Draft #1 (9/16/18)

NOTES to THEN Team only

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CASE: Adverse Life Experiences and Chronic Disease

My vision: **Case in 3 Parts**

At the beginning of Case Discussion, distribute packet to each Student
Packet of 3 pages [1 Part per page] stapled together
Discussion questions for each Part

Discussion Leader – would have additional suggestions for discussion

Process: Have each small group read the Case out loud
Having each person read one paragraph, then pass to next person
Open discussion [modified by Discussion Leader]
Discussion Leader will decide when to move on to next Part

Wrap-up: have one Student/Trainee from each small group report to large group about what their small group thought

CASE: ADVERSE LIFE EXPERIENCES AND CHRONIC DISEASE

Karen* – a 54 y/o African-American woman living on the West side of Chicago.

PART 1:

Current Illness: Karen was brought to the Emergency Room by Chicago Fire Department ambulance for severe shortness of breath. Admitted via ER to the Intensive Care Unit for severe asthma with low oxygen level. After admission to ICU, her condition deteriorated and she was sedated and placed on a ventilator. She gradually improved and was discharged home on Day 6.

Medical Diagnoses:

- Severe asthma (starting age 24)
  This is Karen's third hospitalization this year for severe asthma, each time requiring ventilator ICU care.
- Hypertension (diagnosed age 30)
- Coronary artery disease (diagnosed age 48)
- Two uncomplicated pregnancies age 22 and 25.

Social History:

- lives alone
- never smoked; no alcohol or illicit drugs
- high school graduate; unemployed former retail employee
- insured by Medicaid due to severe medical problems and no private insurance

Physical Exam at time of discharge: Karen is alert and oriented, quiet, cooperative.
Thin. Appears older than age 54. Anxious. Blood pressure remains elevated 160/100. Heart rate rapid. No fever. No wheezing but takes frequent shallow breaths. Cough.

Medications at discharge: Karen has prescriptions for 12 medications.

Followup Care: Karen had no primary care doctor and was assigned to the on-call doctor, Dr. Rush. Karen agreed to be followed by Dr. Rush as an outpatient.

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***DISCUSSION QUESTION #1**: what is your guess about how Karen would answer the question, "How was growing up for you?" Mostly OK - OR - Pretty Difficult?*

***DISCUSSION QUESTION #2:** what factors might have contributed to the onset of multiple severe chronic illnesses at a young age?*

***DISCUSSION QUESTION #3**: if Karen suffered Childhood Adverse Experiences and/or Trauma, how could that be related to the development of her chronic illnesses?*

* This a real case from Dr. Rush's practice, although the name was changed to preserve anonymity.

PART 2:

First two years of Outpatient Care in Trauma-Informed Setting (report from Dr. Rush):

- first priority was to ensure Karen could obtain all her medications and knew how to take them
- 2nd priority was that Karen knew how to reach my office (and on-call coverage) 24/7, so if she felt her asthma was getting worse again, she could contact me immediately.
- Next priority was to build trust and openness in our patient-provider relationship

- Next, we talked in depth about **sleep**. Karen reported she had not slept well in years, "maybe my whole life." One concern was safety in her neighborhood. Community violence was common and she often heard gunshots at night. Karen had difficulty falling asleep, had multiple awakenings during the night, and slept with the room light on. We talked about ways she could make changes to allow more hours of sleep, and more hours of uninterrupted sleep.

- After a few visits, when her medical problems started to stabilize and I felt Karen was getting used to my approach, I began to explore Karen's childhood experience.
  I asked, "How was growing up for you?" PRETTY DIFFICULT.
  Using the ACEs Screen, Karen's score was 6 plus plenty of adult hardships.
- At each visit, we practiced relaxation techniques, deep breathing, and even tried some chair yoga. We talked about trying to go for a walk in safe areas. Encouraged time with family and friends.

- We talked about some of her hardships and the importance of her faith to her.
  We talked about whether she would be willing to see Mental Health for trauma therapy.
  She declined, a major factor being lack of Mental Health services that would accept Medicaid.

- Over two years, we were able to taper her from 12 medications to 8. Her sleep substantially improved. Blood pressure was adequately controlled on 3 medications. Her energy and mood improved. Karen was not hospitalized once.

***DISCUSSION QUESTION #4**: What factors could have contributed to Karen's clinical improvement?*

PART 3:

One day, I got a call from the ER that Karen had been admitted to the ICU with a new asthma attack. I went to see her, and after she was stabilized and able to talk, I asked "Karen, what happened?"

Karen said, "the house my daughter was renting in Milwaukee had a fire and she is homeless."
I said, "Oh, I'm so sorry."

She said "I am so ANGRY. The Wisconsin Department of Child & Family Services (DCFS) took my daughter's 3 children away from her. My daughter is a good mother.
DCFS would not have done this if we were white. This happened because we are black."

***DISCUSSION QUESTION #5**: What factors could have contributed to the worsening of Karen's clinical condition?*

***DISCUSSION QUESTION #6**: What can the primary care provider do to support Karen?*

Extra Notes for Discussion Leaders

Part 1

Q1:	How was growing up for you?	PRETTY DIFFICULT
Q2:	What factors could have contributed?	Any or all of 10 ACEs Everyday Discrimination Poverty Lack of access to Healthcare Etc
Q3:	Why would Trauma cause disease?	Neuro-dysregulation Disturbed Sleep Inflammation Organ-specific disease
	Mention:	6 or more ACEs > decrease of 20 years in life expectancy

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Part 2:

Q4:	Why would clinical status improve?	Improved sleep Improved neuro-regulation within brain & body Decreased stress from being able to talk to trusted listener Consistent medical care and as needed adjustments Less medication Having PCP act as case manager troubleshooting gaps in coverage, medication, etc

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Part 3:

Q5:	Why new clinical deterioration?	New severe stress Anger at perceived injustice & discrimination Extreme stimulation of deep brain with worsening imbalance of autonomic nervous system and Worsening neuro-regulation within brain & body

Note: Repeated studies show that black boys and girls, black men and women are <u>3 times more likely</u> than whites to be arrested or referred to court services for the same behavior as whites in the same situation.

Q6:	What can Provider do?	Validate patient feelings of injustice & severe distress Help patient problem-solve what patient can do to support daughter Increase frequency of outpatient visits with primary care until balance restored Spend time reinforcing to patient progress she has made and Provider's hopeful expectation that when crisis is over, patient will continue to make progress

Note: may want to discuss Multi-generational trauma/injustice from DCFS intervention