FOSTERING RESILIENCE AND RECOVERY:

A Change Package for Advancing Trauma-Informed Primary Care

NATIONAL COUNCIL
for Mental Wellbeing

Acknowledgements

Practice Transformation Team Members

Chair: **Glenda Wrenn, M.D., MSHP**
Chief Medical Officer
180 Health Partners
Associate Professor
Morehouse School of Medicine

Susan Briner, M.D.
Former Medical Director, Center for Youth Wellness

Roger Fallot, Ph.D.
Developed "Creating Cultures of Trauma-Informed Care," Trauma Recovery and Empowerment Model for Men (M-TREM) and Prior Director of Research and Evaluation at Community Connections

Pamela Jacobs, Ph.D.
Adult Mental Health Director, Native American Rehabilitation Association of the Northwest, Inc.

Tracy Knight, LICSW
Social Services Director, Bread for the City

Virna Little, PsyD, LCSW-r, MBA, CCM, SAP
Chief Operating Officer
Concert Health

Edward Machtinger, M.D.
Professor of Medicine and Director of the Women's HIV Program, University of California, San Francisco

Brigid McCaw, M.D., MPH, MS, FACP
Medical Director, Northern California Family Violence Prevention, Kaiser Permanente (retired)

Arabella Perez, LCSW
Assistant Clinical Professor, University of New England

Suganya Sockalingam, Ph.D.
Founding Partner, Change Matrix, LLC

Sharon Wise, MHS
Founder, The House of Sharon

To test the efficacy of the Change Package, the National Council for Mental Wellbeing, in partnership with Iteration Evaluation, conducted a 16-month pilot program with seven Federally Qualified Health Centers (FQHCs) across the country. To ensure the Change Package was nationally applicable, selected sites were diverse in readiness for implementation, geographic location and setting, center size and patient population demographics. Sites received training on a range of topics via consultation with a dedicated practice coach, regular group webinars, and a series of in-person meetings.

Primary Care Learning Community Participants

Malama I Ke Ola Health Center
Wailuku, Hawaii

Colorado Coalition for the Homeless
Denver, Colorado

Richmond Behavioral Health Authority
Richmond, Virginia

Zufall Health Center
Dover, New Jersey

Peninsula Community Health Services
Bremerton, Washington

Oregon Health & Science University, Family Medicine at Richmond Clinic
Portland, Oregon

Willamette Family, Inc.
Eugene, Oregon

Highlights of specific lessons from the pilot appear throughout the Change Package as provider tips and lessons from pilot participants.

Special thanks to Becca Sanders, MS, MSW, Ph.D., and Iteration Evaluation, LLC for providing evaluation for the Learning Community.

National Council for Mental Wellbeing Team

Gabe Abbondandolo
Project Assistant, Practice Improvement

Sarah Flinspach
Project Coordinator, Practice Improvement

Ciara Hill
Project Coordinator, Practice Improvement

Linda Henderson-Smith, PhD, LPC
Director, Children and Trauma-Informed Services

Karen Johnson, LCSW, MSW
Senior Director, Trauma-Informed Services

Jody Levison-Johnson, LCSW-C
Assistant Vice President, Practice Improvement

Laura Leone, DSW, MSSW, LMSW
Integrated Health Consultant, Practice Improvement

Sharday Lewis, MPH
Project Manager, Practice Improvement

Shannon Mace, JD, MPH
Lead Writer
Senior Practice Improvement Advisor

Anthony Salerno, PhD
Consultant, SAMHSA-HRSA Center for Integrated Health Solutions

Cheryl S. Sharp, MSW, ALWF
Exclusive Consultant, Trauma-Informed Services

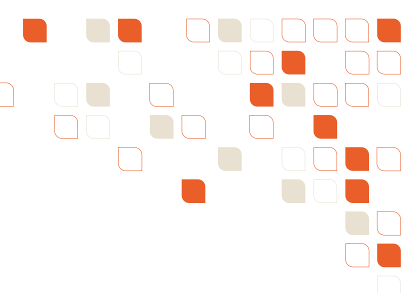


Table of Contents

Introduction	**1**
Why Implement a Trauma-Informed Approach in Primary Care Settings?	**1**
What is Trauma?	**2**
What is Resilience?	**4**
What is a Trauma-Informed Approach?	**4**
How to Use This Change Package	**6**
Who Should Use This Change Package?	**7**
Trauma-Informed Primary Care Action Items Checklist	**8**
Step 1. Change Management Strategies: Create the Conditions for Change	**9**
Develop a CIT	**10**
Ensure Continued Support from Leadership	**11**
Educate CIT Members	**12**
Conduct the Organizational Self-assessment	**12**
Align Trauma-Informed Initiatives with Existing Organizational Initiatives	**14**
Communicate to Stakeholders for Engagement and Support	**15**
Develop a Plan	**16**
Monitor Progress	**17**
Change Concept 1: Help All Individuals Feel Safety, Security and Trust	**19**
Change Concept 1 Goals	**19**
Conduct an Environmental Assessment	**20**
Assess Patient Safety	**23**
Establish Trauma-Informed Rooming Policies	**23**
Foster Trust Through Trauma-Informed Patient Interactions	**24**
Provide Universal Education	**25**
Ensure Staff Safety	**26**
Change Concept 2: Develop a Trauma-Informed Workforce	**27**
Change Concept 2 Goals	**27**
Provide Training to All Staff on Trauma-Informed Principles	**28**
Build an Organizational Culture of Diversity, Equity and Inclusion	**32**
Provide Trauma-Informed Supervision and Staff Support	**33**
Recruit Staff Who Will Succeed in a Trauma-Informed Environment	**34**
Develop and Implement Workforce Policies that Support Trauma-Informed Approaches	**37**

Change Concept 3: Build Compassion Resilience in the Workforce 38
- Change Concept 3 Goals 38
- Educate and Train Staff on Symptoms of Common Workforce Concerns 39
- Create a Culture of Compassion Resilience 41
- Implement Policies and Procedures to Build Staff Resilience 44
- Provide Time and Resources for Staff to Process Difficult Situations 45
- Encourage Staff Assessment of Wellness Practices 45
- Encourage Staff to Develop and Implement Self-care Plans 46

Change Concept 4: Identify and Respond to Trauma Among Patients 47
- Change Concept 4 Goals 47
- Prepare for Trauma Inquiry and Response 48
- Inquire for and Respond to Recent Trauma Requiring Immediate Intervention 52
- Conduct Inquiry for Trauma 53
- Respond to Trauma Disclosure 58

Change Concept 5: Finance and Sustain Trauma-Informed Approaches in Primary Care 61
- Change Concept 5 Goals 61
- Identify All Planned, New and Existing Activities and Procedures Resulting from Implementing Trauma-Informed Approaches 62
- Measure Trauma-Informed Activities 62
- Identify Nonfinancial Resources for Support 67
- Analyze Policy Landscape and Select Advocacy Goal to Support Financing and Sustainment 68
- Develop and Tailor Advocacy Messaging for Identified Stakeholders 68
- Sustain a Trauma-Informed Approach 69

Conclusion 69

References 70

Appendix A 75
- Additional Resources for Implementation 75
- Education and Inquiry Tools 76
- Screening and Assessment Tools 78

Introduction

Implementing trauma-informed approaches within primary care marks a fundamental shift in care delivery that supports improved utilization of services, improved patient outcomes, increased staff satisfaction and healthier work environments.[1,2]

Trauma occurs in all populations regardless of socioeconomic status, race, ethnicity, gender and sexuality or geography and the impacts of trauma are long-lasting affecting development, wellness and stress response across the lifespan.[3] There are effective strategies primary care providers can implement to improve the health and resiliency of individuals with histories of trauma resulting in better patient and provider outcomes.[4]

To better address trauma in primary care, Kaiser Permanente and the National Council for Mental Wellbeing (National Council) launched the Trauma-Informed Care Primary Care: Fostering Resilience and Recovery initiative to develop, test, disseminate and scale a field-informed Change Package. An 11-member national Practice Transformation Team convened to develop the Change Package to provide information, action steps and tools to guide implementation of a trauma-informed primary care approach. Following the initial development of the Change Package, seven primary care organizations, the Primary Care Learning Community, worked with the National Council to pilot the tool and provided feedback to inform its refinement. This Change Package is a result of the generous efforts by the Practice Transformation Team, the Primary Care Learning Community, National Council project staff and partners.

What is a Change Package?

A Change Package is a practical toolkit that is specific enough for clinicians and practices to implement, test and measure progress on an evidence-based set of changes while being general enough that it is scalable in multiple settings.

Why Implement a Trauma-Informed Approach in Primary Care Settings?

Trauma-Informed primary care settings can help establish more appropriate and effective care utilization patterns among individuals with trauma histories.[5] The benefits of creating trauma-informed environments include creating safer spaces for staff, improving clinical decision-making

[1] Wong, E. C., Schell, T. L., Marshall, G. N., Jaycox, L. H., Hambarsoomians, K., & Belzberg, H. (2009). Mental Health Service Utilization After Physical Trauma: The Importance of Physician Referral. Medical Care, 47(10), 1077-1083. doi: 10.1097/MLR.0b013e3181a80fc9.
[2] Hales, T. W., Nochajski, T. H., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An Association Between Implementing Trauma-Informed Care and Staff Satisfaction. *Advances in Social Work*, 18(1), 300-312.
[3] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services Publication No. (SMA) 14-4884.
[4] Davis, R. & Maul, A. (2015). Trauma-Informed care: Opportunities for high-need, high-cost Medicaid populations. Center for Health Care Strategies. Retrieved from http://www.chcs.org/media/TIC-Brief-031915_final.pdf
[5] Wong, E. C., Schell, T. L., Marshall, G. N., Jaycox, L. H., Hambarsoomians, K., & Belzberg, H. (2009). Mental Health Service Utilization After Physical Trauma: The Importance of Physician Referral. *Medical Care*, 47(10), 1077-1083. doi: 10.1097/MLR.0b013e3181a80fc9.

by equipping providers to identify and respond to trauma and building collaborative care networks to increase providers' capacity to address holistic needs.[6,7,8]

Implementing a trauma-informed approach also aligns with and supports existing health care transformation efforts, including integrating primary care and behavioral health services.

"The most important thing I didn't learn in medical school is about adverse childhood experiences, also known as ACEs. To be sure, if I had understood them then the way I do now, I would have been a better and more compassionate physician. Importantly, I would have avoided lots of mistakes."

Dr. Nancy Hardt, Professor Emerita, University of Florida College of Medicine

Organizations currently or planning to integrate behavioral health services are well-positioned to concurrently implement trauma-informed principles and practices. Payment mechanisms associated with integrated care practice can also help support the sustainability of a trauma-informed approach within primary care.

One of the most compelling reasons to implement a trauma-informed approach was documented by the Adverse Childhood Experiences (ACE) Study. The ACE Study revealed a 20-year life expectancy gap between individuals with high and low ACE scores demonstrating the profound impact trauma has on morbidity and mortality.[9,10] Recent research confirms that trauma leads to brain dysregulation and chronic stress that negatively affects development, health outcomes and life expectancy.[11,12] A trauma-informed approach prioritizes understanding life experiences and their impact on psychological wellness, physical symptoms and outcomes, treatment adherence and other behaviors to deliver more effective care to patients.

What is Trauma?

Trauma is "an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being."[13] Trauma is experienced in multiple forms and ways including physical, sexual and emotional abuse;

[6] Calhoon, C. (August 2016). Calculating the ROI on Trauma Informed Care Software. Retrieved from https://www.10e11.com/blog/calculating-the-roi-on-trauma-informed-care-software
[7] Baker, C., & Brown, S. (2016) Measuring Trauma-Informed Care Using the Attitudes Related to Trauma-Informed Care (ARTIC) Scale [PowerPoint Slides]. Retrieved from http://traumaticstressinstitute.org/wp-content/uploads/2016/04/ARTIC-Webinars-2016_Final.pdf
[8] Hales, T. W., Nochajski, T. H.., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An Association Between Implementing Trauma-Informed Care and Staff Satisfaction. *Advances in Social Work*, 18(1), 300-312.
[9] Centers for Disease Control and Prevention. (2010, December 17). Adverse Childhood Experiences Reported by Adults – Five States, 2009. MMWR. Morbidity and Mortality Weekly Reports. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm
[10] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, (14)4, 245-258.
[11] Bremner, J. D. (2006). Traumatic stress: effects on the brain. *Dialogues in Clinical Neuroscience*, 8(4), 445-461.
De Bellis, M. D. & Zisk, A. (2014). The biological effects of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 185-222.
[12] McEwan, C. A. & Gregerson, S. F. (2019). A Critical Assessment of the Adverse Childhood Experiences Study at 20 Years. *American Journal of Preventive Medicine*, 56(6), 790-794.
[13] SAMHSA. (2019). Trauma and Violence. Retrieved from https://www.samhsa.gov/trauma-violence

interpersonal violence; impacts from natural disasters; neglect; serious illness; surviving or witnessing violence; historical trauma; bullying; military trauma and war; racism; and forced displacement, among others.[14,15] Pervasive and long-lasting, trauma can be experienced at any level, have community-wide effects and pass through generations resulting in historical or cumulative trauma.[16]

Trauma is widely prevalent across populations in the United States. Public health surveillance data collected from 23 states over four years showed that approximately 61 percent of adults experienced at least one ACE and nearly 25 percent experienced three or more ACEs.[17] In 2016, it was estimated that 46 percent of youth age 17 and younger experienced at least one traumatic event.[18] While all populations are affected by trauma, certain groups experience trauma at higher rates than the general population, including individuals who identify as Black, Hispanic or multiracial; individuals with incomes of less than $15,000 per year; and unemployed individuals.[19] Additionally, youth who identify as lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ) experience trauma at higher rates than youth who identify as heterosexual.[20] Urban populations show higher rates of trauma, with one study documenting that 83 percent of youth living in urban areas experienced at least one traumatic event.[21] Populations that have suffered discrimination, racism, slavery, genocide, war, forced migration and other forms of oppression are more likely to experience cumulative trauma. An in-depth analysis of the research on trauma can be found in a literature review compiled by Kaiser Permanente and the National Council.

"Trauma"

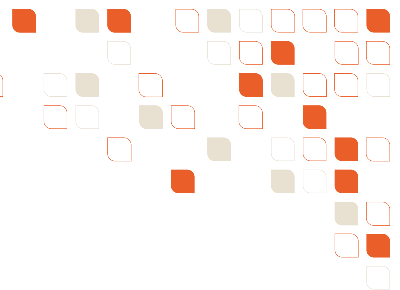
In medical settings, trauma commonly refers to severe physical injuries that require immediate emergency response; however, when applied to trauma-informed care, it encompasses a range of physical, emotional and psychological events and effects across all domains of human functioning.

Individuals with four or more ACEs were:

- 2 times more likely to **smoke**
- 10 times more likely to **inject illicit drugs**
- 7 times more likely to **misuse alcohol**
- 12 times more likely to **attempt suicide**

---

[14] National Child Traumatic Stress Network. (2018). Types of Traumatic Stress. Retrieved from http://www.nctsn.org/trauma-types
[15] SAMHSA. (2016, March 2). Types of Trauma and Violence. Retrieved from https://www.samhsa.gov/trauma-violence/types
[16] Stevens, S., Andrade, R., Korchmaros, J., & Sharron, K. (2015). Intergenerational Trauma Among Substance-Using Native American, Latina, and White Mothers Living in the Southwestern United States. *Journal of Social Work Practice in the Addictions*, 15(6), 6-24.
[17] Merrick, M. T., Ford, D. C., & Ports, K. A. (2018). Prevalence of Adverse Childhood Experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatrics*, 172(11), 1038-1044.
[18] Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences nationally, by state, and by race/ethnicity. Child Trends Publication #2018-03. Retrieved from https://www.childtrends.org/
[19] Merrick, M. T., Ford, D. C., & Ports, K. A. (2018). Prevalence of Adverse Childhood Experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatrics*, 172(11), 1038-1044.
[20] National Child Traumatic Stress Network. (2015). LGBT Issues and Child Trauma. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/safe_spaces_safe_places_flyer_2015.pdf
[21] Collins, K., Connors, K., Donohue, A., Gardner, S., Goldblatt, E., Hayward, A., . . . Thompson, E. (2010). Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions. Family Informed Trauma Treatment Center. Retrieved from https://www.nctsn.org/sites/default/files/resources/resource-guide/understanding_impact_trauma_urban_poverty_family_systems.pdf



"Resilience"

A trauma-informed approach that not only identifies traumatic experiences among patients but builds resilience by identifying and supporting protective factors at the individual and community levels.

What is Resilience?

Resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress."[22] Most individuals can foster hope and strengthen resilience to "bounce back" after experiencing trauma. There are several factors that contribute to increased resilience and hope for adults and protective factors among children,[23] including caring and supportive relationships, capacity to manage strong feelings and emotions and communication and problem-solving skills, among others. In addition to individual resilience, resilience occurs at the community level.

Community resilience is a "measure of the sustained ability of a community to utilize available resources to respond to, withstand and recover from adverse situations."[24] Primary care organizations can identify and strengthen patient and community resilience factors, which are key components of a trauma-informed approach. Strategies, tools and resources to measure and build resilience exist throughout the Change Package.

What is a Trauma-Informed Approach?

A trauma-informed approach provides an organizational structure and treatment framework that embeds the six principles of trauma-informed care (see Table 1) into practice and services.[25]

---

[22] American Psychological Association. (2018). The Road to Resilience. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx
[23] Ibid.
American Academy of Pediatrics. (2018). Promoting Resilience. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx
[24] RAND Corporation. (2019). Community Resilience. Retrieved from https://www.rand.org/topics/community-resilience.html
[25] SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services Publication No. (SMA) 14-4884.

Table 1. Six Principles of a Trauma-Informed Approach[26,27]

PRINCIPLE	DEFINITION	EXAMPLES IN PRACTICE
Safety	Ensuring physical and emotional safety among patients and staff.	• Allow patients to define safety and ensure it is a high priority of the organization. • Create calm waiting areas and exam spaces that are safe and welcoming. • Respect privacy in all interactions.
Trustworthiness and Transparency	Conduct operations and decisions with transparency with the goal of building and maintaining trust with patients, family members and staff.	• Provide clear information on services. • Ensure informed consent. • Schedule appointments consistently.
Peer Support and Mutual Self-help	Promote recovery and healing by valuing and applying lived experience of peers and individuals with trauma histories.	• Facilitate group and partner interactions for sharing recovery and healing from lived experiences. • Include peer supporters in health teams as navigators.
Collaboration and Mutuality	Make decisions in partnership with patients and encourage shared power between patient and provider.	• Give patients a significant role in planning and evaluating services.
Empowerment, Voice and Choice	Patients retain choice and control during decision-making and patient empowerment with a priority on skill building.	• Create an atmosphere that allows patients to feel validated and affirmed with each contact. • Provide clear and appropriate messages about patients' rights, responsibilities and service options.
Cultural, Historical and Gender Issues	The organization embeds principles of diversity, equity and inclusion to deliberately move past cultural stereotypes and biases and incorporate policies, protocols and processes that are responsive to the racial, ethnic, cultural and gender needs of patients served.	• Ensure access to services that address specific needs of individuals from diverse cultural backgrounds. • Display messages in multiple languages to ensure everyone feels welcome. • Provide gender responsive services. • View every policy, practice, procedure and interaction through a lens of diversity, equity and inclusion.

[26] Adapted from SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services Publication No. (SMA) 14-4884

[27] Trauma-Informed Community Initiative of Western New York. (2017). Retrieved from http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/community-partnerships-initiatives/trauma-informed-community-initiative.html

How to Use This Change Package

This Change Package outlines a framework for implementing a trauma-informed initiative within your primary care organization. The framework includes guidance for adopting foundational change management strategies. Address these **first** to create optimal conditions for change. The framework also includes five trauma-informed areas for action or **Change Concepts** (see Table 2. Framework for Implementing Trauma-Informed Approaches in Primary Care) to address after initiating the change management strategies.

STEP 1
Change Management Strategies

STEP 2
Change Concepts 1-5

The five Change Concepts are generally addressed in the order they are presented; however, it is important to prioritize and implement the components of the Change Package in response to the result of your organizational self-assessment (OSA), internal and external priorities and market influences. Not all included recommendations will apply for every organization. As you read the Change Package, focus on each of the Change Concept Action Steps. It is likely that you will not fully complete one Change Concept before moving on to the next. This is a multi-step process implemented over time and Action Steps in one Change Concept may influence action in another.

Table 2. Framework for Implementing Trauma-Informed Approaches in Primary Care

STEP 1: CHANGE MANAGEMENT STRATEGIES: CREATE THE CONDITIONS FOR SUCCESSFUL CHANGE	
STEP 2: TRAUMA-INFORMED ACTIONS – CHANGE CONCEPTS 1 THROUGH 5	
Change Concept 1	Help all individuals feel safety, security and trust.
Change Concept 2	Develop a trauma-informed workforce.
Change Concept 3	Build compassion resilience in the workforce.
Change Concept 4	Identify and respond to trauma among patients.
Change Concept 5	Finance and sustain trauma-informed approaches in primary care.

Action Steps, Implementation Tools and Goals support each Change Concept (see Table 3). Within each Change Concept there are also Key Considerations to help assess if you would benefit from taking additional planning steps prior to implementing the Action Steps. Review the Action Steps within each Change Concept to assess what additional resources or steps your organization will need to take prior to acting. Tips, checklists and other resources throughout the Change Package will guide your implementation efforts. A complete list of resources is available in Appendix A: Additional Resources for Implementation and the Trauma-Informed Primary Care Action Items Checklist provides an easy reference for the Change Concept Action Steps. Leaders in primary care and behavioral health tested and shared these recommendations.

Table 3. Elements of the Change Package

Element	Description
Action Steps	Appear at the beginning of each section and detail planning and implementation steps.
Change Concept Goals	Appear at the beginning of each Change Concept section and outline the objectives for that action.
Implementation Tools	Guide the Core Implementation Team (CIT) to successfully implement the action steps and recommendations.
Key Considerations	Questions for the CIT to resolve to guide implementation efforts.
Checklists	Items that facilitate application such as Implementation Tools for each Change Concept.
Quick Tips	Quick insights into different approaches and ideas for implementation.
Sample Scripts	Examples of dialogue you may want to use in your organization.
Case Examples	Real-world examples of trauma-informed approaches.

Who Should Use This Change Package?

This Change Package is for a Core Implementation Team (CIT) in primary care organizations planning to implement trauma-informed approaches. The CIT will lead planning and implementation efforts and consists of members who represent the diversity of the organization and are motivated and empowered to implement change. See Change Management Strategies: Create the Conditions for Change for more guidance on CITs.

This Change Package recognizes the breadth of diversity across primary care related to organizational size, setting, populations served, level of behavioral health integration and staff composition and provides recommendations for primary care organizations that have onsite behavioral health clinicians and those that do not. All types of primary care settings can benefit from this guidance, regardless of their size, level of behavioral health integration or past progress in advancing trauma-informed approaches.

Trauma-Informed Primary Care Action Items Checklist

STEP 1: CREATING THE CONDITIONS FOR CHANGE

Change Management Strategies

- ❑ Develop a CIT.
- ❑ Ensure continued support from leadership.
- ❑ Educate CIT members.
- ❑ Conduct an OSA.
- ❑ Align trauma-informed initiative with existing organizational initiatives.
- ❑ Communicate to stakeholders for engagement and support.
- ❑ Develop a plan.
- ❑ Monitor progress.

STEP 2: AREAS OF ACTION

Change Concept 1: Help All Individuals Feel Safety, Security and Trust

- ❑ Conduct an environmental assessment.
- ❑ Assess patient safety.
- ❑ Establish trauma-informed rooming policies.
- ❑ Foster trust through trauma-informed patient interactions.
- ❑ Provide universal education materials.
- ❑ Ensure staff safety.

Change Concept 2: Develop a Trauma-Informed Workforce

- ❑ Provide training to all staff on trauma-informed principles.
- ❑ Build an organizational culture of diversity, equity and inclusion.
- ❑ Provide trauma-informed supervision and staff support.
- ❑ Recruit staff who will succeed in a trauma-informed environment.
- ❑ Develop and implement workforce policies that support trauma-informed approaches.

Change Concept 3: Build Compassion Resilience in the Workforce

- ❑ Educate and train staff on symptoms of common workforce concerns.
- ❑ Create a culture of compassion resilience.
- ❑ Implement policies and procedures to build staff resilience.
- ❑ Provide time and resources for staff to process difficult situations.
- ❑ Encourage staff assessment of wellness practices.
- ❑ Encourage staff to develop and implement self-care plans.

Change Concept 4: Identify and Respond to Trauma Among Patients

- ❑ Prepare for trauma inquiry and response.
- ❑ Inquire for and respond to recent trauma requiring immediate intervention.
- ❑ Conduct inquiry for past trauma.
- ❑ Respond to trauma disclosure.

Change Concept 5: Finance and Sustain Trauma-Informed Approaches in Primary Care

- ❑ Identify all planned, new and existing activities and procedures resulting from implementation of trauma-informed approaches.
- ❑ Measure trauma-informed activities.
- ❑ Identify nonfinancial resources for support.
- ❑ Analyze policy landscape and select an advocacy goal to support financing and sustainment.
- ❑ Develop and tailor advocacy messaging for identified stakeholders.
- ❑ Sustain a trauma-informed approach.

STEP 1

Change Management Strategies: Create the Conditions for Change

Implementing change in any organization can be challenging. This is especially true in fast-paced settings that rely on precise time management to be effective and efficient. This section provides Action Steps and Implementation Tools to create optimal conditions for moving your organization's trauma-informed initiative forward.

Action Steps

- ❑ Develop a CIT.
- ❑ Ensure continued support from leadership.
- ❑ Educate CIT members.
- ❑ Conduct an OSA.
- ❑ Align trauma-informed initiative with existing organizational initiatives.
- ❑ Communicate to stakeholders for engagement and support.
- ❑ Develop a plan.
- ❑ Monitor progress.

Implementation Tools

- Trauma-Informed Primary Care CIT Checklist
- Agency-wide Communication Checklist
- OSA
- OSA Action Planning Workbook
- OSA Tutorial
- Trauma-Informed Primary Care Initiative Alignment Tool
- Key Factors to Successful Leadership
- Communicating for Buy-in Tool
- SMART Action Planning Tool

DEVELOP A CORE IMPLEMENTATION TEAM

The first step in the change process is to form a CIT that drives the work of the trauma-informed initiative. This Change Package is for the CIT to help lead the planning and execution of the project's change management strategies and five Change Concepts.

CIT Membership

Because trauma-informed practice involves staff at all levels, it is important that membership includes representatives from all levels of the organization. A successful CIT is comprised of champions in the organization who are willing to take on initiatives even when the directive is not clear, are strong communicators and are social leaders among staff. To help minimize and prevent burnout on the CIT, consider including individuals who are working on different initiatives within the organization to evenly distribute work so that a small group of staff is not overburdened with many initiatives. Table 4 contains recommended membership and responsibilities for your CIT.

Table 4. Example CIT Members and Responsibilities

TEAM MEMBER	RESPONSIBILITIES
Project Lead	Acts as communication liaison across team and as the internal champion of change (e.g., clinical executive, primary care clinician with leadership authority or executive backing). The CIT should include one or more people to carry out the change and someone in a supervisory role to ensure change implementation.
Quality Improvement Lead	Ensures accurate data collection and develops workflow for collection and communicating data (e.g., staff from information technology or quality improvement).
Clinical Lead (including behavioral health clinicians, as available)	Supports care integration and coordination in operations and for patients in need of specialized behavioral health care. May be internal staff or external referral partner (e.g., director or empowered clinician of behavioral health, social services).
Trauma-Informed Champions from Executive, Human Resources, Primary Care and/or Behavioral Health Teams	Supports functional implementation and integration of trauma-informed care into organizational culture.
Individuals with Lived Experience	Individuals with lived experience provide unique and valuable contributions in every stage of planning, implementation and assessment of a trauma-informed approach.

Demands on time and effort make it difficult to organize an optimal team. Only include people who have the interest and time to contribute meaningfully to the project. You may need to adjust your goals, time frames and scope to align with the capacity of the organization and the CIT.

Key Considerations for Choosing CIT Members

- Are there members from leadership positions who are responsible for guiding change processes?
- Do members represent all levels of the organization?
- Is the voice of lived experience represented on the CIT?
- Will members carry out the change in their day-to-day activities?
- Are members involved that will provide trauma-related services (e.g., behavioral health specialists and clinicians)?
- Are members able to access resources to support the ongoing adoption of trauma-informed approaches?
- Are members highly committed to the aims of the change?
- Have all members learned what trauma is, its impacts and its prevalence?
- How will your team explain trauma-informed primary care to others?

ENSURE CONTINUED SUPPORT FROM LEADERSHIP

Throughout the planning and implementation process it is critical to grant the CIT authority to make decisions and take action. The CIT provides on-the-ground support by carrying out the planning, implementation, monitoring and quality improvement steps. Executive leadership removes any barriers to progress and provides the required approval, resources and support to enact the changes in the organization.

Trauma-Informed Leadership

The concept of trauma-informed leadership provides a holistic approach that incorporates the day-to-day tasks of management and the relationship-based skills that facilitate the culture shift needed to change organizational norms, policies, practices, procedures and structure. This framework includes the core principles of trauma-informed approaches, adaptive leadership skills, fostering supportive environments and implementation strategies for organizational change. Monitoring and measuring trauma-informed leadership factors is a useful process to assess the strength of leadership efforts as they relate to adopting trauma-informed principles. Please see The National Council's Framework for Trauma-Informed Leadership to help assess successful leadership in your organization.

Key Considerations for Ensuring Continued Support from Leadership

- Is the organization's leadership visibly supportive of all trauma-informed approach efforts?
- Is leadership willing to remove barriers to implementation, such as freeing up casework, so team members can meaningfully contribute to the initiative?
- Is the governing board engaged and knowledgeable about a trauma-informed approach?
- Are trauma-informed principles part of the organization's vision and mission?
- Are trauma-informed principles embedded in the organization's strategic plan?

EDUCATE CIT MEMBERS

After assembling the CIT, provide education to team members on the principles of a trauma-informed approach and how implementing a trauma-informed approach will impact patients, staff and the entire organization. See Change Concept 2: Develop a Trauma-Informed Workforce for a more in-depth discussion of training.

CONDUCT THE ORGANIZATIONAL SELF-ASSESSMENT

Conducting the OSA provides the CIT with a better understanding of how the organization currently aligns with trauma-informed primary care principles and practices. The OSA is a performance improvement tool designed to help engage primary care organization in a self-reflective process specific to becoming a trauma-informed organization. This process:

- Reinforces activities and interventions that are working.
- Identifies opportunities to change activities that are not working.
- Identifies new activities to advance efforts to become a trauma-informed care organization.

Case Study:
Colorado Coalition for the Homeless

The Colorado Coalition for the Homeless successfully surveyed one-third of its entire organization (200 of 600 employees) when completing the OSA. Before distributing the tool among staff, the CIT and organizational leadership led previous efforts throughout the organization to integrate trauma-informed primary care approaches, including past surveys and trainings. These efforts helped build trust with staff that their input would be anonymous and valued. Because they spent time ensuring staff understood what they were asked to do and how they would use their responses, staff was eager to provide feedback using the OSA.

The OSA questions provoke critical thinking about how you design and deliver your services and the underlying philosophies that define your organization's culture. Unlike a simple checklist to determine fidelity to a clinical guideline or set of accreditation standards, the OSA provides the questions necessary to structure a trauma-informed approach workplan using the OSA Action Planning Workbook.

Results from the OSA will inform the CIT's priorities and action steps as they develop an implementation plan. Repeat this process on an annual basis. The data from each OSA should be in the same workbook to help the CIT track implementation progress over time.

The Organizational Self-assessment (OSA) Tutorial provides step-by-step guidance for conducting the OSA, utilizing the OSA Action Planning Workbook and communicating the results.

Key Considerations for Completing the OSA

- Have you decided who will complete the OSA?
- How will you explain the OSA and why it's important for participants to complete?
- Have you sent the OSA to those chosen to take it?
- Have you provided two-to-three weeks for participants to complete the OSA?
- How will you communicate the results of the OSA outside the CIT?
- After putting your aggregate results in the OSA Workbook, what key indicators stand out as possible Action Steps to support implementation?
- What can you learn from the highest and lowest values and those with the largest discrepancies?

ALIGN TRAUMA-INFORMED INITIATIVES WITH EXISTING ORGANIZATIONAL INITIATIVES

To reduce the challenges of adding another initiative to an organization, the CIT should utilize the Initiative Alignment Tool to identify existing initiatives that align with implementing a trauma-informed approach. Organizations should consider areas of overlap and ways to avoid "reinventing the wheel." The results of this assessment will help determine how to strategically align change processes within an organization.

Case Study:
Oregon Health and Science University, Family Medicine at Richmond Clinic

Oregon Health and Science University, Family Medicine at Richmond Clinic transitioned an existing committee where staff could voice their opinions and concerns to a CIT when starting their trauma-informed primary implementation. The CIT opened its meetings to all staff, created common language and literacy on trauma-informed care, provided monthly trainings and provided a space for staff to voice concerns and issues. The clinic found that the CIT's activities were extremely important to the success of the initiative because, "if they aren't a trauma-informed workplace, they can't perform trauma-informed care."

COMMUNICATE TO STAKEHOLDERS FOR ENGAGEMENT AND SUPPORT

To gain support from leadership and other stakeholders it is important to communicate about the trauma-informed initiative in an effective manner. Understanding the needs and priorities of the leadership team and other stakeholders, such as patients, staff and community partners will help the CIT develop a tailored approach that will resonate for each audience.

Messaging Quick Tips

- Align trauma-informed care with the overall mission and values of the organization.
- Clearly identify the resources necessary for the initiative to be successful.
- Explain the expected outcomes of the initiative for patients, staff and the community.

Case Study:
Colorado Coalition for the Homeless

The Colorado Coalition for the Homeless developed an internal communication strategy to gain support from staff and create shared understanding of trauma-informed primary care. The CIT wanted to ensure their communication methods met the needs and interests of their audience — their staff. Their internal communication strategy included bite-sized content with short monthly blurbs in staff communications about the five Change Concepts that could be read in 10-15 seconds, fliers in staff areas and unified messages about trauma-informed primary care approaches disseminated by supervisors.

There are several important questions to consider, such as the "who, what, where, when and why" that will make communication more effective and result in better engagement. Additionally, using different forms of media and communication tools is important for engagement. The Communicating for Buy-in Tool will help the CIT answer the following checklist questions:

Key Considerations for Communicating for Engagement and Support

- ❑ Why are you proposing the initiative for the organization?
- ❑ Who are the stakeholders?
- ❑ What culturally relevant factors will be considered?
- ❑ What key points are likely to align with the felt needs, concerns or desires of the stakeholders?
- ❑ When will you deliver the message to keep stakeholders continuously engaged?
- ❑ Where will you deliver messages?
- ❑ How will you deliver messages?
- ❑ What are your expected outcomes and how will you measure them?

DEVELOP A PLAN

One of the CIT's main priorities is to develop a detailed implementation plan in response to the OSA that is adapted to the unique needs and resources of the primary care organization. This plan should include:

1. Reasonable and feasible goals. | 2. Actions steps towards achieving the goals.

The CIT uses the results of the OSA to choose one or more of the goals listed under a Change Concept. After choosing a goal, the CIT can clarify how their current policies, processes and procedures relate to the chosen goal. In this way, you may be able to leverage or adapt well-established approaches within the organization to support making progress on your goal. The OSA Tutorial contains detailed guidance.

A Practical Toolkit for Adopting Trauma-Informed Approaches in Primary Care is a useful tool to guide goal identification and development that is a modification of the Plan, Do, Study, Act model adapted specifically for implementing trauma-informed approaches in primary care settings.[28]

Key Considerations for Developing a Plan[29]

- What were the results of the OSA related to your selected change concept-related goal?
- Was this a relative strength or area that needed considerable improvement in relation to the other change concepts?
- What organizational policies may you need to change as a result of the goal you selected?
- What practices and/or workflows are related to or affected by the goal you selected?
- What routine procedures are related to or affected by the goal you selected?

Table 5. SMART Action Steps

Action Step Considerations	
S	Specific and Strategic
M	Measurable
A	Attainable
R	Relevant
T	Timeframe

After the CIT identifies its goals, the next step is to develop Action Steps, an important way to measure progress. Interim, short and medium-term Action Steps help your CIT stay focused and organized and will identify successes to celebrate along the way. Teams should develop SMART goals. Table 5, provides questions that will guide you when developing SMART action steps.

The SMART Action Planning Tool is a useful tool to assist with the Action Plan for your trauma-informed initiative.

[28] Salerno, A. (2018). A Practical Toolkit for Adopting Trauma Informed Approaches in Primary Care. Developed for the National Council for Mental Wellbeing.
[29] Ibid.

MONITOR PROGRESS

It is critical that the CIT develop progress indicators related to each chosen goal and check, study and monitor these indicators to ensure the team has the needed information to evaluate progress and take appropriate action. The OSA Workbook facilitates performance monitoring through sample performance monitoring indicators and a tab for tracking progress. Table 6, provides a partial list of potential performance indicators to consider depending on organizational goals.

Table 6. Sample Performance Monitoring Indicators

CHANGE CONCEPT	PERFORMANCE MONITORING INDICATORS
1. Help All Individuals Feel Safety, Security and Trust	• Active team that is responsible for assuring a safe, secure and trusting physical and interpersonal environment. • Trauma-Informed care (TIC) related informational materials for patients, staff and partners. • Trauma-Informed (TI) strategic plan with clear commitment to TI organizational culture and communication of process to patients, staff and partners.
2. Develop a Trauma-Informed Workforce	• Formalized HR hiring process including integration of TI principles and code of conduct into job descriptions, job announcements, hiring and on-boarding process. • All processes related to workforce development (including hiring, orientation, training and ongoing professional development) are culturally and linguistically appropriate (adoption and integration of CLAS Standards). • Informal HR practices re: managing work-related stress.
3. Build Compassion Resilience in the Workforce	• A policy/procedure on reviewing adverse incidents by the safety team as part of the continuous quality improvement (CQI) process. • A policy/procedure regarding appropriate response to workforce concerns (burnout, secondary traumatization and compassion fatigue). • A policy/procedure for supporting patients with the regulation of their emotions and/or physical responses.
4. Identify and Respond to Trauma	• Observable behaviors and practices that demonstrate a policy/procedure that describes the mechanism and frequency for trauma assessments. • Observable behaviors and practices that demonstrate a policy/procedure that describes a system to collaborate with other treatment providers to coordinate services for patients, when needed. • Observable behaviors and practices that demonstrate a policy related to the identification of and response to trauma in culturally and linguistically appropriate ways (adoption and integration of CLAS Standards).
5. Finance and Sustain Trauma-Informed Initiatives	• Documentation in medical record of patient connection with social, religious, cultural and other community social resources that align with patient interests and needs as a routine part of care. • Consistent engagement and discussion around TI approaches with community stakeholders. • Consistent messaging and discussion about TI practices within the organization.

Key Considerations for Monitoring Progress

- What part of the plan worked well?
- What didn't work well?
- What was surprising?
- What assumptions did you make that were accurate and not accurate?
- Do you need to do things differently?
- Do you need to put the next action steps on hold until you make needed changes?
- If it is too early to tell what needs to change? Should we continue the process and give it more time?

Based on findings and answers to these questions, the CIT should take action to ensure they continue to make progress and/or revisit the initial plan.

Actions will likely reflect one of the following:

- Continue with the implementation that is working. Focus on sustaining gains or addressing another workforce development standard.
- Change or modify aspects of the implementation.
- Abandon or stop the process and analyze implementation barriers.
- Start over and explore what is not working and what other domain and/or approach is likely to be more successful.

Once the organization has found a practical and effective improvement approach, the CIT and leadership may decide to establish a formal policy to sustain the trauma-informed related change.

STEP 2

Change Concept 1: Help All Individuals Feel Safety, Security and Trust

Creating safe, secure and trusting environments enhances the ability of health care staff to provide services in a nontraumatizing manner and supports the health and wellness of employees and patients.[30] A trauma-informed organization strives to address psychological, emotional and physical safety in policy and practice and makes an effort to ensure patients, family members and staff feel safe at all times.[31]

Quick Tip: Safety

Safety, in the context of a trauma-informed approach, encompasses physical and psychological safety, which are equal priorities when creating a trauma-informed environment.

Action Steps

- ❑ Conduct an environmental assessment.
- ❑ Assess patient safety.
- ❑ Establish trauma-informed rooming policies.
- ❑ Foster trust through trauma-informed patient interactions.
- ❑ Provide universal education materials.
- ❑ Ensure staff safety.

Implementation Tools

- Hotspots for Retraumatization or Activation for Patients Worksheet
- Environmental Assessment for Trauma-Informed Care
- Safe and Secure Environment Survey — for Patients
- Safe and Secure Environment — for Children and Adolescent Patients
- Psychoeducational Tools
    - o What do I say? Talking About What Happened with Others
    - o Helping my Child Cope: What Parents Can Do
    - o Video: What is Trauma-Informed Care?
    - o 10 Key Ingredients for Trauma-Informed Care
    - o Encouraging Staff Wellness in Trauma-Informed Organizations
    - o Resources from Echo
- Template Psychoeducational Materials
- 20 Questions for Leaders About Workplace Psychological Health and Safety
- Staff Feedback Survey

Change Concept 1 Goals

1. Our primary care service team adequately addresses the three components of comprehensive safety: Psychological, emotional and physical.
2. Our primary care service team ensures a safe and secure physical and emotional environment.
3. Patients are engaged in efforts to assess the physical and emotional environment.
4. Our organization has a system in place to evaluate the social and emotional experience of patients and staff.
5. Our primary care service team develops, disseminates and displays TIC-related informational materials.
6. Our primary care service team has strategies to resolve conflict and address aggression between staff and between staff and patients.
7. Processes related to the environment of care are culturally and linguistically appropriate.
8. Our primary care service team promotes physical and emotional well-being through wellness-focused activities.

[30] SAMHSA. (2014b). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801.

[31] Schachter, C. L., Stalker, C. A., Teram, E., Lasiuk, G. C., & Danilkewich, A. (2008). Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual abuse. Public Health Agency of Canada. Retrieved from https://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf

CONDUCT AN ENVIRONMENTAL ASSESSMENT

A full range of sights, sounds, smells, touches and tastes may activate trauma survivors, leading to harmful stress responses, so be aware of the ways the senses are affected by the environment. When you assess physical environments,consider beyond your patient to include staff, family members and other individuals who enter the primary care setting. Addressing the physical space of the health care setting and physical safety of patients is not only good practice for creating a trauma-informed environment; patients prefer it. Additionally, a health care facility's physical environment could influence patient perceptions of the quality of and satisfaction with care.[32]

The CIT should conduct a thorough assessment of the organization's physical space beginning with an individual's first contact with the organization to assess for safety and threats of retraumatization. In addition to assessing for physical safety concerns (e.g., entryway lighting), it is important to focus on the ways that the physical environment impacts patients' psychological and emotional safety. Use the assessment questions included in the tool, Hotspots for Retraumatization or Activation for Patients Worksheet.

Environmental Assessment

A complete environmental assessment is provided to identify environmental improvements in primary care settings.

Case Example:
Stephen and Sandra Sheller, 11th Street Family Health Services

11th Street Family Health Services designed its space to align with trauma-informed principles. Patients enter through a bright atrium and pictures and murals created by community members decorate clinic walls. The entire space is sunlit and decorated with natural materials and textures. The space is open but provides plenty of private meeting places.

11th Street Family Health Services

[32] Reiling, J., Hughes, R. G., & Murphy, M. R. (2008). The Impact of Facility Design on Patient Safety. In R. Hughes (Ed.), Patient Safety and Quality: An Evidence-Based Handbook for Nurses (Chapter 8). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2633/

Attending to the psychological and emotional safety of patients is as important as addressing physical safety. From the first contact with a prospective patient through the patient's engagement with the organization, it should be clear that the health care setting is welcoming and supportive. Psychological and emotional safety draws heavily on both the physical and the interpersonal nature of the environment. Some of the key areas to assess follow.

Initial Greeting by Phone

Within a trauma-informed setting, it's preferable to have a staff person receive phone calls, rather than a messaging service. If you must use an answering device, take steps to pace the message in a way that people in acute distress can understand it and respond appropriately.

Key Considerations for Initial Greetings

- Are staff trained to respond to individuals in distress?
- Is the staff person positive and engaging?
- Does the prospective patient receive a thorough briefing about what to expect at the first visit?
- Are interpretation and translation services available if needed?

Initial Greeting in Person

Assign a designated staff person the important role of greeting patients when they come into the office. It is not always feasible for primary care organizations to have a greeter, but when resources are available, this is an important position to staff. It is important to place the greeter close enough to the door that they're recognized, but far enough away they don't block or crowd the entrance. This initial contact with the organization should establish a sense of welcoming, trust and safety for the patient.

Sample Script

"Hello. My name is Jane Doe and I am here to assist people who may be coming here for the first time or may need some help finding their way around. Is there anything I can do to make your visit easier? Do you need directions to any particular place?"

Initial Intake

The person assigned to do intake, usually a receptionist, has a key role in establishing a consistently safe environment of care. When greeting patients, staff should always communicate in a manner that makes patients feel they are equal to staff and are an equal partner in the process they are about to begin together. One strategy to convey this is to discuss options for care with the patient when possible. Offering individuals choice also helps establish safety. Take time to explain the questions and purpose of the forms they will complete and reassure them that confidentiality requirements protect this information. Overall, make patients feel they are in charge of their own care, that they are the experts regarding their own lives.

Security Staff

While uniformed security staff can provide a sense of safety to patients, for some patients with trauma histories, security staff can cause stress and retraumatization. Make efforts to assess the best ways to integrate security staff into your practice to ensure safety while reducing risk of retraumatization.

Case Example:
Colorado Coalition for the Homeless

Colorado Coalition for the Homeless hires security staff that reflect their patient population and trains security staff as greeters. This can help patients feel like they are more supported by security and can increase a sense of safety.

Quick Tips for Greetings and Intake

- When assisting a patient to another location, ask the patient whether they would like to walk ahead of, behind or beside the staff member escorting him or her. This enforces the trauma-informed principles of empowerment, voice and choice and safety.
- Inform patients of every step in the initial intake and offer them a choice about whether to proceed with any steps that are optional to emphasize the choices they have and the possibility of mutuality in their relationship with the service provider.
- Arranging the examination room to fit patients' general preferences and comfort also reinforces physical and emotional safety.
- Ask patients their preference on who should be in the examination room with them and always allow them an opportunity to meet one-on-one with their provider.

ASSESS PATIENT SAFETY

One way to assess whether patients feel safe is to collect patient satisfaction data and specifically inquire about trauma-informed related practices. This data can be collected in an anonymous and confidential manner using the Safe and Secure Environment Survey.

ESTABLISH TRAUMA-INFORMED ROOMING POLICIES

Empower patients to choose who is or is not present with them during their visit. Some patients will feel safer meeting with the provider one-on-one, while other patients will prefer having a friend or family member with them for support. It is important that primary care organizations establish policies that prioritize patient choice to help patients feel safe in the exam room.

Providing a patient the opportunity to meet with his or her provider one-on-one in a private area to discuss confidential matters is an essential step in implementing a trauma-informed approach. Kaiser Permanente found a 100 percent increase in identifying domestic violence among patients after implementing a one-on-one screening policy at each visit.[33] It is important that all patients have an opportunity to meet with their provider alone.

Sample Notice to patients and family members could include:[34]

"The confidentiality of the patient-doctor relationship is important to us. That's why we ask family members and friends to remain in the waiting area during patient examinations. Afterward, you may invited family or friends into the exam room, at the patient's request."

[33] Carlson, K. L. (2012, March 30). Rooming Alone: How to implement a policy by engaging your staff. National Conference on Healthcare and Domestic Violence. Kaiser Permanente.
[34] Ibid.

FOSTER TRUST THROUGH TRAUMA-INFORMED PATIENT INTERACTIONS

Earning trust and building positive relationships with patients are essential pillars of a trauma-informed approach to build a therapeutic relationship. There are several policies and practices providers and organizations can apply that help foster open communication, trust and sense of safety between providers and patients, including prioritizing conversation over accomplishing a checklist, engaging in collaborative documentation and conducting trauma-informed physical exams.

Prioritize Conversation

Primary care and other health care providers have a limited amount of time with each patient and often need to complete a checklist of items during each appointment. This can result in a provider interacting with a patient in front of an electronic health record or running through a mental checklist of items to discuss during the visit. Having a conversation with patients rather than accomplishing the checklist facilitates open dialogue and builds trust. Individuals with trauma histories are more likely to reveal underlying causes of other conditions if they feel heard and respected rather than rushed during an appointment.

Case Example:
Richmond Behavioral Health Authority

The Richmond Behavioral Health Authority plans to incorporate a PowerPoint presentation displayed on waiting room monitors to provide information on trauma to patients. The goal is to transform the waiting room into a safe space for patients and encourage patients to have a conversation about their concerns with their providers.

Trauma-Informed Physical Exam

The Association of American Medical Colleges developed a trauma-informed physical exam curriculum to guide providers to conduct physical exams in a manner that will not lead to retraumatization.[35] The training slides are included in the training plan in Change Concept 2: Develop a Trauma-Informed Workforce. A trauma-informed physical exam infuses the principles of trauma-informed care throughout the appointment and helps level the power differential between provider and patient. For patients with histories of trauma, it can be reassuring to know what will happen during the exam and why. Always ask for permission to conduct the components of the exam using simple, clinical language, particularly when the exam requires physical contact with the patient. Always use professional touch during a physical exam.[36]

---

[35] Elisseou S, Puranam S, Nandi M. A novel, trauma-informed physical examination curriculum for first-year medical students. MedEdPORTAL. 2019;15:10799. Retrieved from https://www.mededportal.org/publication/10799/.
[36] Ibid.

While taking notes during the appointment, acknowledge that patients with histories of trauma may feel uncomfortable not knowing what someone is writing about them. Consider utilizing collaborative documentation strategies and allow patients to add comments to the notes. Collaborative documentation results in high patient satisfaction, improved clinical outcomes, improved engagement, decreased length of treatment episodes and ensures immediate patient feedback.[37,38] It is important to note that you should always exercise clinical judgment and that collaborative notetaking will not be appropriate during every session.

Collaborative Documentation

A practice where the clinician and patient document together during the session.

Quick Tips for Patient Interactions

- Always ask permission before doing anything that involves or will impact the patient.
- Explain why you are doing what you are doing.
- Avoid looking at a computer or device while engaging with patients.
- Apply trauma-informed principles to tools and use tools adapted for individuals with histories of trauma, including the trauma-informed physical exam tool.
- Get immediate feedback from patients by using postcard-sized anonymous surveys they can leave in a box on their way out of the office or by sending a survey via email.

PROVIDE UNIVERSAL EDUCATION

Universal education provides easy-to-understand information to all patients, usually through post-card sized handouts, pamphlets or posters. Providing universal education materials offers an opportunity to inform patients, families, staff and partners about trauma and its impacts and encourages patients to initiate a conversation about trauma. A simple postcard-sized handout with information about trauma, its impact and the services and resources available for individuals can be a valuable tool. Futures Without Violence offers a range of free digital and hard copy universal education materials, including posters. Templates for universal educational materials can help clinics start to create their own materials. Educational materials should also disclose the limits of confidentiality (e.g., mandatory reporting laws). All universal education materials should provide support and information on how to access resources and services.[39]

[37] Lloyd, D. (2004). Concurrent Documentation: A Case Study. Retrieved from https://www.abhmass.org/images/msdp/manuals/concurrentdocumentation/concurrent_documentation_article_revised_1-20-04.pdf
[38] Maniss, S. & Pruit, A. G. (2018). Collaborative Documentation for Behavioral Healthcare Providers: An Emerging Practice. *Journal of Human Services: Training, Research, and Practice*, 3(2). Retrieved from https://scholarworks.sfasu.edu/cgi/viewcontent.cgi?article=1045&context=jhstrp
[39] Chamberlain, L., & Levenson, R. (2016). Happy Moms, Happy Babies: A Train-the-Trainers Curriculum on Trauma Informed Domestic Violence Programming and Practice. Retrieved from https://www.futureswithoutviolence.org/wp-content/uploads/HMHB-and-RAT-Webinar-Final.pdf

Sample Script

"I give these to all of my patients."

ENSURE STAFF SAFETY

Many features that make environments safe, secure and trusting for patients are the same for staff. For example, it is important that staff feel safe entering the building, don't encounter harsh sounds or smells that could activate a stress response and feel empowered and heard. It is important that staff have a quiet space to relax, meditate or simply take a break. There should also be a safe and effective method for staff to report any verbal or physical altercations that occurred during their shift. Make an effort to prevent secondary trauma as discussed in Change Concept 3: Prevent and Address Burnout and Secondary Trauma Among Staff. A critical component in maintaining a safe environment for staff is ensuring a consistent process for soliciting and responding to staff feedback on this issue. Use the Staff Feedback Survey to operationalize and embed this into your existing continuous quality improvement process.

Case Study:
Colorado Coalition for the Homeless

Colorado Coalition for the Homeless hired a safety officer to oversee all safety operations, policies and procedures and monitor guards and safety issues across the organization. The officer's initiatives include developing new policies on staff harassment, providing trainings to share with staff (e.g., how to ride in a car with patients) and implementing a stress debriefing team.

Key Considerations for Establishing Safety, Security and Trust

- What policies exist related to who is in the exam room?
- How are security staff best integrated into the organization?
- Are the steps in the visit described to patients beforehand?
- When is permission sought from the patient throughout the visit?
- How is feedback sought from patients and staff?

Change Concept 2: Develop a Trauma-Informed Workforce

An educated, sensitive, effective and supported workforce is the cornerstone of a trauma-informed organization. The quality of interpersonal relationships and interactions among patients, providers and support staff defines the core of a fully trauma-informed and resiliency-building primary care organization.

Action Steps

- ❑ Provide training to all staff on trauma-informed principles.
- ❑ Build an organizational culture of diversity, equity and inclusion.
- ❑ Provide trauma-informed supervision and staff support.
- ❑ Recruit staff who will succeed in a trauma-informed environment.
- ❑ Develop and implement workforce policies that support trauma-informed approaches.

Implementation Tools

- Self-care Planning Tools:
  - Fatigue and Resilience in the Wellness Compass
  - Wellness and Resilience Strategies — Mind
- ProQOL
- Trauma and Resilience Training Plan
  - Trauma and its Impacts
  - Trauma and the Connection to Health and Addictions
  - Trauma in the Context of Culture
  - Becoming Trauma-Informed
  - Secondary Traumatic Stress and Staff Self-care
  - Infusing Trauma into our Daily Work
  - Introduction to a Diversity, Equity and Inclusion Initiative
  - Trauma-Informed Supervision
  - For Clinical Staff (Primary Care)
    - Introduction to Inquiry for Trauma
    - Trauma-Informed Physical Examination: Practicing Sensitivity
    - Engaging Families and Support Networks
    - Responding to Crisis in a Trauma-Informed Manner
    - Virtual Patient Case Scenarios for All Physicians and Nurses
- Training Evaluation
- Trauma-Informed Supervisor Assessment
- Checklist for Trauma-Informed Human Resources Practices
- Interview Questions for Trauma-Informed Care
- Hiring Guidelines for Peer Specialists
- Human Resources Policy Toolkit
- Strategies for Addressing Historical and Systemic Trauma
- Trauma-Informed Primary Care Policy Audit Tool

Change Concept 2 Goals

1. Our primary care service team provides staff with training and/or resources on trauma and trauma-informed approaches.
2. Behavioral health staff and appropriate medical personnel are educated about the best practices in assessing, treating and evaluating patients who experience significant trauma.
3. Our primary care service's job announcements include job expectations related to providing trauma-informed care.
4. Performance appraisals include expectations that staff provide trauma-informed care.
5. Processes related to workforce development (including hiring, orientation, training and on-going professional development) are culturally and linguistically appropriate.
6. Our primary care service team is equipped to support patients in engaging their social support network into their care processes.
7. Behavioral health staff and appropriate medical personnel are educated about the best practices in conducting comprehensive strengths' assessments.

PROVIDE TRAINING TO ALL STAFF ON TRAUMA-INFORMED PRINCIPLES

All staff should have a basic understanding of how adverse life events may affect a person's physical and mental health, engagement in services, response to treatment recommendations and satisfaction and success in community life. Trauma-Informed organizations are most successful when all staff understand the underlying theories, research, practices and values of the model. At a minimum, all staff should receive training on what a trauma-informed approach is and why it is important.

This Trauma and Resilience Training Plan establishes procedures to plan, develop, implement and maintain the training program and curriculum. The training plan objectives are:

- Educate all staff on trauma, its prevalence and its effects.
- Provide all staff with tools and strategies to implement a trauma-informed approach into their daily work.
- Connect trauma and health outcomes for all staff.

Requirement and Prerequisites

Require that all staff complete the general trainings identified in this plan, including but not limited to, billing staff, front desk staff, facilities staff, clinical staff and leadership. Provide the intermediate trainings that are specific to clinical staff and leadership after completing all general training sessions.

Strategy and Approach

The Trauma and Resilience Training Plan provides sample in-person trainings for primary care sites to utilize with their staff. You can provide all trainings at one time or break them down into different mini-trainings. Also provide information from the trainings in virtual format, such as webinars. If you don't use the trainings developed by the National Council, cover the topics listed here in staff trainings.

Work to ensure that training on trauma is not retraumatizing for participants. It is important to acknowledge that everyone has experienced some form of trauma and aspects of training could be uncomfortable or retraumatizing for certain staff. The training facilitator should encourage participants to take care of themselves as needed during training and make support available from clinical or leadership staff.

Trauma-Informed Training Checklist

- ❑ Have a plan to meet the needs of staff activated by a training.
- ❑ Inform staff that they are able to step out of the training at any point if they feel it is necessary.
- ❑ Separate staff from direct supervisors during training when relevant for the training topic.
- ❑ Conduct regular check-ins with staff.
- ❑ Announce that there is a point of contact for debriefing.
- ❑ Discuss how to use the organization's employee assistance program or consult about one's insurance plans benefits that are available to staff.

Training Topics

For training to be effective, all staff should receive general training in the foundations of the following:

- Trauma-Informed care and trauma-specific treatment.
- Relevant research on the role of developmental trauma as causes for poor health outcomes.
- Trauma in the context of culture.
- The trauma continuum.
- The long-term impact of trauma and loss on physical and mental health.
- The correlation between trauma and addictions.
- Simple interventions for treating shock, trauma and stress states.
- Self-care skills for all staff.

After completing training in these Training Topics, train all clinical staff on new clinical pathways and workflows, including:

- Introduction to inquiry for trauma.
- Trauma-Informed physical examination — practicing sensitivity.
- Engaging families and support networks.
- Responding to crisis in a trauma-informed manner.
- Virtual patient case scenarios.

All staff responsible for supervision should also receive training on trauma-informed supervision. Table 7 provides a recommended training schedule for staff including links to download training materials.

Table 7. Trauma-Informed Approach Staff Training Schedule

Training Level	Course Name	Location	Duration
Beginner	Trauma and its Impacts	Download	1.5 hours
Beginner	Trauma and the Connection to Health and Addictions	Download	1.5 hours
Beginner	Trauma in the Context of Culture	Download	1.5 hours
Beginner	Becoming Trauma-Informed	Download	1.5 hours
Intermediate	Secondary Traumatic Stress and Staff Self-care	Download	1.5 hours
Intermediate	Infusing Trauma into our Daily Work	Download	1.5 hours
Intermediate	Introduction to a Diversity, Equity and Inclusion Initiative	Download	2 hours
Advanced	Trauma-Informed Supervision	Download	1.5 hours
Trainings for Clinical Staff (Primary Care)			
Beginner	Introduction to Inquiry for Trauma	Download	1.5 hours
Intermediate	Trauma-Informed Physical Examination: Practicing Sensitivity[40]	Download	1.5 hours
Intermediate	Engaging Families and Support Networks	Download	1.5 hours
Intermediate	Responding to Crisis in a Trauma-Informed Manner	Download	1.5 hours
Advanced	Virtual Patient Case Scenarios for All Physicians and Nurses[41] (CEs available — up to 10 hours)	Access	10 hours

[40] Elisseou S, Puranam S, Nandi M. A novel, trauma-informed physical examination curriculum for first-year medical students. MedEdPORTAL. 2019;15:10799. Retrieved from https://www.mededportal.org/publication/10799/.
[41] Aquifer. Trauma-Informed Care: A case-based virtual course. 2019. Retrieved from https://www.aquifer.org/courses/trauma-informed-care/.

Case Study:
Malama I Ke OLa

Malama I Ke Ola successfully implemented a work plan to train all staff on trauma-informed care. Once a month the clinic dedicates one hour to training and schedules no patients during that time so all staff are available to attend. The CIT leads developing content, based on the five Change Concepts and presents to their respective departments. Their goal was to be able to educate their entire clinic on trauma-informed care and why it's important, while simultaneously connecting their everyday work to the Change Package to help them see how this work allows them to do what they already do in a more impactful way.

Training Evaluation

For each training, participants should complete an evaluation and the CIT should aggregate the results. A sample Training Evaluation can be used for each of these trainings.

Sustaining and Promoting Training Outcomes

To sustain training outcomes, organizations should align policies and processes with long-term goals in mind. For example, organizations could employ a train the trainer model with multiple trainers and ensure that training programs outlive staff turnover and attrition. While certain trainings should be mandatory for all staff, also make materials for trainings that are specific to certain departments and roles available to all staff, regardless of their position in the organization.

Organizations should also leverage all opportunities to incorporate trauma-informed principles and practices related to training in other messaging and forms of media. Examples include organizational newsletters, websites, establishing a "trauma-informed tip of the week," standing meetings, lunch and learns and staff huddles.

Case Study:
Willamette Family Services

Willamette Family Services offers agency-wide lunch and learns led by CIT members on topics related to the Change Concepts. They invite all staff and the goal is to create trauma-informed champions and leaders throughout the organization. Strategically scheduled monthly lunch and learns align with other ongoing activities to balance capacity and increase attendance.

BUILD AN ORGANIZATIONAL CULTURE OF DIVERSITY, EQUITY AND INCLUSION

Implementing the principles of diversity, equity and inclusion (DEI) is a critical component of trauma-informed organizations. Several steps and considerations organizations that should take to improve its culture follow.

Building a Culture of Diversity, Equity and Inclusion (DEI) Checklist

- ❑ Provide basic cultural competency training for all staff.
- ❑ Identify and convene a workgroup to lead agency diversity, equity and inclusion efforts.
- ❑ Offer staff workshops on practices to promote equity. Examples of workshops and guides are available online.[42]
- ❑ Provide continuous opportunities for learning and dialog through brown bags, webinars and other outlets.
- ❑ Foster relationships with community partners that integrate the community as a resource to improve care.

Improve Staff Competency Related to DEI Training

- Levels of systemic oppression: individual, institutional and structural.
- Types of trauma: community, historical, intergenerational and systemic.
- Continuum of cultural competency.
- Implicit bias.
- Building a culture of compassion (discussed in more detail in Change Concept 3: Build Compassion Resilience in the Workforce).

Case Study:
Oregon Health and Science University

Oregon Health and Science University plans to offer trainings and hold an open conversation around oppression, racism and implicit bias within their agency. Their goal is to have a humility-centered conversation, acknowledging that this is an issue in health care systems nationwide.

[42] W.K. Kellogg Foundation. 2019. *Racial Equity Resource Guide: Guides & Workshops*. Retrieved from http://www.racialequityresourceguide.org/guides/guides-and-workshops

Develop DEI Organizational Values

Organizations that are committed to ensuring diversity, equity and inclusion among staff and patients alike establish policies and practices that reflect those values, including:

- Continual learning about cultural issues.
- Assuming an equity lens to the work.
- Culturally adapting interventions, tools and resources as needed.
- Addressing implicit bias in program design and service delivery.
- Fostering a culture of compassion.
- Establishing and nurturing bidirectional relationships with community partners that integrate the community as a resource to improve care.

Resources for Building a DEI Culture

- The North Carolina Center for Nonprofits, has webinar recordings available for purchase, including:
    - What's White Got to Do with It: Disrupting Race-based Inequities in Well-intentioned Nonprofits
    - White Supremacy Culture: Treachery and Transformation
- Marshall Rosenberg's Non-violent Communication Curriculum
- The Civility Project's Nine Tools of Civility
- Harvard University's Project implicit bias testing
- Community Catalyst's Best Practices for White-led Organizations to Promote Health Equity and Racial Justice in Health Advocacy

PROVIDE TRAUMA-INFORMED SUPERVISION AND STAFF SUPPORT

A trauma-informed organization assesses and develops workforce policies and practices regarding supervision, support and professional development to reflect trauma-informed principles. Effective supervision of employees helps equalize the power differential and creates a space for employees to feel empowered to speak and know they are heard. Similarly, professional development opportunities include trauma-informed topics and areas in which employees can gain skills driven by employee choice. Most important, provide services and supports to employees to reduce stress, alleviate compassion fatigue and prevent secondary trauma.

The following are key considerations for operationalizing trauma-informed supervision. Both supervisor and staff assessment of how trauma-informed supervision is vital and can be achieved with the Trauma-Informed Supervisor Assessment.

Considerations for Trauma-Informed Supervision, Support and Professional Development[43]

- How does staff have voice and choice in performing their work?
- How do employees provide feedback to the organization?
- How are employees informed of career opportunities?
- How do you show appreciation and recognize staff?
- What structures are in place in the organization to assess and minimize vicarious trauma and compassion fatigue in the workplace?
- How does the organization encourage and support self-care?
- How is change processed and communicated throughout the organization?

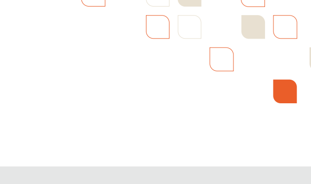
RECRUIT STAFF WHO WILL SUCCEED IN A TRAUMA-INFORMED ENVIRONMENT

A trauma-informed organization benefits from recruiting staff who are familiar with trauma-informed principles. Integrate trauma-informed language and values in all organizational communications including your website, media and patient portal and in recruitment strategies and processes such as developing job descriptions, interviewing candidates and promoting career opportunities within the organization. Sample job description criteria for hiring individuals and a recruitment pre-employment checklist for organizations follow. Sample interview questions are also included.

Sample Job Description Criteria

- Must have a basic understanding of trauma or willingness to learn.
- Must have experience working within a model of trauma-informed care or a desire to do so.
- Must be committed to the following principles: staff and patient safety, trustworthiness and transparency, the value of lived experience, collaboration and mutuality, patient empowerment, belief in the importance of our patients and resilience.
- Must have a strong commitment to promote cultural, racial, language and gender access, diversity, equity and inclusion.

[43] Adapted from Missouri Department of Mental Health. (2017). Retrieved from https://dmh.mo.gov/trauma/



Case Study:
Zufall Health

Zufall Health implemented trauma-informed interview questions into their new hire process. They always ask if the candidate is familiar with trauma-informed approaches and educates the candidates about the agency's commitment to being trauma-informed.

Hire Individuals with Lived Experience

Hiring individuals with lived experiences of trauma not only reflects a commitment to core trauma-informed principles, it also provides an opportunity to add tremendous value to the organization. Individuals with lived experience have unique insight, knowledge, experience and understanding making them well-suited to provide resources and services to patients. Consider individuals with lived experience for positions at all levels. Additionally, CITs benefit from working with and including individuals with lived experience who are already employed in the organization to help facilitate change. Because this may be a new focus within primary care, organizations must be mindful not to tokenize lived experience.

Integrate Peer-based Roles

Behavioral health care settings have utilized peer-based roles including peer recovery specialists, certified peer specialists and peer support specialists. Integrate these roles into primary care as well. In contrast to other types of positions, peer positions require that individuals have lived experience to qualify for employment and a primary component of their role is to provide mutual support to patients and patients through their shared understanding of lived experience. Peer roles vary across organizations and peers often provide a range of valuable services to patients that can include outreach, education, recovery planning and coaching, linking to services and many others.

A toolkit on establishing meaningful roles for peers provided by the California Association of Social Rehabilitation Agencies is helpful for organizations planning peer initiatives and guides on hiring peers and navigating issues related to legal compliance are available. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed core competencies for peers to guide service delivery, job descriptions and performance assessment. While peer support is not yet common in primary care, it is important for primary care organizations to consider adding this role to their workforce. Use these resources to ensure peers are meaningfully employed and supported in their work.

Sample Interview Questions Regarding Lived Experience[44]

- How does your personal and professional background relate to this position?
- Do you have any life experiences that would make you valuable to this program?
- Do you have any experience working with people who have experienced trauma?

Key Considerations for Trauma-Informed Recruitment and Pre-employment[45]

- Does recruitment material describe the job duties and application process in a way that adheres to trauma-informed principles?
- Does recruitment material describe the job duties and application process in a way that promotes diversity, equity and inclusion?
- Do job descriptions include an accurate description of skills and attributes that support a trauma-informed organization?
- How are time frames for interviews and selection communicated to applicants?
- How are applicants not selected for employment informed?
- During the interview process, are applicants provided a safe environment and a safe process for interviewing?
- How is the process and purpose regarding pre-employment testing and background checks communicated?

[44] Legere, L. (2011). Hiring Guidelines for Peer Specialists. *The Transformation Center*.
[45] Ibid.

DEVELOP AND IMPLEMENT WORKFORCE POLICIES THAT SUPPORT TRAUMA-INFORMED APPROACHES

Trauma-Informed organizations recognize that trauma-informed practices occur at all levels and facets of an organization. To achieve this, incorporate trauma-informed language across all policies and procedures to establish a strong commitment to trauma-informed principles. Key areasx include hiring practices, training, performance evaluations and a commitment to diversity, equity and inclusion.

To help organizations develop trauma-informed policies, the National Council created trauma-informed care policy templates. These templates include key documents related to confidentiality, conflict transformation, discipline, harassment, hiring, health and safety, performance management, professional development, rewards and recognition and a code of conduct.

Case Study:
Zufall Health

Zufall Health revised its no-show policy to include trauma-informed language for patients and guidelines for staff. Instead of cancelling an appointment after a 10-minute grace period, staff assess each patient's situation and circumstances individually and consider factors such as how late the patient is, how ill they are, how busy the clinic is and how much of a negative impact this missed appointment will have on the patient. To implement this policy the CIT voiced their concerns with the Department of Operations and collaborated with them to craft the language and communicate with all staff about the policy change. The new policy has been well received.

Trauma-Informed Policies
Key Considerations

- Were policies and procedures assessed for adherence to trauma-informed principles?
- Does the organization have policies to support the health and wellness of employees?
- Do policies promote principles of diversity, equity and inclusion among staff and patients alike?
- Do policies align with cultural and linguistic competence standards?
- Were policies created with input from stakeholders?
- Are there any potential adverse or retraumatizing impacts the policies could have on individuals?

Change Concept 3: Build Compassion Resilience in the Workforce

Workforce concerns, such as compassion fatigue, secondary traumatic stress, vicarious trauma or burnout are common among staff and providers who work with individuals who have experienced trauma.[46] These workforce concerns affect individual staff members and the overall organization. Burnout is associated with lower patient satisfaction, reduced health outcomes and it may increase costs.[47] Burnout and secondary traumatic stress also affect families of staff members.

Building resilience in the workforce involves creating environments in which staff can maintain a compassionate presence in all interactions with patients, their families and colleagues, while maintaining their own well-being.[48] This change concept outlines common workforce concerns that result from working with individuals impacted by trauma and strategies for creating environments in which individual and organizational compassion resilience thrives.

Action Steps

- ❑ Educate and train staff on symptoms of common workforce concerns.
- ❑ Create a culture of compassion resilience.
- ❑ Implement policies and procedures to build staff resilience.
- ❑ Provide time and resources for staff to process difficult situations.
- ❑ Encourage staff assessment of wellness practices.
- ❑ Encourage staff to develop and implement self-care plans.

Implementation Tools

- Compassion Resilience Toolkit for Health and Human Services Leaders and Staff
- How to Avoid the Contagion Effect of Sharing Tough Stories between Colleagues
- ProQOL
- Provider Resilience App
  - Apple Store / Google Play Store
- Self-care Planning Tools:
  - Fatigue and Resilience in the Wellness Compass
  - Wellness and Resilience Strategies — Mind

Change Concept 3 Goals

1. Our primary care service team appropriately respond to workforce concerns (burnout, secondary traumatization and compassion fatigue).
2. Our primary care service team's written policies and procedures include recognition of the pervasiveness of trauma in the lives of people using our services and a commitment to reduce retraumatization and promote well-being and recovery and structures.
3. Our primary care service recognizes that emotional regulation is a cornerstone of resiliency and equips staff to help themselves and patients regulate their emotions and/or physical responses.

---

[46] Compassion Resilience Toolkit. (n.d.). Compassion Fatigue: Connection to Trauma, Stages and Assessments. Retrieved from https://compassionresiliencetoolkit.org/media/Healthcare_Section3_Intro.pdf
[47] Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine*, 573-576.
[48] Compassion Resilience Toolkit. (n.d.). Compassion Fatigue: Connection to Trauma, Stages and Assessments. Retrieved from https://compassionresiliencetoolkit.org/media/Healthcare_Section3_Intro.pdf

EDUCATE AND TRAIN STAFF ON SYMPTOMS OF COMMON WORKFORCE CONCERNS

It is common for staff and providers who work with individuals impacted by trauma to experience adverse effects, including burnout, secondary traumatic stress, vicarious trauma and compassion fatigue. Educating staff on these workforce concerns is an early step in the process of building resilience and preventing workforce concerns among staff.

Burnout

Burnout is a state of chronic stress that leads to physical and emotional exhaustion, cynicism and detachment and feelings of ineffectiveness and lack of accomplishment.[49] In 2019 the World Health Organization classified burnout in the International Classification of Diseases (ICD-11) as an occupational phenomenon or “a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed.”[50]

Characteristics of burnout:

1. Feelings of energy depletion or exhaustion and depression.
2. Increased mental distance from one’s job or feelings of negativism or cynicism related to one’s job.
3. Reduced professional efficacy.

Secondary Traumatic Stress

Secondary traumatic stress (STS) is the emotional duress that results when an individual hears about the firsthand trauma experiences of another.[51] There a high correlation between burnout and STS and burnout can be a predictor of STS.[52,53] It is important for all staff to receive training to identify the symptoms of burnout and STS in themselves and their colleagues, their causes, preventive measures and ways to respond. Change Concept 2: Develop a Trauma-Informed Workforce includes training on this topic.

---

[49] Carter, S. (2011). High Octane Women: How Superachievers Can Avoid Burnout. Prometheus Books.
[50] World Health Organization. (2019, May 28). Burn-out an “occupational phenomenon”: International Classification of Diseases. Retrieved from https://www.who.int/mental_health/evidence/burn-out/en/
[51] National Child Traumatic Stress Network. (2018). Types of Traumatic Stress. Retrieved from http://www.nctsn.org/trauma-types
[52] Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, 11(1), 75-86.
[53] Shoji, K., Lesnierowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & Cieslak, R. (2015). What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland. *PLoS ONE*, 10(8), e0136730.

Table 8. Burnout and STS Symptoms

Burnout Symptoms	STS Symptoms
• Chronic fatigue • Insomnia • Forgetfulness/impaired concentration and attention • Physical symptoms including increased illness • Loss of appetite • Anxiety • Anger or Increased irritability • Depression • Loss of enjoyment • Isolation or detachment • Pessimism, apathy and hopelessness • Lack of productivity and poor performance	• Hypervigilance • Hopelessness • Guilt • Avoidance • Survival coping • Social withdrawal • Minimizing • Sleeplessness • Insensitivity to violence • Illness • Fear • Chronic exhaustion

Vicarious Trauma

Vicarious trauma is the "cumulative transformative effect on the helper of working with survivors of traumatic life events."[54] Symptoms of vicarious trauma can appear similar to post-traumatic stress disorder (PTSD) and can include changes in identity, safety, ability to trust, self-esteem, intimacy and sense of control.[55]

Compassion Fatigue

Compassion fatigue refers to the "feelings of depression, sadness, exhaustion, anxiety and irritation that may be experienced by people who are helpers in their work and/or personal life."[56] Compassion fatigue is a common response among health care providers who work with individuals experiencing trauma. The term "compassion fatigue" often encompasses the experiences of both burnout and secondary trauma.

Compassion Resilience

Building resilience among staff and providers is critical to protect staff and providers from the harms of compassion fatigue, burnout, secondary traumatic stress, vicarious trauma and other workforce concerns. Compassion resilience is "the ability to maintain physical, emotional and mental well-being while responding compassionately to people who are suffering."[57] In health care settings, compassionate resilience involves:

Compassion Resilience Toolkit

Many of the recommendations in this section can be found in more detail in the Compassion Resilience Toolkit for Health and Human Services Leaders and Staff.

[54] Bloom, S.L. (2003). Caring for the Caregiver: Avoiding and Treating Vicarious Trauma, in Sexual Assault, Victimization Across the Lifespan, A. Giardino, et al., (Eds.). GW Medical Publishing: Maryland Heights, MO. p. 459-470.

[55] Ibid.

[56] Compassion Resilience Toolkit. (n.d.). Advancing Adult Compassion and Resilience: A toolkit for Health Care Agencies, Section 2, What are We Talking About? Retrieved from https://compassionresiliencetoolkit.org/media/Healthcare_Section2_Intro.pdf

[57] Compassion Resilience Toolkit. (2019). Compassion Resilience. Retrieved from https://compassionresiliencetoolkit.org/healthcare/compassion-resilience/

1. Maintaining physical, emotional and mental well-being (using energy productively) while compassionately caring for those who are suffering.
2. Identifying and addressing the barriers to caregivers/families and colleagues being able to effectively partner on behalf of patients.
3. Identifying, preventing and minimizing compassion fatigue among staff.[58]

Case Study:
Zufall Health

Zufall Health implemented many small changes that increased staff knowledge and practice of trauma-informed care. They send short motivational tips from their behavioral health department to all staff every other month, focusing on psychological safety, privacy and confidentiality. They are also working to create open lines of communication that make staff comfortable with holding each other accountable if they see someone performing in a non-trauma-informed manner. They also hold staff retreats that allow time for trauma-informed trainings. During these retreats staff have the entire afternoon off, they provide food and share various content as it relates to trauma-informed care and being trauma-informed in general.

CREATE A CULTURE OF COMPASSION RESILIENCE

There are steps CITs and leaders can take to create a culture of compassionate resilience in their organizations. The Compassion Resilience Toolkit recommends four primary steps to build a culture of compassion resilience: expectations from staff and others, compassionate boundary setting, staff culture and staff self-care.

Expectations from Staff and Others

Identifying and assessing staff self-expectations and expectations of others helps staff understand problematic expectations that can lead to compassion fatigue and other workforce concerns. Organizations can help staff better identify and set reasonable expectations for themselves and others through reflection exercises and self-care strategies. Staff can reflect on expectations using the prompts in Table 9. Staff should place a star next to expectations that they feel are helpful or realistic and an “X” next to the expectations that are hurtful or unrealistic.

[58] Ibid.

Table 9. Staff Expectations Reflection Exercise[59]

	Expectations of Self	Expectations of Patients	Expectations of Colleagues	Expectations of Patients' Families
Example	I should enjoy providing care to all of my patients.	Patients should always come to appointments on time.	Colleagues should always stay on top of their appointments.	Families should help patients with their health care needs.
My Examples				

Case Study:
Malama I Ke Ola

Malama I Ke Ola began implementing trauma-informed care within their agency by highlighting trauma-informed actions of staff. This is a form of acknowledgement and motivates other staff members. One patient overheard a staff member doing a call-out and asked what it meant to be trauma-informed. After staff explained what trauma-informed care was, the patient said that he had noticed a positive change in the staff. They seemed to be friendlier and more respectful to each other and their patients.

Compassionate Boundary Setting

Establishing and managing boundaries can help protect staff from compassion fatigue and other workforce concerns. Boundaries are simply "what's okay and what's not okay"[60] and are especially important among staff and providers who work with individuals who have experienced or are experiencing trauma. Clear boundaries protect relationships with patients and allows staff to maintain a level of self-awareness and self-regulation that protects them from compassion fatigue. Organizational policies should codify reasonable expectations related to staff boundaries. Several exercises and tools are available for staff to identify needed boundaries.

[59] Compassion Resilience Toolkit. (n.d.). Advancing Adult Compassion and Resilience: A Toolkit for Health Care Agencies, Section 5, Expectations from Self and Others. Retrieved from https://compassionresiliencetoolkit.org/media/Healthcare_Section5_Intro.pdf
[60] Brown, B. (2018). Dare to lead: Brave work, tough conversations, *whole hearts*.

Quick Tips for Compassionate Boundary Setting
To identify effective boundaries, consider at least five ways that you would complete each of these statements[61]

- I have the right to ... (examples: privacy, information before making a decision).
- To protect my time and energy it is okay to ... (examples: change my mind, set a time limit).
- People may not ... (examples: humiliate me or others, share information that is not theirs to share).

Staff Culture
To create an environment that supports compassionate resilience, leaders and staff can work together in small teams to identify and implement organizational:

- Values: A way of being or believing that is important, such as equity, respect and honesty.
- Beliefs: Convictions we hold to be true, such as "patients have the right to make choices about their treatment process" and "everyone is doing the best they can."
- Practices: Rules for working together.
- Behaviors: How we treat each other and those we serve.

Case Study:
Peninsula Community Health Services

Peninsula has integrated a game to help promote a culture of trauma-informed care among staff. At the beginning of every meeting, staff write questions on vinyl beach balls to highlight self-care ideas. During the meeting, they toss the ball to people who answer the question facing them. "We hope this idea keeps self-care, prevention of burnout and trauma-informed practices touched on routinely and part of our usual work and thoughts."

Key Considerations for Building a Culture of Compassion Resilience[62]

- What is your vision of the most positive work environment to be your best self in your job?
- What staff behaviors and attitudes would lead to such an environment?
- Which of these are you top five-to-eight priorities for the culture you desire?
- What are your strengths in regard to these behaviors?
- Where would you like to see growth in your ability to think and act in these ways?
- What might help you with that?
- How has what happened in your life impacted your ability to contribute to a positive work culture?
- What practices/activities work best for you to enhance connections with your colleagues within these behavior boundaries?

[61] Compassion Resilience Toolkit. (n.d.). Advancing Adult Compassion and Resilience: A Toolkit for Health Care Agencies, Section 6, Compassionate Boundary Setting. Retrieved from https://compassion-resiliencetoolkit.org/media/Healthcare_Section6_Intro.pdf
[62] Compassion Resilience Toolkit. (n.d.). Advancing Adult Compassion and Resilience: A Toolkit for Health Care Agencies, Section 7, Staff Culture. Retrieved from https://compassionresiliencetoolkit.org/media/Healthcare_Section7_Intro.pdf

IMPLEMENT POLICIES AND PROCEDURES TO BUILD STAFF RESILIENCE

Developing and implementing policies and procedures that systematically prevent and address compassion fatigue and build compassion resilience signals to staff that their wellness is a high priority among organizational leadership. Organizations must first evaluate what policies, procedures and pathways may impact compassion fatigue, then review all policies, procedures and pathways for alignment with trauma-informed principles. Use the Trauma-Informed Care Initiative Alignment Tool to assist with that step in the process. Modify any policy that is not in alignment with the trauma-informed principles and could potentially cause burnout.

Checklist of Policies to Prevent and Address Compassion Fatigue

Each organization should, at a minimum, have the following trauma-informed policies to prevent or address compassion fatigue and other workforce concerns:

- ❑ Conflict resolution policy for conflict between staff.
- ❑ Conflict resolution policy for conflict between staff and patients.
- ❑ Formal grievance policy.
- ❑ Policy for staff and/or patients to communicate when the physical environment is unsafe without fear of retaliation.
- ❑ A policy for staff and/or patients to communicate without retaliation when interpersonal interactions are unsafe.
- ❑ A code of conduct policy that states clearly that all staff must participate in creating safe and secure environments.
- ❑ A policy on addressing adverse incidents that includes debriefing and support for those impacted by the incident.
- ❑ A policy ensuring supervised individual or group trauma-informed meetings where staff can discuss potential burnout or STS without fear of retaliation.
- ❑ A benefits policy or plan that includes access to services and supports including, but not limited to, behavioral health services, employee assistance program and wellness activities.

PROVIDE TIME AND RESOURCES FOR STAFF TO PROCESS DIFFICULT SITUATIONS

It is important for primary care organizations to provide time and resources for staff to process difficult situations. Providing time in meetings, supervision and team huddles to process difficult situations and receive support and resources from the team can help prevent burnout and secondary trauma and build compassion resilience.[63] Some primary care organizations utilize Balint Groups as a group supervision model that allows for a safe place for staff to discuss interactions with each other and patients. Others utilize individual trauma-informed supervision, like reflective supervision, or the staff circle framework for facilitating difficult conversations.

Staff Huddles

Daily huddles provide staff an opportunity to convene at the beginning of their shift to discuss concerns that may come up during the day. Staff huddles are brief, usually 10 to 15 minutes, and allow staff to identify important issues they would like to discuss. Staff huddles can address case presentations for patients, but do not need to focus on these issues. Staff huddles provide an opportunity to check in with staff and incorporate trauma-informed principles in practice. For 'example, the University of California San Francisco Women's HIV Program begins each daily 'huddle with a "mindful minute" when staff can breathe, relax and prepare for the day.[64]

Staff Self-care

The fourth major component to building a culture of compassion resilience is staff self-care. Approach staff wellness holistically across four domains: heart, spirit, strength and mind.[65] Staff self-care practices can involve a range of activities and should reflect the individual's unique needs, including culture.

ENCOURAGE STAFF ASSESSMENT OF WELLNESS PRACTICES

Staff can use the Compass Wellness Practices Assessment to conduct a self-assessment of their wellness practices. Through the assessment, staff reflect on their wellness practices across four major domains: heart (relationships, emotions), spirit (core values, rest and play), strength (stress resilience, care for body) and mind (school/work, organization).

---

[63] American Academy of Pediatrics. (2014). Protecting Physician Wellness: Working with Children Affected by Traumatic Events. Retrieved from https://www.aap.org/en-us/Documents/ttb_physician_wellness.pdf

[64] Schulman, M. & Menschner, C. (2018, January). Laying the Groundwork for Trauma-Informed Care. Center for Health Care Strategies.

[65] Compassion Resilience Toolkit. (2019). Compassion Resilience. Retrieved from https://compassionresiliencetoolkit.org/healthcare/compassion-resilience/

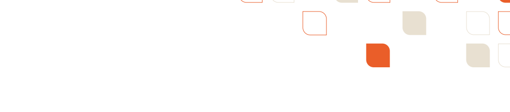
ENCOURAGE STAFF TO DEVELOP AND IMPLEMENT SELF-CARE PLANS

Self-care plans help staff better cope with stress and adversity. Staff should receive information and education on the types of tools and resources available to them from their employer, for example, employee assistance programs. Other preventive strategies include informal and formal self-report screening workplace self-care groups, creating balanced caseloads and providing flextime scheduling.[66] It is important to honor the principles of diversity, equity and inclusion when providing self-care opportunities for staff as not all staff will choose to engage in the same types of self-care.

Quick Tips: Diversity, Equity and Inclusion in Self-care

- Not all staff will choose to engage in self-care in the same way. Consider differences in cultural understandings of self-care.
- Allow staff autonomy in creating their self-care plans.
- Provide staff a range of different options to engage in self-care in the organization, including approaches rooted in individual culture and spirituality.

[66] National Child Traumatic Stress Network. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf



Change Concept 4: Identify and Respond to Trauma Among Patients

Identifying and responding to different types of trauma requires a thoughtful approach tailored to the different experiences and needs of individual patients. Establishing patient trust and safety are critical to support disclosure and acceptance of trauma-related resources. Efforts to create safe environments, as described in Change Concept 1: Help All Individuals Feel Safety, Security and Trust, will facilitate more therapeutic and satisfying patient-provider relationships, which, in themselves, can be healing.

While disclosures of life-threatening situations require immediate response, disclosures of past trauma do not typically require an immediate intervention beyond a statement of empathy and an offer to talk more over time about its impact and available resources to address it. The process of trauma education, inquiry and response can help patients and providers better understand how trauma can lead to maladaptive coping behaviors, like substance misuse or overeating, and how those behaviors may negatively impact health and wellness.[67] Ultimately, this understanding can lead to more satisfying and effective experiences of care for both patients and providers.

Action Steps

- ❑ Prepare for trauma inquiry and response.
- ❑ Inquire for and respond to recent trauma requiring immediate intervention.
- ❑ Conduct inquiry for trauma.
- ❑ Respond to trauma disclosures.

Implementation Tools

- Education, Inquiry and Response Pathway Visual
- Partnership Assessment Tool
- Script Templates for Trauma-Informed Inquiry
- Devereux Resilience Scale
- Psychoeducational Tools
  - What do I say? Talking About What Happened with Others
  - Helping my Child Cope: What Parents Can Do
  - Video: What is Trauma-Informed Care?
  - 10 Key Ingredients for Trauma-Informed Care
  - Encouraging Staff Wellness in Trauma-Informed Organizations
  - Resources from Echo
- Template Psychoeducational Materials

Change Concept 4 Goals

1. Patients have the opportunity to disclose and discuss the presence of significant past and current traumatic life events.
2. Patients have opportunities to further assess (explore and discuss) in greater detail the impact of traumatic life events on their overall health and well-being.
3. Our primary care service team offers patients trauma-related services in a timely manner, when needed.
4. Our primary care service team collaborates with treatment provider to coordinate services for patients, when needed.
5. Processes related to identifying and responding to trauma are culturally and linguistically appropriate.
6. Our primary care service team develops service plans that build on patient strengths and address physical and emotional wellness.

[67] Machtinger, E. L., Davis, K. B., Kimberg, L. S., Khanna, N., Cuca, Y. P., Dawson-Rose, C., . . . McCaw, B. (2019). From Treatment to Healing: Inquiry and Response to Recent and Past Trauma in Adult Health Care. Women's Health Issues, 29(2), 97-102.

PREPARE FOR TRAUMA INQUIRY AND RESPONSE

There are several steps to prepare to conduct trauma inquiry and response. These include:

- Establish policies and clinical pathways for identifying and responding to trauma.
- Develop an adequate referral network.
- Provide education to patients about the connection between trauma and health.
- Build staff capacity to conduct trauma inquiry and response.
- Prevent retraumatization among patients.

Many primary care providers transitioning to a trauma-informed approach have concerns about providing an adequate response when patients disclose experiences of trauma. It is common to hesitate to conduct inquiries about trauma as providers often do not feel that they have the tools and resources necessary to help individuals in need. Engaging in a conversation with a patient about trauma is similar to the way primary care providers approach other types of conditions. It is helpful to understand that while there are different types of trauma that necessitate different types of responses from providers, you can adequately serve most patients through a longer-term engagement with primary care and other health care professionals.

Establish Policies and Clinical Pathways for Trauma Inquiry and Response

Establishing policies and clinical pathways related to trauma education, inquiry and response is a necessary step to develop and sustain a trauma-informed practice. Policies and pathways clarify an inquiry and response workflow comprised of the selected approach for inquiry, the agreed upon algorithm for response and the appropriate roles and responsibilities for each staff member. Create an overarching policy to ensure identifying and responding to trauma is a routine part of medical care.

Figure 1. Example Response Pathways for Organizations — Education, Inquiry and Response in Primary Care Pathway

EDUCATION, INQUIRY, AND RESPONSE WORKFLOW

Phase

Education

Educate Patient

- Provide rationale for asking questions related to trauma
- Explain how gathered info will be used
- Provide options for follow-up

Decision Points:
- What psychoeducational materials/resources?

Inquiry

Conduct Inquiry

- Ensure safe and confidential space for inquiry
- Ask for permission to inquire further
- Utilize MI to deliver questions and elicit responses
- Identify patients' resilient factors

Decision Points:
- What approach for inquiry?
  - Assume a history of trauma without asking
  - Screen for impacts of past trauma
  - Inquire about past trauma using open-ended questions
  - Use a structured tool
- If using structured tool:
  - What instrument?
  - What is response algorithm?

What is detected?

Results of Inquiry

Imminent Danger

Episodic Trauma

Complex Trauma

Shared Decision-Making

- Ask about comfort and identity concerns
- Understand patient desires for services
- Acknowledge strengths and protective factors
- Identify adaptations to care

Decision Points:
- What supportive services will be offered?
- What trauma-specific interventions are available?

Response

Follow state-mandated protocols

Categories of Supportive Services
- Cash Assistance & Cash Management
- Child Care & Child Support
- Employment and Education
- Support for Individuals with Disabilities
- Foster Care
- Food Banks and Nutrition Assistance
- Housing Assistance
- Health, Mental Health Substance Use
- Legal Aid/Juvenile Justice
- Language Access Assistance
- Transportation
- Violence and Abuse

Significant Trauma-Related Symptoms

NO → **Connect to Supportive Services** → **PC follows up to close loop on patient**

YES → **Refer to Behavioral Health**

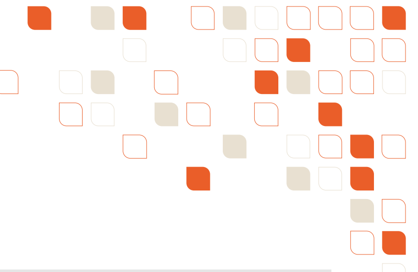
Patient agrees to additional services?

YES → **Individualized Treatment Plan**

NOT NOW → **Set time to ask again; Schedule follow-up**

NO → **Provide psycho-educational materials; Set time to ask again**

BH links back to PC to close loop on patient



Case Study:
Zufall Health

Zufall Health hired a psychiatric nurse practitioner who performs psychiatric evaluations for patients identified by primary care providers. They have developed a workflow for when a patient shows strong indicators that they are in crisis and introduced a trauma-screening tool implemented with assistance from the director of behavioral health. The screening tool is used on a subset of the patient population to pilot best practices and pathways before implementing them more broadly.

Develop an Adequate Referral Network
The CIT should facilitate assessment of available community resources to better understand where to refer patients for trauma-related services (for example, mental health, substance use and shelter) not available in your clinic or that require a deeper level of engagement or expertise. Developing relationships and referral agreements with community partners will facilitate successful referrals and collaborative care for the patient. When possible, refer patients to providers that are trauma-informed and have experience working with individuals with trauma histories. When a patient receives a referral to an external provider, it is important for the primary care provider to take steps to ensure the referral is successful.

Community-based Referral Network Checklist

- ❑ National hotlines for domestic violence, sexual assault and suicide prevention
- ❑ Community domestic violence services
- ❑ Rape and sexual assault crisis services
- ❑ Community behavioral health and substance use disorder services
- ❑ Recovery community organizations and resources
- ❑ Food banks and nutrition assistance agencies
- ❑ Housing assistance agencies
- ❑ Language access assistance
- ❑ Local welfare office(s)
- ❑ Legal services
- ❑ Parenting classes
- ❑ Education and employment supports
- ❑ Supports for populations with unique needs (e.g., members of the LGBTQ community, people with HIV, people with disabilities, people who are immigrants)

Provide Patient Education on Trauma

Patient education provides a foundation for inquiry, prompts a patient-initiated conversation and disclosure and gives the provider additional information about a patient's history. Provide information on trauma through posters, videos, pamphlets, resource cards and conversations. See Change Concept 1: Help All Individuals Feel Safety, Security and Trust for more information on patient education.

Patient Education Checklist

- ❑ Provide rationale for talking with the patient about trauma.
- ❑ Share information about the impact of trauma on health conditions.
- ❑ Receive permission from the patient prior to asking about trauma.
- ❑ Explain to patients how you will use information gathered during the inquiry process.
- ❑ If the patient declines to participate, explain that you can talk about trauma any time in the future when the patient feels comfortable.

Build Staff Capacity to Conduct Inquiry and Response

In addition to the trainings identified in Change Concept 2: Develop a Trauma-Informed Workforce, staff who will be conducting inquiry should receive training to build capacity to conduct inquiry. Motivational interviewing and shared decision-making are two strengths-based clinical tools to use during patient encounters involving trauma. Motivational interviewing is an evidence-based approach that helps people living with trauma, mental illness, addictions and other chronic conditions make positive behavioral changes to support their overall health. It is based on four fundamental processes (engaging, focusing, evoking and planning) and provides a framework for creating a dialogue about behavior change. Shared decision-making enforces patients' voice and choice and enhances patients' care experience and access to care.

Prevent Retraumatization Among Patients

Historically, clinics have been a source of trauma for some patients. Clinics can be reactive, defensive, stressful and fragmented and can actually be traumatizing for both patients and staff. A trauma-informed approach helps clinics move from being potentially traumatizing to reducing trauma. There are a number of ways to help keep the process of trauma inquiry and response from being inadvertently traumatizing, including implementing the action steps in Change Concept 1: Help All Individuals Feel Safety, Security and Trust. Regardless of the methods chosen to conduct inquiry, providers can take steps to prevent retraumatizing patients.

"Retraumatization"

Reliving stress reactions experienced as a result of a traumatic event when faced with a new, similar incident. (Substance Abuse and Mental Health Services Administration, 2017)

Quick Tips for Preventing Retraumatization[68]

- Approach the patient in a matter of fact, yet supportive manner.
- Respect the patient's personal space.
- Adjust the tone and volume of speech to suit the patient's level of engagement and comfort.
- Provide culturally appropriate symbols of safety in the physical environment.
- Be aware of your own emotional response to hearing a patient's trauma history.
- Elicit only the information necessary to determine a history of trauma.
- Overcome linguistic barriers by using professional interpreters.
- Give the patient as much personal control as possible during the assessment.
- Avoid phrases that imply judgment about the trauma.
- Provide feedback about the results of the inquiry and/or screening.

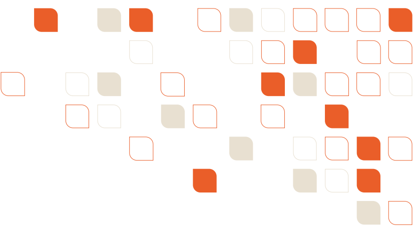
INQUIRE FOR AND RESPOND TO RECENT TRAUMA REQUIRING IMMEDIATE INTERVENTION

Your patients' immediate safety is the top priority. It is essential that practices are prepared to address specific experiences of trauma including current abuse or violence, intimate partner violence (IPV), suicidal ideation and homicidal ideation. These situations require immediate assistance and compliance with mandated reporting laws (where applicable). An appropriate response when a patient discloses such an experience is to affirm that they do not deserve that treatment, express concern for the patient's safety, explain that there are many helpful resources and follow mandated protocols while the patient is still onsite. You may offer a warm handoff to behavioral health staff or to a local agency providing specific services for their immediate needs.

Intimate Partner Violence (IPV)

IPV is a common form of trauma. Generally, inquiring about IPV is part of history taking, intake or done with standardized screening tools, but regardless of the method it should be always be in private. If there are language barriers, use professional (not family) interpreters should always, if necessary. A domestic violence hotline, for example the National Domestic Violence Hotline, can provide emotional support, safety planning, assess for lethality risk and provide resources such as shelter or legal assistance. Many resources and tools are available to help clinics provide or link to more robust IPV services, including IPV Health.

[68] SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services Publication No. (SMA) 14-4884. Trauma-Informed Community Initiative of Western New York. (2017). Retrieved from http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/community-partnerships-initiatives/trauma-informed-community-initiative.html



CONDUCT INQUIRY FOR TRAUMA

After preparing the clinical pathway and training staff, integrate inquiry for trauma into all appointments. Throughout this section, refer to sample scripts at each step. Figure 2, from Machtinger and colleagues, describes four approaches to trauma inquiry.[69] Determine which approach best fits the needs of your patient population and is most appropriate for your level of integration.

Figure 2. Four Approaches to Trauma Inquiry[70]

OPTION 1
Assume a History of Trauma Without Asking
Referrals can be offered to onsite or community-based interventions that address experiences and consequences of past trauma regardless of whether a patient chooses to disclose their trauma history.

OPTION 2
Screen for the Impacts of Past Trauma Instead of for the Trauma Itself
Common conditions highly correlated with trauma, such as anxiety, depression, posttraumatic stress disorder, chronic pain and substance use disorders, can be more effectively addressed when services are trauma-informed and offer evidence-based trauma-specific interventions.

OPTION 3
Inquire About Past Trauma Using Open-ended Questions
Open-ended questions about past trauma sensitively included in a routine history allow patients to disclose any form of trauma they feel is relevant to their health and well-being.

OPTION 4
Use a Structured Tool to Explore Past Traumatic Experiences
Multiple validated scales exist to screen for past trauma. Carefully consider why, when, how and by whom it will be administered, as well as who will have access to the information.

[69] Machtinger, E. L., Davis, K. B., Kimberg, L. S., Khanna, N., Cuca, Y. P., Dawson-Rose, C., Shumway, M., Campbell, J., Lewis-O'Connor, A., Blake, M., Blanch, A., and McCaw, B. (2019). From treatment to healing: inquiry and response to recent and past trauma in adult health care. *Women's Health Issues*, 29(2), 97-102.
[70] Ibid.

Option 1: Assume a history of trauma without asking
Approach all patients using a "trauma lens" that assumes difficult life experiences may have contributed to current illnesses and coping behaviors and educate all your patients about the connection between trauma and physical and emotional health. Regardless of whether or not a patient chooses to disclose their trauma history, offer referrals to onsite or community-based interventions that address experiences and consequences of trauma.

Option 2: Screen for the impacts of past trauma instead of the trauma itself
Another promising way to inquire about trauma that does not require that patients describe details of traumatic experiences is to screen for symptoms of common conditions that are highly correlated with traumatic experiences, such as anxiety, PTSD, depression and suicidality, substance use disorder, chronic pain and morbid obesity.[71] These conditions are often "markers" for trauma and are also often highly stigmatized. A patient experiencing any of these conditions would benefit greatly from having them addressed in a nonjudgmental, compassionate and trauma-informed manner. Treatments for these conditions will be more effective when combined with referrals to onsite or community-based services that are trauma-informed and offer evidence-based trauma-specific interventions.

Option 3: Inquire about trauma using open-ended questions
In contrast to structured tools, open-ended questions included in routine history-taking allow patients to disclose any form of trauma they feel is relevant to their well-being. An example open-ended script follows.

Sample Script

"Difficult life experiences, like growing up in a family where you were hurt or there was mental illness, drug or alcohol issues, or witnessing violence can affect our health. How do you think your past experiences have affected your physical or emotional health? Trauma can continue to affect our health. If you would like, we can talk more about services that are available that can help."

It is important for providers to know that there are many different types of traumatic experiences that may have had a significant impact on patients' health including childhood and adult physical and sexual abuse; bullying; community violence; war; serious accidents or illnesses; structural violence such as racism, xenophobia, homophobia, transphobia and sexism; and experiences in the foster care, criminal justice or immigration systems.

[71] U.S. Department of Veterans Affairs. (2019). National Center for PTSD. Retrieved from https://www.ptsd.va.gov/

Option 4: Use a structured tool to explore past traumatic experiences
When using a structured screening tool or process, carefully consider when, how and who will administer it, as well as who will have access to the information. Some clinics use a pre-visit screening tool administered via electronic tablet, paper or small dry-erase board. In other settings, non-clinical staff administer the tool or medical providers conduct the standardized screening in the exam room. Regardless of the tool you use and how you administer it, it is essential for the patient to have the opportunity to discuss their responses with the provider in private. The National Center for PTSD website houses multiple validated scales exist to screen for past trauma. The Adverse Childhood Experiences (ACEs) Questionnaire was designed as a research instrument to measure the rate of childhood trauma in a clinic population. Since the original ACE Study, the questionnaire has been adapted for different populations. Researchers are actively investigating the clinical benefits of screening for ACEs using the questionnaire in adult primary care.

The approach to trauma inquiry you choose depends on the resources, expertise and patient population of individual providers and practices. It is important to note that for patients who have experienced severe and/or cumulative trauma (i.e., complex trauma, see Table 10) and are experiencing negative physical or emotional health consequences, it will be helpful for the provider or behavioral health clinician to know the general nature of their traumatic experiences (e.g., childhood sexual abuse, abusive parents with serious mental illness, combat-related exposure) to make the most effective referrals to trauma-specific treatments.

Validated Scales to for Past Trauma and PTSD in Primary Care Settings

- Staying Healthy Assessment Questionnaires. Catalog of screening tools for a range of ages in multiple languages from the California Department of Health Care Services.
- National Center for PTSD. Compilation of training materials and tools for assessing PTSD and trauma from the U.S. Department of Veterans Affairs.

Case Study:
Malama I Ke Ola

Malama I Ke Ola increased their clinic's level of cultural humility by collaborating with community health workers who assist them with interpreting and liaising with patients as needed. They also reframed the way they discuss health concerns and trauma with patients, including altering some of the language used in their health history forms and including questions focused on social determinants of health such as housing and food.

Key Considerations for Selecting a Tool

- What is the purpose of the tool? Is it used to facilitate case decision-making or to inform clinical practice?
- What type of research was conducted on the tool? Does it have established reliability, validity and norms?
- What are the budget and the cost for the tool?
- How are data from the measure scored and stored? Do you need to work with information technology to create a system that stores the information gathered? Are you able to provide feedback to the caseworker or clinician in an efficient and timely manner?
- How is the information shared? Are you able to share the information across primary care and behavioral health systems?
- What staff do you have available to administer the tool? What is their level of education and experience? How much extra time is involved in completing a screening and using the information for case and/or treatment planning purposes?
- Does the tool track change over time and allow you to see if the patient has improved?
- Can the tool be adapted to meet the needs of unique populations?

Identify Patients' Resilience Factors

In addition to inquiring about trauma, it is important for providers to identify patients' positive strengths and resilient factors. Similar to inquiring about trauma, providers can use conversational and open-ended questions in addition to formalized instruments to inquire about resiliency. While "resiliency" is a term commonly used by practitioners and researchers, providers should use language that is culturally responsive and will resonate with patients. When conducting inquiry with patients it is important to not only ask about challenges that might be affecting their lives, but also about the positive supports they have or the ways they have successfully coped in the past. An example of a formalized instrument that could be used to inquire about resiliency is the Devereux Resilience Scale and the Connor-Davidson Resiliency Scale (CD-RISC), which is available in two, 10 or 25-item versions.

Sample Script

"In the past, which of your strengths have you relied on to 'bounce back' after difficult experiences?"

Plan to Respond to Different Types of Trauma

It is helpful to understand that different types of trauma require different responses from providers. Patients who have experienced interpersonal, intimate partner or domestic violence; show signs of suicidal ideation; or are otherwise at risk of harm to themselves or others require an immediate response from providers. However, most patients who present with a history of trauma will not need immediate assistance and are adequately served with a longer-term engagement with primary care and other professionals. Table 10 provides recommended responses to different types of trauma.

Table 10. Response to Trauma Disclosures

Type of Trauma	Examples	Response
Experiences of Trauma Requiring Immediate Intervention	• Interpersonal violence, intimate partner violence or domestic violence. • Suicidal and homicidal ideation.	• Connect to appropriate resources. • Comply with mandated reporting laws (where applicable). • Shared decision-making is key to responding to the patient.
Experiences of Trauma	• Episodic trauma: Exposure to an episodic or singular event that impacts an individual (e.g., car accident, robbery). More likely to lead to PTSD. • Complex trauma: Repetitive, prolonged or cumulative. Most often interpersonal, involving direct harm, exploitation and maltreatment. • Systemic trauma: Results from the contextual features of environments and institutions.	• Shared decision-making, connect to supportive services, refer to behavioral health or other supports based on symptoms, choice and readiness. • When referring, encourage and normalize seeking behavioral health services. • Engage in more targeted patient education around the impact of trauma on long-term health and how behavioral health services may support their physical health as well as emotional well-being. • If the patient seeks behavioral health services, primary care providers should maintain an active dialogue with the behavioral health provider to ensure a supportive, team approach to improve the patient's health. • Adapt care to avoid activation and make access to medical care as comfortable as possible for the patient. An example is to ensure patients who have experienced recent pregnancy loss are seen in a different hospital wing then patients with newborns. Discuss adaptations through the shared decision-making process.

RESPOND TO TRAUMA DISCLOSURE

Disclosures of trauma do not typically require detailed discussion or urgent intervention. Rather, responses to such disclosures are often best limited to a statement of empathy, an offer of available referrals to overcome the impacts of trauma and an opportunity to follow-up with you. Providers should begin their response by acknowledging the patient's disclosure with a simple statement of nonjudgmental compassion like the following script.

Sample Script

"I am sorry this happened to you. Thank you for sharing this with me. This information can help me understand how best to care for you. Trauma can continue to affect our lives and health. Do you feel like this experience affects your health or well-being?"

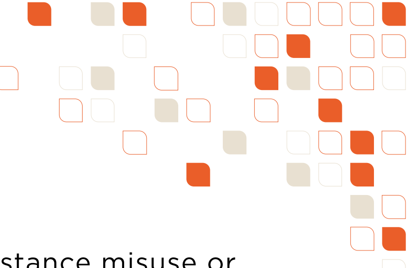
Adapt Care to Patient's Needs and Strengths

Adequate response to trauma disclosure includes a conversation with each patient about adaptations to care. By making small adjustments, you show respect for a patient that honors their concerns and prioritizes their voice in the treatment plan. In the following script, the provider creates an open space for the patient to share what they need to feel comfortable throughout the appointment. Examples of simple adaptations a patient may request include no fragrances in the exam room, a nurse present during sensitive exams and a phone call to discuss exam results rather than written results. If the patient does not have any specific requests at the time, emphasize that they can revisit this at future appointments. Note any identified adaptations in their health record and respect them at each appointment.

Sample Script

"In light of what you've shared today, is there anything I can do to make you feel more comfortable during our appointments together?[72] Do you have any concerns we should address before moving forward? I will note it in the record for future appointments and you can always change or add to it later."

[72] Elisseou S, Puranam S, Nandi M. (2019). A novel, trauma-informed physical examination curriculum for first-year medical students. MedEdPORTAL. 2019;15:10799. Retrieved from https://www.mededportal.org/publication/10799/.



Understanding a patient's trauma can explain how coping techniques like substance misuse or eating disorders may have been adaptive in the past but are currently causing health problems.[73] This understanding can facilitate a more effective treatment plan. For example, treatments for substance use disorder are significantly more effective when addressing co-occurring trauma and/or PTSD is part of the treatment.[74] Using a harm reduction framework can be a good first step. This can include a brief conversation about how a patient can stay safe while still using substances.

Sample Script

"You mentioned that heroin makes you feel calm when you are very stressed and that you have a goal to stop using but are not ready to now. So, let's talk about how you can stay safe when you use heroin. What ideas do you have? Are you familiar with steps to prevent and respond to an overdose, such as using with a friend and carrying naloxone?"

Every patient's treatment plan should utilize their strengths. Engaging in a process to identify strengths and incorporating them in their health care plan is a resilience-building strategy. Developing a plan together that is unique to their needs, goals and strengths increases self-confidence, hopefulness and participation in the treatment plan. Ask your patient about the people, places and activities they rely on to support their health and wellness.[75] Identify their health strengths, including an awareness about preventive screenings, current health status, and strategies to manage personal stressors.[76]

Depending on the needs, desires and readiness of the patient, providers may offer referrals for further evaluation or treatment. This could include a referral to onsite behavioral health providers or community-based programs that are trauma-informed and offer trauma-specific therapies. Patients and providers can find local mental health and substance use services at the SAMHSA National Help Line.

Trauma-specific Interventions

There are many evidence-based techniques and mental health interventions to help patients heal from the impacts of trauma and cope more healthfully and safely with ongoing symptoms and persistent traumas such as racism or xenophobia. Medical providers are not typically resourced

[73] Felitti, V.J., Jakstis, K., Pepper, V., & Ray, A. (2010). Obesity: Problem, solution, or both? *Permanente Journal*, 14, 24–30.
[74] Dass-Brailsford, P.M. & Amie, C. (2010). Psychological Trauma and Substance Abuse: The need for an integrated approach. *Trauma, Violence, & Abuse*, 11, 202–213.
[75] Salerno, A. (2016). Building Resilience for Individuals through Trauma Education (BRITE). 84-88.
[76] Whole Health Action Management (WHAM) Peer Support Training Participant Guide. (2015). Published by SAMHSA-HRSA Center for Integrated Health Solutions. 44-45.

or trained to lead these interventions; however, they have a crucial role in linking patients to treatments in the community or to onsite psychosocial staff members who are skilled in providing them.

Most importantly, providers can communicate hope to patients that it is possible to live a healthy life despite experiences of trauma and to gradually adopt healthier coping strategies. Learning more about trauma-specific interventions can help providers identify what may be most useful to their patient. Trauma-specific interventions include individual and/or group therapies that help patients manage trauma symptoms, process traumatic experiences and/or reduce isolation; trauma-informed somatic interventions like yoga, mindfulness-based stress reduction, acupuncture and somatic experiencing therapy; and medicines and techniques, such as eye movement desensitization and reprocessing (EMDR), to reduce post-traumatic symptoms like insomnia, nightmares, anxiety and depression. Often, a combination of such interventions lead to genuine healing.

It is important to note that many patients may not be interested in or able to tolerate trauma-specific interventions that require processing past traumatic events. Refer these individuals to the many trauma-specific services that do not involve directly processing trauma (e.g., drop-in support groups, dialectical behavioral therapy [DBT] and various forms of expressive and art-based therapies) that can start the healing process by helping patients connect with others and develop healthier coping skills.[77,78] You can also support patients who do not want any trauma-related referrals to begin healing through faith and spirituality, exercise, nature, work, caring for people and pets and other practices that foster connection, comfort and meaning.

[77] Najavits, L.M., Weiss, R.D., Shaw, S.R., & Muenz, L.R. (1998). Seeking safety: Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress*, 11, 437–456.
[78] Copeland, M.E. (2002). Wellness recovery action plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. Occupational Therapy in Mental Health, 17, 127–150.

Change Concept 5: Finance and Sustain Trauma-Informed Approaches in Primary Care

Identifying and developing a sustainable financing strategy is critical to effective implementation and maintenance of a trauma-informed approach in primary care. To do this, an organization must secure adequate financial and organizational resources including identification of relevant policy, reimbursement processes and opportunities within existing service incentive programs. The alignment of workflow and staffing with reimbursement options is paramount to success.

Action Steps

- ❑ Identify all planned, new and existing activities and procedures resulting from implementation of trauma-informed approaches.
- ❑ Measure trauma-informed activities.
- ❑ Use billing mechanisms to finance trauma-informed approaches.
- ❑ Identify nonfinancial resources for support.
- ❑ Analyze policy landscape and select an advocacy goal to support financing and sustainment.
- ❑ Develop and tailor advocacy messaging for identified stakeholders.
- ❑ Sustain a trauma-informed approach.

Implementation Tools

- Trauma-Informed Primary Care Policy Audit Tool
- Trauma-Informed Care Advocacy Handbook
- Building Community Resilience Policy and Advocacy Guide
- Trauma-Informed Care Quality Outcomes Crosswalk
- Sustainability Guide
- Financing Trauma-Informed Primary Care
- Patient-Level Outcomes Data Collection Template

Change Concept 5 Goals

1. Our primary care service's budget includes funding for structural and administrative resources specific to comprehensive integration of trauma-informed approaches.
2. Our primary care service's budget includes funding for ongoing cross-sector training regarding trauma-informed approaches.
3. Our primary care service's budget includes funding for the maintenance of a safe physical environment.
4. Our primary care service recognizes that finances are not our only resource. Equip staff to support patients in engaging with community social resources that align with their care.
5. Our primary care service identifies desired outcomes of the trauma-informed primary care initiative.
6. Our primary care service actively monitors patient-level outcomes of trauma-informed interventions for a target patient population.

IDENTIFY ALL PLANNED, NEW AND EXISTING ACTIVITIES AND PROCEDURES RESULTING FROM IMPLEMENTING TRAUMA-INFORMED APPROACHES

Organizations need to identify activities, procedures, staffing, spaces and equipment related to trauma-informed care. Understanding what exists currently or what will in the future, will enable an organization to plan for funding and reimbursement options.

MEASURE TRAUMA-INFORMED ACTIVITIES

Tracking processes and outcomes related to trauma-informed initiatives and activities helps develop a value case for your services. Each organization's scope of services and data collection, management, analysis, reporting and interpretation capabilities are unique and will shape the ability to understand the effect of trauma-informed primary care efforts at the organization.

Key Considerations for Collecting Data

- What is the desired outcome of a service? For patients? For staff? For the organization? For the community?
- What are the best data sources available to measure that outcome?
- What are the demographics and descriptors of the people receiving services at the organization?
- What types of services are they receiving, in what doses, and for how long?
- What was the impact of those services on patients?

Existing activities and funding streams may inform or drive data collection efforts, particularly for patient level health metrics. By identifying activities, procedures, staffing, spaces and equipment, your organization can decide what kinds of clinical encounters are reimbursable by funders and payers under current agreements versus creating agreements in the future. As part of this process, organizations should cross-reference agency workflows with available reimbursement and funding options through initiatives, incentive and other programs. For example, many health care organizations are becoming patient-centered medical homes, centers of excellence, advanced primary care certified or working to meet the new Medicare quality measures. Many of these efforts require organizations to collect and monitor specific metrics as part of quality, routine care and payment. These same metrics often align with the goals and desired outcomes of trauma-informed primary care. The Trauma-Informed Care Quality Outcomes Crosswalk is a tool that organizations can use to help assist in this process.

Choosing Data to Track

The CIT and staff responsible for quality improvement should explore available data indicators to track over time. The tools provided throughout the Change Package to assess safety, staff and patient satisfaction and training evaluations provide CITs an opportunity to track implementation progress specific to their goals and action steps. The OSA Workbook provides a list of indicators to help assess your implementation. The CIT should also track readily-available information about engagement, such as staff turnover and number of personal and sick days taken. As you integrate trauma-informed care into your organization, these values should decrease and will likely be among the first metrics that change as a result of your initiative.

Eventually, the CIT and staff responsible for quality improvement should identify key health metrics among patients to track over time. The goal of trauma-informed primary care is to improve the quality of care and the health of patients. While it may take time for implementation to settle in before you see demonstrated improvement in these metrics, it is important to capture and track them over time to inform your service provision and action planning.

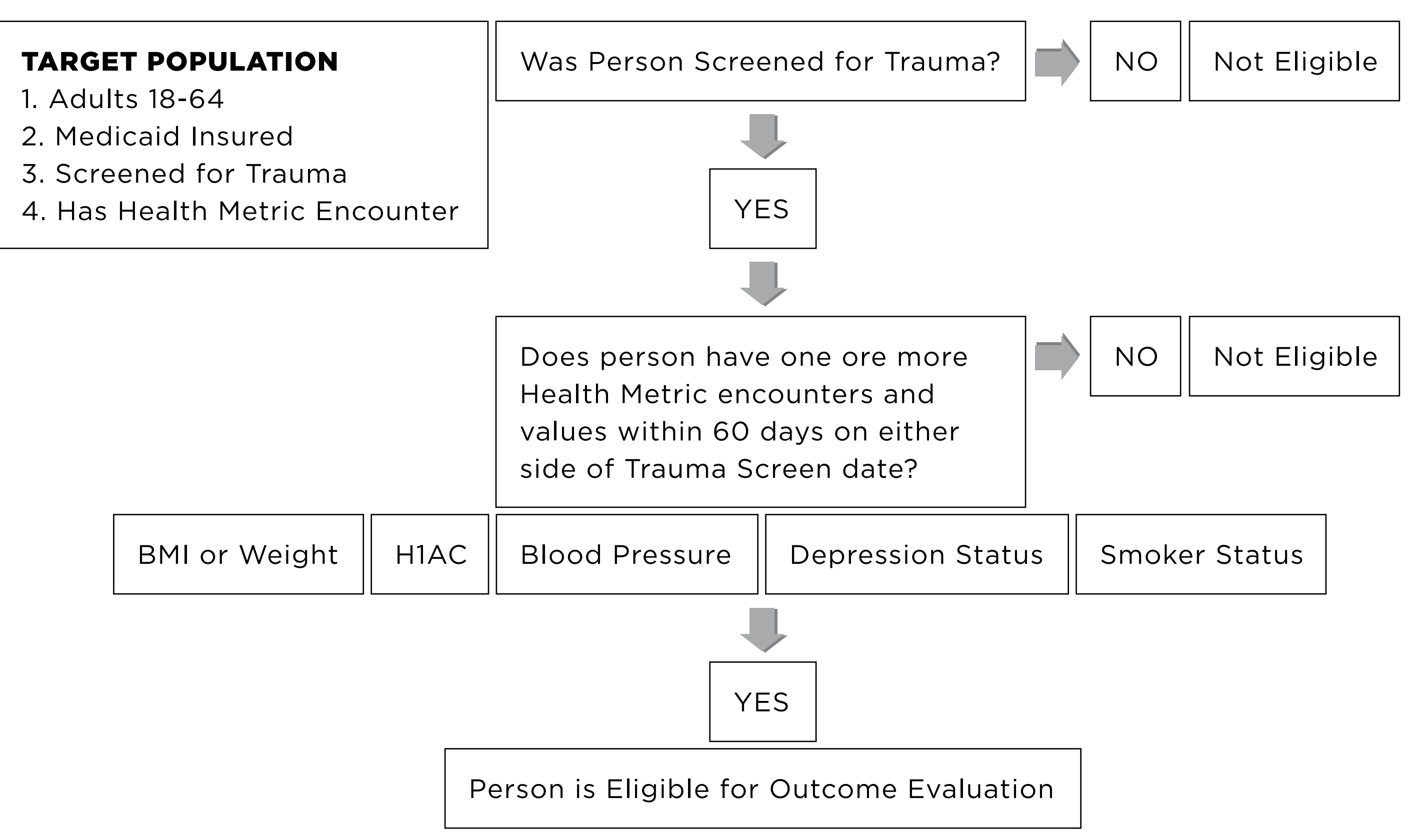
Primary care organizations commonly collect the following metrics, which are covered by Medicaid and often included in continuous quality improvement cycles. Research suggests these chronic health indicators will improve as you adopt trauma-informed care.

Table 11. Examples of Common Patient-level Process and Outcomes Measures[79]

MEASURE	DESCRIPTION
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c >9.0% during the measurement period.
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and adequately controlled blood pressure (less than 140/90 mmHg) during the measurement period.
Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 or older screened for tobacco use one or more times within 24 months and if identified to be a tobacco user received cessation counseling intervention.
Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients age 18 years and older with a BMI documented during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal parameters: Age 18-64 years BMI =>18.5 and <25 kg/m^2, and Age 65 years and older BMI =>23 and <30 kg/m^2.
Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 or older who were screened for depression with a standardized tool and had a documented follow-up plan for positive screening.

Organizations can track their data at the patient level by using the Patient-Level Outcomes Data Collection Template; however, all patients may not be included in the data collection. Figure 3 outlines the target population for the evaluation of the Trauma-Informed Primary Care Learning Community. Your organization's data and quality improvement team will need to determine the appropriate target population for evaluation. This population can expand over time but starting with a sub-population may help establish the process.

Figure 3. Determining Target Population for Patient-Level Outcomes



[79] National Quality Forum. 2019. Measures. Retrieved from http://www.qualityforum.org/QPS/QPSTool.aspx

Use Billing Mechanisms to Finance Trauma-Informed Approaches

Adequate resources are critical to long-term sustainability of trauma-informed practices in primary care settings.[80] Because there are very few direct payment or reimbursement mechanisms specifically indicated for trauma-informed activities, it is important to incorporate trauma-informed practices into existing services that receive reimbursement from payers. Organizations will not see billing codes that read "trauma." To finance trauma-informed activities, organizations should focus on larger shifts in health financing, including the movement toward integrated behavioral health and primary care, value-based payment mechanisms and bundled rates for services.

There are a growing number of value-based and other alternative payment models to support integrated behavioral health services within primary care settings. These include integrating behavioral health outcomes within value-based managed care contracts, pay-for-reporting and pay-for-performance within fee-for-service contracts, shared savings and condition-specific population-based payments. Recently, the National Council and Centers for Health Care Strategies conducted an environmental scan of existing behavioral health value-based payment models within Medicaid that can help to identify potential finance models to better support trauma-informed efforts.

Organizations should also strive to use billing codes strategically to support trauma-informed services. Because there are no billing codes specifically for trauma-informed services, organizations need to understand how trauma-informed services fit into the existing services they provide and bill for. Table 12 provides a list of common billing codes used to support trauma-informed services.

[80] Menschner, C., & Maul, A. (2016, April). Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Care Strategies. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Table 12. CPT Codes Used for Services That Can Be Delivered Using a Trauma-Informed Approach

BILLING CODE	SCREENING	ASSESSMENT	GROUP THERAPY	EVIDENCE-BASED TREATMENTS	WARM HANDOFFS	FOLLOW-UP CONTACTS
90791 **Psychiatric diagnostic evaluation (without medical services)**	X	X	X			
90792 **Psychiatric diagnostic evaluation (with medical services)**	X	X	X			
96153 **Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**	X		X		X	
96150, 1 **Health and behavior assessment**	X					
99211 **Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional**	X	X				
90853 **Group psychotherapy (other than of a multiple-family group)**		X	X	X		
99212-99215 **Office or other outpatient visit for the evaluation of a new patient**	X	X				
99490 **Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per month**	X				X	X
90832, 34, 37 **Individual psychotherapy 30, 45, and 60 minutes**	X				X	X
90839 **Psychotherapy for crisis, for first 60 minutes + crisis code add-on for each additional 30 minutes**	X	X				
99495 **Transitional care management services with moderate medical decision complexity (face-to-face within 7–14 days of discharge)**	X				X	X
99496 **Transitional care management services with high medical decision complexity (face-to-face within 7 days of discharge)**	X				X	X

Aligning trauma-informed practices with other performance improvement efforts tied to incentives is another way to finance trauma-informed services. The Trauma-Informed Care Quality Outcomes Crosswalk is a useful guidance tool for this assessment that aligns trauma-informed practice with other initiatives. For example, using the PHQ-9 to screen for depression is a component of APC, NCQA and MIPS standards. This type of screening may also facilitate identifying patients with trauma histories. Screening for depression supports trauma-informed primary care implementation and accrediting standards. Specific guidance regarding financing trauma-informed practices is found in the Financing Trauma-Informed Primary Care resource.

Case Study:
Willamette Family Services

To sustain staff training, Willamette Family Services created a line item in their agency's official budget to account for each specific training offered. This allowed the agency to be transparent with staff and show its investment in trauma-informed approaches. The new policy emerged as an idea to support staff and help them understand that their wage does not solely define their value.

IDENTIFY NONFINANCIAL RESOURCES FOR SUPPORT

Not all aspects of sustainability are directly related to financial support. There are other resources that are critical to embedding trauma-informed practices, including patients, individuals with lived experience and the community itself. Establishing robust partnerships with existing community services and supports and including a range of community stakeholders on advisory and governing boards are examples of ways to leverage nonfinancial resources to support trauma-informed efforts. By continually involving the community, your organization recommits to the principles of trauma-informed care, particularly empowerment, voice and choice. Increasing community-wide understanding of trauma and resilience increases the capacity of your referral partners to provide relevant and responsive services to advance trauma-informed approaches across systems of care.

Case Study:
Bread for the City

The mission of Bread for the City is to help Washington, D.C. residents living with low income to develop the power to determine the future of their own communities. They do this by providing food, clothing, social services, civil legal services, and holistic health care (primary, dental, vision, and behavioral health) to about 32,000 D.C. residents each year. They also seek justice through community organizing and public advocacy, and they work to uproot racism, a major cause of poverty. They are committed to treating their clients with the dignity and respect that all people deserve. As an example of this, each year, their devoted staff and volunteers work together to make sure that Bread for the City's entire community can enjoy a Thanksgiving meal around their own table through their annual Holiday Helpings program. It is one of their most meaningful traditions, and it gets to the heart of what they do: provide D.C. families with holistic supportive services with dignity and respect.

ANALYZE POLICY LANDSCAPE AND SELECT ADVOCACY GOAL TO SUPPORT FINANCING AND SUSTAINMENT

In addition to looking at an organization's internal policies, it is imperative to assess the current and potential external policy landscape to align support and maintain trauma-informed practices and set an advocacy goal based on that assessment. Legislators, regulators and funders make decisions every day that will either help improve access to care for those who need it or make it more difficult for your organization to serve your community. Ensuring that these stakeholders have current information on the prevalence and impact of trauma and the relevance and effectiveness of trauma-informed approaches will ensure you don't miss opportunities to financially support and sustain this work.

DEVELOP AND TAILOR ADVOCACY MESSAGING FOR IDENTIFIED STAKEHOLDERS

Organizations need to create advocacy messaging that aligns with its trauma-informed practice efforts. The Trauma-Informed Care Advocacy Handbook is a guide you can use to develop a plan and approach to speak to legislators, regulators and funders. Part of the process includes getting to know your legislators, regulators and funders and their positions on your issues; introducing yourself and your organization via email or in-person; and attending upcoming community events or town halls or inviting your legislator to visit your agency.

SUSTAIN A TRAUMA-INFORMED APPROACH

Sustaining trauma-informed practices in primary care requires ongoing financial and operational support. In addition to financial resources, ongoing clear and consistent leadership, engaged staff buy-in and a commitment to continuous quality improvement are factors for sustainability. The Trauma-Informed Care Sustainability Guide contains detailed organizational considerations for sustaining a trauma-informed approach.

Sustaining Trauma-Informed Practices Key Considerations

- Is there ongoing presence and support of the CIT?
- Are trauma-informed policies and procedures institutionalized?
- Is data continuously monitored to assess progress and make improvements?
- Do regular meetings occur with community partners to strengthen trauma-informed efforts?
- Is there continuous review of the changing financing landscape to support trauma-informed practices?
- Have you identified nonfinancial resources to support sustainability efforts?

Conclusion

This Change Package marks a significant step forward in the delivery of trauma-informed primary care services and is the culminating result of years of dedicated research and practice. This effort would not be possible without significant contributions by Kaiser Permanente, the Practice Transformation Team, Learning Collaborative participants, the National Council project team, the primary care and behavioral health provider communities and people with lived experience.

We acknowledge that undertaking an organizational change of this type requires a significant commitment by leadership and staff at all levels and we applaud organizations that are taking on this challenge. As efforts to improve care for individuals who have experienced trauma are continuously evolving, we look forward to your feedback related to the Change Package and encourage you to share your experience with using the tool. We know implementation of trauma-informed primary care is a multi-year process and encourage conversation across the field about this journey. We want to thank you for dedicating the time, resources and energy to improving care for individuals with trauma histories and look forward to partnering with you into the future.

References

ACEs Connection. (2017, September). Update on Bumper Crop of State ACEs bills in 2017-46 bills in 20 states. Retrieved from http://www.acesconnection.com/g/state-aces-action-group/blog/update-on-bumper-crop-of-state-aces-bills-in-2017-46-bills-in-20-states

ACEs Connection. (2018, February 24). State Profiles for 50 States and District of Columbia. Retrieved from http://www.acesconnection.com/g/state-aces-action-group/collection/state-profiles

Agency for Healthcare Research and Quality. (2015, September). Primary Care Practice Facilitation Curriculum. AHRQ Publication No. 15-0060-EF. Retrieved from https://pcmh.ahrq.gov/page/primary-care-practice-facilitation-curriculum

American Academy of Pediatrics. (2014). Protecting Physician Wellness: Working with Children Affected by Traumatic Events. Retrieved from https://www.aap.org/en-us/Documents/ttb_physician_wellness.pdf

American Academy of Pediatrics. (2018). Promoting Resilience. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Promoting-Resilience.aspx

American Psychological Association. (2018). The Road to Resilience. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx

Baker, C., & Brown, S. (2016) Measuring Trauma-Informed Care Using the Attitudes Related to Trauma-Informed Care (ARTIC) Scale [PowerPoint Slides]. Retrieved from http://traumaticstressinstitute.org/wp-content/uploads/2016/04/ARTIC-Webinars-2016_Final.pdf

Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine, 12(6), 573-576.

Bremner, J. D. (2006). Traumatic stress: effects on the brain. Dialogues in Clinical Neuroscience, 8(4), 445-461.

Bruce, S. E., Weisberg, R. B., Dolan, R. T., Machan, J. T., Kessler, R. C., Manchester, G., ... Keller, M. B. (2001). Trauma and Posttraumatic Stress Disorder in Primary Care Patients. Primary Care Companion to The Journal of Clinical Psychiatry, 3(5), 211–217.

Burke Harris, N. (2018). The deepest well: Healing the long-term effects of childhood adversity. New York, NY: Houghton Mifflin Harcourt.

Calhoon, C. (August 2016). Calculating the ROI on Trauma Informed Care Software. Retrieved

from https://www.10e11.com/blog/calculating-the-roi-on-trauma-informed-care-software

Carlson, K. L. (2012, March 30). Rooming Alone: How to implement a policy by engaging your staff. National Conference on Healthcare and Domestic Violence. Kaiser Permanente.
Carter, S. (2011). High Octane Women: How Superachievers Can Avoid Burnout. Prometheus Books.

Centers for Disease Control and Prevention. (2010, December 17). Adverse Childhood Experiences Reported by Adults — Five States, 2009. MMWR. Morbidity and Mortality Weekly Reports. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm

Centers for Disease Control and Prevention. (2017). Adverse Childhood Experiences. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/

Chamberlain, L., & Levenson, R. (2016). Happy Moms, Happy Babies: A Train-the-Trainers Curriculum on Trauma Informed Domestic Violence Programming and Practice. Retrieved from https://www.futureswithoutviolence.org/wp-content/uploads/HMHB-and-RAT-Webinar-Final.pdf

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. Psychological Services, 11(1), 75-86.

Collins, K., Connors, K., Donohue, A., Gardner, S., Goldblatt, E., Hayward, A., . . . Thompson, E. (2010). Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions. Family Informed Trauma Treatment Center. Retrieved from https://www.nctsn.org/sites/default/files/resources/resource-guide/understanding_impact_trauma_urban_poverty_family_systems.pdf

Davis, K. (1997). Exploring the Intersection between Cultural Competency and Managed Behavioral Health Care Policy: Implications for State and County Mental Health Agencies. National Technical Assistance Center for State Mental Health Planning.

DeCandia, C. J., & Guarino, K. (2015). Trauma-Informed Care: An Ecological Response. Journal of Child and Youth Care Work, 25, 7-32.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, (14)4, 245-258.

Hales, T. W., Nochajski, T. H.., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An Association Between Implementing Trauma-Informed Care and Staff Satisfaction. Advances in Social Work, 18(1), 300-312.

Institute for Child and Family Well-Being. (2017). Translating Trauma-Informed Care into Practice, Trauma Screening, Brief Intervention and Referral to Treatment (T-SBIRT). Retrieved from http://uwm.edu/icfw/wp-content/uploads/sites/384/2017/09/TSBIRT.pdf

Institute of Medicine. (2000). To Err is Human: Building a Safer Health System. The National Academies Press. doi: https://doi.org/10.17226/9728

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. Journal of Traumatic Stress, 26(5), 537-547.

Kotter, J. P. (1996). Leading change. Harvard Business Press.

Kotter International. (2017). 8-Step Process. Retrieved from https://www.kotterinc.com/8-steps-process-for-leading-change/

Legere, L. (2011). Hiring Guidelines for Peer Specialists. The Transformation Center.

Mace, S., & Smith, R. (2017). Trauma-Informed Care in Primary Care: A Literature Review. Kaiser Permanente and the National Council for Mental Wellbeing.

McCauley, C. (2014). Making Leadership Happen. Center for Creative Leadership. Retrieved from https://www.ccl.org/wp-content/uploads/2016/09/making-leadership-happen-center-for-creative-leadership.pdf

Menschner, C., & Maul, A. (2016, April). Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Care Strategies. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Merrick, M. T., Ford, D. C., & Ports, K. A. (2018). Prevalence of Adverse Childhood Experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. JAMA Pediatrics, 172(11), 1038-1044.

Mills, V., Van Hoof, M., Baur, J., & McFarlane, A. C. (2012). Predictors of mental health service utilization in a non-treatment seeking epidemiological sample of Australian adults. Community Mental Health Journal, 48, 511-521.

Nakazawa, D.J. (2015). Childhood Disrupted: How Your Biography Becomes Your Biology, and How You Can Heal. New York, New York: ATRIA Books.

National Center for Injury Prevention and Control. (2017, April 28). The National Intimate Partner and Sexual Violence Survey Infographic. Retrieved from https://www.cdc.gov/violenceprevention/nisvs/infographic.html

National Child Traumatic Stress Network. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf

National Child Traumatic Stress Network. (2015). LGBT Issues and Child Trauma. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/safe_spaces_safe_places_flyer_2015.pdf

National Child Traumatic Stress Network. (2018). Types of Traumatic Stress. Retrieved from http://www.nctsn.org/trauma-types

National Council for Mental Wellbeing. (2014). Trauma-Informed Care Sustainability Guide. Retrieved from https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/TIC-Sustainability-Guide.pdf

National Implementation Research Network, Active Implementation Hub. (2017). Implementation Drivers. Retrieved from http://implementation.fpg.unc.edu/book/export/html/134

National Institute of Mental Health. (2007). Global Survey Reveals Significant Gap in Meeting World's Mental Health Care Needs [Press Release]. Retrieved from https://www.nih.gov/news-events/news-releases/global-survey-reveals-significant-gap-meeting-worlds-mental-health-care-needs

National Quality Forum. 2019. Measures. Retrieved from http://www.qualityforum.org/QPS/QPSTool.aspx

RAND Corporation. (2019). Community Resilience. Retrieved from https://www.rand.org/topics/community-resilience.html

Reiling, J., Hughes, R. G., & Murphy, M. R. (2008). The Impact of Facility Design on Patient Safety. In R. Hughes (Ed.), Patient Safety and Quality: An Evidence-Based Handbook for Nurses (Chapter 8). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2633/

Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences nationally, by state, and by race/ethnicity. Child Trends Publication #2018-03. Retrieved from https://www.childtrends.org/

Salerno, A. (2018). A Practical Toolkit for Adopting Trauma Informed Approaches in Primary Care. Developed for the National Council for Mental Wellbeing.

Salerno, A. (2016). Building Resilience for Individuals through Trauma Education (BRITE).

Schachter, C. L., Stalker, C. A., Teram, E., Lasiuk, G. C., & Danilkewich, A. (2008). Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual

abuse. Public Health Agency of Canada. Retrieved from https://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf

Schulman, M. & Menschner, C. (2018, January). Laying the Groundwork for Trauma-Informed Care. Center for Health Care Strategies.

Shoji, K., Lesnierowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & Cieslak, R. (2015). What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland. PLoS ONE, 10(8), e0136730.

Stevens, S., Andrade, R., Korchmaros, J., & Sharron, K. (2015). Intergenerational Trauma Among Substance-Using Native American, Latina, and White Mothers Living in the Southwestern United States. Journal of Social Work Practice in the Addictions, 15(6), 6-24.

Stoltz, P. K. (1996). FOCUS-PDCA. In C. Kinney & R. Gift (Eds.), Today's Management Methods: A Guide for the Health Care Executive (223-244). American Hospital Publishing, Inc.

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services Publication No. (SMA) 14-4884.

Substance Abuse and Mental Health Services Administration. (2014b). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801.

Substance Abuse and Mental Health Services Administration. (2016, March 2). Types of Trauma and Violence. Retrieved from https://www.samhsa.gov/trauma-violence/types

Substance Abuse and Mental Health Services Administration. (2017). Tips for Survivors of a Disaster or Other Traumatic Event: Coping with Retraumatization. Retrieved from https://store.samhsa.gov/system/files/sma17-5047.pdf

The National Domestic Violence Hotline. (2017). Get the Facts and Figures. Retrieved from www.thehotline.org

Whole Health Action Management (WHAM). (2015). Published by the SAMHSA-HRSA Center for Integrated Health Solutions.

Wilson, K.J. (Eds.). (2005). When violence begins at home: A comprehensive guide to understanding and ending domestic abuse. Alameda, CA. Hunter House Publishers.

Wong, E. C., Schell, T. L., Marshall, G. N., Jaycox, L. H., Hambarsoomians, K., & Belzberg, H. (2009). Mental Health Service Utilization After Physical Trauma: The Importance of Physician Referral. Medical Care, 47(10), 1077-1083. doi: 10.1097/MLR.0b013e3181a80fc9.

Appendix A: Additional Resources for Implementation

Trauma Overview

- Trauma-Informed Care in Primary Care: A Literature Review. A summary of existing research on trauma-informed care from Kaiser Permanente and the National Council for Behavioral Health (2017).
- Trauma-Informed Care in Behavioral Health a Treatment Improvement Protocol. A treatment improvement protocol for implementing trauma-informed care from SAMHSA (2014).
- Adverse Childhood Experiences. Information and research from the Centers for Disease Control and Prevention (2016).
- How Childhood Trauma Affects Health Across a Lifetime. Video presentation on the effects of childhood trauma by pediatrician Dr. Nadine Burke Harris (2014).
- Cultural and Linguistic Competence Checklist. A tool to review trauma related documents for cultural and linguistic competence by Suganya Sockalingam, PhD, from Change Matrix LLC (2017).
- Why trauma informed care and culturally competent care are one and the same. PowerPoint slides identifying principles by Suganya Sockalingam, PhD, from Change Matrix LLC (2017).

Change Management Strategies: Create the Conditions for Change

- Trauma Screening, Brief Intervention and Referral to Treatment Issue Brief. Issue brief describing a trauma-informed approach to Screening, Brief Intervention and Referral to Treatment (SBIRT) from the Institute for Child and Family Well-Being (2017).
- Trauma-Informed Care Agency Self-Assessment. Agency self-assessment from Trauma Transformed (2013).
- The Business Case for a Trauma-Informed Approach. Literature review summarizing the existing research to support the development of a business case for trauma-informed approaches.
- Making Leadership Happen White Paper. White paper explaining the application of a whole systems approach to leadership by Cynthia McCauley, Center for Creative Leadership (2014).

CHANGE CONCEPT 1: HELP ALL INDIVIDUALS FEEL SAFETY, SECURITY AND TRUST

Assessment Tools

- Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol. Self-assessment and planning tool for creating a trauma-informed culture by Roger D. Fallot and Maxine Harris (2009).
- Creating Cultures of Trauma-Informed Care: Program Fidelity Scale Instruction Guide. Creating cultures of trauma-informed care scale instruction guide from Community Connections (2015).

Reports and Papers

- Key Ingredients for Successful Trauma-Informed Care Implementation. White paper on key components of trauma-informed care from the Center for Health Care Strategies, Inc. (2016).
- Creating a Safe and High-Quality Environment. Book chapter on creating safe and high-quality spaces from the Agency for Healthcare Research and Quality (2008).

Universal Education, Posters and Signage

- Inspirational and Positive Messaging Signage. Inspirational office signage for purchase from Healthcare Inspirations (2018).
- Hope Beyond Hurt Poster. Poster on hope, trauma and toxic stress from the National Council for Behavioral Health (2014).
- Hope Beyond Hurt Poster (in Spanish). Poster on hope, trauma and toxic stress in Spanish from the National Council for Mental Wellbeing (2014).
- Universal Education Resources and Tools. Universal education materials and resources for a variety of populations from Futures without Violence (2018).

CHANGE CONCEPT 2: DEVELOP A TRAUMA-INFORMED WORKFORCE

Training Resources

Videos

- An Introduction to Trauma-Informed Care with Cheryl Sharp. Video introducing trauma-informed care concepts with trauma expert Cheryl Sharp by Community Healthcore (2015).
- Helping Children Recover from Trauma. Recorded presentation video with trauma expert, Dr. Bruce Perry on helping children recover from trauma from the National Council for Behavioral Health (2014).
- How Racism Harms Pregnant Women — and What Can Help. Video presentation on how racism harms pregnant women featuring doula Miriam Zoila Pérez from TED (2016).
- Unnatural Causes: Is Inequality Making Us Sick? Video series on social determinants of health and trauma from California Newsreel and the National Association of County and City Health Officials (2008).

PowerPoint Presentation Slides

- Trauma-Informed Care 101 Training Presentation. PowerPoint presentation slides for a 2-hour trauma-informed care 101 training from Bread for the City (2017).
- Trauma-Informed Care 101 Training Presentation. PowerPoint presentation slides for a 7.5-hour trauma-informed care 101 training from Bread for the City (2017).
- Introduction to Historical Trauma. PowerPoint presentation training slides for a 1-hour training on historical trauma based on University of Minnesota Extension Historical Trauma and Cultural Healing Program (2017).

Implementation and Evaluation Tools

- Culturally Sensitive Trauma-Informed Care. Tools and resources for implementing culturally sensitive trauma-informed care from the Children's Hospital of Philadelphia (2013).
- Hotspots for Retraumatization or Activation for Clients Worksheet. Worksheet to help identify and replace traumatizing language and behavior among providers from Trauma-Informed Oregon (no date).

Articles and Handouts

- What is Trauma-Informed Care? Brief handout on trauma-informed care from Trauma Informed Oregon (no date).
- REFLECTED. REJECTED. ALTERED: Racing ACEs Revisited. Article analyzing race and ACEs by Kanwarpal Dhaliwal from Trauma Transformed (2016).
- Transforming Historical Harms. Online book on historical trauma and the transforming historical harms approach from the Eastern Mennonite University's Center for Justice and Peacebuilding (2013).

HUMAN RESOURCES TOOLS

Guidelines and Checklists

- Trauma-Informed Care Workgroup Meeting Guidelines. Guidelines for conducting trauma-informed meetings from Trauma Informed Oregon (2016).
- Hiring Guidelines for Peer Specialists. Recommendations and checklist for hiring peer specialists by Lyn Legere from The Transformation Center (2011).
- Human Resources Practices to Support Trauma Informed Care in Your Organization. Practice recommendations for human resources to develop trauma-informed workforces from Trauma Informed Oregon (2016).
- Guide to Reviewing Existing Policies. Checklist guide to reviewing human resources and organizational policies through a trauma-informed lens from Trauma Informed Oregon (2016).
- Policy Guidance for Trauma Informed Human Resources Practices. Guidance document for trauma-informed human resources policies from the Missouri Trauma Roundtable through the Department of Mental Health (2017).
- Agency Wide Communication. Handout with considerations for agency-wide communications from Trauma Informed Oregon (2016).
- Developing your Self-Care Plan. Resources and tools to develop self-care plans from the University of Buffalo School of Social Work (no date).

Assessment Tools

- Attunement and Self-Assessment in Supervision. Checklist and assessment for delivering trauma-informed supervision from Trauma Informed Oregon (2016).
- Trauma-Informed Policy Audit Tool. Tool created to assess organizational policy and provide a roadmap to gauge potential impacts from Trauma Transformed.

Handouts

- A Trauma-Informed Workforce: An introduction to Workforce Wellness. Brief handout on workforce wellness from Trauma Informed Oregon (2016).
- Assuming a Racial Equity Lens. Handout from the National Council for Mental Wellbeing.

CHANGE CONCEPT 3: BUILD COMPASSION RESILIENCE AMONG THE WORKFORCE

Presentation Slides and Videos

- Addressing Secondary Stress: Strong in the Broken Places. Training presentation slides on addressing secondary stress from Trauma Informed Oregon (2014).
- Addressing Secondary Stress. Video presentation from Trauma Informed Oregon (2014).
- Tips for Self-Care. Poster with self-care tips from University of Buffalo School of Social Work (no date).
- Provider Resilience app. A mobile app by the National Center for Telehealth and Technology to support providers.
- Professional Quality of Life Scale (ProQOL). Assessment scale for measuring professional quality of life from the Center for Victims of Torture (2012).

CHANGE CONCEPT 4: IDENTIFY AND RESPOND TO TRAUMA AMONG PATIENTS

Education and Inquiry Tools

- Connected Parents, Connected Kids. Universal education tool from Futures Without Violence (2016).
- Suggestions for Trauma-Informed Responses. PowerPoint presentation slides with trauma-informed responses from Jefferson County Public Health Department (no date).

Screening and Assessment Tools

- Staying Healthy Assessment Questionnaires. Catalog of screening tools for a range of ages and in multiple languages from the California Department of Health Care Services (no date).
- Standardized Measures to Assess Complex Trauma. Compilation of tools to measure trauma for a range of ages from the National Child Traumatic Stress Network (no date).
- Tools for Assessing PTSD and Trauma. Compilation of training materials and tools for assessing PTSD and trauma from the U.S. Department of Veterans Affairs (2017).

Trauma Specific Interventions

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection®
- Sanctuary Model®
- Seeking Safety
- Trauma, Addiction, Mental Health, and Recovery (TAMAR)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

CHANGE CONCEPT 5: FINANCE AND SUSTAIN TRAUMA-INFORMED APPROACHES IN PRIMARY CARE

Advocacy Tools

- Trauma-Informed Policy Audit Tool. Tool created to assess organizational policy and provide a roadmap to gauge potential impacts from by Trauma Transformed.
- State Profiles for 50 States and District of Columbia. State-based profiles on current legislative and advocacy efforts related to trauma across all 50 states and the District of Columbia from ACEs Connection.
- Building Community Resilience — Policy and Advocacy Guide

NATIONAL COUNCIL *for* Mental Wellbeing

TheNationalCouncil.org