Trauma-Informed Primary Care Initiative
A Kaiser Permanente and National Council Partnership

Kickoff Meeting
June 9 – 10, 2015
Cheryl Sharp, MSW, ALWF

National Council for Behavioral Health
June 9th

• Welcome
• Introductions
• Seeking Safety Report Out
• An American’s Resurrection
• What Hurts? What Helps?
• Overview of Trauma-Informed Approaches
• Trauma-Informed Care is Good Medicine!
• Creating a Vision for Trauma-Informed Approaches in an FQHC
• Best Practices in Implementation Science
June 10th

- Takeaways from yesterday
- Implementation Inspiration
- Getting Off to a Great Start
- Assessing Your Organization
- Performance Indicators, Data Collection and Evaluation
- Implementation Planning
- Next Steps
Kaiser Permanente Welcome and Introductions

Winston Wong, M.D., M.S., Medical Director, Community Benefit and Director, Disparities Improvement and Quality Initiatives

and

Coralie Chan, MPH, Executive Consultant, National Community Benefit
National Council Welcome

Linda Rosenberg, President and CEO
National Council for Behavioral Health
The National Council

2350 Behavioral Health Organizations

750,000 staff serving 8 million adults, children, and families with mental illness and substance use disorders...
THE IMPORTANCE OF TRAUMA-INFORMED APPROACHES: AN AMERICAN’S RESURRECTION

Eric C. Arauz MLER
President
Trauma Institute of New Jersey
Adjunct Faculty Instructor: Psychiatry
Rutgers Robert Wood Johnson Medical School
THE ORDINARY RESPONSE TO ATROCITIES IS TO BANISH THEM FROM CONSCIOUSNESS. CERTAIN VIOLATIONS OF THE SOCIAL COMPACT ARE TOO TERRIBLE TO UTTER ALOUD: THIS IS THE MEANING OF THE WORD UNSPEAKABLE. ATROCITIES, HOWEVER, REFUSE TO BE BURIED.”

— JUDITH LEWIS HERMAN, TRAUMA AND RECOVERY
QUALIA VS INTENTIONALITY

(PHENOMENAL CONSCIOUSNESS VS. REPRESENTATION OF MENTAL STATES)

...THE DIFFERENCE BETWEEN THE PATIENT’S EXPERIENCE OF THE DISEASE AND THE DOCTOR’S ATTENTION TO THE DISEASE...

THE ILLNESS NARRATIVES
ARTHUR KLEINMAN MD,
PSYCHIATRIST, HARVARD MEDICAL SCHOOL;
PROF. ANTHROPOLOGY HARVARD UNIVERSITY
MECHANISMS BY WHICH ADVERSE CHILDHOOD EXPERIENCES INFLUENCE ADULT HEALTH STATUS

Adverse Childhood Experiences

Adoption of Health-Risk Behaviors

Social, Emotional, and Cognitive Impairment

Disease & Disability

Early Death

Birth

Death


• Bipolar 1 Disorder
• Addiction
• Posttraumatic Stress Disorder
• Complex Trauma
• 2 Suicide Attempts
• 265 Pounds in 7th Grade
• High Blood Pressure
• Chronic Asthma
WHERE WE FIRST MEET

• 6-14 YRS. OLD
• CHRONIC ASTHMA
• 40-100 POUNDS OVERWEIGHT
• STUTTER AND STAMMER
NEUROBIOLOGY OF HELPlessness

TRAUMA: ANY LIFE EVENT OCCURRING IN A RELATIVE STATE OF HELPlessness—a car accident, the sudden death of a loved one, *A FRIGHTENING MEDICAL PROCEDURE* (...)—can produce the same NEUROPHYSIOLOGICAL CHANGES IN THE BRAIN AS DO COMBAT, RAPE, OR ABUSE.

ROBERT SCAER MD

Neurologist, Traumatologist, Medical Director of Internationally recognized Pain Management Center at Mapleton Rehabilitation Center, Community Hospital Boulder, Colorado
Toxic stress

CORTISOL

Other body systems

Immune system

Gene expression (epigenetics)

Inflammatory response

Infection fighting (antibodies)
Neocortex

Limbic

Diencephalon

Brainstem

Abstract thought
Concrete thought
Affiliation
"Attachment"
Sexual Behavior
Emotional Reactivity
Motor Regulation
"Arousal"
Appetite/Satiety
Sleep
Blood Pressure
Heart Rate
Body Temperature
FRACTURING OF IDENTITY: PULVERIZED VISCERAL AND COGNITIVE NARRATIVES


• STORY OF ATROCITY/LANGUAGE OF ABOMINATION (Herman, J., Trauma and Recovery. New York: Basic Books, 1997.)
WE MEET AGAIN
HOW COULD PRIMARY CARE HAVE MADE A DIFFERENCE?

WHY A TRAUMA-INFORMED APPROACH CHANGES OUTCOMES AND THE TRAJECTORY OF A PERSON’S LIFE?
DIDAGNOSIS
• Bipolar Disorder
• Addiction
• Developmental Trauma
• Posttraumatic Stress Disorder
• Suicide Attempts - Near Lethal
Abstract thought
Concrete thought
Affiliation
"Attachment"
Sexual Behavior
Emotional Reactivity
Motor Regulation
"Arousal"
Appetite/Satiety
Sleep
Blood Pressure
Heart Rate
Body Temperature
Cerebral Hemisphere—Insula Exposed

- Central sulcus
- Frontal lobe
- Parietal lobe
- Occipital lobe
- Retracted temporal lobe
- Insula
Effective treatment is a matter of helping individuals keep the observing prefrontal cortex online as it simultaneously experiences the raw primitive sensations generated in the archaic portions of the brain (the limbic system, hypothalamus and brain stem.)

# How States Become Traits

<table>
<thead>
<tr>
<th>Adaptive Response</th>
<th>Rest</th>
<th>Vigilance</th>
<th>Freeze</th>
<th>Flight</th>
<th>Fight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperarousal</td>
<td>Rest</td>
<td>Crying</td>
<td>Resistance</td>
<td>Defiance</td>
<td>Aggression</td>
</tr>
<tr>
<td>Continuum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociative</td>
<td>Rest</td>
<td>Avoidance</td>
<td>Compliance</td>
<td>Numbing</td>
<td>Fainting</td>
</tr>
<tr>
<td>Continuum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Areas</td>
<td>Neocortex</td>
<td>Subcortex</td>
<td>Limbic</td>
<td>Midbrain</td>
<td>Brainstem</td>
</tr>
<tr>
<td>Cognition</td>
<td>Abstract</td>
<td>Concrete</td>
<td>Emotional</td>
<td>Reactive</td>
<td>Reflexive</td>
</tr>
<tr>
<td>Mental State</td>
<td>CALM</td>
<td>AROUSAL</td>
<td>ALARM</td>
<td>FEAR</td>
<td>TERROR</td>
</tr>
</tbody>
</table>
FEAR/IMMOBILITY CYCLE

(LEVINE, P., IN AN UNSPOKEN VOICE. BERKELEY: NORTH ATLANTIC BOOKS, 2010, 70.)

Immobility → Arousal

Fear/Helplessness → Unsuccessful Escape
Identity is a relational achievement (Mokros, HARTMUT B., Suicide and Shame, American Behavioral Scientist, 38:8 (1995:Aug.))
Mutually Therapeutic Dyadic Attunement (MTDA)

Jumping Together

Recruit the Circuit

- Autonomic Nervous System
- Social Engagement System: Neuroception
- Pro-Social, Fight or Flight, Freezing/Imminent Death
- Interventions: Heart to Face, Heart to Voice, Heart to Eyes

Social Engagement System
Cranial Nerves V, VII, IX, X, XI
Ventral Vagal (X), Dorsal Vagal (X)
An Unique Face-Voice-Heart Connection

ppncenter.com
copyright Kate White 2013
Center for Pre and Perinatal Programs, LLC
Mutually Therapeutic Dyadic Attunement (MTDA)
Interpersonal Neurobiology

Non-Verbal Communication: Eye Contact, Facial Expression, Tone of Voice, Posture, Gesture, Timing of Response

Dr. Daniel Siegel, MD
(Trauma, Brain & Relationship: Help Children Heal.
https://www.youtube.com/watch?v=jYyEEMlMMb0)
What Hurts and What Helps? Table Activity

• Spend 15 minutes exploring and recording what hurts and what helps on your easel sheets based on your identified topic

• Think about the things that hurt and help within your organization
  ✓ Physical Environment
  ✓ Attitudes and Beliefs
  ✓ Relationships

15 minute report out
Introduction on Trauma and Trauma-Informed Approaches
What is Trauma?

Definition (SAMHSA Experts 2012) includes three key elements:

*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as overwhelming or life-changing and that has profound effects on the individual’s psychological development or well-being, often involving a physiological, social, and/or spiritual impact.*
What Does Trauma Do?

Shapes our Beliefs

Worldview

Spirituality

Identity
Results in Vicious Loop
Nadine Burke Harris
Why is Understanding Trauma Important?

• Good medicine
• Many current problems may be related to traumatic life experiences
• People who have experienced traumatic life events are often very sensitive to reminders of the original event
• These reminders or triggers may cause a person to relive the trauma and view our setting/organization as a source of distress rather than a place of healing and wellness
Trauma-Informed Approaches in Primary Care Can:

- Minimize reaction to triggers
- Improve non-adherence to treatment and use or overuse of services
- Help people understand how trauma impacts their current health
- Connect people with appropriate resources

Trauma-Informed Care is Now the *Expectation*, NOT the Exception
Triggers in Healthcare Settings

**Definition:** An external event that causes internal discomfort or distress such as:

- **Sights** - white lab coats, medical equipment, restraints, X-ray bib, room temperature
- **Sounds** - dental drill, ambulance sirens, chaos in environment
- **Smells** - rubbing alcohol, antiseptic odors, latex gloves
Why medical settings may be distressing for people with trauma histories:

- Invasive procedures
- Removal of clothing
- Physical touch
- Personal questions that may be embarrassing or distressing
- Power dynamics of relationship
- Gender of healthcare provider
- Vulnerable physical position
- Loss of and lack of privacy
Empathy – Changing our Lens
Therefore, we need to exercise...
Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and Transparency
- Collaboration and Mutuality
- Empowerment
- Voice and Choice

*(Fallot 2008, SAMHSA 2012)*
Safety

Physical
Psychological
Social
Moral

If you have never felt safe or remembered safety, how will you know it when it is present?
Trustworthiness and Transparency
Collaboration and Mutuality
Empowerment

Today you are YOU, that is TRUER than true. There is NO ONE alive who is YOUER than YOU!

~ Dr. Seuss

"Be who you are and say what you feel because those who mind don’t matter and those who matter don’t mind."

~ DR. SEUSS
Voice and Choice
Defining a Trauma-Informed Approach in Health Care Systems

- Realizes the prevalence of trauma
- Recognizes how trauma affects all individuals involved with the program, organization, or system, including its own workforce
- Resists re-traumatization
- Responds by putting this knowledge into practice

(SAMHSA, 2012)
Domains of a Trauma-Informed Primary Care Setting

**Domain 1:** Early Screening & Comprehensive Assessment of Trauma

**Domain 2:** Patient Voice, Choice and Collaboration

**Domain 3:** Workforce Development and Best Practices

**Domain 4:** Safe and Secure Environment

**Domain 5:** Data Collection and Performance Improvement
Domain 1
Early Screening and Comprehensive Assessment

Develop a respectful screening and assessment process

- Routine
- Competently done
- Culturally relevant
- Sensitive
Screening and Assessment Process

**Screen** - brief, focused inquiry to determine an individual’s

- Experience of traumatic events or current events that might be traumatizing
- Experiencing of invasive thoughts, feelings or behaviors associated with trauma

**Assessment** - more in-depth exploration of the nature and severity of the traumatic events and the consequences on a person’s life including current distressing symptoms

**Refer** to internal or external resources
Domain 2
Patient Voice, Choice and Collaboration

Have system in place to:

• Monitor patient satisfaction and perception of care

• Include recipients of care in processes that influence decision making

• Provide information to patients on the impact of adverse life events on a person’s whole health
Domain 3

Work Force Development and Best Practices

• Increase awareness, knowledge and skills of the entire workforce to deliver services based on the principles of sensitive practices
• Create systems that promote collaboration between primary and behavioral health care
• Provide resources for behavioral health staff to deliver trauma specific interventions
• Implement policies, practices and procedures that build and sustain a trauma-informed work force
Domain 4
Safe and Secure Environments

Create Environments that are

• Safe
• Trusting
• Healing
Domain 5
Data Collection and Performance Improvement

Data related to each domain is tracked, analyzed and used to address challenges and/or reinforce progress.
Data Collection*

LC participants will be expected to:

• Submit limited amount of data including:
  – Numbers of patients screened for history of trauma/adverse life events;
  – Numbers subsequently assessed;
  – Results of workforce surveys conducted pre- and post-Learning Community
  – Health information regarding the individual organization’s target population that is meaningful to the organization and identified in collaboration with the Learning Community faculty

• Participate in up to two focus groups

*All information collected will be aggregate and not at the individual patient level
Patient Cohort

Organizations may choose to focus on patients, such as:

- Poorly controlled chronic health conditions
- Those who are pregnant
- High utilizers of emergency room services
- Who have an unhealthy lifestyle that mitigates the value of primary care
- Who have difficulties adhering to treatment, such as two or more outstanding preventive health measures
Sensitive Practices in Health Care Settings

• Be respectful
• Take time
• Build rapport
• Share information
• Share control
• Respect boundaries
• Foster mutual learning
• Understand non-linear healing
• Demonstrate awareness and knowledge of trauma

Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse
Trauma Informed Care is Good Medicine!

Sarah Y. Vinson, M.D.
Triple Board Certified Child & Adolescent, Adult and Forensic Psychiatrist
Satcher Health Leadership Institute, Morehouse School of Medicine
me@drsarahvinson.com
Traumatic Event Exposure
PTSD Prevalence
Traumatic Exposure

Intrusive
NM, play, memories, dissociation, emotional or physiologic responses to triggers

Avoidance of...
Thoughts, feelings, external reminders

Hyperarousal & Reactivity
Irritability, aggression, self-destructive or reckless behavior, hyper-vigilance, low concentration, sleep problems

Thoughts
Inability to recall features of the event
Persistent negative beliefs about self/world
Distorted blame of self and others

Mood
Trauma related emotions
Diminished interest in activities
Feeling alienated
Constricted affect

Affect Dysregulation
Negative Self-Concept
Interpersonal Problems
Relationship Schemas

Prolonged Repeated Traumatic Exposure
Medical Ethics

Autonomy

Beneficence

Non-Maleficence

Justice
System Changes

- ACO's
- Advanced Primary Care
- Health Homes
- NCQA/PCMH
- DSRIP

Institute for Family Health Victoria Ward, LCSW
Triple AIM

- Improve Patient Experience
- Decrease Costs
- Improve Quality

Institute for Family Health Victoria Ward, LCSW
Not In Addition ......

• In support of.......  
• Messaging to providers and staff  
• What other initiatives are going on such as quality projects, productivity
Quality Outcomes

• Huge focus on primary care quality initiatives
• Review opportunities to tie trauma work to outcomes
• Can have financial impact and therefore stronger buy-in
This is Important **Organizational Work**

- It can’t be just you……..
- Opportunities to weave into existing systems such as CQI, IT, EOC
Why Won’t This Work

• What are the barriers?
• What individuals might not have buy-in?
Discussion

- What would be a meaningful outcome for you and your organization?
- What must you absolutely need to resolve in order to go forward with this project?
Questions???

Institute for Family Health Victoria Ward, LCSW
Best Practices in Implementation Science

Anthony J. Salerno, PhD, Senior Consultant, National Council for Behavioral Health

McSilver Institute for Poverty, Policy and Research, New York University
The Kotter 8 Step Change Lifecycle provides a lifecycle for driving successful “people” change.

1. Increase Urgency
2. Build the Guiding Team
3. Get the Vision Right
4. Communicate for Buy In
5. Empower Action
6. Create Short Term Wins
7. Don’t Let Up
8. Make Change Stick
1. Leadership Communication that Builds a Sense of Urgency

– Communicate to everyone
– Organization “owns” the change
– Aligns with the core mission of the organization
– Content of the message
  • The change is important
  • The change is not easy
  • Everyone is part of making change successful
  • Pros of success and the cons of failure
  • Benefit to all stakeholders
  • We can do it!
Building The Right Team and Consensus Building

- **Knowledge and skills (growth orientation)**
  - Each member expands his/her awareness and understanding of trauma informed care
  - Each member makes the best use of the resources and tools provided by the learning community to gain knowledge and develop competencies

- **Shared Vision**
  - Each member has a shared understanding of trauma informed care
  - Each member communicates the vision every chance he/she gets
  - Each member engages in an honest discussion about TIC to develop a shared vision
  - Team “sees” the purpose and direction of change
  - Articulated in a minute or less

- **Shared commitment**
  - Each member attends meetings and follows through with tasks
  - Participates in Learning community activities
  - Keeps moving forward in the face of inevitable challenges and barriers

- **Outcome orientation**
  - Each member works to translate the vision of trauma informed care into specific and measurable improvements through qualitative and quantitative data.

- **Leadership Perspective**
Team Membership

• Committed leadership with responsibility and authority to guide the change process
• Involve those affected by the change
• Involve those expected to carry out the change in day to day activities
• Involves those with experience or knowledge related to the change
• Involve those who can provide resources to support the ongoing program development process.
• Involves those whose values, interests, beliefs and orientation aligns with the change (champions)
The Team Promotes and Supports Leadership Commitment

• Alignment with leadership concerns/wants/needs
  – Reduce burden
  – Benefits based on leadership values
  – Demonstrate value
  – Address risks
    • Staff reaction, liability, incompatibility with other efforts, time/cost issues
2. Build the Right Team

- Committed leadership with responsibility and authority to guide the change process
- Involve those affected by the change
- Involve those expected to carry out the change in day to day activities
- Involves those with experience or knowledge related to the improvement effort
- Involve those who can provide needed resources
- Involves those whose values, interests, beliefs and orientation aligns with the improvement effort (champions)
3. Get the Vision Right
4. Communicate for Buy-In

What is it?

• Strategies to Influence attitudes, beliefs, expectations and perceptions in a direction that supports the adoption of trauma informed care principles and practices

• Buy-in is designed to activate the support from a specific audience

• Increasing positive feelings about the change in a way that overcomes the “negative” feelings and/or concerns of the workforce that is often associated with change:
  > Control
  > Meaning
  > Status
Communicate for Buy In

• Emphasize the benefits of adopting a trauma-informed care vision for all stakeholders
• Acknowledge the common reactions of the workforce to change. Staff are often concerned that a significant change will negatively affect............
  • The meaning they derive in their work
  • Their control over their work life
  • Their status in the organization
• Involve and engage staff in sharing their ideas about how to successfully adopt trauma-informed care practices and principles.
  – This assists staff to regain control, status and personal meaning in the new direction.
• Emphasize the supports, resources and tools available to support the adoption of trauma informed care principles and practices.
Buy-In Strategies

• Communicate frequently and in a simple and heartfelt manner
• Emphasize the benefits to ALL shareholders
• Include shareholders in the shaping and promoting of the change process
• Address skepticism by insuring that leadership “walks the talk” and stands behind the implementation team
• Acknowledge the very common concerns of the workforce to change:
  • Personal meaning associated with current practices
  • Fear of loss of control
  • Change in perceived professional and personal status
• Assist staff to regain control, status and personal meaning in the new mission/direction
5. Empower Action

- The organizational improvement team has direct relationship with leadership (includes leadership with authority)
- The team has time and resources to take on the serious tasks associated with adopting and sustaining TIC
- Minimize “hoops to jump through to get a green light”
- Test out changes on small scale (rapid and measurable tests)
- Organization encourages, and rewards innovation and creativity
6. Short Term Wins

• Have short term action steps that are observable and meaningful
• Make short term gains public, share with stakeholders
• Reinforce positive changes and acknowledge how everyone contributes to positive outcomes
7. Don’t Let Up

• Expect the process to be non-linear with bumps along the way (bumps are inevitable and signs you’re making real change)

• There will be inevitable forces at work to resist the change and return to the more comfortable habit state.

• Keep an eye on the process at all times
8. Make the Changes Stick

Institutionalize changes you wish to sustain (e.g., policy and procedural requirements)

- Change performance expectations
- Change performance standards to support the change
- Change documentation requirements
- Use data to provide continuous feedback on performance
- Visibly reinforce and recognize positive changes
- Align changes with reliable fiscal streams
- Market one’s unique and added value (system reputation)
First Law of Quality Improvement

*“Every system is perfectly designed to achieve exactly the results it gets”.

Your current system is perfectly designed to get exactly the results/outcomes you currently get for your high priority cohort.

* ©2002 Institute for Healthcare Improvement
Second Law of Quality Improvement

To change the **RESULTS**
you must change the **SYSTEM**!

- Working harder won’t do it!
- Getting rid of poor performers won’t do it!
- Throwing more money at the existing system won’t do it!
- Trying something new in the current system may do it!
Application of Basic Continuous Quality Improvement Approaches - FOCUS PDCA

**Find** an improvement area (cohort selection)

**Organize** a team

**Clarify** current practices (OSA)

**Understand** source of variation/problem (unaddressed trauma contributes to sub-optimal health)

**Select** a strategy (introduce a screening, assessment and support process)

Plan

Do

Check

Act
Continuous Quality Improvement: FOCUSPDCA Method

- **Find**: identify a problem that needs improvement. Problems are pretty easy to identify.

- **Organize a team**: a team that understands or works with the process or problem. The team consists of people who know the process well and can speak to what works and what needs changing.

- **Clarify** the current practices, processes and activities related to the improvement area.

- **Understand** what impacts the variations in the quality of the process.

- **Select a strategy/solution** that meets many of the criteria associated with practical success.
PLAN: What’s a Really Good Improvement Strategy?

- Not expensive
- Can tell if the idea is working or not
- Affects many
- Can be done in a reasonable timeframe
- Is in the control of the organization
- Aligns with regulations, fiscal requirements and law.
- Unlikely to cause other problems (unintended consequences dilemma)
- Practical in light of other organizational priorities
- Reasonable in light of staff demands on time and energy
- Tools and resources available
DO: Implement the Plan

Establish the workflow and implementation process:

– What
– When
– Where
– By whom
– With whom
Study: Did the Change Accomplish the Intended Outcome?

Answers the questions:

• How will we know that the improvement strategy was implemented as designed?

• How will we know if the strategy was practical, effective, measureable and sustainable?

• Is our checking approach reliable and valid?
Act: Make Decisions Based on Outcome of the Improvement Strategy

Based on what was learned from the test:

• Adapt – modify the changes and repeat PDSA cycle.

• Adopt – consider sustaining the improvement plan via policy and procedures.

• Abandon – change your approach and repeat PDSA cycle.
Wrap Up

• What was the biggest takeaway from the day?
• Based on what you learned today, what do you see as most doable?
• Based on what you learned today, what do you see as the biggest challenge?
• What would you most like to accomplish tomorrow?
June 10th

- Takeaways from yesterday
- Implementation Inspiration
- Getting Off to a Great Start
- Assessing Your Organization
- Performance Indicators, Data Collection and Evaluation
- Implementation Planning
- Next Steps
Implementation Inspiration: Trauma Informed Approaches in Primary Care

Glenda Wrenn, MD, MSHP
Disclosures

• I have no relevant financial relationships to disclose.
Learning Objectives

• Recognize the role of leadership in implementation of trauma-informed care

• Identify examples of implementation of trauma-informed practices in FQHC, safety net clinic, and VA systems

• Understand the role of primary care in engagement process in trauma-focused care
Why Start with Leadership?

“Today, the need for leaders is too great to leave their emergence to chance”

-Institute of Medicine, *The Future of Public Health*, 1988
Satcher Health Leadership Institute
Philosophy of Leadership

• We must not leave the emergence of leaders relative to disparities in health to chance alone.

• There are leadership capacities in all of us; we must help to develop that capacity because leadership matters.

• Leaders must be good learners, continually learning more about themselves, those they lead, and the cause or missions for which they work.

• Leadership at its best is mission oriented and ethically based.

Source: Satcher Health Leadership Institute
Leadership Lessons From the Satcher Health Leadership Institute

• Leadership Responds to Opportunities, Challenges, and Crises.

• Leadership is a Relay Race.

• Leadership is Not Position Dependent.

• Leadership is about Partnerships.

• Effective Leadership Transforms Communities.
Case Example: Mercy Care

Field of Light

- FQHC Serving primarily homeless population
- Began with partnership around consultative model of behavioral health integration
- Build upon foundation of services that had many elements consistent with being trauma-informed
- Pilot efforts were used to build capacity and organizational buy-in
Mercy Care-cont’d

- Grants were leveraged to expand behavioral health which rapidly expanded over 2-3 years
- They are currently demonstrating the whole health model of care (addressing the social determinants, mental, dental, physical health)
A Focus on Systems...

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers:

(1) **routinely screen** for trauma exposure and related symptoms; (2) use **culturally appropriate evidence-based assessment and treatment** for traumatic stress and associated mental health symptoms; (3) **make resources available** to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to **strengthen the resilience** and protective factors of children and families impacted by and vulnerable to trauma; (5) **address parent and caregiver trauma** and its impact on the family system; (6) emphasize continuity of care and **collaboration** across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that **increases staff resilience**.

http://www.nctsn.org/resources/topics/creating-trauma-informed-systems
Screening and Workflow

PTSD Screen for Primary Care (4 items- 3 or more ‘yes’ is positive)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1) Have had nightmares about it or thought about it when you did not want to?

2) Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

3) Were constantly on guard, watchful, or easily startled?

4) Felt numb or detached from others, activities, or your surroundings?

Prins, Ouimette, & Kimerling, 2003
Follow-up Positive Screen

PTSD Checklist-DSM-5 (PCL-5)

• 20-item self-report
• 5-10 minutes to complete
• Score range from 0-80 with ~38 being general rule for cutoff
• Can be scored to give provisional diagnosis
• Can be used to monitor symptom severity

Workflow Examples

• VA - Patient Aligned Care Teams
  – Triage nurse administers PTSD-PC annually
  – Providers administer follow up PCL-5

• Grady Asa G. Yancey Health Center
  – Self administered at Wellness Kiosk
  – Annual and for new patients

• Mercy Care
  – Administered as needed in primary care
  – Part of routine MH assessment
Asa G. Yancey: Provider Education through Co-Management & Co-Learning

• Weekly group lunch meetings
• Administered provider surveys addressing satisfaction/burnout
• Taught Acceptance and Commitment applied to Primary Care
VA-Women’s Center of Excellence: Trauma-Informed Engagement

- Multidisciplinary Center
- Shared weekly didactic with practical education (pelvic exam in context of sexual trauma, medication interest)
- Engagement with specialty care can be a “hard sell” even with a “warm handoff”
- Team members are at their best when authentically informed and engage patients to “pave the way”
Engagement in Care: Beyond Recognize and Refer

- Culture Matters (organizational and individual)
- Screening as engagement strategy
  - Understand help acceptance vs. help seeking
- Collaborative Care and “No Wrong Door”
- Referral Guidelines
  - Need a process as well as provider training
- Co-management around comorbidity
Implementation Pearls

• Solutions can be stepwise or system-wide
• Start small with an eye towards scale
• Build your own resilience
• Don’t count out naysayers
• Develop Leadership at all levels-It takes a team
Implementation Planning Guide: Get Off to a Great Start

Linda Ligenza, LCSW, Director Clinical Services
National Council for Behavioral Health
Assessing Your Organization in Alignment with Trauma-Informed Principles and Practices

Cheryl Sharp, MSW, ALWF
Senior Advisor for Trauma-Informed Services
National Council for Behavioral Health
Completing the OSA

• At your table, please score the OSA individually, without conversation.
• Use the Scoring and Graphing Guide to tabulate your cumulative scores.
• Discuss your findings
  – Did you find disparities, differences of opinions?
  – What surprised you?
Using the OSA
(OSA Survey Monkey)

• Share your understanding of the OSA with your other CIT members
• Determine who you want to complete the OSA
• How will you distribute using Survey Monkey?
  • Will you be distributing to multiple sites?
    – Provide those sites to National Council Support
    – Provide a deadline for turnaround
• How will you use this information to guide the work of your team.
Performance Indicators, Data Collection and Evaluation: Questions We Hope to Answer through This Project

Anthony J. Salerno, PhD, Senior Consultant, National Council for Behavioral Health
McSilver Institute for Poverty, Policy and Research, New York University
Measuring Performance- Evaluation and Data Collection

– Overview of key Performance Indicators

– Methods and Tools to support the collection and monitoring of key performance indicators

– Activity for Teams:
  • Complete Workflow decision support tool
  • Review the Patient Data Log
  • Complete goals and objectives planning tool (first thirty days)
Performance Indicators:

Four core areas of evaluation to address:

• Screening and Assessment

• Health Improvement Indicators (those indicators aligned most closely with the needs of the selected cohort)

• Workforce Experience and Perceptions of the Change Process

• Adoption of Trauma-Informed Principles and Practices
Screening/Assessment/Referral

Total number of patients in the selected cohort=

• Number/percentage of patients in the cohort who have been screened for trauma
• Number/percentage of positive screens
• Number/percentage of positively screened individuals who complete a comprehensive assessment
• Number/percentage who were recommended to receive trauma specific support
• Number/percentage of patients who engaged in trauma specific support
Health Improvement Related Indicators

• Patient self-report (e.g., intensity, duration and functional consequence of pain; report of wellbeing; increase in positive perception of primary care; positive feedback about the trauma related inquiries and supports)
• Service utilization (e.g., improvement in appointment keeping, follow up with specialty care; less use of emergency services)
• Health behavior change (e.g., improvement in weight, blood pressure, BMI, activity level)
• Blood chemistry indicators
• Standardized measures of wellness, health, self-management, patient activation
Workforce Experience and Perceptions of the Change Process

– Pre and post surveys of staff involved in processes related to the aims of this project

– Focus groups with select participants to discuss critical issues in detail related to one or more of the following topic areas:
  • Impeding and facilitating organizational conditions
  • workflow approaches to insure practical and reliable screening and assessment activities
  • patient engagement issues
  • behavioral health capacity and practice skills
  • infrastructure challenges; human resources and suggestions to improve implementation strategies.

– Sustainability (intent to continue TIC approaches)
Methods and Tools to support the collection and monitoring of key performance indicators

Examples:

- Patient Data Log
- Workflow Decision Support Tool
- Goals and Objectives Planning Tool

Let’s examine and review each one
# Patient Data Log

<table>
<thead>
<tr>
<th>ID</th>
<th>Screened (+ -)</th>
<th>Received trauma assessment Y N</th>
<th>Recommend Trauma service</th>
<th>Accepts Recommendation 1,2,3,4</th>
<th>Engagement In service 1,2,3,4</th>
<th>Perceived Helpfulness 1,2,3,4</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.K</td>
<td>+</td>
<td>Y</td>
<td>Y</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>B.V.</td>
<td>-</td>
<td>N</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>T.S.</td>
<td>+</td>
<td>Y</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>R.F.</td>
<td>+</td>
<td>Y</td>
<td>N</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Example: Performance Indicators

Data

Cohort: Patients with poorly managed chronic pain
Total number estimate = 84

- Number likely to be seen in the health center during the course of the project = 65
- Number screened for trauma = 41
- Positive screens = 31
- Number who are recommended to meet with the BH practitioner = 31
- Number who met and completed a trauma assessment = 19
- Number who were recommended to receive trauma specific support:
  - Individual in house = 11
  - Group in-house = 6
- Number recommended for outside trauma support = 2
- Number of patients who engaged in trauma specific support
  (Individual in house = 6, Group = 4, Outside = 1)
Workflow Decision Support

- Identify Cohort (high priority population)
- Screening process
- Trauma Assessment Process
- Trauma related support
- Health Outcomes
## Goals and Objectives Planning Tool

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Goals/objectives to accomplish</th>
<th>Who Involved</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Thirty Days</td>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JULY 10, 2015</td>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Using the Performance Monitoring Tool

(PMT Survey Monkey)

• The PMT is tied directly to the OSA and Implementation Planning Guide

• The PMT will be completed by the team and submitted via Survey Monkey by 3 times during the learning community
  – PMT 1 – Due by June 30th
  – PMT 2 – Due by October 30th
  – PMT 3 – Due by February 28th
Next Steps and Wrap Up – Cheryl Placeholder