Trauma-Informed Primary Care Initiative Learning Community

Domain 4: Safe and Secure Environments
December 15, 2015
Overview

• Setting the Stage
  – Domain 4 Standards
  – Triggers
  – Principles of Sensitive Practices

• Establishing Trust in our Primary Care Settings

• Creating Safe Spaces: How to Talk with Patients About Medication Interest
Today’s Presenters

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Today’s Presenters

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If you have never felt safe or remembered safety, how will you know it when it is present?
Domain 4 Standards

System in place to

• ensure all staff recognize their role in promoting safe and healing relationships within a safe and comfortable environment

• monitor and evaluate the changes that have occurred within the environment

• identify and address environmental concerns that may affect safety, security, comfort and respect
Triggers in Healthcare Settings

**Definition:** An external event that causes internal discomfort or distress such as:

- **Sights** - white lab coats, medical equipment, restraints, X-ray bib, room temperature
- **Sounds** - dental drill, ambulance sirens, chaos in environment
- **Smells** - rubbing alcohol, antiseptic odors, latex gloves
Dynamics that Highlight Need to Focus on Safety

- Invasive procedures
- Removal of clothing
- Physical touch
- Personal questions that may be embarrassing or distressing
- Power dynamics of relationship
- Gender of healthcare provider
- Vulnerable physical position
- Loss of and lack of privacy
Principles of Sensitive Practice

• Be respectful
• Take time
• Build rapport
• Share information
• Share control
• Respect boundaries
• Foster mutual learning
• Understand non-linear healing
• Demonstrate awareness and knowledge of trauma

*Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*
Safe and Secure Environments

Establishing Trust
Who is Seeing, Who is Hearing?
Unexplained Changes

• Another way to establish trust is to be predictable.
  – If there is a new prescribing policy, is it thoroughly explained in advance?
  – If a provider retires or is moved to another clinic, how is the patient told?
  – If you are a teaching facility, is this explained in advance?
The Impact of Language

• Aberrant behavior
• Non-compliant
• Drug-seeking
• Frequent flyer
• No-show
• Notes in the 3rd person: “Patient states....”
  – Diagnosis codes, if not explained ahead of time, can be very harsh.
• Your (heart attack, diabetic, 3:00) is in Room X?
A Word About Health Literacy

• "Health literacy" is the ability to understand and act on health information. Unfortunately, nearly half of the U.S. adult population has a low level of health literacy. Those with low health literacy:
  • Are less likely to follow treatment instructions and seek preventive care
  • Are also twice as likely to be hospitalized

How to make a difference:
• Plain language: Using one- to two-syllable words and short sentences, as in a conversation at home
• Teach back: Asking patients to explain in their own words or show what they have been advised to do
• Ask questions: What questions do you have?
  • Legacy Health, Oregon
Is Trauma Part of the Conversation?

“I think it (TIC) opens things up enormously by allowing patients to view themselves from a developmental standpoint, and not solely that they are ‘just this way’. After I talked with one patient about the effect of cortisol on the developing brain, it was like a light bulb went off over her head, and she said, ‘Do you mean I might have such bad anxiety because I saw my dad shoot himself when I was 5?’ I think it gives some hope to people to be able to say that is possible to change, get control of their anxiety or their addiction, for example, but it takes time because it literally takes a long time for an adult brain to rewire. It's not just a matter of will power.”

–Kerri Hecox, MD, Birch Grove Health Collaborative, Oregon
Power and Control

- Do you introduce yourself and discuss any issues before the patient disrobes?
- Are you making eye contact or instead documenting in the EHR?
- Do you remain standing after the patient is seated?
- Is your hand on the doorknob while you are talking?
The Importance of a Team

• Education
  – Value added vs. concerns

• Tell the stories
  – Create a sense of urgency AND accomplishment
Creating Safe Spaces: How to Talk with Patients About Medication Interest

Glenda Wrenn MD MSHP
When Patients Don’t Take Medications: Core Principles

- Numerous studies have found that patients with chronic diseases take their medications as prescribed only about 50%-60% of the time.
- Whether adhering or not, 1/3 of patients with chronic disease have strong reservations about the medications they are on (at risk for discontinuation).
- “Nonadherence” is ubiquitous. Most of us are guilty of it.
- One study of elderly patients Rx digoxin showed that they refilled their scripts for only 111 days of the year (30%).
- 60% of primary care patients discontinued antidepressants before completing the recommended 6 months of therapy.
- “Nonadherence” is associated with treatment failure and poor outcomes.
- Patients may also “catch up” with medications or “become compliant” shortly before follow-up appointments so that even monitoring medications with serum levels do not always tell the “truth” about “adherence.”
The Nature of Non-Adherence:

- Confusion over directions
- External Limitations (money, transportation)
- Cognitive problems (Dementia to forgetfulness)
- Don’t want to take them
Resistance

• Definition: The patient is not doing what you want, AND you are not doing what the patient wants.
• Resistance is not a behavior that one person does, rather an experience that two people share, with both parties experiencing an unpleasant sensation
• The more intensely one side pushes, the more likely the other side will push back
• Regardless of the intensity, resistance resolves when one person yields (even if just a bit)
• Traditionally, resistance related to “medication adherence” was viewed as a patient problem, and techniques for resolving resistance focused on how to change the patient’s “oppositional thoughts”
• However, if you can lessen how much a patient feels you are pressuring them to take a medication, the likelihood that they will choose to take it may paradoxically increase.
Why Roll with Resistance?

• What drives the intensity of our patients’ resistance is not how much we are truly opposing them or pressuring them, but that their perception is that we are.
• Patient perception is not created so much by what we say, but how we say it.
• We can hold opposing views from our patients without being an opponent, depending on the words we use to share those views
• Our words convey RELATIONSHIP
How do Patients Choose to Take a Medication?

- The process of choosing to put a foreign substance into one’s body is always a complex one...think about your own experiences of adherence.
The Choice Triad: in real life

- 25 year old patient with first break schizophrenia does not believe there is anything wrong with him
- Middle-aged woman fairly symptom-free except for unusually frequent daytime urination, nighttime awakenings with trips to the bathroom and recent onset of feeling weary. She is moderately overweight and out of condition. Her blood sugars suggest the need for diet, exercise and an oral hypoglycemic, but she feels generally “fine”.
- Our role is to help the patient become better informed and motivated for change
- What helps is to change your perception by recognizing this patient is making a completely logical choice based off his perception and beliefs

*Patients take medications because of THEIR beliefs, not ours*
Motivators: Inquiry into Lost Dreams

• For many patients, it is not so much that they want relief from something the illness has given them (i.e., symptoms), they want back something the illness has taken from them (dreams, livelihood, peace of mind)
• This motivation is more powerful in helping the patient to overcome side effects, inconvenience, stigma of taking medications
• “Is there anything that your (diabetes, depression) is keeping you from doing that you really wish you could do again?”
Why Non-Adherence fails as a communication term

- Non-adherence is simply the PC version of non-compliance.
- Both terms presume that the physician is in control of making the treatment recommendation and the patient's job is to comply or adhere to this plan.
- Only a small percentage of patients are purposefully oppositional, but the term does not distinguish between the reasons for non-adherence.
- There's no easy way to talk to your patient about “treatment adherence” without setting up a fight.
Introducing Medication Interest

“My goal as a physician is to always give you the best advice, whether that advice is to start a medication, stay on it, or get off it. Together we want to find a medicine that you are genuinely interested in taking because it makes you feel better. You’re the one who is putting the medication into your body so it’s your opinion that’s most important, not mine. So please always let me know exactly what you think about the medications we are trying. I’m counting on your input. You know your body better that I do. And I can think we can be a great team in finding a medication that works well for you---that really makes you feel better. How does that sound to you?”
Key initial questions:

1. How interested is the pt in taking the medication? What %age of doses do you think they are taking?
2. How does the pt list the pros and cons that lead to low interest?
3. What step of the Choice Triad is low interest related to?
4. Any ideas about how to increase her interest? How interested is her family in her taking the med?

“At this point in time, in your opinion, do you feel that you are on too little, too much, or just the right amount of this medication?”
The soul of the pill

“What does it say about me that I have to take this drug?

• Demoralizing “tapes” and how to change them with affirmations
  – “Take that”, “Not today you don’t”, “This day I’m bringing the sunshine!”
• Dismantling the “Addiction Myth”
• Dismantling the “Crutch Myth”
• Testing the waters
• Get a read on the patient’s medication grapevine
  – Probe for resistance from patient’s support network
  – Anticipate friend’s opinions
Prescribing new medications to well-known patients

• Ask for the patient’s recommendations
  – “Do you have a medication in mind that you might want to take?”
  – “What do you think might help with your symptoms?”
• Attempt to directly uncover ambivalence:
  – What are your thoughts about starting up this med?
  – Now that I’ve talked about all of the benefits and potential common side effects, what are your thoughts about whether or not you think this medication is worth a try?
  – What’s most appealing to you about trying this med?
  – What concerns do you have?
• Don’t push the initial decision
• Proactively recommend discontinuation
Key Takeaways:

• Don’t be an ostrich about the medication administration of your patients!
• *Think Medication Interest* vs Compliance
• Practice the interviewing tips to explore and improve your ability to preserve the relationship
• Roll with resistance and be honest about your own contribution!
Reference

• http://www.amazon.com/Improving-Medication-Adherence-Patients-Medications/dp/0781796229
Implementation in Primary Care

- Can sometimes be difficult ......
- Many competing priorities
- Little training
- Understanding Resistance
Engaging Practices

• Use competing priorities - not in addition to in support of!
• Use processes in place to support your work-like cqi
• Take advantage of initiatives and see how your work might support (gain sharing, measures)
• Use the electronic health record
Providing Information

• Providing education and information in the practice on waiting room televisions or bulletin boards
• Giving information to all staff in the practice – particularly nursing and nursing support, front desk
Engaging Providers

• Think about a population of patients who we might focus on....
• Role modeling in staff meetings
• Seize educational moments through conversations and case discussions
• Show individual provider or practice data
Don’t Give Up!

• Change takes time…..
• Systems take time to change
• Be persistent – keep your work on the agenda for all staff or clinical meetings
• Bring changes up at staff meetings and solicit ideas, get staff involvement and buy in
Contact Information

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Next Steps

• Coaching Calls: January 2016
  • various dates and times

• PMT and Bi-Monthly Report Submission
  • February 10th

• Next webinar: Tuesday, February 9th, 3:00-4:00pm EST

Questions? Email Stephanie at StephanieQ@thenationalcouncil.org
Data Polling Question 1

Indicate if your CIT team has discussed the safety and security of the environment (e.g., waiting room, patient room, other aspects of the physical environment) at your site.

a) We **have not** yet started to do this
b) We are still **in progress** of developing our policies and procedures to do this
c) We have designed our policies and procedures to address safety and security but **have not yet implemented** them
d) We **have implemented** our policies and procedures
Data Polling Question 2

We have incorporated physical and emotional safety into our agency's intakes and assessments.

a) We have not started to do this
b) We are still in progress of developing how to do this
c) We have done this but have not yet implemented it
d) We have implemented this
Data Polling Question 3

We have pursued consumers' feedback to ensure the physical and sensory space is non-triggering and non-re-traumatizing.

a) We have **not yet started** to do this
b) We are still **in progress** of developing how to do this
c) We have done this but **have not yet implemented** it
d) We **have implemented** this
Data Polling Question 4

We have already assessed our environment and are making/have made a plan to address changes.

a) We have **not yet started** to do this
b) We are still **in progress** of developing how to do this
c) We have done this but **have not yet implemented** it
d) We **have implemented** this
Thank you!