TraumaCon 2023

The Use of a Nurse-administered Trauma-focused Treatment to Lessen the Effects of PTSD and Depression After an Injury

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Objectives:

- Identify the key stakeholders to implement a nurse-administered treatment for PTSD
- Verbalize potential barriers to implementing a new treatment
- Verbalize the importance of a screening and intervention protocol for PTSD

Medical Trauma

A contributor to risk for post-injury PTSD?

"A set of psychological & physiological responses to pain, injury, serious illness, medical procedures, and frightening treatment experiences" occurring in the context of the health care system.

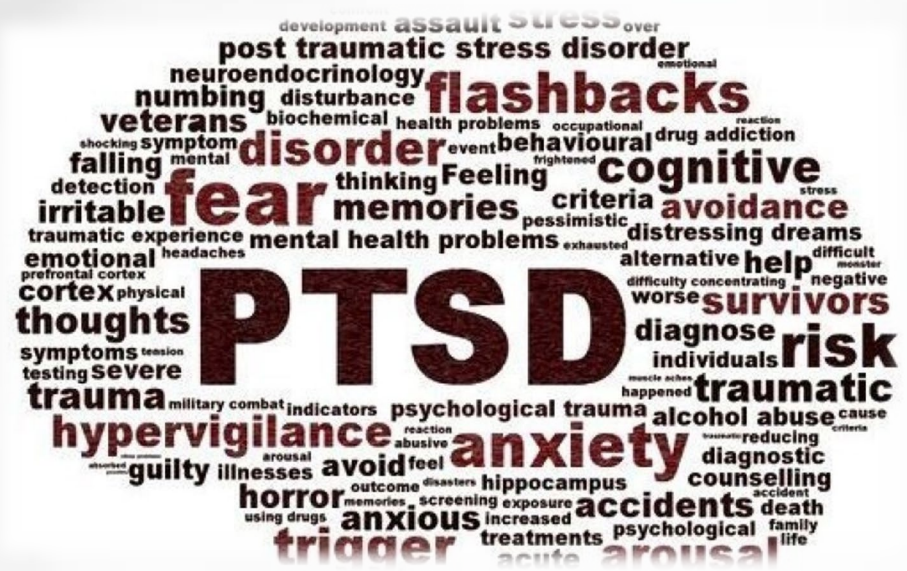
Potentially Distressing Medical Events following Injury:

- The nature of the injury
- Treatment-related
- Life-altering complications or unexpected medical intervention
- Uncontrolled postoperative pain
- Conditions of the hospital environment
- Hallucinations caused by delirium
- Perceived and actual mistreatment by staff

Kazak et al. (2006); Edmonson (2014); the GVtM-US Steering Council

Post Traumatic Stress Disorder (PTSD)

Strong correlation of quality of life, decreased physical health, and increased health care utilization and heath care costs



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Post Traumatic Stress Disorder (PTSD)

• **Risk Factors**	**Resilience Factors**
• Living through dangerous events and traumas • Getting hurt • Seeing another person hurt, or seeing a dead body • Childhood trauma • Feeling horror, helplessness, or extreme fear • Having little or no social support after the event • Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home • Having a history of mental illness or substance abuse	• Seeking out support from other people, such as friends and family • Finding a support group after a traumatic event • Learning to feel good about one's own actions in the face of danger • Having a positive coping strategy, or a way of getting through the bad event and learning from it • Being able to act and respond effectively despite feeling fear

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30 million

injured patients are seen in US Emergency Departments annually

2.6 million

require hospitalization for treatment

1 in 3 patients

meet criteria for PTSD and depression within one year post-injury

1 in 5 patients

report poor mental health outcomes post-injury

Giummarra et al (2018)

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Arousal & reactivity symptoms

Avoidance symptoms

Intrusion symptoms

Changes in cognition & mood

Psychological distress within 3-months of an injury is the strongest determinant of disability 12-months post-injury.

Early symptoms of PTSD increase the likelihood of chronic pain and other negative post-injury HRQoL outcomes.

PTSD is also related to readmissions for substance-use related injuries.

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Giummarra et al (2018); deRoon-Cassini et al (2019)

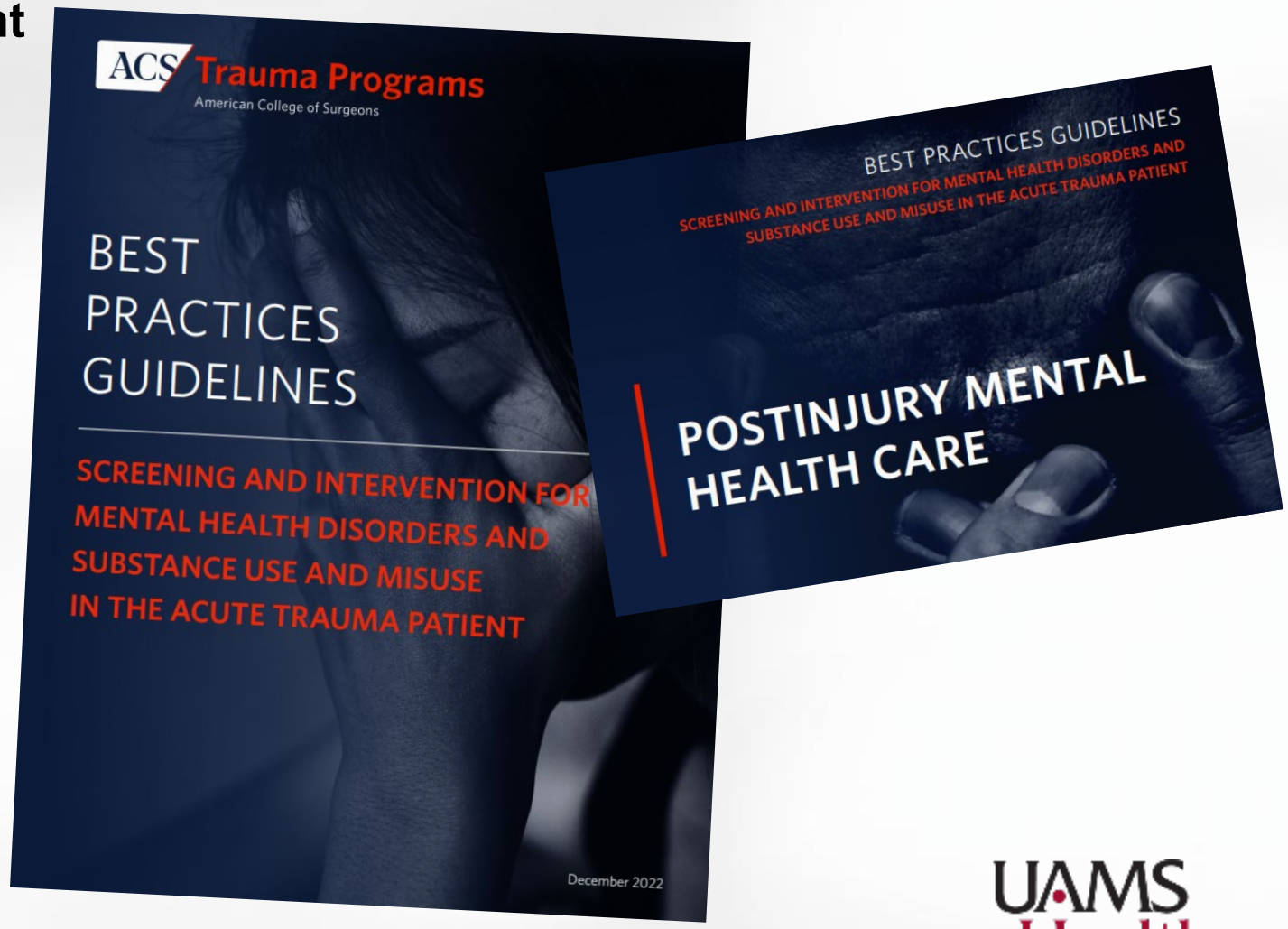
Trauma-Informed Approach

- Integrating an understanding of traumatic stress into organizations & patient care can:
  - Reduce the impact of difficult or frightening medical events
  - Minimize modifiable risk factors
  - Help patients and families cope with emotional reactions to illness and injury
  - Mitigate provider burnout & traumatization

American College of Surgeons Best Practice Guideline

Screening & Intervention for Mental Health Disorders and Substance Use and Misuse in the Acute Trauma Patient

- *2022 Resources for Optimal Care of the Injured Patient*
  - Mental health screening and standardized protocols for referral to services in the
- Core Postinjury Mental Health Care Program Components
  - Screening
  - Assessment
  - Brief Intervention
  - Referral



https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/

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TLC to Recover

- Talk, Listen, and Communicate (TLC) to Recover
- 2 session, dyadic, nurse-administered intervention (or other healthcare provider)
  - Session 1: Psychoeducation
  - Session 2: Review
- Primarily focused on injury/illness
- Targets post-injury PTSD and depression symptoms using psychoeducation and motivational interviewing to facilitate support and disclosure, and improve coping
- Found to reduce the risk for PTSD development at 6 months and 2 years post-injury

TLC to Recover

Promotion of Emotional Disclosure Following Illness and Injury: A Treatment Manual for Medical Patients and Their Families

Authors:

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Stanford University and VA Palo Alto Health Care System

Josef I Ruzek, PhD

National Center for PTSD, Education Division, Menlo Park CA and VA Palo Alto Health Care System

TLC to Recover Session 1 Overview

- Orientation
- Common Reactions
- Importance of Processing
- Social Constraints
- Do's and Don'ts in Communicating about Feelings (disclosing, responding, feedback)
- Motivational Interview
- Do's and Don'ts in Coping
- Discussion
- Recap
- Written Support Materials
- Scheduling Second Session

Implementation Process

- Pre-Implementation Study
- Identification of Key Stakeholders
- Training for Personnel performing intervention
- Introduction of Program into the Clinic Process
- Evaluation of the program and clinic process

Pre-Implementation Study

Semi-structured qualitative interviews with key stakeholders

Main Takeaways

- Most agreed PTSD screening & brief intervention would be helpful.
- Advantages related to improved patient-centered outcomes
- Barriers were related to system strain
- A standard approach & clear protocol
- Reinforcing factors included getting buy-in and real life examples of it working
- Screening should be delegated to non-physician staff and possibly a new role

Open access Brief report

Trauma Surgery & Acute Care Open

Barriers to and facilitators of a screening procedure for PTSD risk in a level I trauma center

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ABSTRACT

Background Patients admitted to the hospital after an injury are at a greater risk for developing post-traumatic stress disorder (PTSD) due to the nature of the injury and the traumatic nature of necessary medical interventions. Many level I trauma centers have yet to implement screening protocols for PTSD risk. The goal of the study was to characterize the barriers to and facilitators of implementation of a screening procedure for PTSD risk in a level I trauma center.

Methods We conducted semistructured qualitative interviews with multidisciplinary academic medical center stakeholders (N=8) including those with clinical, research, teaching, and administrative roles within an urban academic medical center's Department of Surgery, Division of Acute Care Surgery. We analyzed the qualitative data using summative template analysis to abstract data related to participants' opinions about implementation of a screener for PTSD.

Results Participants' general perception of screening for PTSD risk after injury was positive. Identified challenges to implementation included timing of screening, time burden, care coordination, addressing patients with traumatic brain injury or an altered mental status, and ensuring appropriate care after screening. Reported facilitators included existing psychosocial screening tools and protocols that would support inclusion of a PTSD screener, a patient-centered culture that would facilitate buy-in from providers, a guideline-driven culture, and a commitment to continuity of care.

Conclusions This study offers concrete preliminary information on barriers to and facilitators of PTSD screening that can be used to inform planning of implementation efforts within a trauma center.

Level of evidence Level V, qualitative.

drug use, and 92% for alcohol use.[6] To address this gap in care, the American College of Surgeons Committee on Trauma (ACS-COT) recommends trauma centers screen all trauma patients for PTSD and depression risk.[7] Abbreviated PTSD screening may be successfully integrated into trauma services and inpatient surgical services of level I trauma centers and has value in predicting and treating those who are likely to develop chronic PTSD.[1 8–10] However, there is a paucity of information available on how to implement PTSD screening in level I trauma centers. Given this lack of information, the goal of the current study was to identify and describe the barriers to and facilitators of implementation of a screening procedure for PTSD risk in a level I trauma center.

METHODS

Setting

The current study was conducted in an urban academic medical center's Department of Surgery, Division of Acute Care Surgery that holds designations as an American College of Surgeons verified level I trauma center. The trauma center is a 24-bed surgical intensive care unit composed of an interdisciplinary team that provides tertiary medical care to critically ill and injured adult patients throughout the state. In 2018, there were a total of 2598 admissions to the trauma center. Of those 2598 admissions, 809 patients had a Glasgow Coma Scale score greater than 13 and a length of stay longer than 2 days suggesting they may be appropriate for PTSD screening.The table 1 describes the primary injury type and Injury Severity Score (ISS) of those who may be appropriate for screening.

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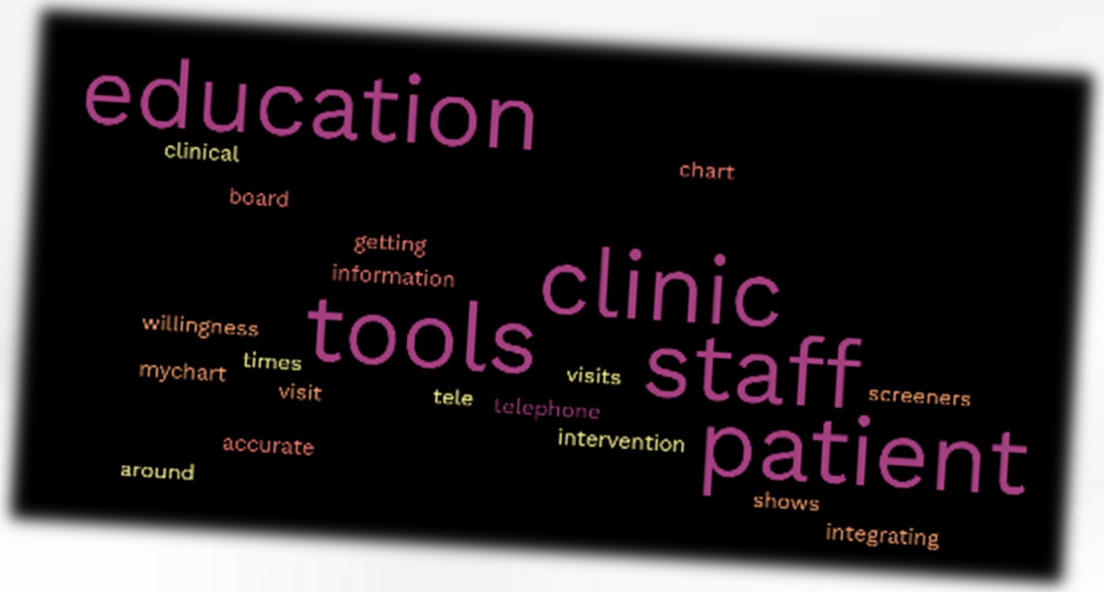
Key Stakeholders

- Brain Writing Activity
  - Group of Key Stakeholders (virtually and in person)
  - Anonymous
  - Work on identifying/addressing potential barriers prior to implementation
  - More dynamic conversation to use collaborative thinking
- Interviews of Key Stakeholders
  - Trauma Interdisciplinary Team (APRNs, RNs, Clinic Nurses, Attending Physicians, Residents, and Social Workers)
  - Trauma Patients and Support Person



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Implementation Process – Training for Personnel

- Training for Personnel
  - Virtual training by Dr. Cordova and Dr. Ruzek
  - 4 hours
  - Interactive training
- Introduction of Program
- Evaluation of Program (in progress)

Initial Screening & Determining Eligibility

DATE

Inpatient Screening Procedure

- ITSS (Injured Trauma Survivor Screen)
  - 9-item measure
    - PTSD – 5 items
    - Depression – 5 items

    (1 item overlaps)

    ITSS PTSD – 75% sensitivity, 78.8% specificity
    ITSS MDE – 80.4% sensitivity, 65.6% specificity

Injured Trauma Survivor Screen (ITSS)

1 = Yes 0 = No

Before this injury	PTSD	DEP
1. Have you ever taken medication for, or been given a mental health diagnosis?		1 0
2. Has there ever been a time in your life you have been bothered by feeling down or hopeless or lost all interest in things you usually enjoyed for more than 2 weeks?		1 0
When you were injured or right afterward		
3. Did you think you were going to die?	1 0	1 0
4. Do you think this was done to you intentionally?	1 0	
Since your injury		
5. Have you felt emotionally detached from your loved ones?		1 0
6. Do you find yourself crying and are unsure why?		1 0
7. Have you felt more restless, tense or jumpy than usual?	1 0	
8. Have you found yourself unable to stop worrying?	1 0	
9. Do you find yourself thinking that the world is unsafe and that people are not to be trusted?	1 0	
≥ 2 is positive for PTSD risk ≥ 2 is positive for Depression risk SUM =		

https://pubmed.ncbi.nlm.nih.gov/33797497/

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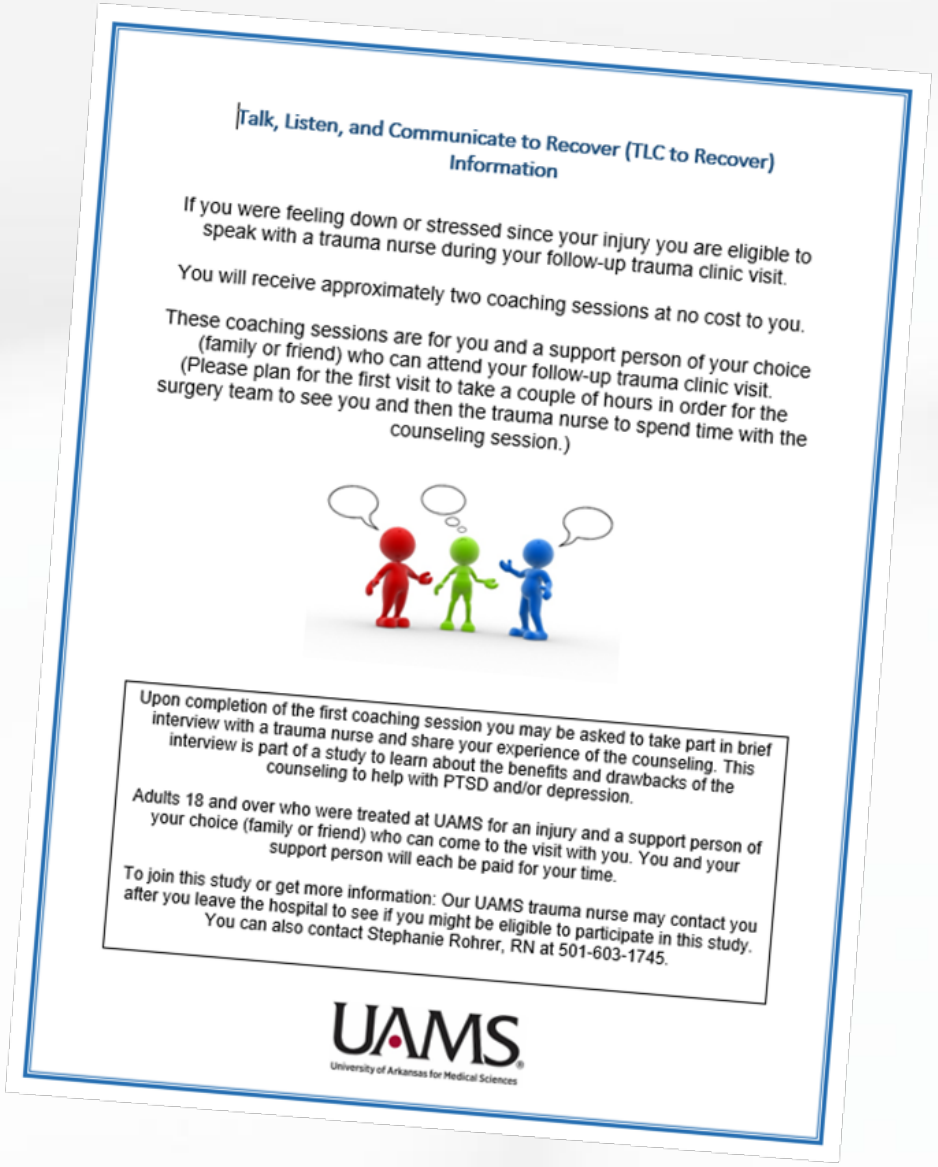
Introduction of Information

Inpatient

- TLC to Recover is introduced if individual scores positive for PTSD or Depression

- Informational materials in After Visit Summary
  - About Medical Trauma
  - About Post-Traumatic Stress Disorder
  - How to Get Help for PTSD
  - A Breathing Exercise to Help with Tension and Fear
  - Changing Your Unhelpful Thoughts
  - How to Cope with Drug and Alcohol Problems from PTSD
  - How to Cope with Sleeping Problems from PTSD
  - How to Cope with Feeling Angry and Irritable



Talk, Listen, and Communicate to Recover (TLC to Recover) Information

If you were feeling down or stressed since your injury you are eligible to speak with a trauma nurse during your follow-up trauma clinic visit.

You will receive approximately two coaching sessions at no cost to you.

These coaching sessions are for you and a support person of your choice (family or friend) who can attend your follow-up trauma clinic visit. (Please plan for the first visit to take a couple of hours in order for the surgery team to see you and then the trauma nurse to spend time with the counseling session.)

Upon completion of the first coaching session you may be asked to take part in brief interview with a trauma nurse and share your experience of the counseling. This interview is part of a study to learn about the benefits and drawbacks of the counseling to help with PTSD and/or depression.

Adults 18 and over who were treated at UAMS for an injury and a support person of your choice (family or friend) who can come to the visit with you. You and your support person will each be paid for your time.

To join this study or get more information: Our UAMS trauma nurse may contact you after you leave the hospital to see if you might be eligible to participate in this study. You can also contact Stephanie Rohrer, RN at 501-603-1745.

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TLC to Recover Intervention

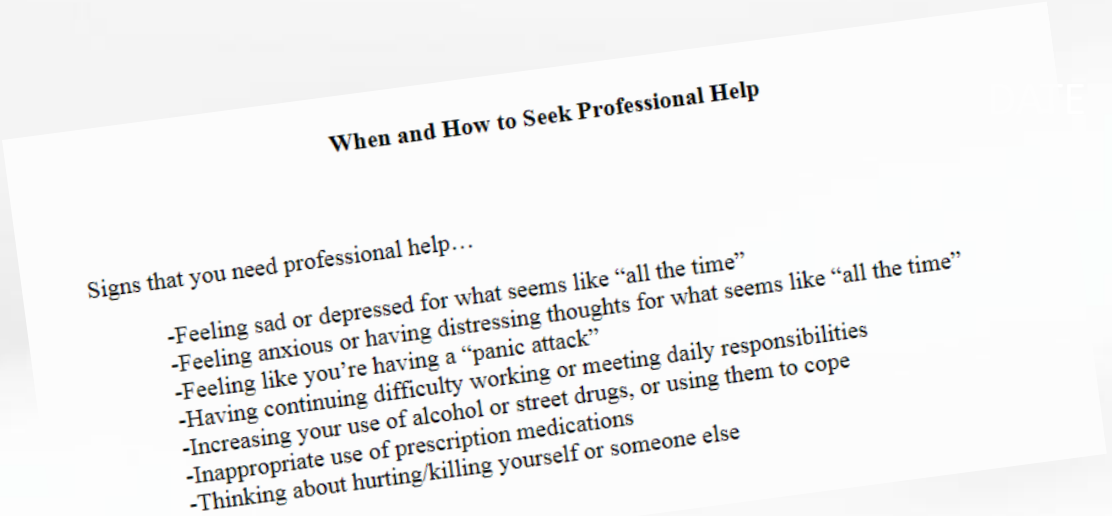
Trauma Clinic

- Contacted within the week prior to follow-up visit with trauma clinic and asked to completed PCL-5 and PHQ-9 in MyChart
- If patient is experiencing an elevation in PTSD or depression symptoms, they are offered the TLC to Recover Intervention by the trauma clinic RN
- If the patient agrees, they are asked to bring an identified support person
- Appointment is scheduled for an hour
- The trauma nurse then follows up with the patient by phone 2 weeks later to check in, assess symptoms, and boost skills, as needed

Tools

Handouts

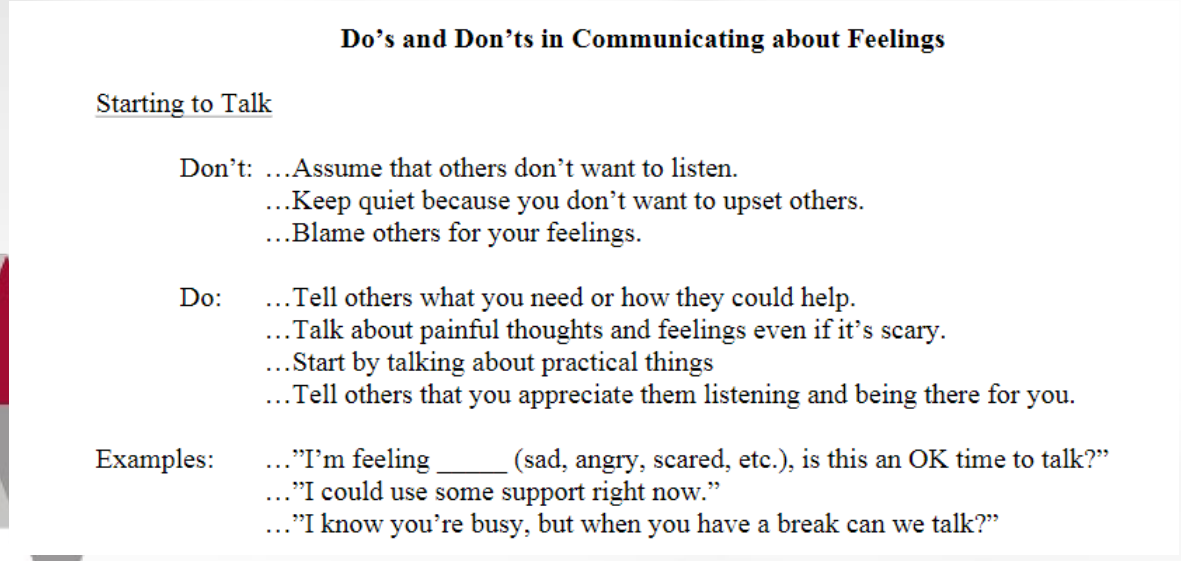
- When and How to Seek Professional Help
- Good Communication and Coping
- Daily Coping Checklist
- Do's and Don'ts in Coping
- Do's and Don'ts in Communicating about Feelings



When and How to Seek Professional Help

Signs that you need professional help…

-Feeling sad or depressed for what seems like "all the time"
-Feeling anxious or having distressing thoughts for what seems like "all the time"
-Feeling like you're having a "panic attack"
-Having continuing difficulty working or meeting daily responsibilities
-Increasing your use of alcohol or street drugs, or using them to cope
-Inappropriate use of prescription medications
-Thinking about hurting/killing yourself or someone else



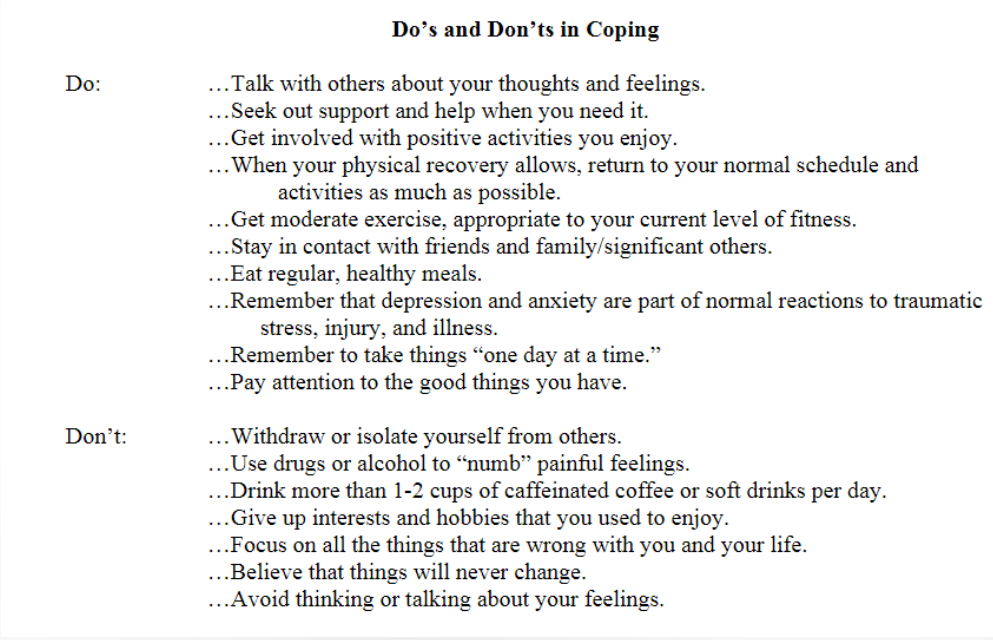
Do's and Don'ts in Communicating about Feelings

Starting to Talk

Don't: …Assume that others don't want to listen.
…Keep quiet because you don't want to upset others.
…Blame others for your feelings.

Do: …Tell others what you need or how they could help.
…Talk about painful thoughts and feelings even if it's scary.
…Start by talking about practical things
…Tell others that you appreciate them listening and being there for you.

Examples: …"I'm feeling _____ (sad, angry, scared, etc.), is this an OK time to talk?"
…"I could use some support right now."
…"I know you're busy, but when you have a break can we talk?"



Do's and Don'ts in Coping

Do: …Talk with others about your thoughts and feelings.
…Seek out support and help when you need it.
…Get involved with positive activities you enjoy.
…When your physical recovery allows, return to your normal schedule and activities as much as possible.
…Get moderate exercise, appropriate to your current level of fitness.
…Stay in contact with friends and family/significant others.
…Eat regular, healthy meals.
…Remember that depression and anxiety are part of normal reactions to traumatic stress, injury, and illness.
…Remember to take things "one day at a time."
…Pay attention to the good things you have.

Don't: …Withdraw or isolate yourself from others.
…Use drugs or alcohol to "numb" painful feelings.
…Drink more than 1-2 cups of caffeinated coffee or soft drinks per day.
…Give up interests and hobbies that you used to enjoy.
…Focus on all the things that are wrong with you and your life.
…Believe that things will never change.
…Avoid thinking or talking about your feelings.

Barriers

- Patient Level
  - Lack of follow-up post discharge
  - May not be eligible because not following up in trauma clinic but a different specialty (next step to incorporate across specialties)
  - Engagement can be difficult even when expressing interest

- Organizational Level
  - Staff Understanding

Facilitators

- Dedicated clinic space
- Interdisciplinary collaboration
- Trauma team culture
- Trauma psychology (inpatient and outpatient)
- Utilized existing workflows
- Flexibility in administration (in person vs virtual)

Next Steps

- Continue Implementation Study regarding feasibility
- Evaluate outcomes
- Initiate TLC to Recover in other clinic areas

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Thank You!

Questions?

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