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Psychosocial Aspects of Burn Management in a Changing Model of Care

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Abstract

As there has been a shift in burn care, from primarily inpatient to more outpatients, there has been a need to address the varying needs of patients in this new setting. The need for a multidisciplinary approach for optimal outcomes remains an important aspect of effective care for those with burn injury including addressing quality of life, psychological care, and social needs. This article will describe one burn center's transition and development of an outpatient program that addresses both the medical aspects of care but also the psychosocial aspects of coping with injury. The second purpose is to describe our outpatient approach and some of the accompanying challenges.

Keywords: Outpatient burn care; Outpatient psychological screening; Psychosocial aspects of burn injury; Multidisciplinary team

Abbreviations

ABA: American Burn Association; PHQ-4: Patient Health Questionnaire-4; PTSD: Posttraumatic Stress Disorder

Introduction

Surviving burn injuries can be a traumatic and distressing injury to cope with and the often prolonged recovery process can stress an individual or family's resources. Burn injury patients survive with larger and more severe burns within the current medical system and as the nature of burn injury treatment has changed over the years the challenges of addressing patient's psychological reactions and coping with recovery have changed as well. Most recent data reports that burn survival rate in the United States is 96.6% with hospitalizations remaining relatively consistent [1]. Years ago most often patients were hospitalized for weeks to months during the recovery process which allowed a number of concerns to be addressed during this hospitalization process. The burn units as a result of these typically longer stays have often developed a team of providers including not only medical burn specialists, but also psychologists, social workers, case managers, nurse practitioners, etc. as a comprehensive burn treatment team to address the multiple needs of surviving such an intense injury.

Multidisciplinary Team Care

The importance of a comprehensive and multidisciplinary treatment team has been discussed in the literature and found to have many benefits for patients in general and burn injury patients specifically [2]. In addition to burn-related medical care, patients in our inpatient burn service are all assessed by a social worker and based on this initial assessment may require further evaluation and intervention by the Burn Service Psychologist. The inpatient burn injury survivors who scored high on depression screening or who were admitted with a known history of mental health concerns are automatically evaluated by the psychologist. This allowed all burn injury patient's needs to be assessed and interventions provided during the acute phase of recovery as well as allowing the psychologist and burn team to make appropriate referrals for ongoing psychological care for patients upon discharge. Patients are also evaluated by attending physicians, residents, physical and occupational therapists, case manager, and nursing staff. Each patient is reviewed weekly in a multidisciplinary staff meeting to address any concerns, discharge plans, or follow up needs.

Shifts in Burn Injury Treatment

However, many burn services, including ours have been shifting their care to a more coordinated care system which often focuses on shorter hospital stays with ongoing follow up at either home, rehabilitation centers, or other community medical care centers with accompanying follow up from a Burn Service outpatient clinic. In addition, many burn centers have been seeing an increase in the number of outpatients treated. Our burn service has seen a steady increase in new outpatient visits from 2012-2014, many of which would have likely never been admitted to the hospital and thus never interacted with various team members. During this transition in our Burn Service, length of hospitalizations decreased with the average length of stay going from 8.53 days in 2012 to 5.74 in 2014. This does not appear to be due to a reduction in severity of burn injury as burn severity appeared to have slightly increased during this same period. Despite the decreased length of stay the rates of unplanned readmissions has also decreased from 42% to 36% while recovery has remained stable indicating that reducing hospitalizations and therefore costs doesn't necessarily cause harm or delay recovery when being administered by a comprehensive outpatient Burn Service. This model allows for shorter hospital stays and lower costs, while also providing appropriate medical follow up with possible future hospital stays if determined appropriate by the burn medical team.

Challenges of Treating Outpatient Burn Injuries

While this shift has often resulted in positive outcomes for both the patient and the hospital, there have been challenges as

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well including how to appropriately meet the diverse needs of these patients in the more limited outpatient setting. Despite the severity of burns seen in the outpatient setting typically being less severe there remains a number of needs including a number of psychological concerns. These patients are often not accessing traditional inpatient comprehensive treatment teams and as a result often struggling with various psychosocial needs including anxiety, depression, body image concerns, and a lack of resources. Even those that are seen as inpatients, many issues that impact quality of life may not manifest until many months after the burn; it may not be months later during follow up that the patient reports psychological distress and a need for intervention.

As treatment began to change to a more outpatient based service many of these outpatients were not getting the full impact of having access to the inpatient compressive service providers. Although, these patients weren't experiencing significant hospital stays, many of our outpatients were expressing similar distress, psychological symptoms, and need for compressive services. This comprehensive model wasn't initially available despite many of the psychological and social needs being similar to those that were inpatient. Thus the Burn Service evaluated and assessed how these needs could potentially be met with the resources available.

In an attempt to provide additional comprehensive services related to outpatient's mental health and well being, the Burn Service attempted to start several assessment and intervention procedures. Firstly all outpatients have started to be screened with a short but relatively valid and reliable screener for depression and anxiety, the Patient Health Questionnaire for Depression and Anxiety (PHQ-4) in order to identify possible patients with psychological needs [3]. Secondly, if someone is identified then an appointment to see the Burn Service psychologist is provided to the patient on days during the Burn Service clinic. If the patient isn't able to see the psychologist that day due to time constraints or other reasons, an appointment with the psychologist can be made for the same day as their medical follow up in order to reduce the burden for patients. Many of our patients have limited resources and social issues that can make multiple appointments particularly difficult, thus coordinating appointments reduces this strain on many. In addition the psychologist's time is essentially built into the clinics budget, thus reducing the concern of many patients about lack of insurance or other financial resources to be able to access needed psychological care. Over time this has shown to be a successful model as patients have been screened, formally assessed, and then treated or referred who may have otherwise never been seen by the inpatient treatment team.

In addition to the change in treatment approach, our Burn Service continues to cope with many issues relevant to a large Burn Injury Treatment Center. One major challenge is that the Burn Service provides burn treatment to a large geographical catchment area making social support, transportation, and referral for follow up care significant hurdles that often need to be managed. Many of our patients travel over 100 miles for treatment, this often leaves them with little support in the hospital or during follow up appointments as family often cannot make the trip easily or regularly. In addition this often means patients live in rural areas that have few formal support networks, mental health treatment options, or skilled home health providers. Often, if there are mental health programs, they are woefully underfunded with lengthy waiting lists; therefore getting a patient linked quickly is an ongoing challenge. In addition, the services that do exist may not have people trained specifically to deal with posttraumatic stress disorder (PTSD) or body image issues specific to burn survivors. PTSD is a mental condition that has specific treatments that have been developed and these treatments have been found to be very effective, if they are available [4]. Many psychosocial treatment areas are scarce in these smaller communities including trauma-related psychotherapy, substance use treatment, and serious mental illness, psychiatry, and support groups. People without insurance or people under insured have the hardest time linking with providers.

In areas where there may be fewer support services, the treatment team often attempts to find additional sources of support including through the use of the internet or follow up appointments with the Burn Service. One source of beneficial support has been the Phoenix Society, who is a major national organization for burn support. They not only provide information for patient education but also have features that include an online support group, a place to ask questions, and opportunities for national burn meetings. It's important for all burn programs to have trained and available SOAR mentors to assist pt's with the emotional, practical, and family related short-term and long-term adjustment process. Support groups have also been identified as a means of supporting burn patients through the recovery process. Our program has successfully put together a burn survivor support group run by social work to provide newer and older injury survivors an opportunity to learn from each other and provide support. Due to the large area that the burn program draws from, the Burn Service is also looking into ways to utilize technology to support people. Facetime, Skype and Blue jean are all technologies that could be incorporated into the program to help survivors connect and feel supported.

Summary

Ultimately this transition has been a relatively successful one as patients are able to be treated with shorter hospital stays or purely at an outpatient basis. By adding additional psychological and other support services, the Burn Team has made significant improvements in providing compressive care to burn survivors despite this change in the medical treatment model. Though it is important for every Burn Center to assess their unique patient population, needs, and resources and develop the approach that works best for each system. In addition, as these changes in the care system are ongoing, it is valuable to assess the treatment process and make adjustments as appropriate. Overall compressive treatment of patients, both inpatient and outpatient, will provide the burn survivors with key elements to assist them in their recovery process and allow them to return to leading active, meaningful, and engaging lives.

References

1. American Burn Association (n.d.). Burn Incidence and Treatment in the United States: 2013 Fact Sheet. 2014.

2. Al-Mousawi AM, Mecott-Rivera GA, Jeschke MG, Herndon DN. Burn teams and burn centers: the importance of a comprehensive team approach to burn care. Clin Plast Surg. 2009; 36: 547-554.

3. Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009; 50: 613-621.

4. Ursano RJ, Bell C, Eth S, Friedman M, Norwood A, Pfefferbaum B, et al. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry. 2004; 161: 3-31.

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