



# *SAMHSA-HRSA Center for Integrated Health Solutions*

## **It's Just Good Medicine: Trauma- Informed Primary Care**

**Tuesday, August 6, 2013**



## ***SAMHSA-HRSA Center for Integrated Health Solutions***

**Slides for today's webinar are  
available on the CIHS website at:**

[www.Integration.samhsa.gov](http://www.Integration.samhsa.gov)

*under About Us/Webinars*

# Welcome!

## Today's Presenters:

- **Larke N. Huang**, PhD, Senior Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA)
- **Cheryl S. Sharp**, MSW, ALWF, Senior Advisor for Trauma-Informed Services, National Council for Behavioral Health
- **Tara Gunther**, PsyD, Section Chief – Psychology, Truman Medical Centers

## Moderator:

- **Rose Felipe**, SAMHSA-HRSA Center for Integrated Health Solutions

# Objectives:

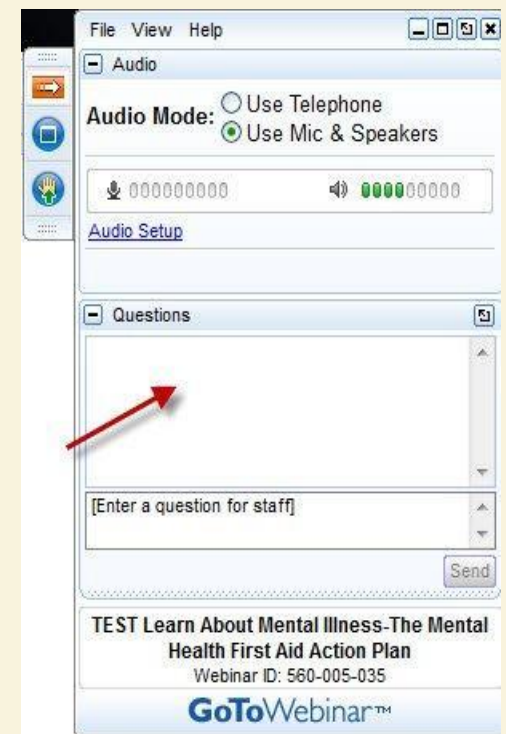
- Understand the prevalence of adverse life experiences and their effect on a person's physical and behavioral health.
- Recognize how a history of adverse life experiences affects an individual's engagement and use of primary care services and learn about strategies to promote an individual's comfort and engagement in primary care.
- Understand how to integrate a trauma-informed care perspective using practical skills that align with the practice of good medicine.
- Access and use trauma-informed tools designed for primary care settings.

# How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**





## ***SAMHSA-HRSA Center for Integrated Health Solutions***

# **SAMHSA's Concept of Trauma and Framework for a Trauma-Informed Approach**

Larke Nahme Huang, Ph.D.

Lead ,Trauma and Justice Strategic Initiative

Administrator's Office of Policy Planning and Innovation

Substance Abuse and Mental Health Services Administration

# **SAMHSA's Trauma and Justice Strategic Initiative**

- Integrating a trauma informed approach throughout health, behavioral health and related systems in order to reduce the harmful effects of trauma and violence on individuals, families and communities.
- Utilizing innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

# Reported Prevalence of Trauma in Behavioral Health

- Majority of adults and children in inpatient psychiatric and substance use disorder treatment settings have trauma histories (Lipschitz et al, 1999; Suarez, 2008; Gillece, 2010)
- 43% to 80% of individuals in psychiatric hospitals have experienced physical or sexual abuse
- 51%-90% public mental health clients exposed to trauma (Goodman et al, 1997; Mueser et al, 2004)
- 2/3 adults in SUD treatment report child abuse and neglect (SAMHSA, CSAT, 2000)
- Survey of adolescents in SU treatment > 70% had history of trauma exposure (Suarez, 2008)



# SAMHSA's Comprehensive Public Health Approach to Trauma

**DRAFT- SAMHSA's Comprehensive Public Health Approach to Trauma DRAFT – 2-19-13**

**VISION:** An integrated trauma-informed approach throughout health, behavioral health, and related systems that addresses the behavioral health needs of individuals, families, and communities across the lifespan.

	Community		Individual and Family		Community, Individual and Family		
Domain	Prevention		Early Identification and Intervention		Treatment	Recovery and Well-being	
<b>Goal</b>	Reduce the impact of trauma on communities and individuals across the lifespan.		Making trauma-informed screening and early intervention common practice.		Making trauma-informed treatment common practice.		Promote recovery, well-being, and resilience by addressing the needs of individuals using a trauma-informed approach.
<b>Grants</b>	-Early Jail Diversion -(DFC) -(SSHs) -(Suicide) -(Launch)		-Early Jail Diversion -National Child Traumatic Stress Initiative	-(PHBCI) -(GATSBI)	-NCTSI -ATR -BHTCC -ORP -CMHI	-(PPW) -(Homelessness) -Mental Health Transformation -State-wide Consumer and Family Grants	
<b>TA</b>	-Seclusion and Restraint -DTAC	-(NACE) -(Native Aspirations)	-NCTIC -DTAC -GAINS		-GAINS -S&R -NCTIC -DTAC	-NCTIC -DTAC -GAINS	
<b>Policy/Initiatives</b>	-Prevention SI -Forum Youth Violence Prevention -Defending Childhood Initiative -Reducing/Eliminating Seclusion and Restraint -Trauma and Trauma-informed Approach Concept		-HHS Child Trauma Goal -NCTSI -NCTIC		-HHS Child Trauma Goal -NCTSI -NCTIC		-HHS Child Trauma Goal -NCTIC
<b>Measures Strategy</b>	Surveillance: NSDUH Facilities: 2010 National Mental Health Services Survey; 2013 National Survey of Substance Abuse Treatment Services Grant Data: CSAT GPRA Client-Level Outcome Measures for Discretionary Programs; CMHS NOMs Client-Level Outcome Measures for Discretionary Programs; GPRA Data from NCTSI; GPRA Data from NCTSI Cat II and CAT III Program Specific Guidance						
<b>Workforce Strategy</b>	<i>(Trauma Training and Technical Assistance Center Pilot)</i>						
<b>Partners</b>	-ACF, CDC, DOJ -(Dept Ed), (HRSA), (DOL) -OAH (Adolescent Health WG) -ASPE (IWG on Youth Programs) -Federal Partners Committee on Women and Trauma -Justice Federal Partners		-ACF, CMS, DOJ -(Dept Ed), (HRSA), (DOL) -NCTSN -Federal Partners Committee on Women and Trauma -Justice Federal Partners		-ACF, CMS, DOJ -(Dept Ed), (HRSA), (DOL) -NCTSN -Federal Partners Committee on Women and Trauma -Justice Federal Partners		-ACF, CMS, DOJ -(Dept Ed), (HRSA), (DOL) -Federal Partners Committee on Women and Trauma -Justice Federal Partners
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Shared cross-sector understanding of trauma and trauma-informed approach.</li> <li>- Increased capacity in behavioral health and related sectors for addressing trauma.</li> <li>- Increased number of substance abuse and mental health treatment facilities engaged in trauma-focused work; improved behavioral health outcomes for individuals in SAMHSA-supported service programs who are experiencing or at risk of experiencing trauma.</li> <li>- Increased SAMHSA staff that are trauma-informed and increased trauma and trauma-informed approach trainings across different service sectors</li> </ul>						
<b>Impact</b>	<ul style="list-style-type: none"> <li>- Promote recovery, well-being, and resilience</li> <li>- Trauma-informed communities that understand the impact of trauma</li> <li>- A trauma-aware and trauma-informed behavioral health workforce</li> </ul>						



# TIMELINE: THE EVOLUTION OF TRAUMA-INFORMED CARE

2003 – From 2003 – 2004, SAMHSA provides preparedness grants for disaster planning.

2004 – CMHS develops the report titled, *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings).

2004 – CMHS provides an update of *Trauma Services Implementation Toolkit for State Mental Health Agencies*, with number of states reporting trauma-related activities increasing from 15-31 states.

2004 – SAMHSA launches the Alternatives to Restraint and Seclusion State Incentive Grant (ARS SIG) for the first cohort.

2005 – Center for Women, Violence and Trauma (CWVT) is created and is funded by SAMHSA/CMHS after the WCDVS study and the 1994 Dare to Vision and Dare to Act conferences.

2006 – Report titled, *Responding to Childhood Trauma: The Promise and Practice of Trauma-Informed Care* (Hodas).

2006 – CMHS renames CWVT as the National Center for Trauma-Informed Care (NCTIC) in response to cascading numbers of requests for training in TIC.

2006: NCTSN develops their Learning Collaborative Toolkit

2006 – Second national conference on trauma: *To Act: Trauma Workers, Practitioners, Researchers and Policymakers Creating a Blueprint for Change* is held by SAMHSA/CMHS and held by NTC.

2005 – National Center on Domestic Violence, Trauma and Mental Health is established through a grant to the Domestic Violence and Mental Health Policy Initiative (DVMHPI) from the Family Violence Prevention and Services Program (FVPSA) at AC

2006 – Report titled, *Organizational Stress as a Barrier*

2005: Center on Women, Violence and Trauma (CWVT) was created by SAMHSA/CMHS

2006 – NCTSN develops their Learning Collaborative Toolkit.

2007 – SAMHSA awards the ARS SIG to the second cohort.

2007 - NCTIC launches targeted outreach strategy to engage consumers and consumer leaders nationally in dialogue around trauma-informed peer support.

2008 – *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services for Children* (Jennings).

2007 – NCTSN develops their Learning Collaborative Toolkit.

2007 – SAMHSA funding.

2007 – SAMHSA funding for victims of trauma and other national disasters.

2007 – SAMHSA/CMHS awards a contract that establishes the National Coordinating Center to Reduce and Eliminate the Use of Seclusion and Restraint.

2007 – SAMHSA completes assessment of preparedness plan.

2008 – CMHS funds the third national conference on

2008 – SAMHSA advances efforts to Promote

2009 – CMHS funds an update on state systems' activities in developing and implementing trauma-informed care and trauma specific services.

2009 – The National Center for Child Traumatic Stress (NCCTS) Family and Youth Involvement Team and the Consumer Consultant Group is formed to support NCTSN action items, materials, and resources.

2007: SAMHSA/CMHS awards a contract that establishes the National Coordinating Center to Reduce and Eliminate the Use of Seclusion and Restraint

2009 – SAMHSA sponsors first meeting of trauma informed care experts to develop an approach for system leaders to use in building and assessing trauma informed care in their organization.

2010 – Federal Partners Committee on Women and Trauma holds 1<sup>st</sup> Roundtable.

2010 – Trauma-Informed Care (TIC) as the framework for the practice/ service chosen and implement trauma screening, assessment, and recovery support.

2010 – SAMHSA/CMHS awards 19 Statewide Consumer Network Grants, two of which are focused on Trauma-Informed Peer Support.

2011 – Federal Partners Committee on Women and Trauma holds 2<sup>nd</sup> Roundtable.

2011 – Development of 2 products begins on community approaches to trauma, one a video on "Healing in Community" and the other an issue brief on "Trauma, Culture, Community: Healing Together."

2010 – SAMHSA's Federal Partners Transformation Committee establishes a new sub-committee on Women and Trauma that attracted 40 representatives from other Federal agencies and sub-agencies to join.

2010 – Chadwick Trauma-Informed Systems Project led by Charles Wilson, is listed as a Category II site funded by NCTSN.

2010 – SAMHSA/CMHS awards 19 Statewide Consumer Network Grants, two of which are focused on Trauma-Informed Peer Support.

2011 – SAMHSA holds internal trauma meeting with NCTSN, NCTIC, NCTJ's Seclusion and Restraint, Disaster Technical Assistance Center, etc.

2011 – Audience Testing and First Draft of Technical Assistance Product on Engaging Women in Trauma-Informed Peer Support.

Compiled by Tenty Pau

Compiled by Tenty Pau

# **SAMHSA's – Experts Panel, Concept Development & Public Comment**

- **Trauma and Trauma-Informed Care Experts Panel (May, 2012)**
- **National Leading Experts:** Researchers, Practitioners, Survivors, Across Service Sectors
- **Concept/Framework:**
  - Experts' Working Definitions of Individual Trauma and Trauma-Informed Approach
  - Core Values and Principles of Trauma-Informed Approach
  - Guidelines for Developing a Trauma-Informed Approach
  - Preliminary discussion on the definition of community trauma
- **Public Comment (December, 2012)** Online posting

# **SAMHSA's Concept of Trauma (draft)**

**Trauma:** Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and/or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being

# **SAMHSA's Concept of a Trauma-Informed Approach (draft)**

A program, organization or system that is trauma-informed

- (1) **realizes** the prevalence of trauma and taking a universal precautions position;
- (2) **recognizes** how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
- (3) **responds** by putting this knowledge into practice; and
- (4) **resists** retraumatization.

# Principles of a Trauma-Informed Approach (draft)

**Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.

**Trustworthiness and transparency:** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.

**Peer support** (peers refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery) and mutual self-help are key vehicles for establishing safety, building trust, enhancing collaboration, and maximizing a sense of empowerment

**Collaboration and mutuality:** Partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; demonstrates that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach; “one does not have to be a therapist to be therapeutic.”

**Empowerment, Voice and Choice:** throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon; the experience of having a voice and choice is validated and new skills developed.. The organization fosters a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma; building on strengths and not just addressing perceived deficits.

**Cultural, historical, and gender issues:** the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

# **Guidance for a Trauma-Informed Approach**

(draft)

- 1. Governance and leadership**
- 2. Policy**
- 3. Physical environment of the organization**
- 4. Engagement and involvement of people in recovery, trauma survivors, consumers, and family members of children receiving services**
- 5. Cross sector collaboration**
- 6. Screening, assessment, and interventions**
- 7. Training and workforce development**
- 8. Progress monitoring and quality assurance**
- 9. Financing**
- 10. Evaluation**



# TIA Implementation Matrix

SAMHSA plans to adapt these suggested guidelines into a matrix worksheet that organizations and systems can use to plan and assess the implementation of a trauma-informed approach. Examples of matrices from various sectors will also be made available.

SAMHSA's Trauma-Informed Approach Guidance for Implementation Matrix *Draft 7-11-13*

	Safety	Trustworthiness and Transparency	Peer Support	Collaboration and Mutuality	Empowerment, Voice, and Choice	Cultural, Historical, and Gender Issues
<b>Governance and Leadership</b>						
<b>Policy</b>						
<b>Physical Environment</b>						
<b>Engagement and Involvement</b>						
<b>Cross Sector Collaboration</b>						
<b>Screening, Assessment, Treatment Services</b>						
<b>Training and Workforce Development</b>						
<b>Progress Monitoring and Quality Assurance</b>						
<b>Financing</b>						
<b>Evaluation</b>						

# What is Trauma?

Cheryl S. Sharp, MSW, ALWF  
Senior Advisor for Trauma-Informed  
Services National Council for Behavioral  
Health

# What is Trauma?

- Trauma refers to intense and overwhelming experiences that involve serious loss, threat or harm to a person's physical and/or emotional well being.
- These experiences may occur at any time in a person's life. They may involve a single traumatic event or may be repeated over many years.
- These trauma experiences often overwhelm the persons coping resources. This often leads the person to find a way of coping that may work in the short run but may cause serious harm in the long run.

# Examples of Traumatic Life Experiences

- Physical, emotional and/or sexual abuse in childhood or adulthood
- In Childhood
  - neglect or abandonment (food insufficiency, lack of money to met basic needs, homelessness)
  - death of a parent
  - divorce
  - family life that includes drug addiction, alcoholism, parental incarceration, violence
- Rape
- Serious medical illness or disease (disabling conditions, loss of function, invasive and distressing procedures)

# Trauma experienced in adulthood may also affect a persons emotional and physical well-being

## Examples:

- Combat related trauma
- Refugee/torture/civil unrest
- Witnessing or experiencing violence
- Catastrophic loss (natural disasters)
- Terrorism

Bottom line findings: These experiences raise the individuals risk for severe emotional distress, suicide, physical illness, substance abuse and a host of other life difficulties

# How Does Trauma Affect People?

# How Does Trauma Affect People?

- What have we learned about the affect of trauma on people?
- What are some examples of what happens to people who have experienced trauma early in their lives?
- What experience have you had working with individuals with trauma histories?



## What the research tells us- The Adverse Childhood Experiences (ACE) Study?

- **Center for Disease Control and Kaiser Permanente (an HMO) Collaboration**
- **Over a ten year study involving 17,000 people**
- **Looked at effects of adverse childhood experiences (trauma)over the lifespan**
- **Largest study ever done on this subject**



# Impact of Trauma Over the Lifespan

Increases the risk of neurological, biological, psychological and/or social difficulties such as:

- Changes in brain neurobiology;
- Social, emotional & cognitive impairment;
- Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence); and
- Severe and persistent behavioral health, physical health and social problems, early death.

*(Felitti et al, 1998)*

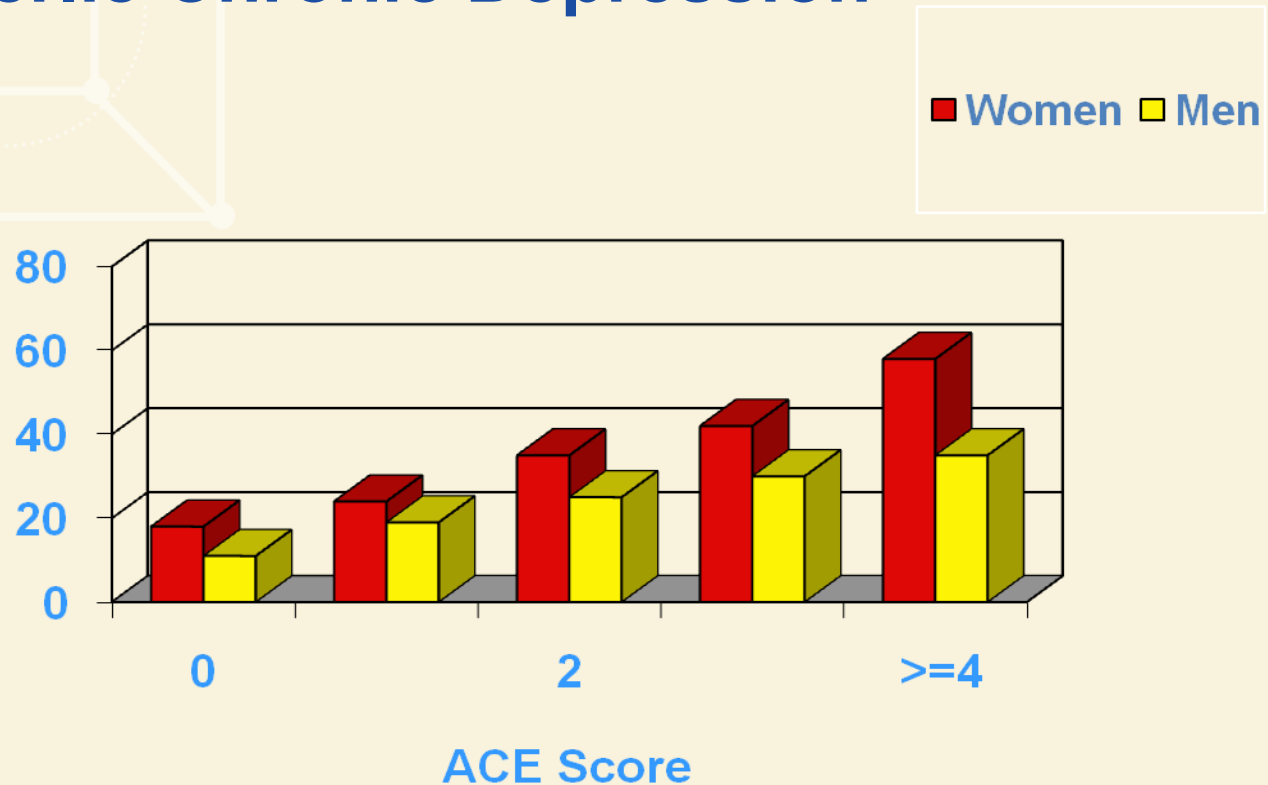
# Healthcare conditions often associated with a history of adverse childhood experiences:

- Diabetes
- COPD
- Heart Disease
- High Blood Pressure
- Obesity
- Cancer
- Liver Disease
- Gynecologic Disorders
- Sexually Transmitted Diseases
- Unintended Pregnancies

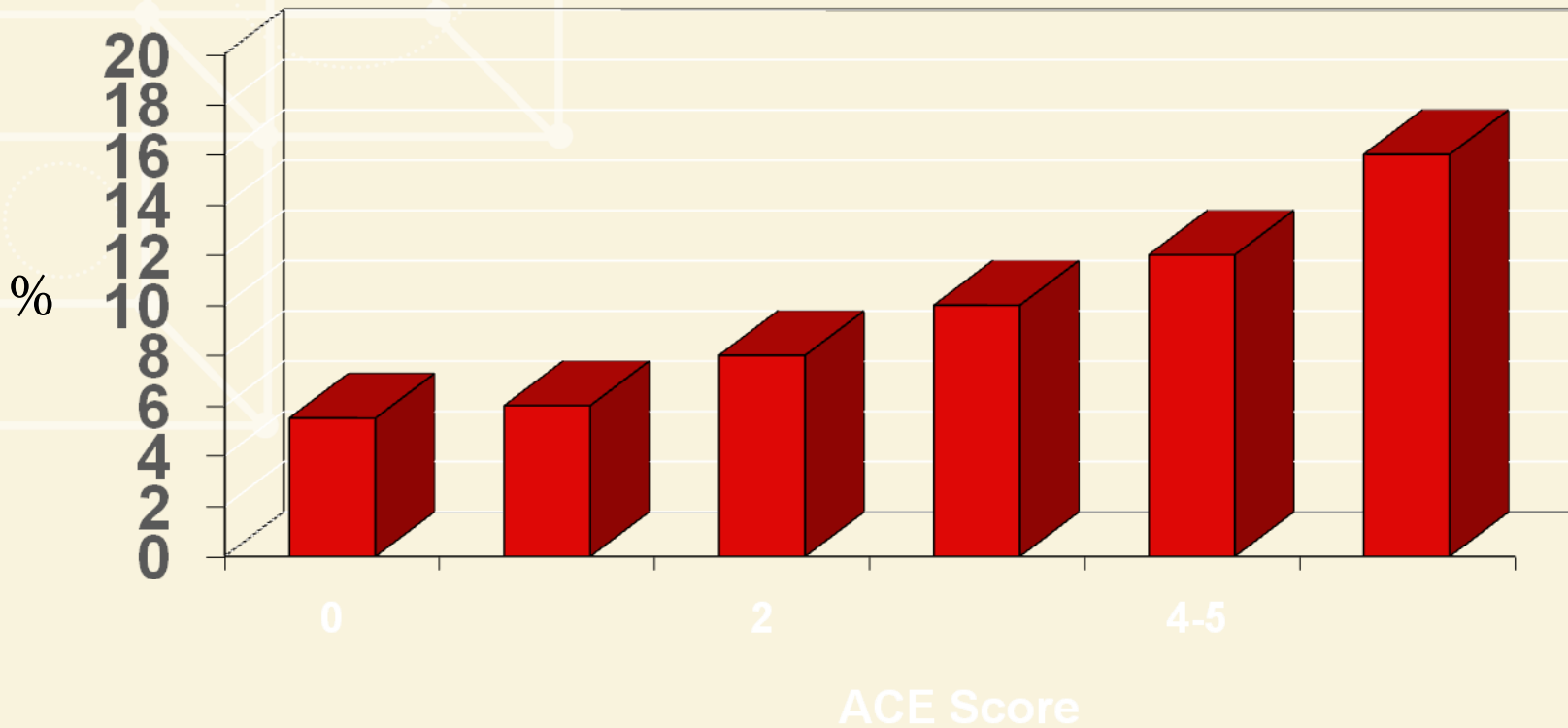
*“The Hidden Impact of Early Life Trauma On Health and Disease. Chapter 8. in Lanius,. By Felliti and Anda, 2010.”*

# Childhood Experiences Underlie Chronic Depression

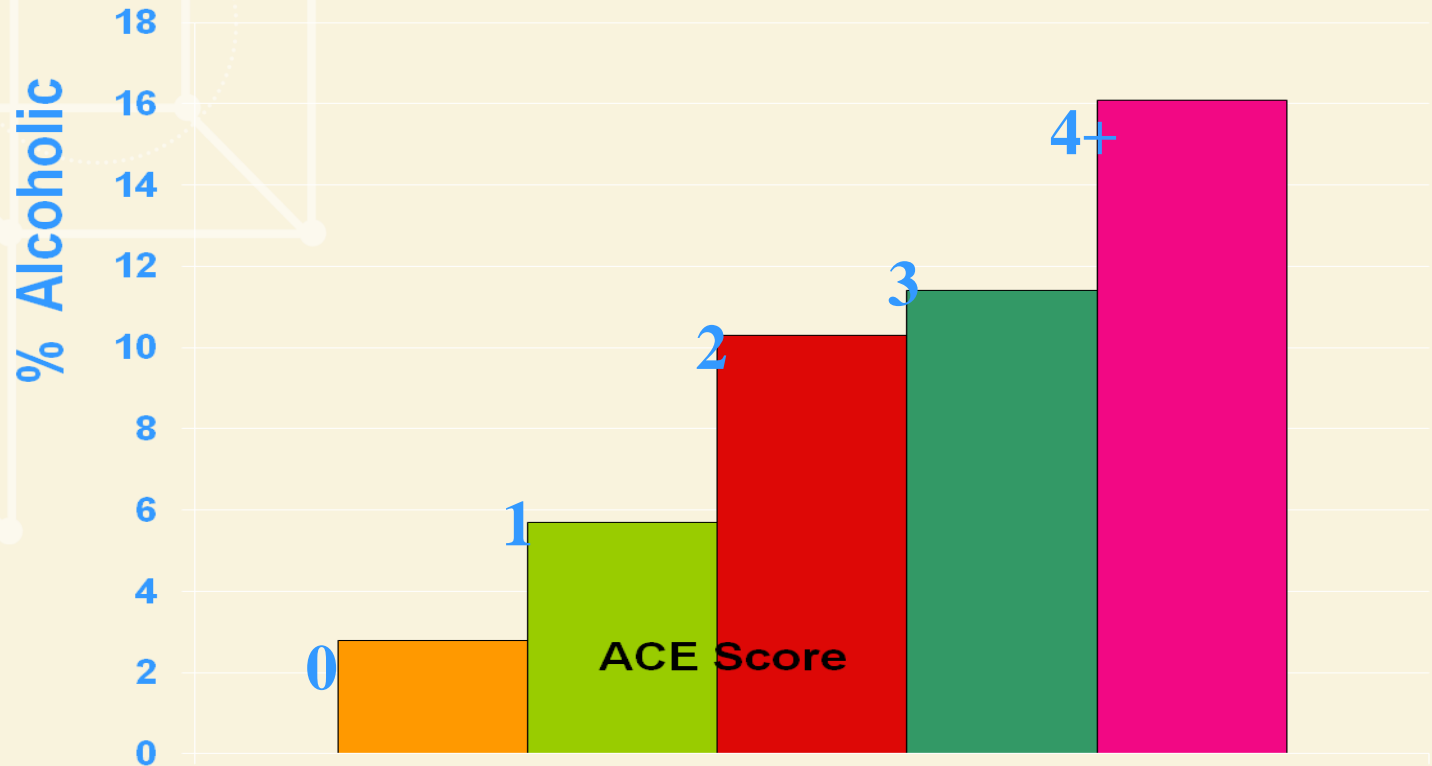
**% With a Lifetime History of Depression**



## Adverse Childhood Experiences and Current Smoking



# Childhood Experiences and Adult Alcoholism



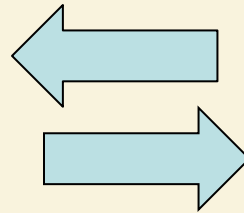
# Why is Understanding Trauma in Primary Care Important?

# Why is Understanding Trauma Important?

- What are the implications for bi-directional work initiative?

Primary Care

Behavioral Health



- What are the challenges facing healthcare providers?

# Why is Understanding Trauma Important?

- To provide effective services we need to understand the life situations that may be contributing to the persons current problems
- Many current problems faced by the people we serve may be related to traumatic life experiences
- People who have experienced traumatic life events are often *very sensitive* to situations that remind them of the people, places or things involved in their traumatic event
- These reminders, also known as 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



# 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 experiences:**

- Invasive procedures
- Removal of clothing
- Physical touch
- Personal questions that may be embarrassing/distressing
- Power dynamics of relationship
- Gender of healthcare provider
- Vulnerable physical position
- Loss of and lack of privacy

## **Signs that a person may be feeling distressed:**

- Emotional reactions – anxiety, fear, powerlessness, helplessness, worry, anger
- Physical or somatic reactions – nausea, light headedness, increase in BP, headaches, stomach aches, increase in heart rate and respiration or holding breath
- Behavioral reactions – crying, uncooperative, argumentative, unresponsive, restlessness
- Cognitive reactions – memory impairment or forgetfulness, inability to give adequate history

## **Trauma may negatively influence access to and engagement in primary care:**

1. Avoidance of medical and dental services
2. Non-adherence to treatment
3. Postponing medical and dental services until things get very bad
4. Misuse of medical treatment services – ex. over use of ER Services and misuse of pain meds

# **Poll Question 1:**

## **Why do you think trauma is not routinely addressed in primary care settings?**

- Lack of time
- Lack of awareness
- Lack of tools
- Lack of training
- Misconceptions/discomfort

# What Can We Do to Provide Trauma Sensitive Care and Practices?

# What Can We Do To Provide Sensitive Care and Practices?

- A. Train “all” staff about trauma, sensitive practice and sharing critical information
- B. Screen and assess for trauma
- C. Communicate a sensitivity to trauma issues
- D. Create a safe and comfortable environment
- E. Provide services in a trauma informed manner – some practical tips

## **A. Train Staff about Trauma, Sensitive Practices and Sharing Critical Information**

- Increase awareness and importance of trauma as a factor in health outcomes
- Primary and behavioral health have communication channels to inform each other about a person's trauma and it's affect on...
  - mental health, substance use and physical wellbeing
  - the person's comfort with and use of medical and dental services



# Basic Training of Staff: Overview of Trauma-Informed Care Presentation

What do we mean by trauma?

How does trauma affect people?

What can we learn from listening to the voices of people who have experienced trauma?

Why is understanding trauma important in the work we do at \_\_\_\_?

What can we do to insure that we help those we serve who have experienced trauma?

Why we all matter!

The stresses of our own work and lives may also make trauma a personal concern

How understanding trauma and improving our services helps all of us

Provide us with feedback (complete survey)

## **B. Screen and Assess - Health Appraisal Questionnaire - Examples of Questions with Yes/No Responses (completed in private)**

- I have been physically abused as a child
- I have been verbally abused as a child
- I was sexually molested as a child or adolescent
- I have been raped
- I have been threatened or abused as an adult by a sexual partner
- My partner has threatened, pushed, shoved me
- My partner has threatened or abused my children

Vincent J. Felitti, MD

## **A brief, empathic, validating response by a healthcare provider to someone who discloses a trauma history may be:**

- “I’m sorry that that happened to you; no one has the right to hit another person/force another person to have sex”
- “Growing up in an environment of violence is so difficult for a child – no one should have to face such upsetting and scary situations”
- “We know that there is a direct relationship between these experiences and a person’s physical health; have you ever had a chance to explore these?”

**Poll Question 2:**  
**Do you have a mechanism in place to  
learn about prior or current trauma  
experiences ?**

- Yes
- No

## **C. Communicating a Sensitivity to Trauma Issues**

- Trauma related materials in waiting areas
- Posters inviting individuals to talk about trauma and/or needs located in exam rooms
- Asking questions about trauma and/or needs before and during exams

## **D. Creating a Safe and Secure Environment**

- Survey service recipients to gain feedback about their experiences, including the physical environment
- Solicit staff to suggest improvements to care and the environment
- Insure individuals feel welcome and comfortable from reception through exiting
- Do no harm – prevent re-traumatization
- Provide trauma sensitive practices and care

## **E. Trauma Informed Care: Principles of Sensitive Practice**

- 1. *Respect***
- 2. *Taking Time***
- 3. *Rapport***
- 4. *Sharing Information***
- 5. *Sharing Control***
- 6. *Respecting Boundaries***
- 7. *Fostering Mutual Learning***
- 8. *Understanding Non-linear Healing***
- 9. *Demonstrating Awareness and Knowledge of Trauma***

*Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse* was researched and written by Candice L. Schachter, Carol A. Stalker, Eli Teram, Gerri C. Lasiuk and Alanna Danilkewich

# Trauma Informed Care: Practical Tips

- Engage person, develop rapport and build trust over time
- Provide calm and soothing office environment
- Give relaxed, unhurried attention
- Talk about concerns and procedures before doing anything (ex. asking patient to disrobe)
- Give as much control and choice as possible
- Validate any concerns as understandable and normal
- Allow a support person or female staff person to be present in the room
- Explain thoroughly each procedure and get consent



# Trauma Informed Care: Practical Tips

- Ask if person is ready to begin and inform them that they can pause or stop procedure at anytime
- Encourage questions and ask about any worries or concerns and how you can help (ex. leaving door ajar)
- Maintain a personable, respectful, kind and honest manner
- Talk to person throughout to let them know what you are doing and why
- Encourage person to do what feels most comfortable (ex. keeping coat on, listening to music, keeping dental chair upright)
- Place a high priority on culture; including ethnicity, race, religion, sexual orientation, historical and social trauma such as homelessness and poverty



5302

# Health Appraisal Questionnaire

*Please Print Legibly*

Office Use Only

name and other information above correct? ....  Y  N  
(Please make corrections)

**FEMALE**

Please fill in your Social Security Number:

\_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

If you have an E-Mail address, please enter it here:

\_\_\_\_\_

Note your appointment times.  
First appointment:

Second appointment:

## WELCOME

Complete medical evaluation which you are about to receive at the Health Appraisal division of Kaiser Permanente's Intensive Primary Care Medicine has three major components: medical history, laboratory tests, and direct physical examination. Of these, medical history is the most important. This questionnaire is likely to be the most detailed collection of medical information we have ever experienced.

Answer each question by blackening the appropriate oval with a black ball point pen. Your effort doing this well will be appreciated and is the basis of our understanding your health.

Mark bubbles completely, like this: ●

Vincent J. Felitti, MD



# *SAMHSA-HRSA Center for Integrated Health Solutions*

## **Trauma Informed Care in Primary Care Settings**

Truman Medical Centers, Kansas City, MO

Tara Gunther, Psy.D.

# Truman Medical Centers

## Description of TMC

- A two-hospital, not-for-profit health system located in Kansas City, MO. In addition to 380 acute-care beds, the TMC system includes TMC Behavioral Health, the Jackson County Health Department, a 188-bed long term care facility, more than 30 ambulatory clinics and a number of primary care practices and clinics (the largest provider of outpatient specialty care in Kansas City), operates the busiest adult emergency department in the city, and has one of the top Level 1 trauma centers in the Kansas City metropolitan area

# Background

## Truman Medical Center's structure

- TMC joined the national trauma-informed care Learning Community initiative organized by the National Council for Community Behavioral Health.
- We have organized a Core Implementation Team consisting of staff from any discipline or role.
- We also have a larger oversight group that helps to guide and make decisions that are practical and beneficial to all of us.

# TMC Vision Statement

The Steering Committee will support Truman Medical Center in creating a Culture of Trauma-Informed Care, incorporating the principles of Safety, Trustworthiness, Choice, Collaboration, and Empowerment, while expanding the quality of Trauma-Specific services.

## **Primary Functions:**

- Commit to a Trauma-Informed Care Organizational Mission and Dedicate Resources to Support It
- Incorporate Values and Approaches Focused on Safety, Trustworthiness, Choice, Collaboration, and Empowerment for Consumers, and Survivors
- Create Strength-Based Environments and Practices that Allow for Consumer and Survivor Empowerment
- Coordinate Ongoing Trauma-Informed Care Staff Training and Education
- Improve and Target Staff Hiring Practices for Trauma-Informed Care
- Update Policies and Procedures to Reflect New Trauma-Informed Care Mission

# Early days...

## Executive and physician leadership buy-in

- Monthly TIC “tidbits” (e.g., handout on one value each month)
- Inserting TIC language and interventions into presentations and daily interactions
- Targeted use of language and partner with other initiatives



# Training, training, and re-training

## On-going training

- New nurse orientation
- Video (all new employee orientation and current 4000)
  - 30” on Provider self care and caring for each other
  - 30” on Trauma Informed Care principles
- Train new rotating residents in Women’s Health every 3 weeks and this program partners with MOCSA to create seamless referral in trauma informed manner
- 45” Resident training module by Dr. Sullivan

# Training, continued

## Organic method

- Wherever we are invited (or invite ourselves...)
- PTSD Education
  - Lunch and Learn on PTSD symptoms in the workforce
  - Recognizing signs of PTSD
  - After a major incident, offering education on acute stress and what to look for in progression to PTSD
- TIC introductory presentations (15", 30", 60")
  - Cardiology, Sleep Clinic, Primary Care

# Training, continued

## Organic method, continued:

- Self care and burnout for hospital social workers
- TIC principles for our KC SANE
- Trauma, attachment and PTSD for Mother and Child Coalition
- Coaching—how to ask the questions
- Wellness initiatives across all levels and disciplines
- Second victim acknowledgement and outreach

# PTSD Specific Services

- Seamless referral system
- No catchment restrictions
- Provide much of the coaching, support for secondary trauma, staff referrals, and education within system
- Evidence based practice: Prolonged Exposure, Cognitive Processing Therapy, TF-CBT, Eye Movement Desensitization and Reprocessing
- PTSD patient wallet card

## Doctor: I have Post Traumatic Stress Disorder (PTSD)

This means that I have been diagnosed with this disorder by a mental health professional.

### What is PTSD?

I have experienced a traumatic event that involved actual or threatened injury, death, or sexual violation which causes me to:

- Persistently have unwanted thoughts, memories, or images of the traumatic event(s) (i.e. nightmares and flashbacks)
- Want to constantly avoid things or situations that remind me of the trauma
- Have increased symptoms of arousal (i.e. sleep problems, irritability/anger, hypervigilance and/or exaggerated startle response).

For more information on PTSD, please go to this website: <http://www.ptsd.va.gov/>

My therapist is: \_\_\_\_\_ Phone: \_\_\_\_\_

### You can help me in this appointment by:

- Introducing yourself and anyone else who may come in the room.
- Allowing me to remain clothed for as much of the appt as possible.
- Asking permission to touch me.
- Being patient and trying to understand that I am likely anxious/not comfortable.
- Patiently talking me through procedures, even very routine ones.
- Repeating information if I ask.
- Coming to check on me if I'm left alone in the room for a while.
- \_\_\_\_\_
- \_\_\_\_\_

# Find Your Natural Partners

When the goal is to reduce cost and improve outcomes, we recognize more and more how trauma underlies

- Places where we have some level of PC BH integration
- Health Home
- Innovation grant: High cost utilizer of medical services and provide intense wrap around
- Zip code analysis

# Workflow to consider

Nursing assessment for all psychology appointments

- Vital signs and other medical trends
- Screeners:
  - Primary Care-Posttraumatic Stress Disorder screener (PC-PTSD)
  - PTSD Checklist
  - Beck Depression Inventory
  - St. Louis Primary Care Behavioral Health Screener

# Where are we now

PCP's Perspective: "It's my job to recognize and refer..."

- Fear: How much screening? Are we opening a can of worms that we are not trained to address? But we are trained enough to ask the questions and refer...It's OK to start the discussion.
- Most PTSD patients seem to be younger. Perhaps hypertension and ER visits would be good to trend. They have lower tolerance for symptoms.
- Helping with burnout and stress: look at research on physician suicide rates.



# Where are we now

## PCP Perspective: TIC has taught me...

- “That those really [emotional] clients usually have had something really, really bad happen in childhood”.
- “[TIC] has helped me look at the underlying cause of their behaviors”.
- “I can’t believe how much trauma is there...and now that I’ve started to ask, I realize how much our patient’s health is tied to early trauma.”

# Where are we now

- Other achievements
- No finish line
- Keeping the momentum
- Back to the role of leadership

# Resources:

- **Primary Care Behavioral Health Screener User Guide:**  
[http://www.integration.samhsa.gov/clinical-practice/PCBHS\\_Screener - User Guide.pdf](http://www.integration.samhsa.gov/clinical-practice/PCBHS_Screener_-_User_Guide.pdf)
  - **Primary Care Behavioral Healthy Screener:**  
[http://www.integration.samhsa.gov/clinical-practice/PCBHS\\_Questionnaire.pdf](http://www.integration.samhsa.gov/clinical-practice/PCBHS_Questionnaire.pdf)
- **The National Council for Behavioral Health's trauma-informed care checklist:**  
[http://www.integration.samhsa.gov/clinical-practice/TIC\\_Flyer\\_web\\_2013\\_new.pdf](http://www.integration.samhsa.gov/clinical-practice/TIC_Flyer_web_2013_new.pdf)
- **SAMHSA's National Center for Trauma-Informed Care (NCTIC) Technical Assistance Center:**  
<http://www.samhsa.gov/nctic/default.asp>
- **GAINS Center for BH and Justice Transformation:** <http://gainscenter.samhsa.gov/>
- **Addiction, Technology, Transfer Center (ATTC) Trauma Informed Care Series :**  
<http://www.attcnetwork.org/regcenters/generalContent.asp?rcid=10&content=CUSTOM2SUB3>

**Additional Resources can be found on the SAMHSA-HRSA Center for Integrated Health Solutions Trauma Webpage:**

<http://www.integration.samhsa.gov/clinical-practice/trauma>

# How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



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## ***SAMHSA-HRSA Center for Integrated Health Solutions***

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