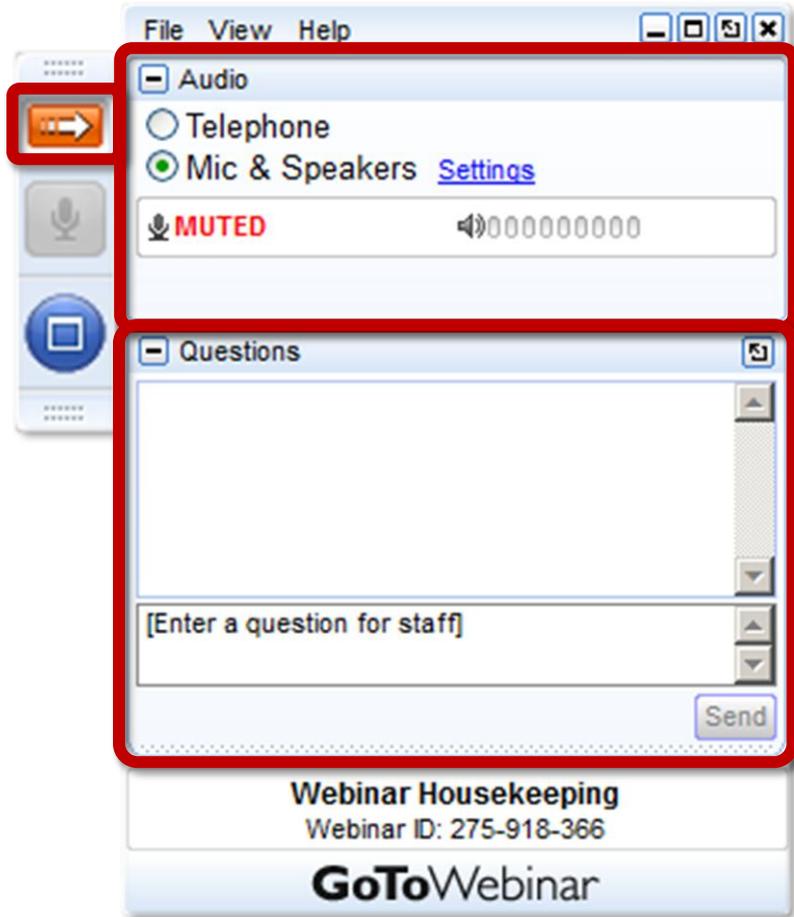


GoToWebinar Housekeeping: Attendee participation



Your Participation

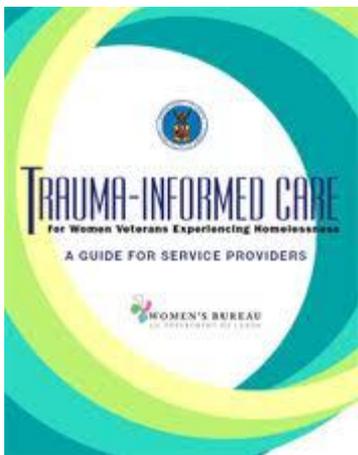
Open and hide your control panel

Join audio:

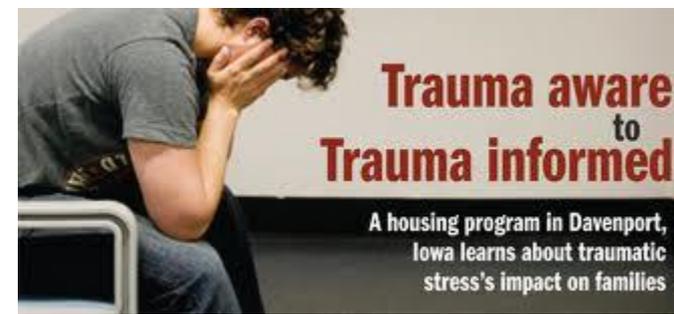
- Choose "Mic & Speakers" to use VoIP **OR**
- Choose "Telephone" and dial using the information provided

Submit questions and comments via the Questions panel

Note: Today's presentation is being recorded.



Best Practices for Providers Trauma Informed Care



Trauma Informed Care in Primary Care Settings

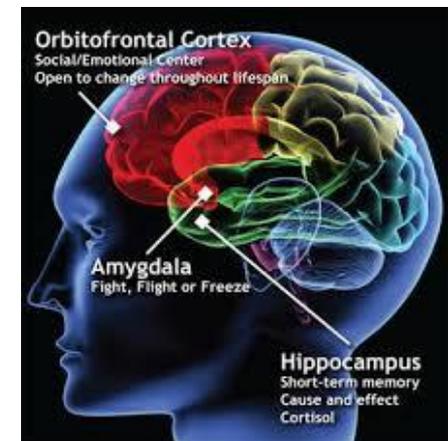
David Labby
Laurie Lockert
Rebecca Ramsay
Reba Smith



Trauma-Informed Care Resources Guide

Already an Instructor or Site Member?
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Overview of Adverse Childhood Experiences (ACEs) data

David Labby, MD

Chief Medical Officer

Health Share of Oregon

Adverse Childhood Experiences (ACE) Study

- 1998 Kaiser Permanente & the Centers for Disease Control study examining effects of adverse childhood experiences over one's lifespan (>18,000 people)
 - V. Felitti and R. Anda
- Demographics
 - Average age 57
 - “Solidly middle class”
 - White
 - Attended college
- Surveyed experience up to 18 yo
- “ACE Score” Computed based on positive response to each domain

Adverse Childhood Events / Rate:

- Substance Abuse 27%
- Parental Separation/Divorce 23%
- Mental Illness 17%
- Battered Mother 13%
- Criminal Behavior 6%
- Psychological Abuse 11%
- Physical Abuse 28%
- Sexual Abuse 21%
- Emotional Neglect 15%
- Physical Neglect 10%

Adults with “ACE Score” 4+

- 7x increase in alcoholism
- 3x increase in depression in men; 5x in women
- 13x increase in the prevalence of attempted suicide
- 10x increase in use of IV drugs; for males with 6+ACEs 46x increase
- 4.5x increase in intimate partner violence; 5x increase in risk of rape; with ACE .5, 9x

Other research - graded relationships between ACES and behavior problems:

- Early initiation of alcohol use. (Dube et al, 2006)
- Problem drinking behavior into adulthood (Dube et al, 2002)
- Increased likelihood of early smoking initiation (Anda et al, 1999))
- Continued smoking, heavy smoking during adulthood (Ford et al, 2011)
- Prescription drug use (Anda et al, 2008)
- Lifetime illicit drug use and self-reported addiction (Dube et al, 2003)
- Increased risk of suicide attempts during adolescence (Dube et al, 2004).
- Lifetime depressive episodes (Chapman et al, 2004).
- Sleep disturbances in adults (Chapman et al, 2011)
- Sexual risk behaviors (Hillis et al, 2001)
- Teen pregnancy (Hillis et al, 2004)

More

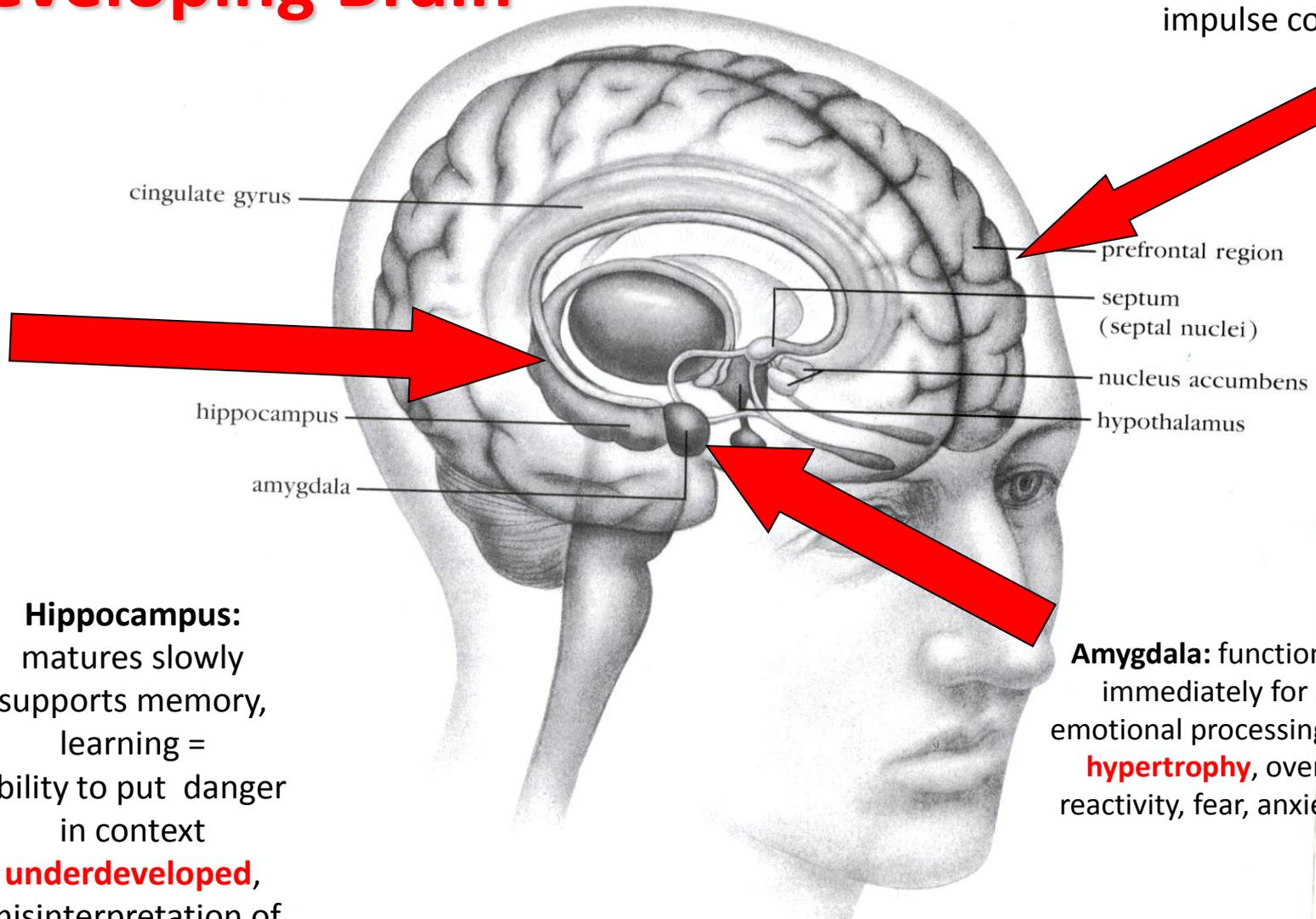
- 15 year follow up: people with 6+ ACEs died nearly 20 years earlier than those w/o (Brown, Am J Prev Med 2009)
- Other correlations with grade failure, language difficulty, job troubles, incarceration, being in substance abuse treatment, homelessness
- Incidence of ACES:
 - KP study “middle class” population: 16% had ACE Score 4+
 - Homeless population study: 58% had ACE Score 4+; 32% had ACE Score 6+ (Larkin and Park, 2009 ppt)

Bio-social Mechanisms

- Early neurological development depends on infant's exposure to others: brain pathways develop in response to how others meet needs
- “Wiring” develops in “use dependent” manner (Perry 2009)
- If others are experienced as unpredictable, a source of pain, anxiety, fear, pathways will develop to monitor for threat, for immediate reaction, to avoid risky attachment
- Toxic stress is thought to drive overproduction of stress hormones (cortisol, norepinephrine, adrenaline) effecting growth of differ parts of the brain.

Stress Hormones and the Developing Brain

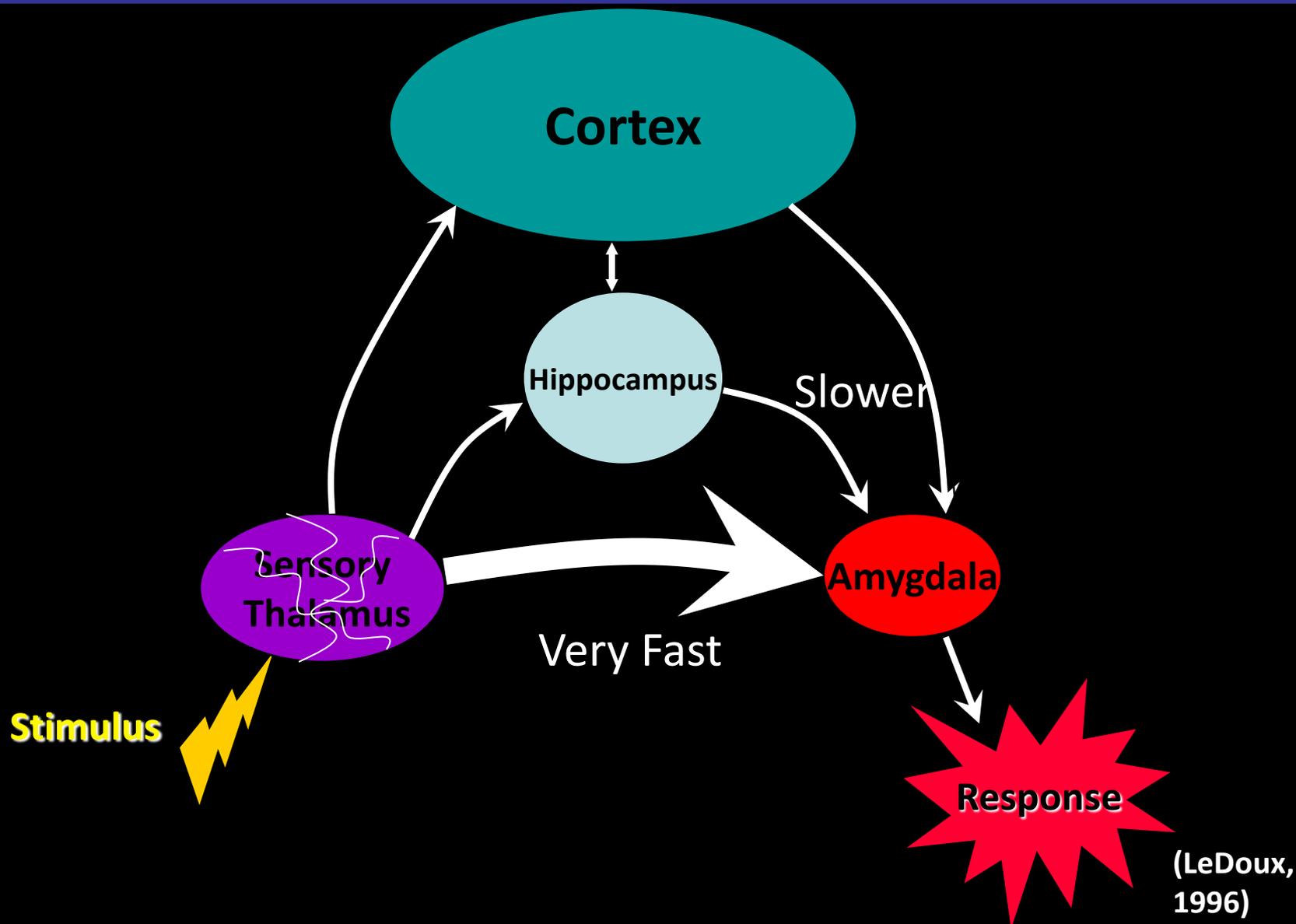
Prefrontal Cortex:
executive function =
neuron loss, poor
impulse control



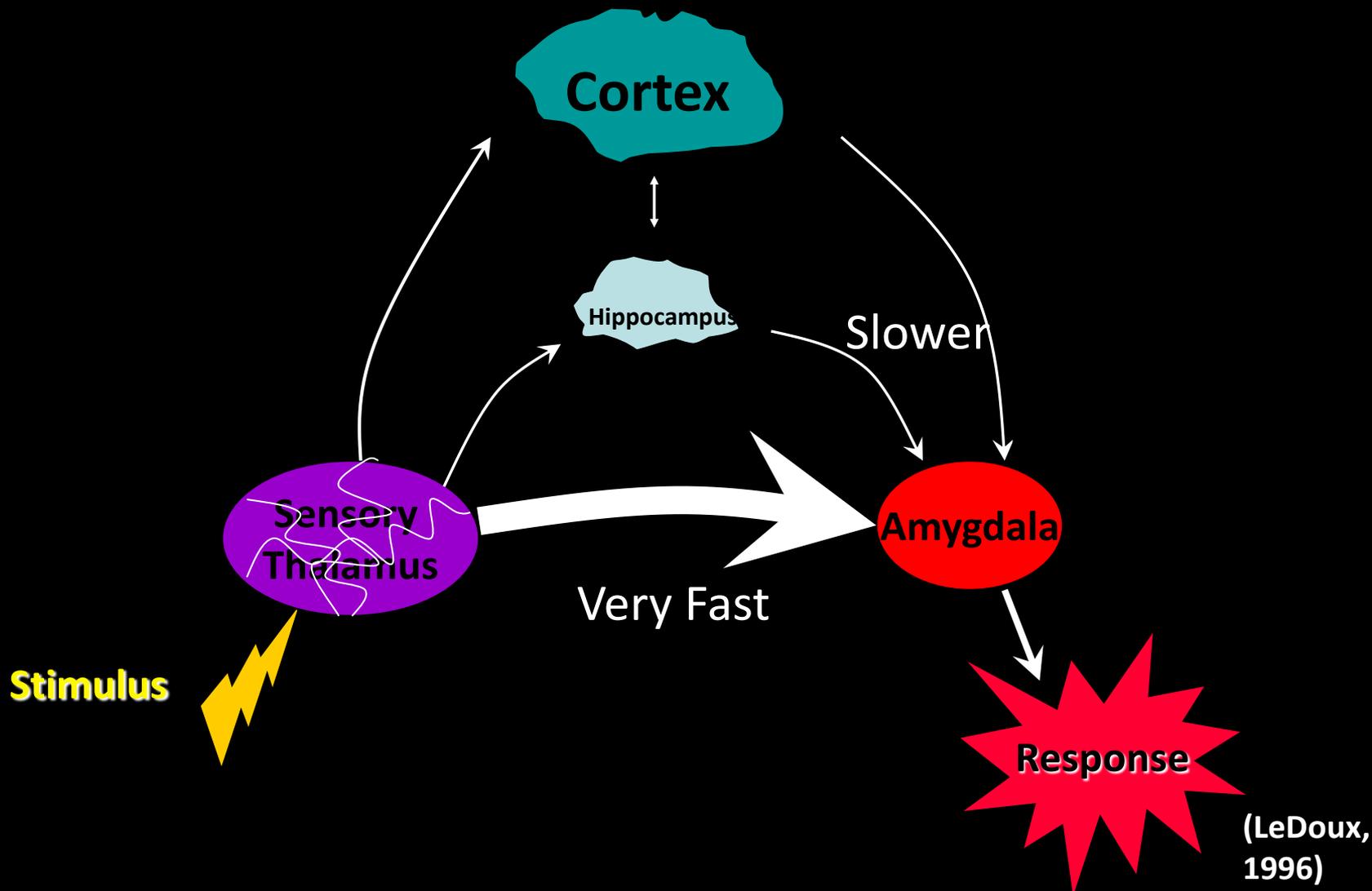
Hippocampus:
matures slowly
supports memory,
learning =
ability to put danger
in context
underdeveloped,
misinterpretation of
threat

Amygdala: functions
immediately for
emotional processing, =
hypertrophy, over
reactivity, fear, anxiety

Between Stimulus and Response

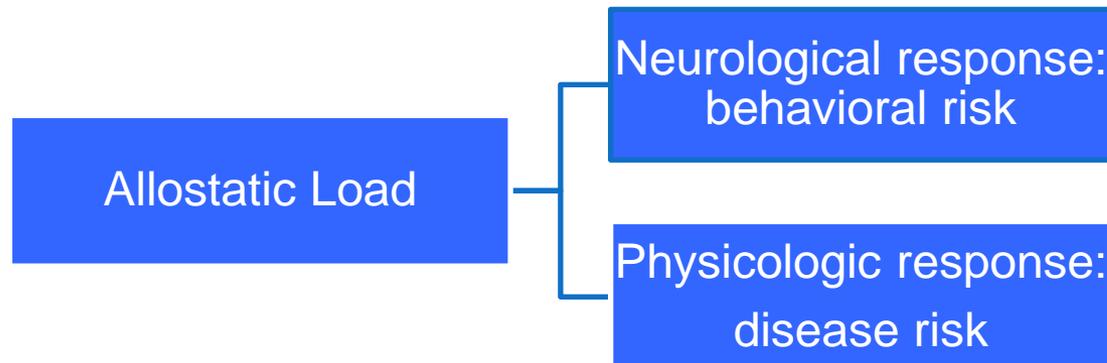


Between Stimulus and Response



“Allostatic Load”

- Increased stress hormones also cause elevated inflammatory / immune response
 - Associated with poor health outcomes including cardiovascular, pulmonary and auto immune disease (Shonkoff et al, Pediatrics 2013)
- Wear and tear on the body from chronic repeated over responsiveness



Just Childhood Adversity?

- VA Study of Vietnam vet twins: incidence of coronary heart disease more than double in those with PTSD (22.6%) vs those without (8.9%) (Vaccarino, JACC 2013)
 - World Trade Center disaster victims: PTSD = 62% increased risk of CAD in men; 68% in women (Jordan et al, Prev Med 2011)
 - Multiple similar studies
- Emerging evidence from Iraq and Afghanistan Vets with trauma experience

“Violence is not randomly distributed.”

Poverty And Trauma

- Children in households below \$15,000 / year, with non HS grad parents or someone on public assistance, >5x more likely to experience maltreatment
- Families with under/unemployment have increased risk of intimate partner violence
- Hospitalizations for assaults increase with the level of neighborhood deprivation



Poverty, Trauma and Health

- 77% of children exposed to school shooting and 35% of urban youth exposed to community violence develop PTSD -- a higher rate than soldiers deployed to combat areas
- Young people exposed to violence as victim or witness are a significantly higher risk for PTSD, Depression and Substance Abuse

Trauma Informed Care

Laurie Lockert MS, LPC

Health Resilience Program Manager

CareOregon/Health Share of Oregon

Trauma Definition

- 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 person's 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.

A Trauma-Informed System...

- Provides all services with the understanding of delivering services in ways that do not re-traumatize already traumatized individuals
- Comprehends the impact and role violence plays in the lives of those seeking treatment from us

Shifts the frame from “What’s wrong with you?”

To “What happened to you?”

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

Why is it important to understand TIC?

Our Delivery System is struggling to reach this population.

Examples of trauma Behaviors :

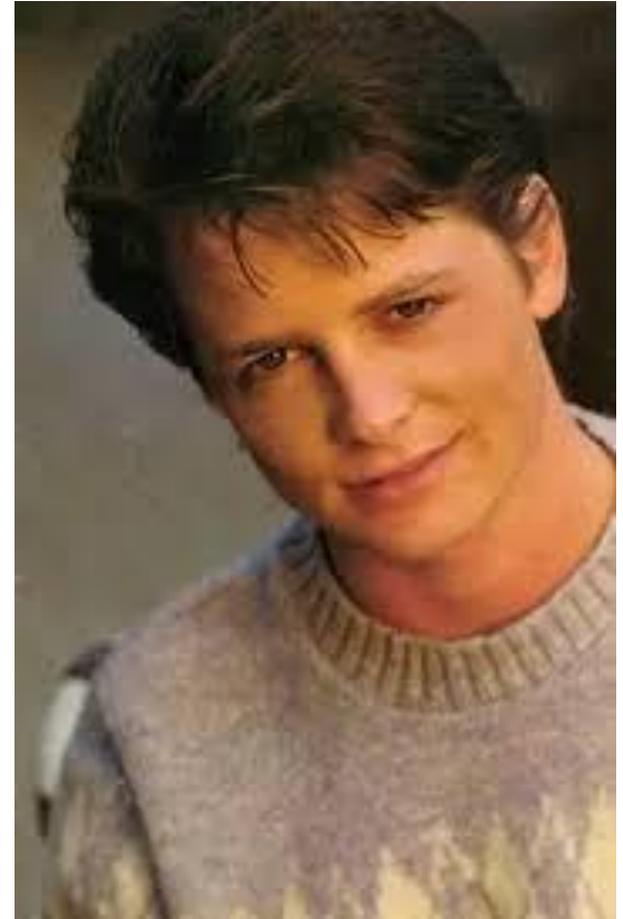
- No shows
- Not following through with treatment plans
- Emotional Reactivity

FQHC's serve a high proportion of these clients

There are tools available to be more effective

Who is Jake?

- 30 yr old male
- on HSO since April
- At time of engagement:
 - Homeless (July 2013)
 - 19 ER visits since April 1
 - EMR Note stating
“Aggressive Behavior”



Jake's "Problem List"

Alcohol dependence in remission

Self-injurious behavior

Hand Pain

Renal calculi

Cannabis abuse

Antisocial personality disorder

Vaccine refused by patient

ICH

Benzodiazepine abuse, continuous

GAD (generalized anxiety disorder)

Noncompliance with medication treatment due to overuse of medication

Acute bronchitis

Hx of suicidal ideation

Bipolar disease, manic

Drug-seeking behavior

Hand fracture

Panic disorder

PTSD (post-traumatic stress disorder)

What Lisa learned from Jake...

...outside of Jake's Medical Record

Passions and Interests

- He loves dogs and likes to help elderly people
- He is meticulous in grooming and keeping his surroundings clean
- He enjoys landscaping and yard work
- He would ask to walk on the street side of Lisa so she would not be splashed
- He insisted on opening doors for her "my mom taught me to be respectful"

Life Experiences

- Joined white supremacy group which provided a place where he could belong
- DX of borderline intellectual functioning in elementary school
- Acknowledged substance abuse to address mental health symptoms
- He and his mother were physically & verbally abused by an alcoholic father – he requested a female provider due to this abuse ("it is hard not to freak out when guys touch me")
- Easily overwhelmed by loud voices, large numbers of people and language that is "over my head"

Human Stress Response to *Recurrent* Threat

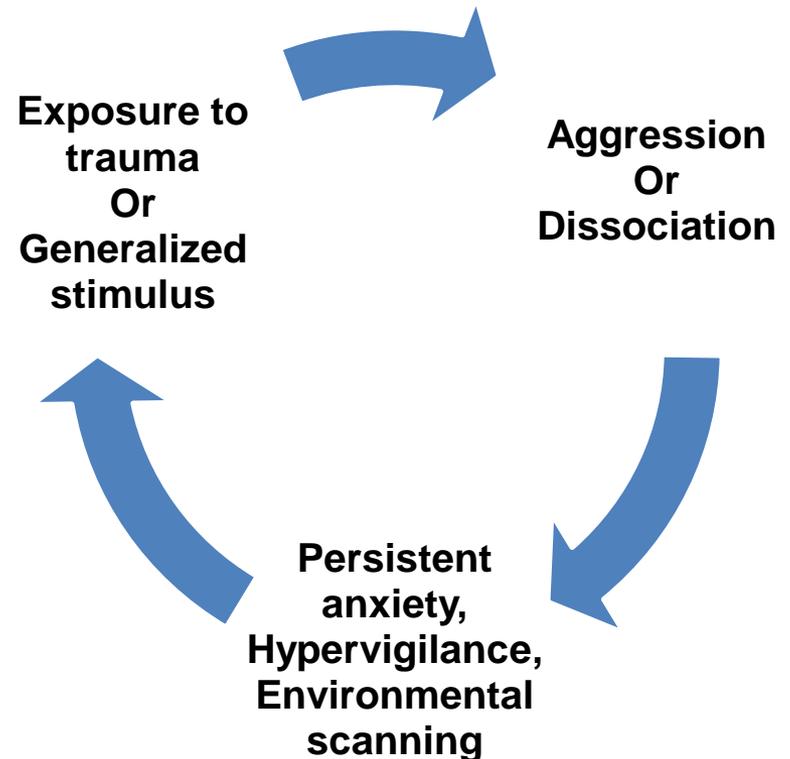


- Reset CNS
- Aggression become chronic
- Chronic hyperarousal interferes with cognitive clarity
- Loss of (or failure to develop) affect modulation
- Reinforcing a sense of helplessness
- Tendency toward traumatic reenactment

Evolving Characteristics

Have you seen these traits?

- Everyday stressors begin to elicit *exaggerated reactivity* (*hair trigger*)
- Persistent state of *fear* (*paranoia*)
- Rapid transition from anxiety to *terror* (*0 to 60 in no time!*)



Bruce Perry, 1995

Common Triggers

an external event that causes internal discomfort or distress...a hint of the past trauma

- Authority figures
- Sensory cues of past events
- Lack of power/control
- Separation or loss
- Feeling threatened or attacked
- Transitions and routine/schedule disruption
- Feelings of vulnerability and rejection
- Sensory overload



Red flags

Jake presented with *'red flag' trauma behaviors*:

- Drug use/multiple psych meds
- Multiple MH diagnoses /behaviors:
 - PTSD
 - Antisocial
 - Panic Disorder
 - Self injurious
 - Easily overwhelmed by loud noises



“Trauma Organized Person”

- Lack Basic safety and trust
- Loss of emotional management
- Problems with cognition
- Communication problems
- Problems with authority
- Confused sense of justice
- Inability to grieve or anticipate future

Sandra Bloom, MD

How do engage our clients?

How Lisa developed trust with Jake

- Listened..Often to the same stories, reflecting back the content with emotions that he expressed
- Asked for permission to help
- Preparation for appointments
- Slow things down—allow lots of time to express concerns, ask questions or sit and think.
- Provide an environment of openness vs judgment

Jake...Post-Engagement

- Got into housing closer to a TIC informed Clinic..transferred to OTC
- He is in a program that addresses chronic pain, attends weekly meetings, engages in meditation with staff members
- PCP is knowledgeable about both chronic pain and trauma informed care. At first appt, pt states, “ You are the first doctor who has looked me in the eye and listened to me”. This first appt lasted approximately 40 minutes with Jake speaking for the first 20 minutes
- “Most people just move me from place to place without any answers and without coming to see me again” (Lisa)

Rebecca Ramsay, BSN, MPH

Community Care Director, CareOregon

**HOW HAS THIS CHANGED OUR
DELIVERY MODEL FOR HIGH RISK/HIGH
COST PATIENTS?**

What (we are learning) Trauma Survivors Need from a Primary Care System



1. Transparency (COMPLETE)
2. Trust
 - Reducing the hierarchy in the relationship makes it safer
 - Trust comes easiest with peers, mentors and guides
3. Turf, theirs
4. Time
 - Neurobiologic changes in the brain make it challenging for trauma survivors to process information quickly, especially when a lot of sensory input is occurring (think busy PCP office)
 - It takes time for a trauma survivor to open up and share honest struggles
5. Tailoring
 - Lack of a conventional agenda driven by payment and billing

And this...



And this...





Health Resilience Specialists are paired with primary health homes and specialty practices to provide individualized ‘high touch’ and ‘trauma-informed’ support to patients with exceptional utilization.

Staff are supported by clinically licensed supervisors who provide daily and weekly guidance, mentoring and clinical supervision.

- * High PCP/Specialist involvement
- * Documentation occurs in the practice’s EMR; population view and process metrics stored in a community care registry
- * Voluntary Program



Target Population for Health Resilience Specialists



Approach = Who has high cost, potentially modifiable utilization?

ID Method = Most Recent 12 mos Claims Experience + Primary Care Assignment

Multnomah County Health Department-NE Clinic Population

| Population Segment | # Members | % Members | Avg Total Paid Cost per Member/ 12 mos | % Paid Cost of Segment/ 12 mos | # ED visits | # IP Admits |
|--|-----------|-----------|--|--------------------------------|-------------|-------------|
| No inpatient/ 6+ ED visits | 81 | 3% | \$8743 | 5% | 786 | 0 |
| 1 Non-OB inpatient and 0-5 ED visits | 97 | 4% | \$18,767 | 14% | 147 | 97 |
| 2+ Non-OB inpatient OR 1 Non-OB inpatient AND 6+ ED visits | 71 | 3% | \$59,440 | 32% | 383 | 189 |

10% of patients accounting for 51% of health care spend

Health Resilience Interventions



- Client advocacy within and among multiple systems
- Assistance in navigating health care system
- Care coordination
- Health literacy education
- Self management skill development
- Assistance with complex problem solving related to living in poverty with multiple health issues
- Motivational Interviewing to resolve ambivalence about health-related behavior change
- **Providing opportunities to identify as something other than a “*patient*”**
- **Providing opportunities to experience success and feel confident**
- **Deep listening, acknowledgment and respect for each individual**
- **Role modeling advocacy and relational skills; trauma-recovery**

Trauma Recovery Interventions Within the Health Resilience Program

Client Focused

SAFETY:

- Always asking permission (Can we talk about something? Is it alright for me to accompany you?)
- Reframing conflict so its not re-traumatizing
- Identifying triggers (check in repeatedly during loud noises/procedures)
- Helping to make situations more predictable

EMPOWERING:

- Offering choices (Where would you like to sit? Here are some options we could consider, esp with chronic pain, Advocating for a female PCP)
- Reframing the power dynamic & taking some of the provider authority out of the relationship (you can say “no”, you don’t have to tell all the details)
- Acknowledge and build on small successes (self worth)

Trauma Recovery Interventions Within the Health Resilience Program

Client Focused

PLANNING:

- Role modeling and guiding clients to plan ahead – skill building (we buy a lot of calendars!)
- Helping clients plan for their medical visits – prioritizing, making sure they have a voice

WORLDVIEW:

- Nonjudgmental as possible (the use of language is powerful!)
- “We keep showing up to support the client”
- Strength-based, always looking for personal assets
- Social justice viewpoint

Trauma Recovery Interventions Within the Health Resilience Program

Provider Focused

ROLE MODELING:

- Slowing down, simplifying instructions (all patients need this)
- Highlighting client successes
- Use of respectful language and nonjudgmental worldview
- Sitting side-by-side rather than at computer
- Need to be more flexible

KEY INFORMANTS:

- Sharing client history (with permission)
- Exposing triggers
- Sharing client strengths and assets (pt who marched with Dr. King)
- Sharing barriers (personal and system)

TEACHERS:

- Consciousness raising about the effect of trauma
- Always offering a quick exit

IMPLEMENTING TRAUMA- INFORMED CARE IN ORGANIZATIONS

REBA SMITH, MS
ADDICTIONS RECOVERY
CENTER, MEDFORD, OR

“Please, not one more thing.....”

What we know so far:

- Individuals with trauma histories are hard to work with
- Individuals with trauma histories have poorer health outcomes
- Now what??

Possible options

- Fire them
- Lay low and hope they don't come back
- Refer them

Is avoidance the only option?

Is it good care?

What if....?

- Something could be done so we could continue to care for them?
- Caring for them was less difficult?
- It wasn't only up to 'us'?
- We actually began to enjoy it?

What we had

- Lots of individuals with behaviors that were hard to tolerate
- Lots of tools in our 'kits' that didn't work all that well
- A belief that the individual had to 'want it' bad enough to change
- A strong culture of 'Why me?' and 'Don't you dare ask me to do one more thing!'

What we did



Trauma-Informed Care learning community with The National Council for Behavioral Health

Seven domains:

- Early Screening and Assessment
- Involving Consumers
- Workforce Development
- Best Practices
- Community Engagement
- Safe and Secure Environment
- Measuring Progress

How it went

- Reduction in ER visits
- Minimization of 'chaos', i.e., conflict, crisis
- Increase in cooperation
- Increase in retention
- Increase in completion rates

A word about what TIC *is not*

- Lack of accountability
- Primary provider as therapist
- 'Technique of the day'

Contact us:



www.transformationcenter.org

Ronald.Stock@state.or.us

971-673-3361

Emilee.i.Coulter-Thompson@state.or.us

971-673-1244