Integrating Trauma-Informed Care Into Family Medicine Residency & the Practice of Osteopathic Manipulative Treatment

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Objectives

- Describe the unique role family physicians can play in supporting the health and wellness of patients affected by trauma

- Articulate the organizational and clinical changes required for the implementation of universal trauma-precautions and trauma-screening to result in improved health outcomes

- Discuss trauma-informed care as it relates to the practice of osteopathic manipulative treatment

Definitions

- **Trauma-informed care:** a framework for identifying and responding to patients' experiences of trauma to avoid retraumatization[1]

- **Universal trauma-precautions:** a lens for viewing every patient as though they may have a trauma history, and expanding capacity into all health services to care for the effects of trauma[2]

- **Universal trauma-screening:** competently screening every patient for a trauma history as appropriate[3]

- **Osteopathic manipulative treatment:** a set of hands-on techniques used by osteopathic physicians to diagnose, treat, and prevent illness or injury[4]

Background

- Trauma-informed care is an emerging field within primary care[5]
- There is a need for education on trauma-informed care in family medicine residency programs[1]
  - Results of the 2017 Council of Academy Family Medicine Educational Research Alliance survey of program directors: **27%** of participating PDs reported trauma-informed care training in their curriculums
  - Perceived barriers: lack of a champion and lack of time

Objective 1: What Is Our Role as FM Physicians?

- An estimated **70%** of adults in the U.S. have experienced some type of traumatic event at least once in their lives[6]

- Trauma exposure, especially in childhood, significantly increases the risk of serious health problems: chronic lung, heart, and liver disease, obesity, depression, PTSD, STIs, and tobacco, alcohol, and illicit drug abuse[3,7]

- We are positioned to support the health and wellness of our patients affected by trauma, given our breadth of practice, longitudinal care, and connection to the community[7,8]

  - Delayed presentation after a traumatic event is common in the primary care setting[9]

Objective 2: How Do We Implement Universal Trauma-Precautions & Trauma-Screening Effectively?

- Incorporate trauma education into graduate medical education and continuing medical education[3,10,11]

- Integrate trauma competencies early into clinical practice[3,10]

- Organizational changes and clinical changes are required[2,3]

Organizational Changes Required in Universal Trauma-Precautions & Trauma-Screening[3]

- Lead and communicate the changes
- Engage patients in organizational planning
- Train clinical and non-clinical staff
- Create a safe environment
- Prevent secondary traumatic stress in staff
- Hire a trauma-informed workforce

Clinical Changes Required in Universal Trauma-Precautions & Trauma-Screening[3,8,12]

- Involve patients in the treatment process
- Screen for trauma
  - Upfront and universal screening vs. later screening
  - Avoid re-screening
- Train staff in trauma-specific treatment approaches
- Engage referral sources and partnering organizations

Specific Examples of Trauma-Informed Care Practices[5,9]

- **Pre-visit:**
  - Review the patient's chart for trauma-related documentation to avoid re-screening
- **Encounter:**
  - Ensure privacy
  - **Provide culturally-sensitive interpretation services:** inquire about gender/cultural preferences
  - Meet the patient before they disrobe
  - Knock and ask for permission to enter
  - Be seated and face the patient
  - Offer options to interview the patient alone
  - Emphasize confidentiality
  - Manage expectations (i.e., visit overview, timing, team introductions, documentation, etc.)

Specific Examples of Trauma-Informed Care Practices[5,9]

- **Encounter continued:**
  - Normalize the ubiquity of trauma
  - Explain rationale
  - Use supportive and empowering language
  - Avoid touching the patient to express concern, support, etc.
  - Allow time for questions
  - Elicit the patient's concerns and values and incorporate them into their care
  - Practice shared decision-making
- **Physical examination:**
  - Ask for permission before examining the patient
  - Ask how you can make the patient more comfortable
  - Ask the patient to lift their clothing out of the way (instead of doing it yourself)

Specific Examples of Trauma-Informed Care Practices[5,9]

- **Invasive examinations and procedures:**
  - Manage expectations
  - Explain rationale
  - Offer choices and respect the patient's choices
  - Obtain consent
  - Have all procedure and post-procedure supplies set up before the patient disrobes
  - Ask the patient if they would like to have a family member, friend, or staff member in the room
  - Ask the patient how they can let you know if they need a break or need to stop
  - Use suggestive vs. instructive language
- **Imaging:**
  - Same as the above

Specific Examples of Trauma-Informed Care Practices[5,9]

- **Referrals:**
  - Connect the patient with community-based resources
  - Confidentially notify referrals in advance that the patient has a trauma history
- **Post-visit:**
  - Provide additional after-care instructions and follow-up plan (written, or oral at a later time) in case the patient experiences distracting anxiety or dissociation during the visit

Potential Benefits of These Changes[3,7,8,11]

- Improved patient engagement
- Improved mental and physical health outcomes
- Improved provider and staff wellness
- Decreased unnecessary utilization of healthcare services

Barriers to Making These Changes

- Lack of behavioral health integration[3]
- Lack of reimbursement[3]
- Lack of organizational buy-in and organizational training[3,13]
- Lack of clinical training[3,13]
- Lack of provider openness, willingness to self-assess ACE score, compassion satisfaction, extraversion, and conscientiousness[13,14]
- Burnout, trait neuroticism, need to alter the medical environment, perceived time constraints, trait agreeableness, and fear of retraumatizing patients[13]

Recognizing Secondary Traumatic Stress[3]

- **Secondary traumatic stress:** emotional stress from hearing another person's firsthand traumatic experiences

- **Signs and symptoms:** chronic fatigue, disturbing thoughts, poor concentration, emotional detachment and exhaustion, avoidance, absenteeism, and physical illness

Preventing Secondary Traumatic Stress[3,15]

- Provide training to raise awareness of secondary traumatic stress
- Offer opportunities for staff to explore their own trauma histories
- Support **reflective supervision:** a service provider and supervisor meet regularly to address feelings regarding patient interactions
- Encourage and incentivize physical activity, yoga, and meditation
- Allow mental health days for staff
- Such interventions can also reduce burnout and stigma and improve perceived resiliency and self-compassion among providers

Objective 3: How Do We Incorporate Trauma-Informed Care Into OMT?[16]

- Assessing trauma reflects the osteopathic principle of caring for the whole person: body, mind, and spirit

- We practice trauma-informed OMT when we
  - Explain the nature and purpose of applying a technique to the patient's body
  - Address what the patient might experience during an examination or treatment
  - Ask the patient to let us know if they are ready for OMT and if so, which areas of the body are ok to touch

How Do We Incorporate Trauma-Informed Care Into OMT?[16]

- We practice trauma-informed OMT when we
  - Ask the patient if they would like to have a family member or friend in the room
  - Ask the patient if they would prefer to have a staff member present
  - Notice, stop, and ask if a patient is ok if they become uncomfortable during treatment
  - Validate the patient's experiences, advocate for their needs, and support their autonomy
  - Accept that some patients may not feel comfortable receiving OMT

Trauma-Informed Care and OMT[16]

- **The bottom line:** when combining trauma-informed care with OMT, osteopathic-trained physicians have the tools to foster a safe, comfortable, and healing practice environment that promotes a trusting relationship with patients

References

1. Dichter, Melissa E; Teitelman, Anne; Klusaritz Heather; Maurer, Douglas M; et al. "Trauma-Informed Care Training in Family Medicine Residency Programs: Results From a CERA Survey." Family Medicine, September 2018.

2. Stokes, Yehudis; Jacob, Jean-Daniel; Gifford, Wendy; Squires, Janet; et al. "Exploring Nurses' Knowledge and Experiences Related to Trauma-Informed Care." Global Qualitative Nursing Research, October 2017.

3. Menschner, Christopher; Maul, Alexandra. "Key Ingredients for Successful Trauma-Informed Care Implementation." Center for Health Care Strategies, Inc., April 2016.

4. American Osteopathic Association. “What is Osteopathic Manipulative Treatment?” 2021.

5. Ravi, Anita; Little, Virna. "Providing Trauma-Informed Care." American Family Physician, May 2017.

6. National Council for Behavioral Health. “How to Manage Trauma.” May 2013.

7. Tomaz, Teresa; Castro-Vale, Ivone. “Trauma-Informed Care in Primary Health Settings—Which Is Even More Needed in Times of COVID-19.” Healthcare, September 2020.

8. Purkey, Eva; Patel, Rupa; Phillips, Susan P. "Trauma-informed care | Better care for everyone." Canadian Family Physician, March 2018.

References Continued

9. Farahi, Narges; McEachern, Morgan. “Sexual Assault of Women.” American Family Physician, February 2021.

10. Goldstein, Ellen; Murray-Garcia, Jann; Sciolla, Andrés F; Topitzes, James. "Medical Students' Perspectives on Trauma-Informed Care Training." Nursing Research Practice, January 2018.

11. Green, Bonnie L; Saunders, Pamela A; Power, Elizabeth; Dass-Brailsford, Priscilla; et al. "Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers." Family Medicine, January 2015.

12. Davies, Jon A; Todahl, Jeff; Reichard, Anna E. "Creating a Trauma-Sensitive Practice: A Health Care Response to Interpersonal Violence." American Journal of Lifestyle Medicine, October 2015.

13. Stevens, Natalie R; Ziadni, Maisa S; Lillis, Teresa A; Gerhart, James; et al. "Perceived lack of training moderates relationship between healthcare providers’ personality and sense of efficacy in trauma-informed care." Anxiety Stress Coping, November 2019.

14. Strait, Joshua; Bolman, Tiffany. “Consideration of Personal Adverse Childhood Experiences during Implementation of Trauma-Informed Care Curriculum in Graduate Health Programs." Permanente Journal, 2017.

15. Knaak, Stephanie; Sandrelli, Marika; Patten, Scott. “How a shared humanity model can improve provider well-being and client care: An evaluation of Fraser Health’s Trauma and Resiliency Informed Practice (TRIP) training program.” Healthcare Management Forum, 2020.

16. Cuevas, Kristen M; Balbo, Jane; Duval, Krista; Beverly, Elizabeth A. "Neurobiology of Sexual Assault and Osteopathic Considerations for Trauma-Informed Care and Practice." Journal of the American Osteopathic Association, February 2018.

Discussion Questions

- What experiences or ideas have you had in integrating trauma-informed care into family medicine residency training?
- Have you implemented trauma-precautions in your practice and teaching? What does that look like?
- Have you implemented trauma-screening in your practice and teaching? What does that look like?
- For those who practice osteopathic manipulative treatment, have you integrated trauma-informed care into your practice and teaching of OMT? How so?
- How do you feel now (e.g., same, better, or worse) about integrating trauma-informed care into your family medicine residency program?

Open Discussion

Please share any remaining questions or points that you have that you feel are pertinent to this discussion.

Feedback and Correspondence

For feedback on this presentation/discussion and interest in future research or collaboration, please email me at lweinand@arizona.edu

THANK YOU!