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Defining trauma in complex care management: Safety-net providers' perspectives on structural vulnerability and time

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ABSTRACT

In this paper, we delineate how staff of two complex care management (CCM) programs in urban safety net hospitals in the United States understand trauma. We seek to (1) describe how staff in CCM programs talk about trauma in their patients' lives; (2) discuss how trauma concepts allow staff to understand patients' symptoms, health-related behaviors, and responses to care as results of structural conditions; and (3) delineate the mismatch between long-term needs of patients with histories of trauma and the short-term interventions that CCM programs provide. Observation and interview data gathered between February 2015 and August 2016 indicate that CCM providers define trauma expansively to include individual experiences of violence such as childhood abuse and neglect or recent assault, traumatization in the course of accessing health care and structural violence. Though CCM staff implement elements of trauma-informed care, the short-term design of CCM programs puts pressure on the staff to titrate their efforts, moving patients towards graduation or discharge. Trauma concepts enable clinicians to name structural violence in clinically legitimate language. As such, trauma-informed care and structural competency approaches can complement each other.

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1. Introduction

“What if we approached all care assuming that everyone has been exposed to trauma?” –Presenter at a Complex Care Management Conference

In the U.S., 1% of the population accounts for approximately 20% of health care expenditures (Cohen and Yu, 2012). In an effort to improve healthcare quality and decrease costs, “super-utilizers” –patients with multiple chronic conditions and frequent hospital visits—have been identified as a population whose care is particularly costly and fragmented (Gawande, 2011; Hasselmann, 2013). The Centers for Medicare and Medicaid funded complex care

management (CCM) demonstration projects, interdisciplinary teams of health care providers integrated into primary care who work to improve outcomes and reduce expenditures for “super utilizers.” CCM programs draw on the growing body of research that shows trauma and chronic stress are strongly associated with poor physical and mental health, as well as with social and structural barriers to accessing care (Felitti et al., 1998; Lee et al., 2014; Sinnott et al., 2015). More recent research shows extremely high rates of trauma among CCM patients (Haas and Dupuy, 2014; Hong et al., 2014a,b).

In this paper, we delineate how staff of two CCM programs in urban public hospitals use concepts of trauma. We seek to (1) describe how staff in CCM programs talk about trauma in their patients' lives; (2) discuss how trauma concepts allow staff to understand patients' symptoms, health-related behaviors, and responses to care as results of structural conditions; and (3) delineate the mismatch between long-term needs of patients with histories

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of trauma and the short-term interventions that CCM programs provide. We will argue that CCM staff use trauma concepts to understand patients' social histories as a relevant part of their health. CCM staff face the challenges of patients' social vulnerabilities on a daily basis, and some talk about trauma and health in ways that align with social scientific understandings of structural violence (Anglin, 1998; Farmer et al., 2006) and structural vulnerability (Quesada et al., 2011). In addition to conventional notions of trauma as individual episodes of violence, some staff also define trauma to include traumatic experiences accessing health care and exposure to racial violence and homelessness that echo social scientific understandings of community trauma and structural violence. Staff describe trauma as a precipitating factor in patients' hospitalizations, and talk with patients about connections between traumatic experiences, health behaviors, and physical symptoms. Conversations and practices, we observed made clear that even in health care settings that do not officially consider themselves to provide trauma-informed care, trauma concepts can permeate the work of clinical staff, who may informally implement elements of trauma-informed care.

We first summarize recent literature on trauma, health and trauma-informed care, as well as structural understandings of health. We then delineate the three kinds of trauma that CCM staff describe, with a case of a patient whose story exemplifies each: (1) individual experiences of violence; (2) structural violence; and (3) health care as traumatizing. We examine how time acts as a barrier to trauma-informed care in these CCM programs, and conclude by pointing out potential intersections between trauma-informed care approaches and structural understandings of health.

2. Background

2.1. Complex care management

Complex care management programs have been implemented with private insurance and Medicare patient populations, and more recently in settings that serve Medicaid recipients. They typically enroll patients for a limited period, provide team-based care and health coaching for symptom management, and “graduate” patients back into standard primary care when CCM providers deem them able to self-manage their health. Reviews of CCM best practices do not discuss an optimal length of the time for enrollment. Across CCM programs serving Medicaid patients, high levels of substance use, mental illness, and childhood trauma have been reported (Hasselmann, 2013; Hong et al., 2014a,b). In some cases, CCM programs have developed networks of medical and social service referrals to support their patients in addressing social needs (Garg et al., 2016).

2.2. Trauma, health, and trauma-informed care

Diagnosis with multiple chronic illnesses (multimorbidity) in adulthood is associated with a history of Adverse Childhood Experiences (ACEs) such as abuse and parental incarceration (Sinnott et al., 2015), and multimorbidity is universal among CCM patients. ACEs are now a widely-used approach to measuring individual experiences of stress and trauma in childhood. Perhaps the most widely used definition of trauma in the US comes from the Substance Abuse and Mental Health Services Administration (SAMHSA): “Individual trauma results from 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” (2014). Though SAMHSA acknowledges elsewhere that trauma can affect whole

communities and multiple generations, its definition focuses on the individual, which some argue separates trauma from the neighborhood and structural conditions and community exposures to adversity that make it so common and damaging (Cronholm et al., 2015; McKenzie-Mohr, Coates, and McLeod, 2012; Pinderhughes et al., 2016). In contrast, Machtinger and colleagues define trauma broadly to include experiences of structural violence (2015:193), suggesting that trauma can affect whole communities (Pinderhughes et al., 2016), over multiple generations (Brave Heart et al., 2011).

The term “trauma-informed care” originated in fields including juvenile justice and mental health, and has recently spread to medical settings. Bowen and Murshid (2016) define trauma-informed care as “an organizational change process centered on principles intended to promote healing and reduce the risk of re-traumatization for vulnerable individuals.” Machtinger et al. (2015) provide a clinical framework for “trauma-informed primary care.” It encompasses *environment* (including staff training and interdisciplinary collaboration); *screening* (including universal screening for abuse, mental health conditions, and chronic pain); *response* (including connecting patients with services such as housing as well as trauma-specific therapy); and a strong organizational *foundation* that includes community partnerships and support for clinicians. These elements draw on other frameworks organized around elements of trauma informed-care, commonly including safety, trustworthiness, collaboration, empowerment, and choice (SAMHSA, 2014; Wolf et al., 2014). We use the trauma-informed primary care framework to aid in description and analysis of trauma-informed care in safety-net CCM programs.

2.3. Structural understandings of health

Structural violence, a concept widely used by social scientists, describes how inequality is made visible when “persons are socially and culturally marginalized in ways that deny them the opportunity for emotional and physical well-being, or expose them to assault or rape, or subject them to hazards that can cause sickness and death” (Anglin, 1998). *Structural vulnerability* refers to the manifestation of structural violence in the social positions of individuals and communities, and subsequently, in poor health (Quesada et al., 2011). Recently, some have called for clinicians to develop *structural competency*, coupling awareness of how structural issues influence individual health with skills to address these issues in clinical practice:

the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (Metzl and Hansen, 2014: 128).

Trauma is implicitly present as both cause and symptom of disease in the structural competency framework. However, many trauma-informed care approaches define trauma as an individual phenomenon, separate from “upstream” or social determinants of health, which structural competency advocates view as necessarily connected to clinical medicine. We will examine the use of trauma concepts in CCM programs, including how staff members define trauma broadly to include patients' structural vulnerability. Neither the CCM programs nor the larger hospitals they are part of claim to be implementing trauma-informed care, yet staff consider trauma an important element of their patients' past and present health.

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