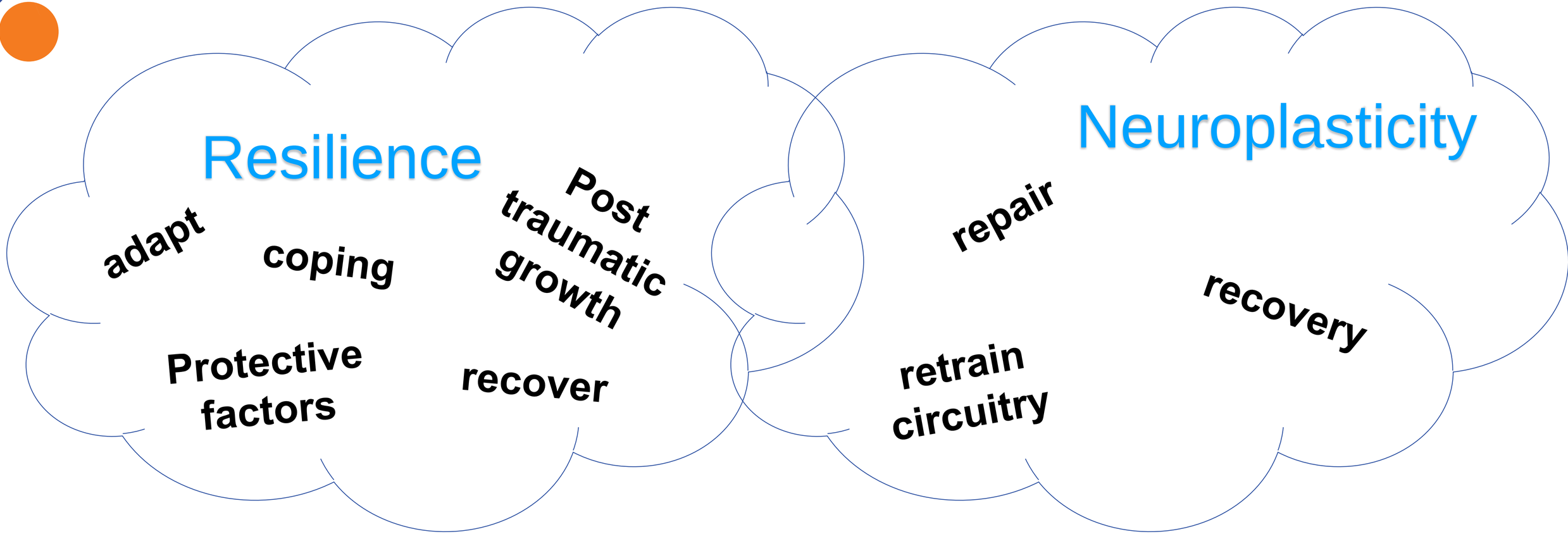


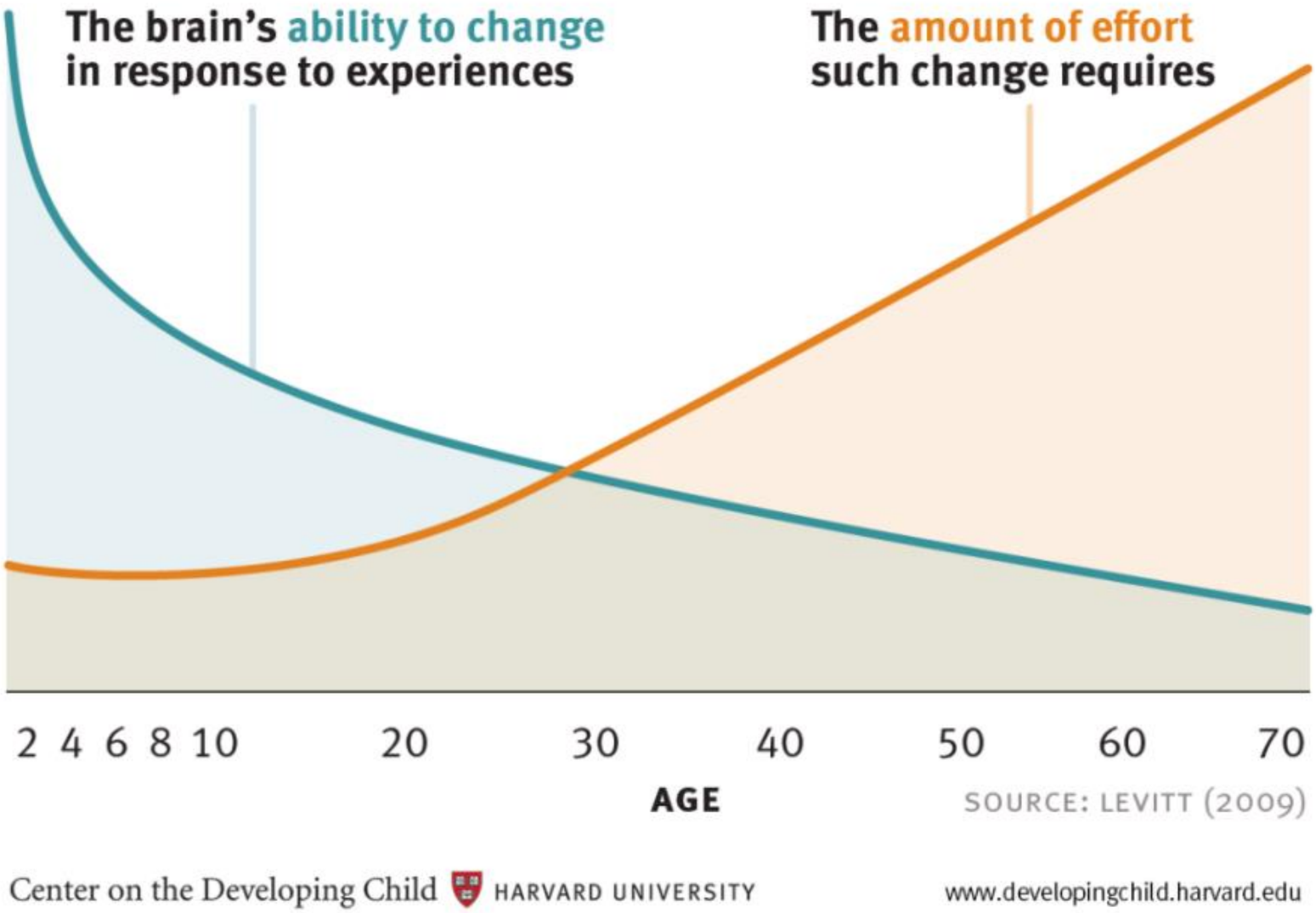
Smoking



Depressive Disorder







Source: https://developingchild.harvard.edu/science/key-concepts/brain-architecture/

Good News:
Trauma Informed Integrated Care

- Enhance Positive Attachment and connections
  - -self regulation
  - - positive beliefs about oneself
  - - motivation to act effectively
- Decrease secondary stressors and traumas
- Appropriate assessment and treatment
- ID and Cope with traumatic reminders
- General Sense of Safety

- Relationship – neutral, lack of stigma, longitudinal, continuity, point of first contact – only?

- Opportunity – look at long term health effects

(Amaya – Jackson, 2014)

- “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.” – Gillece, 2012

Screening – What is right for your practice?

- How? When? What to do with Positive Screens?
- How the questions are asked – relationship – neutral, lack of stigma
- Provider comfort
- Parent/patient comfort – get their input on which screener to use

- Universal Inquiry about stressors:
- "Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family"
- (Cohen, Kelleher & Mannarino, 2008)

- Tools:
- Ages and Stages
- Survey of Well-Being of Young Children (SWYC)
- https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx
- https://www.seekwellbeing.org
- https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx

Part of the Solution

- Medical providers are often the only contact families have with trauma responsive systems

(Source: CDC.gov)

Universal Precautions

- Understanding the relationship between previous trauma and present coping and illness
- Creating an atmosphere of respect and trust, emphasizing patient strengths, striving for cultural competence, and seeking to minimize re-traumatization
- Providers can screen for trauma and, once identified, provide emotional support and validation, as well as refer to appropriate in-clinic and community resources to address the trauma.
- Self-care – insight into your own trauma and coping strategies

Importance of Treatment Teams

- Increased continuity of care
- Defined roles can lead to effective collaboration and improved patient outcomes
- Increased job satisfaction and reduced burn out
- Address health complexity, patient defined goals and support the patient to be an active participant in health
- Behavior a strong predictor of health outcomes

Building Healthy Teams

- Five key factors: trust, communication commitment, accountability and results
- Create role clarity, pathways for communication and point person for health goals
- Culture of professionalism can develop a culture of interprofessionalism
- Deal with challenges to team care openly and quickly

Patient Centered Biopsychosocial Care Planning

Patient driven health goals – developed in collaboration with PCP and health team

Creating Continuity of Care – identifying goals in treatment, adherence barriers, follow through, stressors

Building Care Teams – Who is on the team? Defined by best way to support patient to reach health goals. Defining roles.

Incremental Implementation –Support patient to develop new treatment goals as previous goals are accomplished

References

- ASTHO Brief on primary prevention strategies for ACEs: http://www.astho.org/generickey/GenericKeyDetails.aspx?contentid=20543&folderid=5150&catid=7184
- ASTHO's Essentials for Childhood Policy Guide: http://www.astho.org/prevention/essentials-for-childhood-policy-guide/
- ASTHO's Early Brain Development Technical Assistance Framework and Database: http://www.astho.org/earlybrain/Library/
- Cohen JA, Kelleher KJ, Mannarino AP. Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers. *Arch Pediatr Adolesc Med.* 2008;162(5):447–452. doi:10.1001/archpedi.162.5.447
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- Gone, J. P., Hartmann, W. E., Pomerville, A., Wendt, D. C., Klem, S. H., & Burrage, R. L. (2019). The impact of historical trauma on health outcomes for indigenous populations in the USA and Canada: A systematic review. *American Psychologist, 74*(1), 20-35.http://dx.doi.org/10.1037/amp0000338
- Perry, B. D. (2002). *Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. Brain and Mind*.
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- https://www.slideshare.net/MCChangaris/changaris-beneath-the-skin-interrupting-the-pathways-to-pathology
- https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html
- https://www.cdc.gov/brfss/

Brain Break Activity

Evidence Based Practices for Children Who Have Experienced Trauma

BECKY PARTON, MSW, LICSW
Project Coordinator, Dartmouth Trauma Interventions Research Center

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Becky Parton, MSW, LICSW,** Project Coordinator, Dartmouth Trauma Interventions Research Center

Evidence Based Practices For Children That Have Experienced Trauma

BECKY PARTON, MSW, LICSW

DARTMOUTH TRAUMA INTERVENTIONS RESEARCH CENTER

Love and belonging are the irreducible needs of all men, women and children. We are hardwired for connection-its what gives purpose and meaning to our lives. The absence of love, belonging and connection always leads to suffering.

~Brené Brown

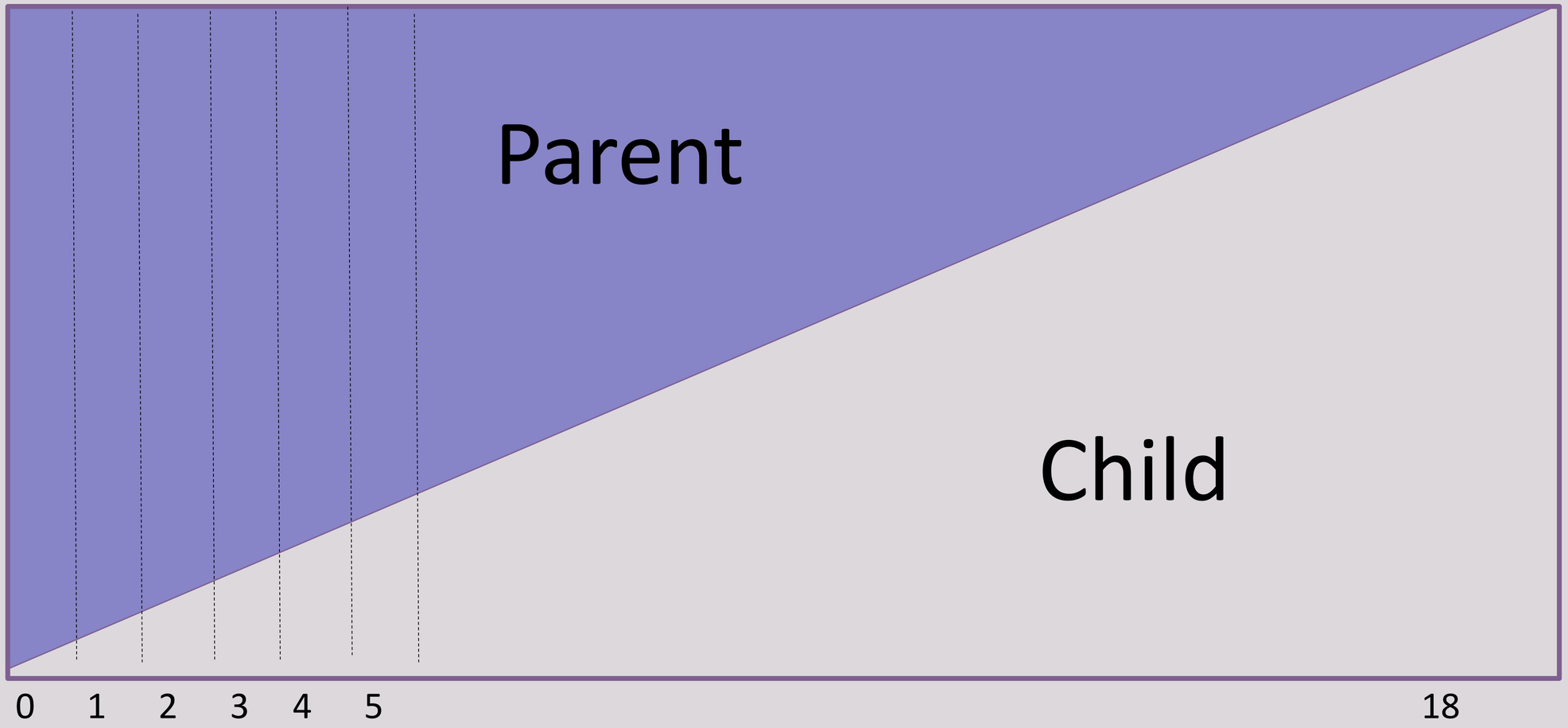
It’s about relationships

We learn from our caregivers

- Language for, behaviors for, context for emotions
- How to be in relationships with others
- What are our cultural norms? What is expected of us as we explore the world?

Co-Regulation and Self-Regulation

Based on Bruce Perry lecture, 2016



Who is providing the regulation?

Co-Regulation & Working Models

As infants, we lean on parents for regulation

- Observation
- Attunement

Develop beliefs about self, others, world based on experiences with caregivers- becomes our “Internal Working Model”

Dr. Dan Siegel- We see ourselves through our caregiver’s eyes

Four S's of parenting: Dan Siegel

Our children need to be:

Seen — this is not just seeing with the eyes. It means perceiving them deeply and empathically — sensing the mind behind their behavior, with what Dr. Siegel calls "mindsight"

Safe — we avoid actions and responses that frighten or hurt them

Soothed — we help them deal with difficult emotions and situations

Secure — we help them develop an internalized sense of well-being

From: https://www.parentmap.com/article/the-four-ss-of-parenting-dan-siegels-whole-brain-child

(Siegel & Payne Bryson, 2011)

Evidence Based Practices

There is intuition, educated practice and EVIDENCE BASED PRACTICE

Image from: http://www.cebc4cw.org/home/understanding-evidence-based-practice/

Why pick an Evidence Based Practice?

Studies have shown the treatment to be effective

- EBPs are associated with specific diagnosis', designed to treat a specific set of symptoms
- Often EBPs are standardized, have some form of a manual or set of instructions
- Therapists must meet minimum requirements (education level, training, consultation)
- Therapy will be delivered in a generally similar way across therapists

Which models are Evidence Based for Young Children?

According to NREPP (2018), Programs with EFFECTIVE OUTCOMES:

Attachment and Biobehavioral Catch-up (ABC) (6-24 months)

Child Parent Relationship Therapy (3-8)

Partners with Families and Children- Spokane (involved with CW)

Theraplay (0-18)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (ages 3-17)

Child-Parent Psychotherapy (CPP) (ages 0-6)- on the legacy list

Nurturing Parenting Programs (group therapy for parents)- on the legacy list

Parents as Teachers (working with parents of 0-Kindergarten)- on the legacy list

Young Child Trauma Treatments on CEBC

RATING OF 1 (WELL SUPPORTED BY RESEARCH EVIDENCE):

EMDR (2-17 y.o., adults)

Trauma-Focused Cognitive Behavioral Therapy (3-17)

RATING OF 2 (SUPPORTED BY RESEARCH EVIDENCE):

CPP (0-6)

RATING OF 3 (PROMISING RESEARCH EVIDENCE):

Combined Parent-Child Cognitive Behavioral Therapy (3-17)

Alternatives for Families: A Cognitive Behavioral Therapy (5-17)

Bounce Back (5-11)- directed at the child only, school based

Preschool PTSD Treatment (3-6 y.o.)- parent not in the room-use TV monitors to observe sessions

Which models are Evidence Based for Adolescents?

According to CEBC, Programs WELL SUPPORTED BY RESEARCH EVIDENCE:

Eye Movement Desensitization and Reprocessing (EMDR) (ages 2-adult, but most providers will only use with adolescent and up)

Prolonged Exposure Therapy for Adolescents (ages 12-18 but has been used as young as 6)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (ages 3-18, but most NH agencies use it with 7-18)

PROMISING RESEARCH EVIDENCE:

Seeking Safety (Adolescent Version)

Parent Training Programs

78 Programs listed on the NREPP site, 3 are highly rated:

Parent-Management Training- Oregon Model (Ages 3-12)

- Direct work with child and family

The Incredible Years (two programs ages 2-6 or 5-10)

- Group parent education

Triple P- Positive Parenting Program (0-12)

- Combination of group and/or individual, personalized to meet the need

(Developmental Services Group, 2015)

Which EBPs are available in NH?

CPP

Theraplay (no clinicians listed as completing Level 1 training or higher)

TF-CBT (most clinicians use with children over 7)

EMDR (many are trained for working with adults, some will see adolescents)

The Incredible Years

Review of models

Child Parent Psychotherapy (CPP)

Age range: 0 – 6 years

Typically 50 sessions (1 year or more)

- Relationship-based form of intervention focused on parent-child interactions and perceptions
- Developed to treat young children exposed to interpersonal violence
- Based on play and understanding a child's thoughts and feelings based on their play

Demonstrated Outcomes for CPP

Improvements in:

- Child PTSD symptoms
- Child behavior symptoms
- Child representational models
- Attachment security
- Maternal PTSD symptoms
- Maternal symptoms

(Cicchetti, Rogosch, & Toth, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Weston, & Pawl, 1991; Lieberman & Van Horn, 2006; Toth et al., 2002; Toth et al., 2006)

NH Providers Trained in CPP

- 116 Clinicians trained by DTIRC from 2013 to 2016 (approx. 104 completed consultation requirements, some have left agencies, changed jobs)

- 29 Clinicians participated in a Learning Community from either March 2016- Sept. 2017 or Oct. 2017- March 2019 & met requirements to be “rostered”

www.nhchildparentpsychotherapy.com/

Theraplay

NOT the same as “play therapy”

Focused on 4 essential components of parent-child relationships:

- Structure
- Engagement
- Nurture
- Challenge

https://theraplay.org/

Demonstrated Outcomes for Theraplay

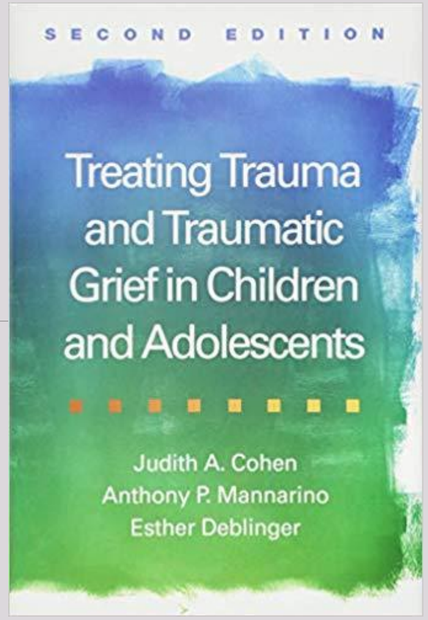
- Fewer internalizing symptoms
- Improved family communication
- Improved child symptoms: assertiveness/ confidence, trust, social communication

Summarized from https://theraplay.org/theraplay-research

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- Ages 4-18 (sometimes listed as age 3)- but often in NH starts at age 7
- Originally designed to be 8-16 sessions; in reality, with children and youth with complex trauma, it takes considerably longer
- Can be delivered in diverse settings – outpatient, residential, in home may be possible

TF-CBT Outcomes



- Trauma-Focused CBT is the most rigorously tested treatment for traumatized children and families
- Improved PTSD, depression, anxiety, shame and behavior problems compared to client-centered or nondirective therapy
- Improved parental distress, parental support, and parental depression compared to client-centered or nondirective treatment

Summarized from https://tfcbt.org/category/research-public/ and https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/

NH Providers Trained in TF-CBT

- **Over 100 clinicians trained by DTIRC** (95 finished training and required consultation from 2013-2016)

- There is online training that is free

  https://tfcbt.org/ https://tfcbt2.musc.edu/

- Some of the insurance agencies have been providing training, there is national certification with longer training/LC

Eye-Movement Desensitization and Reprocessing (EMDR)

- EBP for adults, but is used with children as well
- Developed to treat a 1 time traumatic event (in as little as 1-3 sessions) and chronic trauma (no set number of sessions)
- Uses imagery and body based interventions
  - Following therapists finger, light
  - Tapping
  - Headphones
- Based on the idea of replicating REM sleep, providing bilateral stimulation, integrating both sides of the brain

EMDR Outcomes

Improvement in:

- PTSD symptoms
- Anxiety symptoms
- Depression symptoms
- Overall mental health functioning

Summarized from: http://www.nrepp.samhsa.gov/ and http://legacy.nreppadmin.net/ViewIntervention.aspx?id=199

The Incredible Years

- 12-20 week parenting class (2-3 hours each)
- Focus on:
  - Strengthening parent-child interactions and relationships
  - Reducing harsh discipline
  - Fostering parents' ability to promote children's social, emotional, and language development

Incredible Years Outcomes

According to NREPP, research shows improvement in:

- Parenting skills
- Child externalizing problems
- Child emotional literacy, self-regulation, and social competence
- Teacher classroom management skills
- Parents' involvement with the school and teachers
- Parents were more positive, supportive, more consistent*

Previously available on https://www.samhsa.gov/nrepp

*From current review of research available at https://www.cebc4cw.org/program/the-incredible-years/

Promising Practices Available in NH

Trust-Based Relational Intervention (TBRI)®

- Connecting Principles
- Empowering Principles
- Correcting Principles

https://child.tcu.edu/

TCU Institute of Child Development

Based on the science behind complex trauma and attachment. You must first help a child feel safe, connected, before correcting behavior.

"Stay Calm *No Matter What*

See the Need *Behind the Behavior*

Meet the Need *Find a Way*

Don't Quit *If Not You, Then Who?"*

Not an EBP, but considered a "promising practice"

Can be used by non-clinical, non-masters level staff
They have trainings for schools, residential treatment centers, foster parents

Circle of Security (COS)

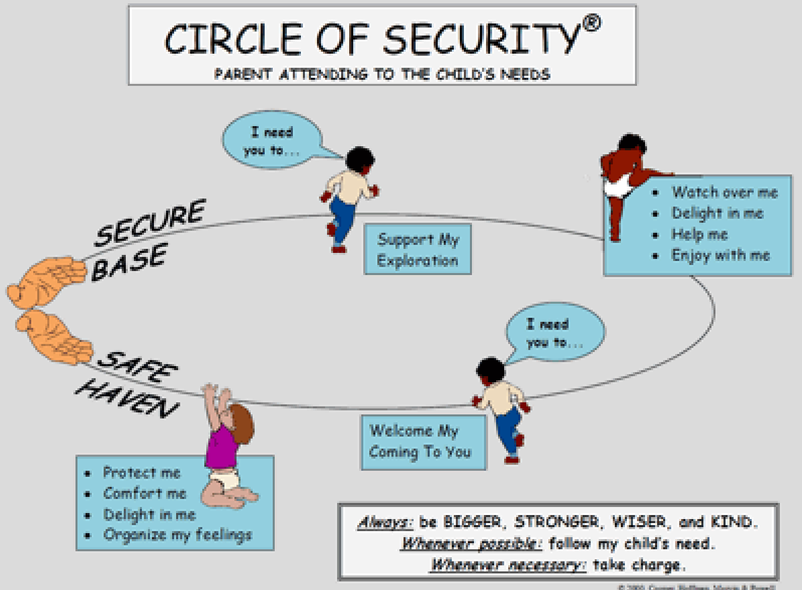
- Ages 0-6, targeted at parents
- Psychoeducation about attachment, understanding behavior and skill building for parent

Home Visiting (COS-HV4)– promising research evidence for preventing and treating abuse and neglect (CEBC)

- 4 home visits, review of video interaction

Circle of Security Parenting (COS-P) not rated on CEBC

- Typically a parenting group, review material together over 8 weeks
- Can be delivered individually and/or in home



Picture from: http://circleofsecuritynetwork.org/the_circle_of_security.html

Helping the Noncompliant Child (HNC)

- Ages 3-8
- Skills training program for parents
- Focused on positive interactions between caregiver/child; ignore minor behaviors, provide appropriate limit setting and consequences
- Typically therapist, caregiver and child together, can be done with a group
- Meant to be short term

Core Components of Treatment for Complex Trauma

Safety

Self Regulation

Self Reflective Information Processing

Traumatic Experience Integration

Relational Engagement

Positive Affect Enhancement

(Cook et al., 2005)

Those who feel lovable, who love, and who experience belonging simply believe they are worthy of love and belonging…. They are able to get to this belief by developing practices that enable them to hold on to the belief that they are worthy of love, belonging, and joy.

~Brené Brown

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http://nrepp.samhsa.gov

http://www.cebc4cw.org/home/understanding-evidence-based-practice/

http://www.cebc4cw.org

Networking Break

Personal Perspective on Trauma and the Impact on Receiving Health Care

MICHAEL SKINNER

Founder, Director, Performer, Trainer, Advocate, and Spokesperson, The Surviving Spirit

Consultant, Trainer, National Center for Trauma Informed Care, Substance Abuse and Mental Health Services Administration

Michael Skinner Music and Advocacy

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Michael Skinner,** Musician and Spokesperson, The Surviving Spirit

Brain Break Activity

Panel: Trauma-Informed Care in Practice

MODERATOR: JAN THOMAS, ADRN
Project Director, NH Citizens Health Initiative

LISA DIBRIGIDA, MS, MD
Associate Medical Director, Pediatrics, Child Health Services at Manchester Community Health Center

PETER FIFIELD, EdD, MLADC, LCMHC
Substance Use Disorder Program Manager, Behavioral Health Department

VERONICA TRIACA, MD
Director of Pelvic Medicine and Reconstructive Surgery Program, Concord Hospital Center for Urologic Care

Clinical Associate Professor of Surgery, Geisel School of Medicine at Dartmouth

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Janet Thomas,** ADRN, Project Director PTN, NH Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire
- **Presenter: Lisa DiBrigida, MS, MD,** Associate Medical Director-Pediatrics, Child Health Services at Manchester Community Health Center
- **Presenter: Peter Fifield, Ed.D, MLADC, LCMHC,** Substance Use Disorder Program Manager, The Doorway at Wentworth-Douglas Hospital
- **Presenter: Veronica Triaca, MD,** Director Pelvic Medicine and Reconstructive Surgery Program, Concord Hospital Center for Urologic Care

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

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

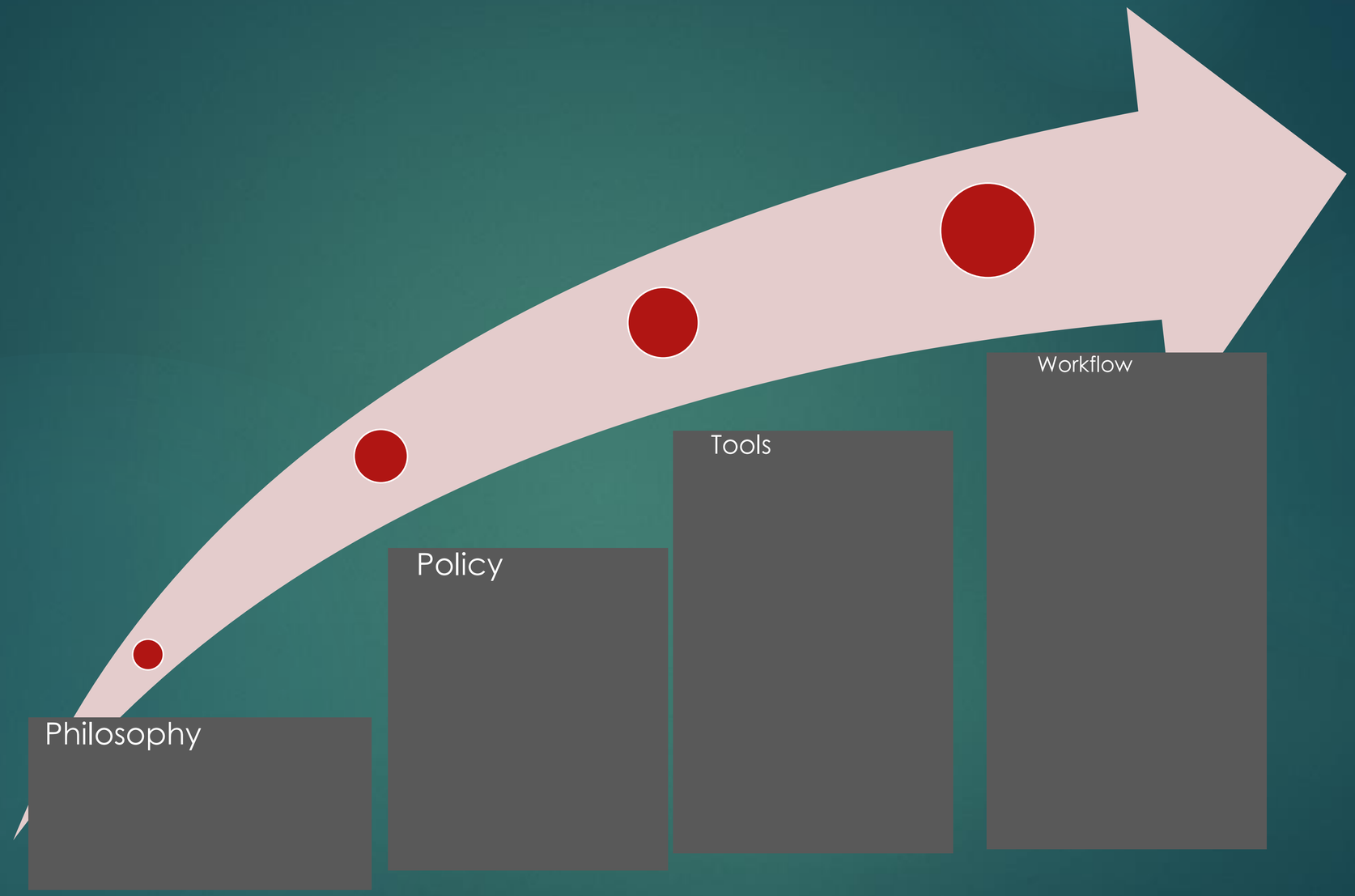
- Creating the environment of safety—full survey of all environmental elements
- Prevent re-traumatization of clients and staff—utmost goal
- Intentional hiring processes—put this in the job description

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

WENTWORTH-DOUGLASS HOSPITAL

MASSACHUSETTS GENERAL HOSPITAL SUBSIDIARY

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

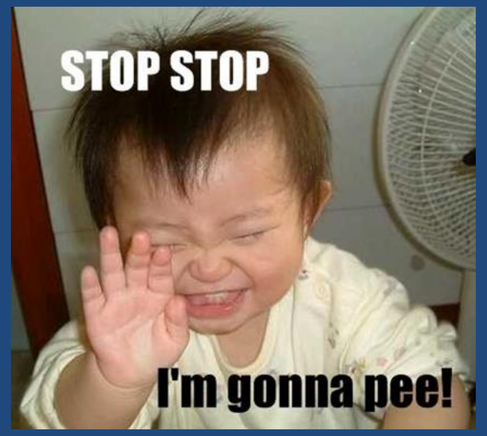
No Disclosures

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

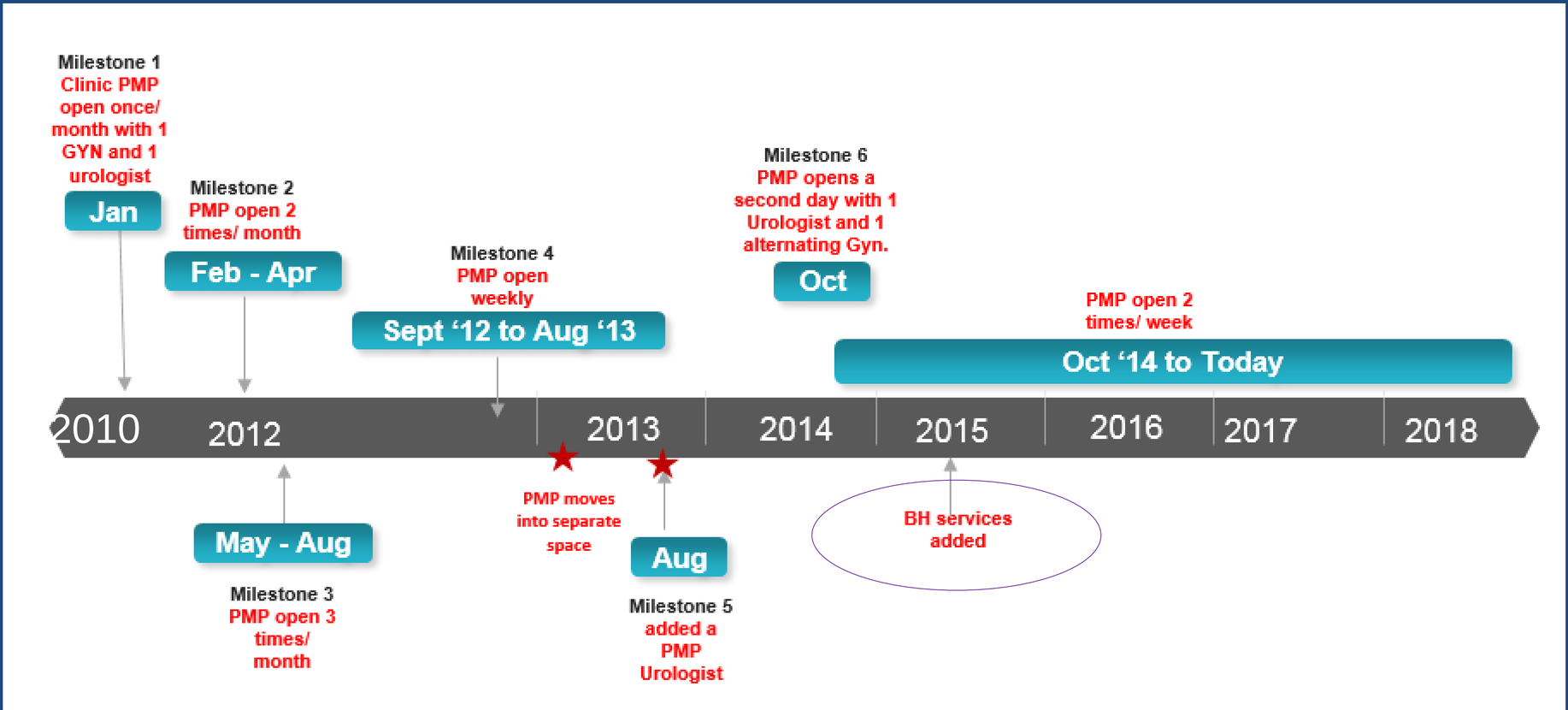
Katherine Cail, APRN

Sheryl Cheney, RPT

Jennifer Savage, LSW

Stacey Lillios, RPT

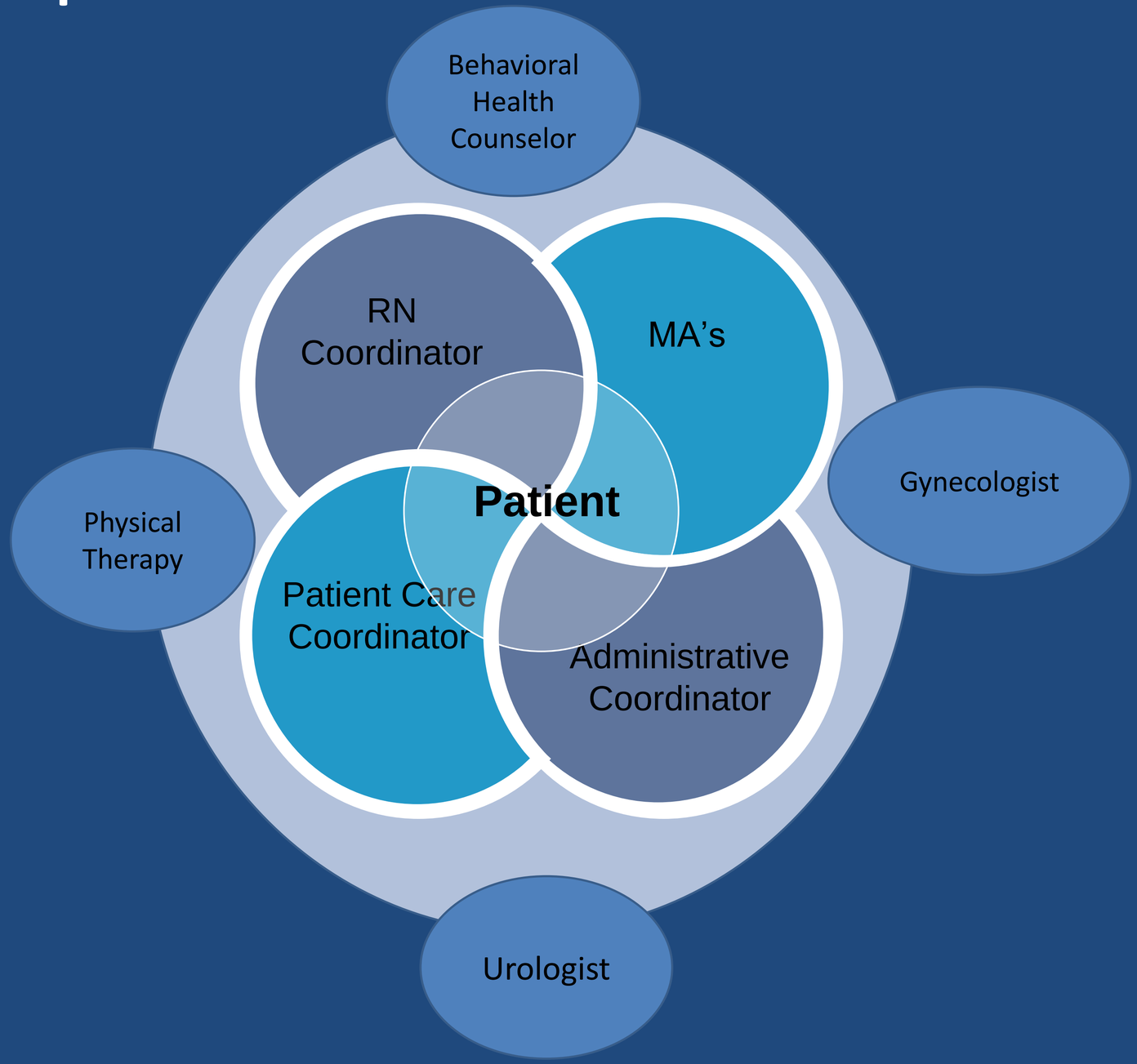
History


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 women 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.

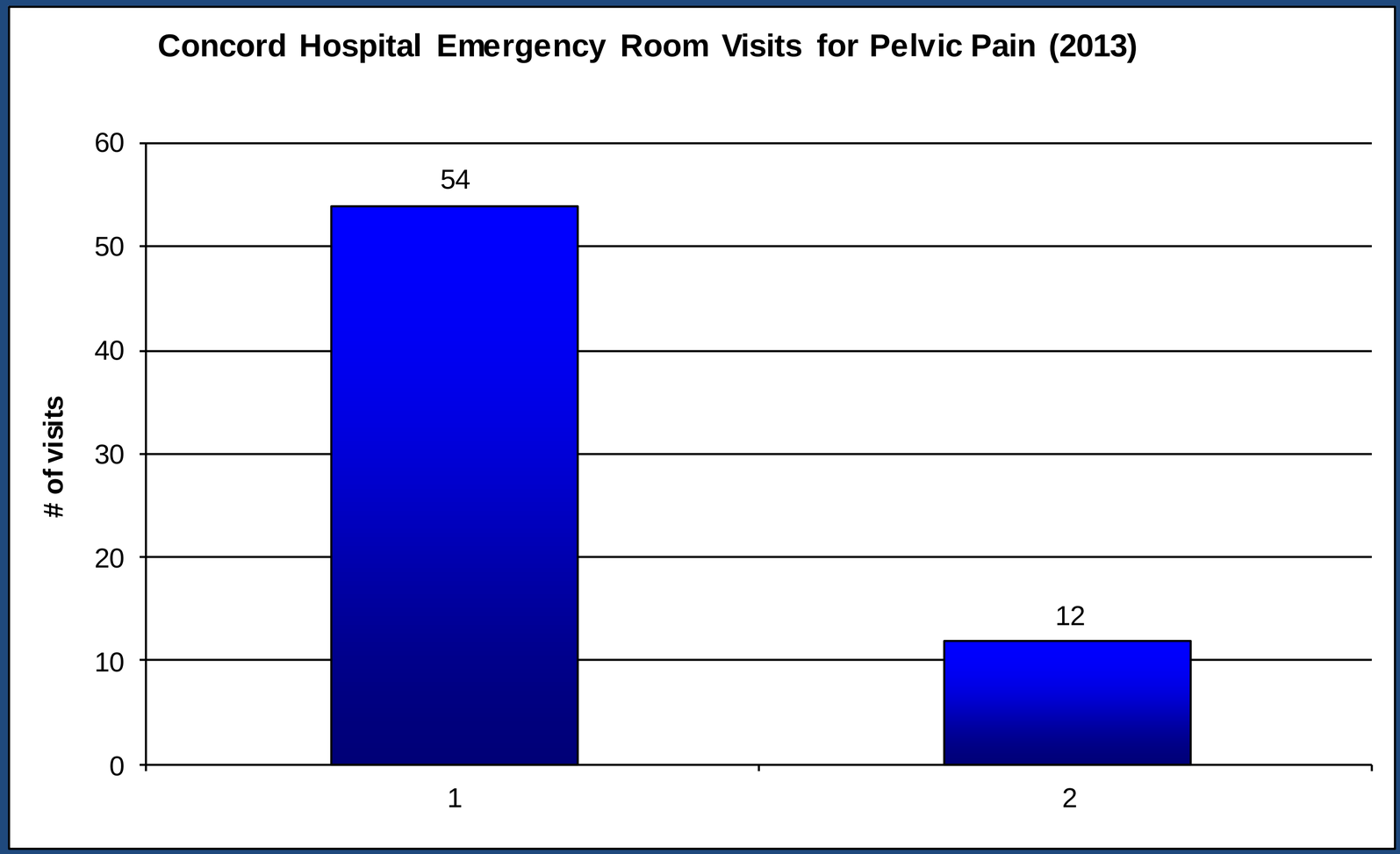
- 713 women seen in a referral-based pelvic pain clinic
- 46.8% reported having either a sexual or physical abuse history.
- 31.3% had a positive screen for PTSD
- trauma history was associated with worse daily physical functioning due to poor health (P<001), more medical symptoms (P<001), more lifetime 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/

Tel: 603-224-3388 or 603-227-7000 x2221

vtriaca@crhc.org
nmarcoux@crhc.org

CLOSING REMARKS

JEANNE RYER, MSc, EdD
Director, NH Citizens Health Initiative

CONTINUING EDUCATION CREDITS

For those who would like 3.5 CME, CNE, CEU, or SW CEU credits, please fill out the survey using the link below.

https://www.surveymonkey.com/r/EvalBHLCMay2019

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