Dear Dr. Steve: Increasingly, our facility gets more admissions with significant behavior issues and stress-related disorders. I hear staff talk about regulations regarding “trauma-informed” care. What is this all about, and what should I (as a clinician or medical director) do about it?

Dr. Steve responds:
When it updated the Omnibus Budget and Reconciliation Act of 1987 (OBRA) regulations and the related Interpretive Guidelines a few years ago, the Centers for Medicare & Medicaid Services added a provision about “trauma-informed” care (F699). However, as of February 2022, corresponding guidance to surveyors is still pending. The relevant sections of the regulations include §483.23, §483.35, and §483.40 (F743) as well as parts of other sections including Comprehensive Care Plans (F659) and Staff Competencies (F726).

The following summarizes these regulations and Interpretive Guidelines:

- A resident with a mental disorder or psychosocial adjustment difficulty, or with a history of trauma including, but not limited to, posttraumatic stress disorder, must receive appropriate treatment and services to either correct the assessed problem or attain the highest practicable mental and psychosocial well-being.
- Trauma survivors must receive trauma-informed care, which refers to culturally competent, person-centered care that is consistent with professional standards of practice, accounts for an individual’s experiences and preferences, and eliminates or mitigates triggers that may traumatize the resident.
- A facility must provide or arrange for this care to be given by qualified persons in accordance with a resident’s written plan of care.
- A facility and its staff and practitioners must determine and document underlying causes of a resident’s symptoms and decline or lack of improvement in function.
- Someone who is admitted without symptoms or a prior diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma does not exhibit these problems subsequently unless it is clinically unavoidable.
- A facility must ensure that a qualified professional has made an accurate diagnosis of a mental disorder or psychosocial adjustment difficulty or a trauma-related diagnosis.

The Challenge
How can a nursing facility and its staff and practitioners achieve these objectives, given the complexities of these patients and the many other extensive regulatory requirements? How are the staff and practitioners to know whether a person’s behavior is somehow related to trauma or to something else? When symptoms persist despite interventions, how do we know whether we have done enough or done the right things?

This is not a simple endeavor! However, it should not be made unnecessarily complicated. A careful review of the requirements identifies the need for the same thorough clinical reasoning and problem-solving approaches that apply to all care issues (see Caring for the Ages 21(2):11, https://bit.ly/3qXEFLw).

Defining the Issue Precisely
As discussed in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (5th ed., APA, 2013), there is a spectrum of disorders and symptoms related to psychological distress and trauma. All psychiatric diagnoses reflect a constellation of symptoms and specific history elements. They are not defined by any one symptom such as fear, anxiety, or delusions.

While experiencing trauma is common, the impact of trauma on individuals varies widely, from intermittent and minor to frequent or continuous and highly disruptive to the individual and to others. The spectrum of possible reactions includes anxiety, fear, depression, anger, hostility, aggression, withdrawal, delusions, or overt psychosis. Often, these individuals show multiple symptoms simultaneously or alternately.

The common denominator of what the DSM-5 categorizes as “trauma and stressor-related disorders” is exposure to a traumatic or stressful event. Examples of these conditions include posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Additionally, the DSM-5 notes that these diagnoses and conditions are closely related to anxiety disorders, obsessive-compulsive and related disorders, adjustment disorders, dissociative disorders (e.g., detachment from reality, avoidance, or social withdrawal), and hyperarousal (e.g., increased startle response or difficulty sleeping).

Not all trauma necessarily leads to PTSD, and no one symptom or finding defines PTSD. Instead, PTSD reflects a collection of symptoms that may include, among others, reliving the stressful event (e.g., flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g., outbursts of anger, irritability, or hostility), and extreme discontentment or inability to experience pleasure.

In addition, we cannot automatically assume that symptoms in individuals who have a history of trauma are necessarily trauma related. It is always relevant to rule out and address medical conditions, medications, and coexisting mental health issues that may cause or exacerbate the situation. Disturbances of mood, cognition, and behavior are not necessarily psychosocial in origin.

As noted in the OBRA Interpretive Guidelines, medical factors often complicate or cause disturbed mood, cognition, and behavior, such as:
- Medical conditions including diabetes, hypothyroidism, infections, heart failure, hypotension, dehydra
tion, Parkinson’s disease, or stroke;
- Diverse medication-related adverse consequences and interactions.

Coexisting mental health disorders (e.g., major depression, suicidality) and substance use disorders are prevalent in individuals with serious trauma and trauma-related disorders. These need to be screened for and addressed proactively if present. In addition, it is essential to review thoroughly all medications in the regimen of anyone with behavior and psychiatric issues, including possible trauma-related symptoms. Many medications in all categories—not just primary psychopharmacologic medications—can cause or exacerbate behavior and psychiatric symptoms, including any of those that are present in someone with a trauma-related history.

Managing the Individual Affected by Trauma
As discussed in many of my OBRA and clinical columns throughout 2020 and 2021, defining the history of a diagnosis and current symptom details accurately and precisely is an essential prerequisite for choosing treatment.

As with all behavior and psychiatric issues, management of the patient impacted by trauma should be both general and cause-specific. It starts with general approaches that apply to all individuals with impaired cognition, mood, and/or behavior, along with specific interventions tailored to clearly identified underlying causes. Subsequent approaches depend on the results of the initial approaches and the nature and impact of trauma for the individual.

Management of trauma-related issues includes both pharmacological and nonpharmacological interventions. The mainstay of treatment may be nonpharmacological interventions (Desai A, Grosberg G. Psychiatric Consultation in Long-Term Care, 2nd ed., Cambridge University Press, 2017), examples of which include the following:
- Seek to understand a resident’s life story (especially history of abuse, neglect, and trauma) without trying to manipulate or control that individual.
- Have team members who know a resident’s history of traumatic experiences share that information with other appropriate team members (with the resident’s consent).
- Take specific steps to minimize re-traumatizing the resident. For example, have only female staff provide personal care for a woman who has experienced previous trauma from a male.
- Have staff identify and share a resident’s strengths with other interdisciplinary team members.
- Try to form a trusting, nonjudgmental, and supportive relationship between staff and the resident.
- If feasible, consider reassigning to other patients the staff who have difficulty being nonjudgmental toward the resident.
- Try to enhance a resident’s social support. Reach out to specific staff, friends, family, volunteers, chaplains, or others whom the resident trusts and who are willing to be part of a resident’s support system.
- Establish boundaries and institute nonjudgmental limit setting. Guide staff to confront some of the resident’s behaviors (e.g., calling staff names, yelling at or demeaning staff) and consistently and firmly set limits.
- Avoid reflexively reacting to the resident’s provocations and other negative behaviors.
- Try to identify practical ways to provide choices to the resident regarding meeting his or her human needs for affection and positive experiences.

There are not really any trauma-specific pharmacological interventions (except for prazosin, used carefully, as a potential intervention for nightmares that do not
As with all behavior and psychiatric issues, medications always need a clinically plausible foundation and should be chosen appropriately to target specific underlying causes and contributing factors such as depression, severe anxiety, and psychosis. Clarify with the primary care practitioners and psychiatric consultants that they are not being asked or expected to prescribe drug “cocktails” (antipsychotics, antidepressants, antiepileptics, anxiolytics, etc.) for these patients in the hope of eventually stumbling on something that works. Avoid adding medications without considering the possibility that the current regimen is not indicated, is inappropriate, or is causing or exacerbating the symptoms it purports to treat.

For example, although benzodiazepines may be appropriate for intermittent mild to moderate anxiety, antidepressants are generally more appropriate as a baseline medication treatment for more severe or chronic anxiety. But certain benzodiazepines may help individuals who have major panic attacks, and short-term benzodiazepine treatment may help reduce the anxiety that often accompanies the initiation of antidepressants. As another example, the widespread use of antiepileptics to treat “aggression” is likely to be problematic when the aggression is actually related to depression because antiepileptics often have major side effects of agitation and dysphoria.

Addressing Regulatory Compliance
The optimal way to address regulatory compliance regarding trauma-informed care is to follow and document the details of the care delivery process steps (recognition/assessment, diagnosis/cause identification, management/treatment, and monitoring) as they relate to individual residents’ needs and issues. So, based on the items identified in the Interpretive Guidance that accompanies related regulations, you will want to review for the same things (but in more detail) that surveyors are directed to look for:

- Whether adequate screening was done for psychosocial and behavior issues.
- What was done if a resident’s Care Area Assessments (CAA) trigger for activities, mood state, psychosocial well-being, and psychopharmacological medication use.
- Whether symptoms are described in detail (i.e., characteristics, chronology, frequency, intensity, and duration).
- Whether and how the facility assessed causes of decline, potential for decline, or lack of improvement.
- Whether and how the care plan addresses mental and psychosocial adjustment difficulties, a history of trauma, and/or PTSD.
- Whether and how the facility assessed the effectiveness of its interventions.

In summary, care of individuals with a history of trauma is another complex challenge for post-acute and long-term care staff and practitioners that benefits from the right thought framework and strict adherence to the care delivery process and relevant clinical standards of practice. Trauma-informed care should not be a separate and distinct project or program (i.e., another care “silo”); instead, it should be a subset of existing facility-wide processes and practices that focus on doing the right thing correctly for all patients in everyday practice, no matter what the diagnosis or situation. Less than optimal results are more likely with haphazard approaches based primarily on guessing.

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