Addressing Hidden Wounds:
Trauma-Informed Care

Introduction

Over half of Americans report exposure to at least one traumatic event within their lifetime. Among individuals in behavioral health settings, the number climbs to 90 percent.[1,2] Ignoring these statistics, as studies have demonstrated, can negatively impact health outcomes and increase health care expenditure.[1] Traditionally, managing trauma has been directed to behavioral health treatment facilities and targeted towards children and adolescents who have reported psychologically harmful experiences. However, as we move towards a health care system increasingly focused on value and proactively managing the care of high utilization patients, opportunities are developing to diagnose and treat trauma in adults in other areas of the health system. Patients labeled as difficult, untrusting, or non-compliant are often individuals who have been impacted by trauma and have the most to gain from better rapport and engagement from their care team.[1] To address this need, some health care providers are developing unique strategies for integrating new health screening practices and trauma-sensitive treatment for their clientele, often called Trauma-Informed Care (TIC).

This brief examines the current understanding of the impact of trauma on individuals and provides examples within the health care system to change culture and behaviors to support a more TIC environment. Neighborhood Health Plan of Rhode Island (Neighborhood) and the Rhode Island Health Center Association (RIHCA) believe now is a critical time to address trauma within our health system as Rhode Island and the country contend with a plethora of potentially traumatic circumstances. Most notably, the impact of COVID-19 pandemic and the longstanding adverse treatment of populations of color. Preparing our primary care infrastructure to take these and other factors into account is maximizing our ability to support our patients, members and neighbors. We look forward to collaborating with other community stakeholders for a robust dialog on how to help place Rhode Island at the forefront of delivering holistic, restorative care for all populations.

Defining Trauma

Trauma is often defined as an emotional response to an event, experience or set of circumstances that adversely affect an individual's mental and physical wellbeing.[1] Traumatic events may be acute, such as a natural disaster, or chronic, as in the case of domestic abuse. Following a traumatic event, individuals may experience any number of physical, cognitive, behavioral, or psychological symptoms. The onset, range and duration of trauma symptoms are highly individual.[3] Infrastructure is often in place to address and

support high-profile traumatic events, while other forms of trauma are often overlooked. Examples of trauma that are often unaddressed in the health care setting include the death of a close family member, a significant life transition or receiving a life-changing health care diagnosis. All forms of trauma have the potential to limit the ability of someone to access or receive appropriate and necessary health care services.

The impact of trauma can cause very real physical and mental effects that are debilitating factors in someone's life. Studies support the connection between trauma and increased risk of depression, anxiety, smoking, substance abuse, heart disease, and premature mortality with some consistency across race and socioeconomic status.[4] We also know that individual responses to real or perceived adversities are unique and do not always result in poor physical or mental health. In some cases, individuals are influenced by trauma in ways that make it difficult for them to be compliant with their treatment plans.

How someone responds to trauma may be influenced by a wide range of factors, including social support, socioeconomic status, previous adverse events, perceived danger, mental health status, and extent of exposure.[4] Individuals with strong support structures, including social and financial, may be better positioned to avoid or overcome many of the impacts of traumatic experiences. While a lack of supporting variables can place individuals at additional risk for responding negatively to trauma.[4] For many, the effects of trauma clear relatively quickly. However, it is estimated that one in eleven people in the United States will suffer Post-Traumatic Stress Disorder (PTSD) in their lifetime, with the risk being greater for women.[4]

Health care providers who treat patients with trauma can be at risk for experiencing secondary trauma. Chronic exposure to trauma-impacted individuals, coupled with a stressful work environment, can contribute to increased burnout and staff turnover. Further complicating the issue, much like those directly impacted

by trauma, it is not easy to determine which providers are at risk as a variety of factors can contribute to the issue.

[CARLOS]

Carlos is 46 years old, has diabetes, and his sporadic employment makes him eligible to be insured through the Medicaid program.

Previously, Carlos was an established patient with a primary care provider (PCP), but the recent death of his father due to complications associated with heart disease caused Carlos to have a significant aversion toward the medical system. Since then, he has had several visits to the emergency room each year and avoids any preventive health care visits with his PCP. However, Carlos recently visited his local health center or CHC for treatment of a serious cold. Health center staffs, who practice trauma-informed care, worked to understand Carlos's hesitancy to seek care without blaming him; his assigned case manager held conversations in an office setting, not an examining room, and his health care provider worked with him to develop a care plan tailored to his needs. As a result, over time, Carlos has come to trust the health center staff, stabilize his diabetes, and reduce his emergency room visits.

What is Trauma-Informed Care?

TIC is an organizational structure and treatment framework built on understanding, recognizing and responding to all kinds of trauma. Healthcare organizations delivering TIC take universal precautions with patients, even when trauma hasn't been identified. TIC requires

acknowledging that even well- intentioned medical care can re-traumatize already impacted individuals and damage rapport between provider and patient.

As a result of increased awareness of trauma's impact on health and wellbeing, a variety of TIC models have emerged with a few common themes. Implementation of the care models varies dramatically based on the organizations, but common strategies change organizational and clinical policies and practices with intent towards changing the culture. These strategies are often governed by elements that include safety, trustworthiness, choice, collaboration, and empowerment for patients, staff and health care providers alike.[5] Senior leadership plays a critical role when implementing a TIC approach—their ability to dedicate financial resources, lead plan development and communicate new procedures and policies.[6]

The Robert Wood Johnson Foundation's Advancing Trauma-Informed Care (ATC) pilot,

a national initiative to embed trauma-informed practices in the health care sector, recommends starting with an organizational level approach before widespread implementation. They have provided four foundational steps health centers might consider,[7]

- Building awareness and generating buy-in for a trauma-informed approach;

- Supporting a culture of staff wellness;

- Hiring a workforce that embodies the values of trauma-informed care; and

- Creating a safe physical, social, and emotional environment.

Community stakeholders and patient feedback can also help inform and tailor the model of care. Many trauma-informed healthcare organizations have adapted similar strategies to make their environment feel safer, enhance patient engagement and improve health outcomes.

Trauma-Informed Care in Health Centers and Managed Care Organizations

The experience of the community health centers (CHCs) and managed care organizations (MCOs) make them rational institutions to advance TIC in the primary care setting. CHCs and MCOs are the primary point of access for a large portion of diverse and often marginalized patient populations. Many of their shared patients may have continued exposure to a variety of social determents, such as poverty, homelessness, and unsafe neighborhoods. Such conditions can exacerbate patients affected by trauma and contribute to missed medical appointments and poor medication adherence. While not all individuals cared for by CHCs are survivors of trauma, those experiencing its effects might mistrust the medical system, frustrate easily, and act out. Many may also be at risk or have a chronic disease, a substance use disorder or other mental health conditions. Studies also indicate such patients may use high-cost, often-fragmented medical care as compared to those without traumatic episodes.[4,8]

Health centers are also ideally situated among other providers to adopt TIC due to a history of interventions focused on delivering care focused on the patient and adopting new best practices. The level of behavioral health integration within treatment plans, the attributes of the populations they serve, and even the physical space of their facilities can all make health centers ideal for the delivery of TIC. The investment in adopting a TIC model can pay off with improved patient outcomes,

medication adherence, lower no show rates, and reduction in provider and staff burnout.

In consideration of the elements of TIC and the health centers' relationship with the most at-risk populations for trauma, community health centers should evaluate their unique qualities in creating a system of TIC.

Mary is 72 years old, lives alone in an apartment, and recently underwent leg amputation surgery due to medical complications.

Despite a successful surgery, Mary has been depressed and her health has declined since the procedure. She is still having difficulty walking and has missed follow-up appointments. If she continues on this path, she knows she will need to move into a nursing home, and after two trips to the emergency room in one week, her health plan's care managers called Mary. The care manager, trained in TIC, engaged Mary to develop clear goals and connect her with new resources. Her health plan's care management team sent providers to her home, including a nurse practitioner, community health worker and social worker, who were careful to ask Mary's permission before providing care and help connect her with behavioral health supports. The new rapport with her team has helped Mary improve steadily since the initial engagement.

Likewise, MCOs can directly engage in trauma-informed care through education and screening delivered through care managers, customer service representatives and other front-line staff. Care managers or coordinators are common roles employed by health plans that may not often be involved in the direct provision of care. However, their role in coordinating or coaching individuals could be enhanced through an understanding of trauma-informed care principles.

For example, Neighborhood specifically employs teams of nurse practitioners, social workers, community health workers and pharmacists who operate in the community through the Health@ Home program. Providing this training could help them better manage complex cases in which trauma is a strong influencing factor. Customer service staff could, through understanding key questions to ask or how to discuss trauma, serve as a first line of defense or source of rapport with patients. While improving the knowledge of health plan staff can be impactful, also important is the access managed care can provide through its financial resources to the adoption of these principles within the provider network.

Health plans can use health outcomes measurement tied to financial incentives to support providers adopting TIC practices. Currently, fee-for-service is the primary system of payment, compensating providers for each medical service they provide. This model offers a limited financial opportunity to support the adoption of TIC outside of grants and narrow initiatives. However, as more experimentation occurs with providers owning more risk under a grouped, consistent payment model, providers will increasingly be incentivized to focus on variables, like trauma, impacting patient outcomes.

These new models of care are often referred to as: Accountable Care Organizations, Accountable Entities, Pay for Success, or Bundled Payment. The common features of these models are payment tied to quality performance rather than quantity of services.[9] Providers' success with these models is based upon what metrics payers select to determine high-quality performance. For TIC, potential measures may be related to screening for trauma or structural modifications to create an environment that feels safer. There is ample opportunity to leverage the work of existing behavioral health integration and team-based care models as a platform for creating more trauma-sensitive care.

Innovators in Trauma-Informed Care

Montefiore Medical Group

Montefiore Medical Group is located in the Bronx, a borough of New York City, and has focused on improving trauma-informed care in 22 of its primary care practice sites. The physician's group has built on existing structures of transformation efforts, such as patient-centered medical home and behavioral health integration. Montefiore leveraged training staff already responsible for practice transformation to help push the TIC information and training. Also, Montefiore leveraged specialized training for behavioral health staff, increased the use of a screening questionnaire, and created a critical incident management team.[10] This model of leveraging existing mechanisms for transformation is an ideal model for advanced practices looking to integrate trauma sensitivity into their care model.

San Francisco Department of Public Health –

In California, the San Francisco Department of Public Health model focused on transitioning to a "healing organization" that creates wellness and resilience rather than a system that induces trauma to those it serves. The department's Trauma-Informed Systems Initiative identified "champions" as well as other staff throughout the organization to help orchestrate the change. While all employees received foundational training, champions received specialized training not just on TIC, but on organizational change, project implementation, evaluation, racially focused cultural humility, and participatory decision making. The department continually surveyed the organization and came together to discuss progress.[10]

Stephen and Sandra Sheller
11th Street Family Health Services

Stephen and Sandra Sheller 11th Street Health Center in Philadelphia, PA, embarked on its journey to become a trauma-informed center. The model is a set of interactive tools for moving a whole organization toward being trauma-informed and trauma-responsive.[11] 11th Street

began with a small core planning team and over time, expanded trainings to the larger staff. In addition, the health center developed several unique elements including forming an Undoing Racism committee, enabling primary care providers to make warm handoffs to in-house support staff, and providing services like creative art therapy, mindfulness classes, cooking classes and an on-site fitness center.[10]

Rhode Island Policies to Consider

The following policy options are recommended pathways to the creation of a trauma-informed primary care system in Rhode Island.

> **Support TIC training for the workforce serving the adult population in primary care and health plan settings**

Increase the number of practice staff who complete Mental Health First Aid training or other evidenced-based programs that teach strategies for how to help someone in both crisis and non-crisis situations. Organizations can commit to leveraging initial trainings and having those individuals train others within their organizations. In parallel, identify and disseminate resources designed to address provider burnout.

> **Include TIC in the evolving Accountable Entity (AE) discussions**

Executive Office of Health and Human Services (EOHHS) and collaborative AEs are engaged in the shift toward a more value-based payment option for delivering care to the Medicaid population. The inclusion of TIC in dialog, with potential investments in such areas as social determinants of health, will increase the likelihood TIC is considered as part of the transition to quality performance measures for payment incentives.

> ### Host a Health Care Leadership Forum

Bring together leaders across Rhode Island's health care system to promote organizational culture and practice for implementing TIC in medical care setting modeled after "SAMHSA's Concept of Trauma and Framework for a Trauma-Informed Approach" and Center for Health Care Strategies (CHCS) tools.

> ### Assess screening tools

In current screening tools, seek opportunities for improvement to questions asked to determine if individuals have been impacted by trauma.

Conclusion

Addressing trauma in the adult population has quickly become a significant concern for the health system to contemplate as we work to integrate behavioral health, address influencing factors outside of the traditional medical system, and move towards more value-based payment models. Neighborhood and RIHCA believe in exploring policies in Rhode Island that can foster the growth of TIC care models in our state. We look forward to engaging partners to overcome the barriers of trauma and deliver better outcomes for the communities we serve.

Endnotes

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