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From Uncertainty to Understanding: An Update on Trauma-Informed Care

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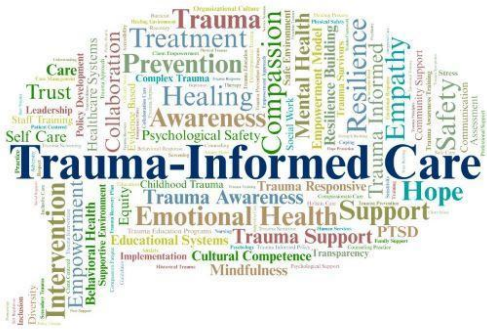

In November 2019, the Centers for Medicare & Medicaid Services (CMS) launched the final phase of a trauma-informed care (TIC) provision for post-acute and long-term care (PALTC) as part of F-tag F699, which requires facilities to provide trauma survivors with culturally competent trauma-informed care. Early on, there were some questions and uncertainties about how to implement and document TIC. Five years later, facilities generally have a greater understanding of what CMS expects and how they can provide and document TIC effectively.

In addition to F699, several other F-tags include TIC mandates. These are F656 (Develop/Implement Comprehensive Care Plans), F659 (Comprehensive Care Plans), F740 (Behavioral Health Services), F742 (Treatment/Services for Mental/Psychosocial Concerns), F743 (No Pattern of Behavioral Difficulties Unless Unavoidable), F745 (Provision of Medically Related Social Services), and F949 (Behavioral Health Training). Clearly, TIC has a widespread impact, and facility leaders and teams have made this a priority.

From Anxious to Accomplished?

As Lisa Lind, PhD, ABPP, chief clinical officer at Deer Oaks – The Behavioral Health Solution, recalls, "When TIC regulations were first introduced, there seemed to be a lot of anxiety among facility staff, most likely due to a perceived lack of guidance; though the focus seemed to be on the importance of screening for trauma in residents." She adds, "Several months after the initiation of phase three, the COVID-19 pandemic hit, and the focus shifted to managing resident care during an unprecedented time."

Today, Dr. Lind says, "Overall, the initial anxiety related to TIC expectations seems to have subsided. Most facility staff appear to recognize that everyone who interacts within a post-acute setting could have trauma histories that we may or may not know about." As a result, she says, many facilities seem to be more focused on other issues such as having proper documentation for a schizophrenia diagnosis and gradual dose reductions for psychotropic medications.

Guidance Is Greater

CMS' guidance on TIC has evolved over time. According to Dr. Lind, "CMS has clearly communicated their expectations that nursing facilities recognize the impact of trauma, avoid re-traumatization, and provide care that promotes physical, emotional, and psychological safety for all residents." It has become clear, she observes, that this isn't just a behavioral health issue. It also relates to resident rights, staff competency, and quality of life—all of which contribute to person-centered care.

However, Dr. Lind notes, "I think one area that could be clarified is related to how staff can ensure that residents aren't re-traumatized as a result of staff following TIC regulations and whether exceptions could be made to account for this." For example, she says, "What if a resident does not want their trauma status disclosed to anyone, even when staff believe this information would be beneficial to provide the best possible care for that individual? It would be helpful for CMS to include language in the regulations about guidance related to possible exceptions." And David Smith, MD, CMD, a retired geriatrician in Texas, says, "Sublimation or healthy avoidance-focused coping may not be the mental health professional's favorite tactic; but if it's effective, well, if it ain't broke, don't fix it."

At the same time, Dr. Lind observes, "There isn't much guidance on providing TIC screening for residents who have severe cognitive impairment, communication limitations, or other conditions that may make it difficult to obtain information via direct screening." Additional guidance on indirect screening methods and when these might be appropriate would be helpful for staff. Dr. Smith echoes the need to address this, as direct screening of someone with dementia could "resurrect bad memories that have been largely dealt with or resolved and cause them to re-experience or relive the experience."

There is also a need for more guidance and information on how to address TIC during a mass and/or critical incident, such as an outbreak, natural disaster, or sudden death that impacts residents and staff. As Dr. Lind explains, "The uniqueness of these situations is that the trauma is currently occurring or has very recently occurred and impacts numerous people—residents and staff alike—simultaneously. Guidance on this would be very helpful."

Facility leaders need to understand what surveyors will be looking at to determine noncompliance with F699, such as a failure to identify trauma survivors' cultural preferences and a resident's past history of trauma and/or triggers that could retraumatize them, as well as a lack of consistently used, culturally competent TIC approaches.

Training Is Key, But Not One and Done

First things first, everyone needs to understand what trauma is, so they start out and stay on the same page. CMS uses the following definitions:

- Trauma is the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
- Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumas. A trauma-informed approach to care delivery

recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization.

CMS has adapted the principles of TIC from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Concept of Trauma and Guidance for a Trauma-Informed Approach: Safety, trustworthiness and transparency, peer support and mutual self-help, collaboration, and empowerment, voice, and choice.

Dr. Lind suggests, "TIC training should be an ongoing process that includes teaching a practical approach that guides staff skills to assess situations and respond effectively while protecting resident and staff safety. At a foundational level, it should include how to identify what trauma is, signs and symptoms to watch for, common examples of traumatic events, how trauma might present in long-term care settings, and common behavioral presentations that might be missed as trauma-related." Training, she says, should be proactive and predictive, rather than reactive in response to a situation or issue, whenever possible.

Staff need to be aware of age-dependent differences in the experiences of residents and how this may impact how they feel about and interpret trauma. It is also important for staff not to impose their own experiences, feelings, and biases on residents, and to use non-judgmental language.

Ultimately, says Dr. Lind, training must help ensure that staff understand the four Rs of TIC as developed by SAMHSA:

- **Realize** the prevalence and widespread impact of trauma and its effect on residents and staff.
- **Recognize** the signs and symptoms of trauma in clients, families, colleagues, and others. This means understanding that shifts in a resident's cognition, sleep pattern, appetite, social interaction, or physical functioning may represent trauma-related responses rather than medical issues.
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices. For instance, Dr. Lind says, "Policies would ideally include the goals of prioritizing resident and staff safety—emotional, physical, and psychological—using the least restrictive and non-pharmacological approaches first, as well as committing to preventing re-traumatization." TIC can be incorporated into policies on admissions and care planning, abuse prevention and reporting, grievance and complaints, resident rights, and psychotropic use, to name a few.
- **Resist** re-traumatization while fostering resident and staff empowerment within a culturally responsive framework.

As training is essential to meeting CMS' mandate on TIC, facilities need to document what training is offered and when. As Dr. Lind notes, "Documenting attendance at TIC training programs isn't sufficient. It is important to assess their competence in the four Rs."

Dr. Smith suggests training staff to stay alert to residents' facial expressions and body language, which can offer clues about their past traumas. For instance, if a resident flinches when touched, acts fearful of

a visiting dog, or cries during a thunderstorm, this may suggest a past trauma. At the same time, this can even uncover an ongoing trauma. Dr. Smith says, “We had a patient with dementia whose legal guardian would take her out of the facility on occasion. When she returned, she was severely distraught. It was discovered that he was sexually abusing her, and we were able to intervene.”

When Families Can Help

While there are privacy policies that staff must adhere to, families may be a useful source of trauma-related information, particularly if the resident is unable to communicate. As Dr. Smith says, “The family can be one of your best sources to help get to the heart of the issue at hand or uncover previously unaddressed trauma.”

At the same time, Dr. Lind observes, “Residents may disclose trauma history to their mental health providers or facility staff that they have never shared with their immediate family. The first time some family members learn about their loved one’s traumatic experience is during a care planning meeting.” When this happens, they may respond in ways that can derail the conversation, such as getting defensive or denying that the trauma ever happened. The team needs to be prepared to help support the family so, in turn, they can support their loved one.

Taking Charge

Team leaders play a key role in helping to ensure everyone understands the importance of TIC and their role in respecting residents’ feelings, as well as preventing re-traumatization. Tanya Procell, RN, president of Provider Professional Services, says, “I think that facilities should adopt trauma-informed care as part of the organization’s culture. It needs to be a focus and include education on the definitions that impact the outcomes, as well as understanding how behaviors like anxiety, changes in sleep patterns, and refusal of care can be related to previous life trauma.”

Ms. Procell advises, “Make sure that you're promoting a sense of emotional and physical safety for your residents and your staff. Practice empathy and share with staff how we respond to avoid triggers whenever possible. Identify and acknowledge the champions in your organization who are especially skilled at TIC.”

Dr. Lind observes, “Trauma-informed care was once viewed by some as primarily being a frontline responsibility. However, experience has demonstrated that effective implementation requires systems-level leadership.” She says that the medical director plays a key role in determining whether TIC is consistently embedded in practice or applied variably, adding, “By modeling TIC principles during daily clinical interactions, QAPI activities, care planning, and rounds, medical directors set expectations for the interdisciplinary team. They also serve as role models for staff by demonstrating TIC principles in how they think, speak, and make decisions, especially under pressure.”

Helpful Resources

Trauma-Informed Care Toolkit

An Introduction to Creating a Trauma-Informed Culture in the Post-Acute and Long-Term Care Facility –

Part 1

The Impact of Trauma & How Trauma-Informed Care Helps Create a Healing Environment

Resources Guide: Trauma-Informed Care

Trauma-Informed Care In Behavioral Health Services: Quick Guide for Clinicians

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https://paltmed.org/news-media/uncertainty-understanding-update-trauma-informed-care