TRAUMA-INFORMED CARE IN LONG-TERM CARE: MEETING THE NEEDS OF A UNIQUE POPULATION

Timothy J. Legg, PhD, PsyD, MSN, MPA, MSc, LPC, LMAC, PMHNP-BC, CFT
University of North Dakota, Grand Forks, ND

Dr. Matthew Berger, MD
Offices of Psychiatry and Counseling Services, Moosic, PA

Abstract

Having lived their lives during a period in which minimal attention was provided to adverse childhood events or the impact of trauma on the developing psyche, older adults represent one of the population's largest segments. Recent changes to federal regulations have required America's nursing homes to provide trauma-informed care. Unfortunately, the existing infrastructure of the American nursing home is not necessarily conducive to the provision of such care and services. Trauma providers are in a unique position to positively impact America's older adults through a combination of direct care and consultative services designed to bring about systemic changes to organizations that provide care to this vulnerable segment of the population. Unfortunately, limitations to reimbursement also pose a restriction to trauma counselors providing these services.

Keywords: Trauma-informed care, nursing homes, older adults, adverse childhood experiences, federal regulations, re-traumatization

---

Introduction

Whether we work with clients in a private outpatient practice struggling with anxiety, or those who have recently attempted suicide admitted to an inpatient psychiatric unit, or those who struggle with addictive disorders in a partial hospitalization or an intensive outpatient setting, therapists are accustomed to working with clients who have experienced trauma. However, few therapists working with trauma have turned their attentions or practices to America's nursing homes.

Defined as an "event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual wellbeing" (SAMHSA, 2014, p. 7), trauma continues to receive increasing attention as our knowledge of its impact on the lives of those it effects continues to expand. This increased attention, however, seems to have avoided older adults living in America's nursing homes.

The problem of trauma in older adulthood has not received considerable attention. Few therapists consider themselves competent to work with older adults, and more often than not, work with older adults has focused on depression, anxiety, grief, loss, etc., and typically takes place in private practice or other outpatient settings. Our understanding as to "why" nursing home residents have not received trauma-informed services is incomplete. Perhaps it is the belief that the physical ailments of aging that result in the need for nursing home placement have usurped the effects of trauma. Maybe it has to do with the fact that approximately 65% of individuals admitted to a nursing

home die within one year of their admission (Smith & Kelly, 2010). It may even be linked to beliefs that if you live long enough, you will simply "get over" your trauma (after all, it hasn't bothered them all these years, right?). The true answer is probably that we will never have the answer.

Independent of "why" the issue has gone unaddressed, recent changes in federal regulations that govern America's nursing homes have necessitated that nursing home owners/operators provide individuals who have experienced trauma with trauma-informed services while simultaneously preventing retraumatization. In this article, we shall explore the regulatory changes, briefly examine the unique manifestations and consequences of trauma in older adults, and explore how trauma therapists may partner with nursing homes to transform their facilities into trauma-informed organizations.

Historic Neglect of Trauma in America's Nursing Homes

Nursing homes (also referred to in regulatory language as "skilled nursing facilities or "SNFs") in America that participate in Medicare and Medicaid programs receive an annual survey, which is conducted by the health department in each state in order to determine whether or not the facility is in substantial compliance with the rules and regulations governing nursing home care as outlined in Appendix PP of the State Operations Manual, published by the Centers for Medicare and Medicaid Services (CMS). The most recent revision to this manual, which was released on November 22, 2017 contains a variety of regulations that nursing homes must adhere to. Failure to adhere to the required regulations results in a variety of punishments (or "remedies" in regulatory language) which can be imposed on the facility, ranging from having to write a plan of correction, to civil monetary penalties, up to and including facility closure. State health departments may also survey facility's for state-specific regulations at the same time of their Medicare/Medicaid survey.

Reviewing the State Operations Manual (SOM), Revision # 26 from August 17, 2007 will reveal that the word "trauma" appeared only as it related to injury from a fall (as in an injury that resulted from the physical "trauma" of a fall), or injury to the urethral mucosa, related to the use of urinary catheters (which are medical devices used to assist some older adults who have difficulty urinating on their own because of a variety of different medical conditions). The regulations from that time also mentioned "post-traumatic stress disorder" as one of the acceptable diagnoses for which antidepressant medications may be prescribed. The November 2017 revisions to the SOM Appendix PP includes 14 different regulations which specifically mention "trauma" in a psychological sense or suggest other regulations that the surveyors who conducting the survey should investigate to determine facility compliance with the rules/regulations.

Trauma and Older Adults

While it is understood today that adverse childhood events and a variety of other tragic experiences may negatively impact the developing psyche of the child, more often than not, the role of these early life traumas has not been considered in terms of its potential impact to those in their older adulthood. Perhaps this is because we have allowed ourselves to believe many of the popular "myths" regarding aging (for example, a popular myth that people were "tougher" years ago), or perhaps we think that many older adults were more resilient to trauma because they experienced more of it and lived to tell about it, or maybe we believe that the older adult simply "got over it" with the passage of time. Despite how good these platitudes might make some people feel, research tells us that our reaction to trauma can be temporary or enduring, and our clinical experience also tells us that people don't just "snap out it" when it comes to trauma and PTSD. While PTSD is the diagnosis we most often consider as the inexorable result of trauma, we should also recall that trauma can result in anxiety disorders, phobic avoidance, depression, and even substance use disorders. Additionally, trauma can lead to medical problems that were not causally related to the traumatic event experienced (for example, chronic pain or headaches). Any of the various types of trauma, including sexual abuse or assault, physical abuse or assault, emotional abuse or psychological maltreatment, neglect, serious accidents or illnesses, a victim of or witness to domestic/community violence, etc., (SAMHSA, 2014) may have been experienced by older adults. It is important to remember that we are working with a population who were born and raised in a time in American history where people did not talk about mental health issues for fear of being "locked up" in the

local asylum, as mental health laws during the last century didn't truly begin to modernize until the 1970s/1980s. Stigma surrounding mental health still exists.

Specific to the various trauma types, we also need to remember that today's cadre of older adults were born/raised and lived during a time before many of the legal protections we currently enjoy came into being. While it seems inconceivable to us today, there was a time in American history where spousal abuse and child abuse were considered "family matters" and police seldom intervened. In my own clinical practice, female clients have told me multiple stories of marital rape because "he was the husband" and it was "the night" for intimacy- independent of the woman's desire for intimacy. While this may sound far-fetched, recall that approximately 80% of traumas are inflicted by family members (SAMHSA, 2014).

There are many other types of trauma which may have been experienced by older adults clients throughout their lifetime. Consider potential trauma related to medical procedures, death of a loved one, life-threatening illnesses, historical-community, natural or man-made disasters, war, terrorism, political violence, and specific to those who live in America's nursing homes, system-induced trauma (SAMHSA, 2014). Some forms of treatment or circumstances in a nursing home (especially procedures which require disrobing in front of others such as in front of a nurse during a bath) can also result in re-traumatization, depending on the older adult's trauma history.

While we are typically accustomed to identifying the usual or more common signs/symptoms of trauma in children and adults, many providers may not be aware of the unique presentation patterns of trauma in older adults. Some of the usual signs/symptoms of trauma seen in younger adults may be absent in older adult clients because of a combination of normal and pathological changes of aging. For instance, we may not always see an older adult demonstrate an exaggerated startle response. Clients with dementia will have baseline difficulties with concentration, so we may not consider the classic symptoms of difficulty concentrating as pathognomonic for trauma among members of this population.

We may also see issues with sleep problems, nightmares, and even hallucinations and delusions, which may be mistaken for dementia or another psychiatric illness. The institutionalized older adult may also report multiple somatic complaints, anxiety, and mood disturbances. They may also avoid common areas or specific areas of the facility, or avoid group activity altogether.

Pathophysiologic Consequences of Trauma Relevant to Old Adults

In my own efforts to help nursing homes transition to trauma-informed institutions, I invariable meet with a staff member or two who attempt to demonstrate their prowess in pointing out the "futility" of my efforts, directed towards a group of individuals at the end of their lifespan, who could not possibly benefit from psychological intervention. Instead of shutting these well-meaning, but ill-informed persons down by quoting the new regulatory requirements, I focus my response to them on the way in which treatment can potentially enhance the quality of life that remains for that older adult. I have also used these situations as opportunities to help nursing home staff develop a greater appreciation of the impact of unaddressed trauma and re-traumatization on certain diseases typically seen among members of their resident population (some of which can potentially be improved, if not avoided) in the older adult. This is an area of particular expertise among trauma therapists. Some examples worth nothing include:

- Glucocorticoids stimulate the amygdala, which in turn potentiates the hippocampus. If glucocorticoid levels remain elevated, atrophy and memory impairment can occur. In fact, it is known that dendritic arborization in the basolateral amygdala may be one of the reasons why individuals have difficulty forgetting traumatic events (Hategan, Bourgeois, Hirsch, & Giroux, 2018). In older adults, elevated glucocorticoid levels may contribute to age-related neuronal atrophy and cognitive decline (Hategan, Bourgeois, Hirsch, & Giroux, 2018).

- Stress has been linked to neuronal dysregulation and inflammation, and chronic inflammation which have been linked to an increased risk in the diseases of aging. In a Danish population study, it was found

that post-traumatic stress disorder was associated with the increased risk of myocardial infarction (MI), coronary vascular accidents (CVA), and venous thromboembolism. Sexual assault history has also been associated with increased arthritis and breast cancer in older women and thyroid disease in older men. Posttraumatic stress disorder has also been found to accelerate cellular aging (Hategan, Bourgeois, Hirsch, & Giroux, 2018).

- It is also known that the odds of having cancer before the age of 50 increased twofold amongst women who had two or more adverse childhood experiences. Additionally, PTSD has been associated with a 50% increase in the risk of new-onset heart failure over the course of 8 years. The likelihood of chronic cerebral infarction is nearly three times higher in those with moderately high levels of emotional neglect in childhood versus those who experience low levels of emotional neglect (Hategan, Bourgeois, Hirsch, & Giroux, 2018).

- PTSD has also been linked to an increased prevalence of metabolic syndrome, including central adiposity, elevated blood sugars, high blood pressure, and dyslipidemia. In fact, 40% of individuals with PTSD meet the criteria for metabolic syndrome-nearly double the prevalence compared to a control population. PTSD related metabolic syndrome has also been associated with bilateral reductions in cerebral cortical thickness, shorter telomere length, and advanced DNA methylation age in comparison to chronologic age (or advancing of the epigenetic clock) (Hategan, Bourgeois, Hirsch, & Giroux, 2018).

The examples provided above represent only a small sampling of the expanding field of traumatology. With each passing year, more and more discoveries as to the link between traumatic experiences and physical and mental health continue to be made. In addition to the above examples, it is known that those individuals with a trauma history or PTSD demonstrate greater use of health care services than non-traumatized individuals (Classen & Clark, 2017; Luyten, et al., 2017; SAMHSA, 2014). In some cases, psychological issues may manifest as complaints of physical symptoms (SAMHSA, 2014). As America's nursing homes are now reimbursed under the patient driven payment model (PDMP), a significant reimbursement change which occurred in 2019, reimbursement is now based on resident need versus "volume" of services provided (such as physical or occupational therapy). Skilled nursing facilities need to be certain that they are correctly identifying the care needs of their residents and providing care that meets their need to avoid paying for services that a resident may not need (Unruh, Khullar, & Jung, 2020), including extensive medical evaluations for somatic symptoms which may be resulting from unidentified and untreated trauma, as opposed to an organic basis. From this perspective, identifying and treating trauma and preventing re-traumatization has both a human and financial cost component.

Prevalence of PTSD/Trauma

A question that has arisen during my consultation work with nursing homes has been "how likely are we to find PTSD among nursing home residents?" While the actual number of older adults with psychological trauma is unknown, the DSM-5 indicates that the lifetime risk of developing PTSD is approximately 8.7%. In a given 12-month period, 3.5% of adults are at risk for its development (APA, 2013), however these numbers reflect the entire population and are not specific to older adults in general or older adults living in America's nursing homes in particular. We also know that women are at nearly double the risk of developing PTSD than men (Kirkpatrick et al., 2017). The reason for this is multiple, including the fact that women tend to have higher levels of rape or other forms of sexual assault. Women also tend to bear the brunt of domestic violence more so than men. This is particularly salient when considering the time (historically) when older adult females in the nursing home were young women. We also know that nursing homes tend to have a higher female population.

It is also worth noting that persons with PTSD 80% more likely to meet the criteria for other mental health diagnoses (e.g., depressive, bipolar, anxiety, and substance use) (APA, 2013). It is also known that one in four older adults experience mental health issues such as anxiety, depression, or substance use issues (National Council on Aging, 2021). Some studies have suggested that PTSD may increase the risk for development of neurocognitive disorders (previously known as dementia) which are also prevalent in

America's nursing homes (Rehman, Zhang, Ye, Fernandes, Marek, Cretu, & Parkinson, 2020).

New Regulatory Requirements
F-699 §483.25(m) Trauma-informed care

The new regulation dealing with trauma informed care is found at subsection 483.25(m) of Appendix PP of the state operations manual. It has been assigned the tag number "F-699." The regulation requires that the nursing home "ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause retraumatization of the resident" (CMS, 2017, p. 401). Another federal tag, F-740, that deals with "behavioral health services" requires that each resident must receive, and the facility must provide the necessary

> *Behavioral healthcare and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders (CMS, 2017, p. 449).*

While these regulatory requirements may seem basic to trauma therapists, they have created considerable challenges for nursing homeowners and operators. Unfortunately, there are typically no qualified/trained individuals typically employed by nursing homes to provide these services. While federal regulations require nursing homes to have a full-time social worker, the law is only applicable to those nursing homes that have 120 beds or more (CMS, 2017, p. 655). State laws/regulations may be more stringent, but this varies from state to state. Additionally, the social worker requirements are not typically consistent with the definition of a "social worker" in most states. Regulation F-850 defines a social worker as "an individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and"….[has] "one year of supervised social work experience in a health care setting working directly with individuals" (CMS, 2017, p. 655). Again, state laws can be stricter, but again, this varies from state to state. It is also worth noting that the regulations do not require the facility to provide these services themselves, but the facility must arrange for these services to be provided by contractors if the facility does not have the internal talent to provide required care and services. This is where trauma therapists can be of immeasurable value to the skilled nursing facility.

The *Trauma-Informed* Skilled Nursing Facility:
The Challenge for Trauma Therapists

The therapist may initially feel intimidated by the thoughts of helping nursing homes on their journey to becoming trauma-informed organizations. Serving as a consultant and change agent can be a harrowing task, but the experience of being a therapist experienced in working with trauma survivors can be of immeasurable value to nursing homes struggling to become trauma informed organizations in order to achieve compliance with the new regulatory requirements. While the owners/operators are tasked with fulfilling this regulatory requirement, there is a paucity of knowledge in this area among existing staff typically employed in America's nursing homes. As discussed above, most facilities lack the internal talent to implement the new regulatory requirements fully and completely in a meaningful way. This has created an opportunity for therapists with experience in working with trauma survivors. The therapist may consider reaching out to nursing homes, offering their assistance to help the facility with a variety of tasks, including but not limited to developing assessment protocols for identifying current residents with a history of trauma, implementing assessment protocols that may help to identify newly admitted residents who may have a history of trauma for the purposes of case finding and treatment (if the resident is interested in such services) or at the least, preventing re-traumatization. In terms of re-traumatization the trauma therapist could help the organization to explore existing policies and procedures in order to identify existing processes and practices which have the potential to re-traumatize residents with a trauma history. For instance, procedures

requiring disrobing, or care being provided in the resident's bedroom. The therapist can also help the organization form interdisciplinary committees (with resident involvement) to review existing policies/procedures to identify how existing policies/procedures may traumatize or retraumatize individuals. The therapist can also help to educate the staff on trauma and trauma-informed care and practices.

The focus of transformation of the skilled nursing facility trauma-informed care involves vigilance in anticipating and avoiding institutional processes and individual practices among staff members that are likely to retraumatize individuals who already have histories of trauma. Any meaningful transformation must recognize the importance of resident participation in developing, delivering, and evaluating services. From this perspective, the therapist can help facilities to identify opportunities to offer their residents choices in care/treatment, thus empowering them and reducing feelings of helplessness which can also invoke traumatic memories. Mechanisms through which the residents can provide feedback on care/services received by staff to "someone" who cares about their opinion can go a long way towards creating an environment of empowerment and decreasing the risk for re-traumatization. Involvement of the entire staff in the assessment of the organization is still another mechanism by which the organization can become a trauma-informed organization. Recall that some staff members themselves may have experienced trauma in their own lives, and through the process of transforming the organization into a trauma informed organization, staff may become empowered and some personal healing can also take place.

While there are many approaches that the trauma therapist as a consultant can take, one approach that may be particularly useful in working with nursing homes is the strengths-based service delivery approach that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper, Bassuk, & Olivet, 2010, p. 82). The actual approach adopted, however, will depend on a variety of factors and will always include input from the organization and its internal and external customers.

Assessment of Older Adults in Nursing Homes for Trauma

When it comes to assessing trauma, a famous quote from Sigmund Freud is quite appropriate, "One hardly comes across a single patient who does not make an attempt at reserving some region or other for himself as to prevent the treatment from having access to it." This is true in persons of all ages, as talking about trauma hurts. When considering unaddressed trauma in older adults, we must recall that we are working with a population that has not only experienced trauma but may have spent a lifetime trying to either forget about their trauma or at least try to bury it. Unfortunately, to those of us who work with trauma survivors, we know that neither approach works.

There are several assessments that are completed by professionals in the nursing home that can be of assistance in learning about potential trauma, including the Minimum Data Set (now in its third version). The MDS is part of

> *a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process entails a comprehensive, standardized assessment of each resident's functional capabilities and health needs. Assessments are conducted by trained nursing home clinicians on all patients at admission and discharge, in addition to other time intervals (e.g., quarterly, annually, and when residents experience a significant change in status) (National Institutes of Health, 2020, para. 1).*

Responses to various items on the MDS either alone or in combination, can result in "triggering" care area assessments (CAAs)- which are more in-depth assessments beyond the basic screening process of the MDS. While a comprehensive overview of the MDS assessment is beyond the scope of this paper, it is sufficient to note that through this assessment instrument, clients can be screened for life situations/circumstances that may have put them at increased risk for trauma. The clinician who considers

partnering with nursing homes should familiarize themselves with this instrument and its contents.

Additional assessments could include instruments that the therapist is probably already familiar with including the Life Events Checklist (LEC) or the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)- this 5-item screening tool is designed to identify individuals with probable PTSD (Prins, Bovin, Kimerling, Kaloupek, Marx, Pless Kaiser, & Schnurr, 2015). The PTSD CheckList – Civilian Version (PCL-C) can also be considered (Lang, Wilkins, Roy-Byrne, Golinelli, Chavira, Sherbourne, Rose, Bystritsky, Sullivan, Craske, & Stein, 2012). In addition to screening instruments, trauma therapists could use various other assessment techniques, depending on the clinician's background and training. Instruments can be used alone or in combination in addition to a comprehensive clinical interview to identify residents who may have experienced trauma.

Reimbursement: The Ultimate Challenge to Trauma-Informed Therapists

While therapists who provide care and services to those with trauma in the community may have the skillsets needed to help older adults in America's nursing homes, a major barrier persists, depending on the professional licensure held by the therapist. Succinctly stated, "Medicare presently recognizes psychiatrists, psychologists, clinical social workers and psychiatric nurses to provide covered mental health services. Mental health counselors and MFTs have equivalent education and training to clinical social workers but are not eligible to serve Medicare beneficiaries" (Medicare Access Coalition, n.d.). Medicare covers approximately 17% of the United States population, or, approximately 55 million Americans- among whom are the sickest and most disabled citizens, also those who probably have the most significant mental health/counseling needs (Davis, Schoen, and Bandeali, 2015).

The American Counseling Association further notes that

> *There are more than 140,000 licensed professional counselors across the country ready to provide needed treatment, especially in rural areas where they are often the only mental health professional available. LPCs are not able to be reimbursed by Medicare, despite the fact they have education, training, and practice rights equivalent to or greater than existing covered providers. LPCs are licensed for independent practice in all 50 states and are covered by private sector health plans (n.d., para. 3).*

While there are over 106,000 psychologists in the United States, most of them are concentrated in major metropolitan areas, with approximately 33% of counties in the United States having no licensed psychologists registered (American Psychological Association 2016). Interestingly the areas with few to no psychologists are among those areas that are the country's poorest. This is significant as poverty is an independent risk factor for developing mental health trauma (Hughes & Tucker, 2018). Paradoxically, while professional counselors have a more substantial presence in underserved geographic regions (United States Department of Labor Statistics, 2017), they are ineligible for Medicare reimbursement and, thus, unable to meet this vulnerable population's needs. To meet this vulnerable population's trauma-informed care needs, alterations to reimbursement structures through professional advocacy will be needed.

Independent of reimbursement challenges, nursing homes can still use those mental health professionals who are not reimbursed directly by Medicare in a consultant capacity, or the nursing home could privately contract with the therapist.

Conclusion

Although barriers to reimbursement can serve as a challenge, and while advocacy is needed to address this disparity, the trauma informed therapist can still be of value to nursing homes. As Freud pointed out, individuals could conceal trauma from us despite our best efforts at screening and assessment. But we can be secure in knowing that we offered our services, began the discussion with the older adult that help is available. Even if we never identify a resident with a history of trauma, by helping nursing homes to transform into trauma-informed organizations we can at the very least help to prevent older adults who live in these facilities from being re-traumatized. The process of transformation can also be beneficial to staff who may themselves be trauma survivors, thereby improving the organization for everyone.

References

American Counseling Association. (n.d.). Medicare coverage. Retrieved from https://www.counseling.org/government-affairs/federal-issues/medicare-reimbursement#

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2016). Datapoint: Where are the highest concentrations of licensed psychologists? *Monitor, 47*(3). Retrieved from https://www.apa.org/monitor/2016/03/datapoint#:~:text=There%20are%20approximately%20106%2C000%20licensed,no%20records%20of%20licensed%20psychologists.

Bloom, S. L. (2017). The sanctuary model: Through the lens of moral safety. In Gold, S. N., Cook, J. M., & Dalenberg, C. J. (Eds.), APA handbook of trauma psychology, volume 2, trauma practice (pp. 499-513). Washington, DC: American Psychological Association.

Brown, V. B. (2017). Through a trauma lens: transforming health and behavioral health systems. New York, NY: Routledge.

Centers for Medicare and Medicaid Services. Appendix PP: (Rev. 173, issued 11-22-17) Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Classen, C. C., & Clark, C. S. (2017). Trauma-informed care. In Gold, S. N., Cook, J. M., & Dalenberg, C. J. (Eds.), APA handbook of trauma psychology, volume 2, trauma practice (pp. 499-513). American Psychological Association.

Davis, K., Schoen, C., & Bandeali, F. (2015). Medicare: 50 years of ensuring coverage and care. The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2015_apr_1812_davis_medicare_50_years_coverage_care.pdf

Freud, Sigmund. (1916-1917). Introductory Lectures on Psycho-Analysis, Part III. Standard Edition of the Complete Psychological Works of Sigmund Freud. Hogarth Press & The Institute of Psycho-Analysis.

Hategan, A., Bourgeois, J. A., Hirsch, C. H., & Giroux, C. (Eds.). (2018). Geriatric psychiatry. Cham, Switzerland: Springer International Publishing.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80–100.

Hughes, M. & Tucker, W. (2018). Poverty as an adverse childhood experience. *North Carolina Medical Journal, 79*(2) 124-126; DOI: https://doi.org/10.18043/ncm.79.2.124

Kirkpatrick, D. G., Badour, C. L., & Resnick, H. S. (2017). Trauma and posttraumatic stress disorder prevalence and sociodemographic characteristics. In Gold, S. N., Cook, J. M., & Dalenberg, C. J. (Eds.), APA handbook of trauma psychology, volume 2, trauma practice (pp. 499-513). Washington, DC: American Psychological Association.

Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a guide to clinical response. *General Hospital Psychiatry, 34*(4), 332–338. https://doi.org/10.1016/j.genhosppsych.2012.02.003

Luyten, P., Van Assche, L., Kadriu, F.. Krans, J., Claes, L., & Fonagy, P. (2017). Other disorders often associated with psychological trauma. In Gold, S. N., Cook, J. M., & Dalenberg, C. J. (Eds.), APA handbook of trauma psychology, volume 2, trauma practice (pp. 499-513). Washington, DC: American Psychological Association.
Medicare Access Coalition. (n.d.). Medicare coverage of mental health counselors and marriage and family therapists https://centerstone.org/wp-content/uploads/Medicare-Coalition-Packet-5-17-18-002-1.pdf

National Council on Aging. (2021). Getting the facts on healthy aging. Retrieved from https://www.ncoa.org/article/get-the-facts-on-healthy-aging

National Institute of Health. (2020). SEER-Medicare: Minimum data set (MDS) - Nursing home assessment. https://healthcaredelivery.cancer.gov/seermedicare/medicare/mds.html

Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G, Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *Primary care PTSD screen for DSM-5 (PC-PTSD-5).* https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf

Rehman, Y., Zhang, C., Ye, H., Fernandes, L., Marek, M., Cretu, A., & Parkinson, W. (2020). The extent of the neurocognitive impairment in elderly survivors of war suffering from PTSD: meta-analysis and literature review. AIMS neuroscience, 8(1), 47–73. https://doi.org/10.3934/Neuroscience.2021003

Smith, A. K. & Kelly, A. (2010). Social support is key to nursing home length of stay before death. University of California at San Francisco. https://www.ucsf.edu/news/2010/08/98172/social-support-key-nursing-home-length-stay-death

Substance Abuse and Mental Health Services Administration. (2014). Treatment Improvement Protocol # 57: Trauma-informed care in behavioral health services. Rockville, MD: Author.

Unruh, M. A., Khullar, D., & Jung, H. Y. (2020). The patient-driven payment model: Addressing perverse incentives, creating new ones. *American Journal of Managed Care, 26*(4). https://www.ajmc.com/view/the-patientdriven-payment-model-addressing-perverse-incentives-creating-new-ones

United States Department of Labor Statistics. (2017). Occupational employment and wages, May 2016, 21-1014 mental health counselors. Retrieved from https://www.bls.gov/oes/2016/may/oes211014.htm

---

Dr. Timothy Legg is an assistant clinical professor and graduate track director of the psychiatric mental health nurse practitioner and adult/gerontology primary care tracks at the University of North Dakota, College of Nursing and Professional Disciplines and is a psychiatric and mental health nurse practitioner in employed practice at the Offices of Psychiatry and Counseling Services, Dr. Matthew Berger, MD, PC, Moosic, PA.