

# **IMPROVING THE CAPACITY OF PRIMARY CARE TO SERVE CHILDREN AND FAMILIES EXPERIENCING TRAUMA AND CHRONIC STRESS**

## **A TOOLKIT**

**Prepared by the Pediatric Integrated Care Collaborative (PICC),  
a project of the Center for Mental Health Services  
in Pediatric Primary Care  
Johns Hopkins University  
Bloomberg School of Public Health  
[www.jhu.edu/pedmentalhealth](http://www.jhu.edu/pedmentalhealth)**

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## Acknowledgements

This Toolkit is part of the **Pediatric Integrated Care Collaborative (PICC)** project. The overall goal of PICC is to improve access to trauma prevention and treatment services for families with young children. PICC is part of the National Child Traumatic Stress Network (NCTSN, [www.nctsn.org](http://www.nctsn.org)). The Substance Abuse and Mental Health Services Administration (SAMHSA), a US federal agency that is part of the Department of Health and Human Services, fund NCTSN and this project.

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We are especially grateful to the participants in the initial PICC Breakthrough Series (2013-14) and Learning Collaborative (2014-15). They are the source of many of the ideas, examples, and resources in the Toolkit. The names and locations of the teams are listed in Appendix A.

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## TOOLKIT OVERVIEW

### Purpose of the Toolkit

This toolkit provides the *why* and the *how* of trauma-informed pediatric integrated care, while encouraging adaptive practices and customization based on the needs of unique communities, environments, and organizational structures. The toolkit can be used (1) to guide Learning Collaboratives or (2) as a stand-alone guide to implement trauma-informed pediatric integrated care.

### Who Should Read This Toolkit?

This toolkit is designed for primary care providers, mental and behavioral health professionals, families, and community organizations who:

- Believe in the power of primary care settings to prevent, identify, and address trauma-related problems.
- Believe that closer collaboration between specialty services and primary care will better serve families who have experienced or may experience trauma or significant stress.
- Aspire to develop the best possible solutions for the community being served and are willing to put thought into cultivating programs that have the highest chance of fitting with the community and the service system.
- Are willing to learn and implement new approaches to care and new ways of working with children, families, colleagues, and other partners.

### How to Use This Toolkit

The toolkit contains information, examples, and practical resources that primary care providers, mental and behavioral health professionals, families, and community agencies can draw from as they work together to develop, implement, and practice trauma-informed integrated care that reflects their unique priorities and communities.

It includes the following sections:

**Toolkit Overview:** Creation, purpose, audience, and organization of the toolkit

*Sections I II and III cover the WHY of trauma-informed integrated care*

#### **Section I.**

**Trauma in early childhood:** Describes traumatic experiences and childhood traumatic stress. Discusses how trauma can affect gene regulation and importance of buffering traumatic experiences through early intervention and promoting resiliency

## **Section II.**

**Key Factors in Pediatric integrated care:** Overview of the critical elements to implement integrated care.

## **Section III.**

**Trauma-informed integrated care:** Defines trauma-informed integrated care and explains why it is a goal, including example success stories from the previous collaborative

*Sections IV and V cover the HOW of trauma-informed integrated care*

## **Section IV.**

**Trauma-informed integrated care foundations:** Discusses four key foundations of trauma-informed integrated care; includes how to make the business case for trauma-informed integrated care

## **Section V.**

**Step-by-Step guide to trauma-informed integrated care:** Provides assessments, information, examples, and tools for teams to use in order to implement and practice trauma-informed integrated care that reflects their unique priorities and communities

## **PICC and Creation of the Toolkit**

**The Pediatric Integrated Care Collaborative (PICC)** strives to improve access to trauma prevention and treatment services for families with young children by identifying and developing the best practices for trauma-informed integrated care. PICC brings together teams of health care providers, mental and behavioral health professionals, families, and community agencies using the “learning collaborative” method. In this method, teams come together to learn about new processes and work in parallel, sharing the challenges and solutions they encounter as they implement these processes into practice.

### **Goal of Pediatric Integrated Care Collaborative (PICC)**

*Improve access to trauma prevention and treatment services for families with young children*

This toolkit was developed from the collective input of participants in PICC’s Breakthrough Series Collaborative and first Learning Collaborative. PICC began with a “Breakthrough Series Collaborative” (BSC) that ran from 2013-2014. The BSC encouraged participating teams to test practical, sustainable processes of integrating trauma/chronic stress prevention, detection, and early intervention into primary care for young children. The ten nationally participating teams identified important methods for making the office more trauma-informed, setting up structures and procedures to facilitate the integration of care, providing primary and secondary prevention, screening for trauma-related problems, and treating trauma-related problems. The BSC teams used small tests of change (Plan-Do-Study-Act cycles), and then once successful processes were identified, the

changes were “spread” to reach further within the office and within the partner agency(ies). After the BSC was completed, the lessons learned were compiled into the first draft of this toolkit.

(A list of the BSC teams is provided in Appendix A.)

In 2014-2015, 10 new teams took part in the first Learning Collaborative (LC1). The LC1’s aim was to test the implementation of the BSC toolkit’s recommended structures and processes. In July 2015, the lessons learned from the first LC were incorporated into the BSC toolkit, resulting in this updated version. (A list of LC1 teams is provided in Appendix A.)

What you are holding now is a work in progress. This toolkit may never be fully finished – our hope is that it will be a living document, always being updated as collective property of the Breakthrough Series and Learning Collaborative teams who have contributed their time, experiences, and expertise.

### **A Note on Terminology**

You will notice throughout this toolkit the appearance of the terms “mental” and “behavioral” in reference to specific health conditions and types of care providers. We will use these terms interchangeably in this text though it is worth noting the varied histories and definitions. People are usually more familiar with the term, “mental health.” A “mental” illness generally refers to a biological condition that impacts a person’s thinking, feeling, or mood and may affect one’s ability to function. Behavioral health has historically been associated with substance abuse, but over time has grown to include all contributions to mental wellness including behavior, habits, and other external factors. Along these lines, mental health refers to a state of well-being in which an individual is able to realize his or her potential, cope with normal life stresses, and make a contribution to the broader community. Importantly, we emphasize a focus on building mental and behavioral wellness. Wellness is more than the absence of disease or disorder. Instead, to support mental and behavioral wellness, emphasize strategies to strengthen positive relationships, build resiliency for children and their families, and contribute to each child’s flourishing. In this toolkit, both terms are intended to include all aspects of mental and behavioral wellness.

## CHAPTER I. TRAUMA IN EARLY CHILDHOOD

### Key Ideas

- ❖ Many children experience trauma
- ❖ There are many types of traumatic experiences
- ❖ Each child responds differently to traumatic events
- ❖ Trauma can have lifelong effects
- ❖ Early intervention and promoting resiliency can mitigate the effects of childhood traumatic stress

### What Is Childhood Trauma?

Throughout childhood, many (if not most) children experience some type of *traumatic experience*, an event that threatens or harms their emotional or physical well-being. The NCTSN estimates that one in four children will experience a traumatic event before they are 16 years old. Traumatic experiences can be the result of a natural disaster such as an earthquake or tornado. Children can also experience trauma within their communities as a result of community violence and racial, cultural, or socio-economic discrimination. Sexual and physical abuse, loss of a parent, bullying, or medical procedures can also be traumatic.

#### Traumatic Experience

An event that threatens or harms emotional or physical well-being.

- Poverty
- Community violence
- Refugee/ war zone
- Racial and ethnic disparities
- Physical/sexual abuse
- School violence
- Neglect
- Medical trauma
- Traumatic grief
- Natural disasters

### What Is Child Traumatic Stress?

While many children experience one or more traumatic events, every child has different physiological and psychological responses. Though most of us would agree that certain stresses are serious – experiencing a life-threatening attack or losing a loved one – we always have to remember that stress and trauma can only be judged by those experiencing them. Variations in experiences, expectations, resources, and to some extent the way our brains and bodies are hard wired determine to a great extent what each individual perceives as stressful or traumatic.

*Stress* comes in many forms. It can be positive, alerting us to dangers. Some stresses can focus our attention on challenges that, if we can face them, will lead us to better places in our lives. Some stresses are tolerable but others can lead to long lasting physical and emotional affects. Stress and trauma can change the way

we look at the world – making us more attentive to risk than to possibility. Furthermore, it does not take a major disaster to create levels of stress that impact health: the “hassles” and worries that come from feeling economically vulnerable or scrutinized because of one’s race, religion, gender, or sexuality, are potentially as or more dangerous than exposures to even serious one-time trauma.

*Child traumatic stress* is caused when a child is exposed to trauma or chronic stress and develops persistent reactions that affect the way they function on a day-to-day basis. Traumatic stress can make it difficult for a child to succeed at school or interact with others. It can also plant the seeds of physical and mental health problems that children may have to face for decades. Child traumatic stress can have an impact on many areas of development: emotional and behavior regulation; relationship formation and trust; maintaining attention while trying to learn new skills and knowledge. Children who have experienced traumatic stress may come to providers’ attention because of problems with their behavior, difficulties with sleeping or eating, or problems adapting to child care and school settings. In some cases, but certainly not all, childhood traumatic stress can lead to symptoms that are clinically diagnosed as post-traumatic stress disorder (PTSD). For example, the fifth edition of the Diagnostic and Statistical Manual (DSM-5) defined a developmental subtype of PTSD for children ages six years and younger. The preschool age-specific definition of PTSD is developmentally sensitive and focuses on recurrent psychological distress, avoidance behaviors, and increased arousal.

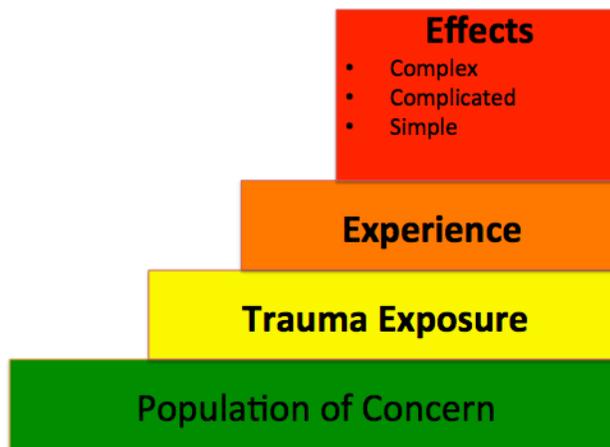
**Child traumatic stress**  
When a child is exposed to trauma or chronic stress and develops persistent reactions that affect their day-to-day functioning

## Exposure and Experience of Trauma

Exposures to chronic stress are fundamentally different than our experiences of chronic stress and should be assessed and addressed separately. *Exposure* encompasses any population subjected to a traumatic event. *Experience* of trauma refers to how an individual responds to trauma exposure.. Stress can be experienced as positive, tolerable, or chronically unsoothed (“toxic”) depending on:

- The event
- Characteristics of the individual (e.g. resiliency and vulnerability)
- Factors in the family and community

Some of those who experience stress will continue to show *effects*. Effects can be targeted with simple interventions, specialty services for physical and/or psychological complications, or coordinated teamwork (see Figure 1)



**Figure 1: Trauma Exposure, Experience, and Effects**

### Child Traumatic Stress and Gene Regulation

Though it has long been recognized that early childhood adversity can cause lifetime problems, it is only more recently that we have come to isolate and understand some of the mechanisms involved. For example, the field of epigenetics has produced evidence that our experiences can alter the function of our genes. Though the links are not well understood, we now know that experiences can change the ways that genes regulate key processes within our bodies.

Two systems that have been explored in relationship to stress and trauma are the genes that regulate oxytocin and glucocorticoid receptors.

Stress and trauma can alter both of these systems, leading an individual to being chronically “on-guard” around others. For example, children raised in stressful environments may be more likely to have elevated blood pressure or allergies as adolescents compared to children raised in less stressful environments.

Epigenetics has also started to explain how parental exposure to stress and trauma, even before children are conceived, may be passed down to future generations.

#### **Oxytocin**

A hormone that plays a role in how we relate to other people (e.g., emotions we feel when we see our children and the desire we have to be close to and nurture others)

#### **Glucocorticoid System**

Part of the body’s mechanism for responding to stress at a chemical level

## Mitigating the Impact of Child Traumatic Stress through Early Intervention and Promoting Resiliency

The fact that people react differently to stress and trauma suggests that there might be ways to help those who experience traumatic events to feel less impact or recover more quickly. *Resilience* refers to the ability to buffer the impact of stress as it happens and recover from the impact more quickly and completely.

Resiliency has two main components that are closely related: a person's own abilities – both innate and learned – to regulate their emotions and behaviors at a time of challenge, and the resources – social and material – that a person can mobilize for protection and response.

### Resiliency

The ability to:

- Blunt the impact of trauma as it happens and,
- Recover from the impact more quickly and more completely

There are many ways to define and measure recovery from a traumatic experience. For example, recovery can be measured by how quickly the body's stress responses return to a normal state. Alternately, we might consider what it takes for someone to return to a state of optimism and security or adapt to new realities peacefully (for strategies on promoting resilience see Theme 6: Addressing Trauma-Related Health and Mental Health).

Research in a number of fields support promising interventions for trauma and stress-related concerns in early childhood, some of which might be able to alter physiologic responses with long-term somatic and cognitive effects. Table 1 lists some of those with the strongest evidence:

**Table 1: Promising Interventions for Mental and Physical Health Professionals to Use for Young Children Experiencing the Symptoms of Childhood Traumatic Stress**

Screener	Source(s)	Domains, age, target population	Pros	Cons
<p><b>ACES Checklist (various versions derived from original Adverse Childhood Events study)</b></p>	<p>acestudy.org and <a href="http://www.cdc.gov/nccdphp/ace">www.cdc.gov/nccdphp/ace</a> for original version; adaptations from Center for Youth Wellness (<a href="http://centerforyouthwellness.org">centerforyouthwellness.org</a>) and others</p>	<ul style="list-style-type: none"> <li>Parent’s childhood maltreatment and family dysfunction</li> <li>Adaptations to refer to children/youth up to 18</li> <li>Different versions cover traumas/stresses within and outside family including abuse, discrimination, medical trauma, food and housing insecurity</li> </ul>	<ul style="list-style-type: none"> <li>Asks about parent’s childhood exposure to trauma</li> <li>Covers wide variety of stresses (depending on version)</li> </ul>	<ul style="list-style-type: none"> <li>Sensitive items. Some families wary of answering.</li> <li>Some versions involve disclosing actual traumas versus count of domains experienced</li> <li>Does not ask about parent’s current exposure.</li> <li>As yet no data/consensus on scoring or optimal clinical use</li> </ul>
<p><b>Protective Factors Survey</b></p>	<p>National Center for Community-Based Child Abuse Prevention <a href="http://www.friendsnc.org/protectiv-e-factors-survey">www.friendsnc.org/protectiv-e-factors-survey</a></p>	<ul style="list-style-type: none"> <li>Based on protective factors framework (<a href="https://www.childwelfare.gov/topics/pr-venting/promoting/protectfactors/">https://www.childwelfare.gov/topics/pr-venting/promoting/protectfactors/</a>; <a href="http://www.cssp.org/reform/strengthening-families">www.cssp.org/reform/strengthening-families</a> (parental resilience, social connections, concrete support, parenting/developmental knowledge, child social and emotional competence)</li> </ul>	<ul style="list-style-type: none"> <li>Questions phrased to cover both strengths and risks</li> <li>Used in agency evaluations</li> <li>Sensitive to change; considered evidence-based instrument</li> </ul>	<ul style="list-style-type: none"> <li>Few questions specifically tap child development</li> <li>Does not explicitly ask about most current or past traumas/stresses</li> </ul>
<p><b>SEEK (Safe Environment for Every Kid)</b></p>	<p><a href="http://theinstitute.umaryland.edu/seek/">http://theinstitute.umaryland.edu/seek/</a></p>	<ul style="list-style-type: none"> <li>Parents asked about household risk of poison, fire, smoking exposure, lack of food</li> <li>Possible physical abuse</li> <li>Parent depression, stress, substance use, parenting difficulties,</li> <li>Domestic violence</li> </ul>	<ul style="list-style-type: none"> <li>Efficient</li> <li>Screener is part of suggested implementation program for which training and support available including parent handouts, clinician decision algorithms, possible links to EMRs, QI and MOC programs</li> <li>Impact of program tested in RCTs</li> </ul>	<ul style="list-style-type: none"> <li>Does not cover development.</li> <li>Smaller range of stresses; child traumatic exposures covered compared to ACES</li> </ul>
<p><b>SWY/C (Survey of Well-Being of Young Children)</b></p>	<p><a href="http://www.theswy.c.org">www.theswy.c.org</a></p>	<ul style="list-style-type: none"> <li>Age-specific forms and specific forms for post-partum depression</li> <li>Developmental Milestones: Gross Motor, Fine Motor, Language and Communication</li> <li>Infant/Preschooler social-emotional development</li> <li>Family psychosocial: (Depression, SA, DV, socioeconomic)</li> <li>Open question for parent concerns about child development or behavior</li> </ul>	<ul style="list-style-type: none"> <li>Covers several screening recommendations: developmental and behavioral screening; autism screening; and parental mental health, SA, DV, food availability</li> <li>Incorporates evidence-based tools</li> </ul>	<ul style="list-style-type: none"> <li>Relatively more time to administer (author estimate 15 minutes) and score (sections of form have their own scoring guides), but meets other screening needs simultaneously so overall may contribute to efficiency</li> <li>Doesn’t ask about the parent’s own childhood</li> </ul>

## Core Readings and Resources

- Johnson SB, Riley AW, Granger DA, Riis J. The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics* 2013;131:319-327.
- Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*. 2012 Jan;129(1):e232-46.
- Stirling, Amaya-Jackson, 2008: Understanding the Behavioral and Emotional Consequences of Child Abuse. *Pediatrics*, 122(3):667-673.
- Materials on brain development and toxic stress at the Harvard University Center on the Developing Child: <http://developingchild.harvard.edu>
- Blueprints for Healthy Youth Development provides a registry of evidence-based positive youth development programs designed to promote the health and well-being of children and teens. Online at: <http://www.blueprintsprograms.com>

## CHAPTER II. TRAUMA-INFORMED INTEGRATED CARE—DEFINITIONS AND WHY IT IS A GOAL

### Key Ideas

- ❖ Definition of trauma-informed care
- ❖ Models for integrating services with families/communities
- ❖ Models for integrating services between mental and physical health providers

### What Do We Mean by “Trauma-Informed Integrated Care”?

The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines three criteria for *trauma informed* services, programs and organizations:

- **Awareness:** Realizes the widespread impact of trauma and understands potential paths for recovery
- **Detection:** Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- **Integration:** Responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization

The Agency for Healthcare Research and Quality (AHRQ) defines integration as a process unifying care across different providers and sites. In our case, it specifically means breaking down barriers between primary care, mental health services, families, and communities (Figure 2). If viewed from a family perspective, integration also includes unifying services for children and other members of their families, especially parents.

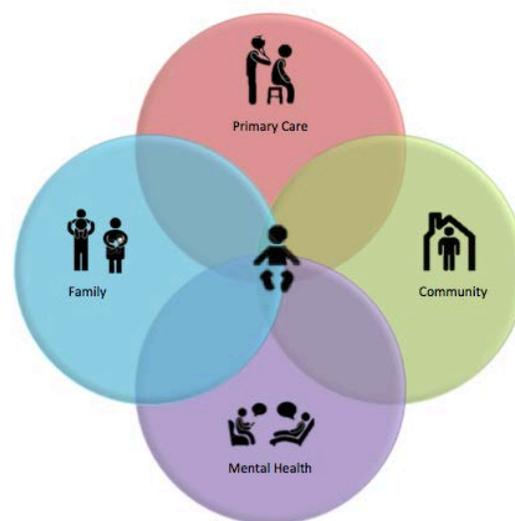


Figure 2: Integrated Care

For us, *trauma-informed integrated care* refers to services that unite primary care, mental health, families, and communities while also integrating knowledge of the impact of trauma on all aspects of care. Trauma-informed integrated care seeks to understand the origins of trauma faced by members of communities, to aid efforts to prevent trauma, and to help those who experience trauma flourish despite it. The first step to trauma-informed integrated care is bringing together all members of the team representing primary care, mental health, families, and community services. Only once these key players are “at the same table” can care be transformed using a trauma-informed lens. In the next sections we will explore models of pediatric integrated care. In the following chapters we will outline *how* services for children and families can be integrated and trauma-informed.

#### **Trauma-Informed Integrated Care**

Services that unite primary care, mental health, families, and communities to effectively understand, prevent detect, and address trauma in the community

## **Models of Integrating Services, Families, and Communities**

### ***Medical Home Model***

In the 1960s, the American Academy of Pediatrics proposed the idea of the “medical home” for children as “a cultivated partnership between the patient, family, and primary care provider in cooperation with specialists and support from the community.” Though the idea has proven more difficult to implement than initially thought, medical homes are now more widely established. Many states and agencies have sponsored medical home learning collaboratives, from which we have drawn valuable lessons. More information is available at [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org).

### ***Chronic Care Model***

The chronic care model (CCM) (Wagner 1996) has provided a way of thinking about how to integrate primary and specialty care for conditions that need treatment and monitoring over time. The CCM outlines roles for patients, primary care providers, staff, and specialists as well as principles of collaboration between generalists-specialists and providers-patient-community.

The CCM provides the following guidance for specialist-generalist collaboration:

- **Systematic monitoring:** Generalists should routinely look for common problems faced by their patients so that they can intervene early or try to prevent the problems altogether.
- **First-Line Intervention:** Generalists should have the tools and assistance to provide first-line care for the problems right away.
- **Follow-up Systems:** Systems should be in place to follow-up the first-line treatment and decide if it has been successful.

- **Collaboration:** When more treatment is needed, generalists should be able to work closely with specialists to assure that patients get the added care they need, and that the added care fits with the patient’s other medical needs (this is often referred to as “stepped care”).

In addition, the CCM emphasizes provider-patient-community collaboration. The CCM is a model of behavior change, and one of its goals is to help providers partner with patients to develop and nurture over time the skills required for “self-management.” In our case, that means helping families feel more in control of their lives and develop the skills and knowledge to navigate the stressful circumstances that they face.

Table 2 looks at specific activities associated with the CCM to integrate services, families, and communities:

**Table 2. Activities Associated with the Chronic Care Model (CCM)**

Element of the CCM	Activities
<b>Patient self-management support</b>	<ul style="list-style-type: none"> <li>• Develops patient skills through coaching, education, and problem solving. <i>(e.g. Psychotherapy and psycho-education to promote self-management and engagement in care)</i></li> </ul>
<b>Clinical information systems use</b>	<ul style="list-style-type: none"> <li>• Facilitates information flow from relevant clinical sources to treating clinicians – most often this means assuring that information from specialists, community programs, and primary care providers can be shared and used to provide the best care with the least burden to the patient/family; <i>(e.g. “patient portal” with ability for families to access and track their own information; update system with progress reports or follow-up surveys)</i></li> </ul>
<b>Delivery system redesign</b>	<ul style="list-style-type: none"> <li>• Re-definition of physician and staff work roles to facilitate anticipatory or preventive rather than reactive care <i>(e.g. screening, discussing concerns, prevention counseling)</i></li> </ul>
<b>Provider decision support</b>	<ul style="list-style-type: none"> <li>• Facilitated provision of expert-level input to generalists to reduce need for consultation separated in time and space from clinical needs <i>(e.g. telephone consultation services for primary care doctors or easy ways to contact specialists)</i></li> </ul>
<b>Community resource linkage</b>	<ul style="list-style-type: none"> <li>• Support for family needs from resources outside the health care organization <i>(e.g. resource box in clinic for community support organizations)</i></li> </ul>
<b>Health care organization support</b>	<ul style="list-style-type: none"> <li>• Organization leadership and tangible resources to support goals and practices of the CCM</li> </ul>

*Adapted from Woltmann (2012)*

## Models of Integrated Clinical Services

Each primary care office has a unique structure in place to work with their mental health affiliate – and vice versa. At the level of health care organizations, different services might be provided by the same organization (possibly even the same location) or require coordination across sites. Scheduling and medical record systems might be unified or separate. Clinicians caring for a family might meet regularly as teams, have protocols for talking with each other one-to-one, or have little or no communication with each other. The following table sets out some of the possible combinations and assigns each a “degree of integration,” with close and full integration theoretically being better.

**Table 3. Levels and Degrees of Integration**

Degree of Integration	Organization	Facility	Records and Scheduling	Communication
Minimal	Separate	Separate	Separate	Sporadic
Basic distance	Separate	Separate	Separate	Periodic
Basic on-site	Separate	Co-located	Separate	?
Close partly	Same	Co-located	Some shared	Regular
Close fully	Same	?	Shared	Team meetings

*Adapted from Doherty (1995)*

We will now take a moment to explore three specific models of integrated clinical services that can effectively facilitate collaboration between primary care providers and mental health providers: (1) co-location (2) screening, brief intervention, and referral to treatment and (3) task shifting. In practice, elements of all three of these models are often combined.

### ***Co-location***

*Co-location* refers to the placement of a specialist physically in a primary care office (or the opposite – placing a general medical provider at a site that mostly provides mental health services). There is some evidence that co-location increases the proportion of patients who are able to complete a mental health referral. However, there are a number of potential pitfalls, and not all co-location efforts have been successful. Benefits and pitfalls of co-location are summarized in Table 4.

**Table 4: Benefits and Pitfalls of Co-located Services**

Benefits	Pitfalls
<ul style="list-style-type: none"> <li>• <b>“One stop shopping”</b> Reduces the number of places clients have to visit, and sometimes allows more than one type of care to be delivered back-to-back in the same place</li> <li>• <b>Reduce stigma:</b> May reduce some of the stigma or visibility associated with obtaining mental health or trauma services – the facility is not associated uniquely with mental health or trauma care</li> <li>• <b>Personalized referrals:</b> Offers the opportunity for personalized referrals – specialist and generalist providers can meet together with a family to jointly plan how they will work together</li> <li>• <b>Increase consultations:</b> May increase the chance that specialists and generalists can informally consult with each other or work as a team – they are in the same place and more readily find each other</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Does not ensure communication:</b> Being in the same building does not mean that generalists and specialists will meet each other or understand each other’s jobs. This usually requires additional work</li> <li>• <b>Diverts responsibility:</b> The presence of the specialist can lead the generalist to take even less responsibility for knowing about mental health or trauma care – the responsibility can just be shifted</li> <li>• <b>Overload specialists’ capacity:</b> The co-located specialist can be swamped with referrals, creating delays in treatment that discourage patients from returning (the same as when the specialist is located somewhere else)</li> <li>• <b>Budget:</b> No one business model will work across all sites – in some places the specialist can bill separately for her services, in others there will have to be ways of factoring specialist costs into an overall budget</li> </ul>

Below are a few suggested best practices for those interested in co-locating services:

■ **Develop a work plan**

Start off by developing a shared understanding between generalists and specialists about how they will work together. What the specialist will help the generalists learn? What criteria should be used to trigger informal consultations, team discussions, and referrals? The specialist may need to learn how the generalists work, too. Before starting, he or she may need to “shadow” the generalists and spend some time understanding how patients flow through the site.

■ **Make a communication plan**

Both generalists and specialists should set up rules for how they will communicate with each other and how their “native” work style will be modified to fit the shared environment. For example, mental health workers typically do not interrupt visits for telephone calls or knocks at their door, while primary care providers frequently break visits up into segments and, in some settings, may actually be seeing more than one patient simultaneously. How will these styles mesh, especially when there is a perceived need for a quick consultation or introduction of the patient and co-located therapist?

■ **Set up mechanisms for sharing information**

How will referrals be made, what information should they contain, and how will the specialist communicate their findings and suggestions back to the generalist? Can both specialist and generalist access the same medical record? How will families be able to control and consent for the exchange of information? How will mental health or substance treatment notes be kept separately from general medical records?

■ **Develop a business plan**

With different types of funding, reimbursements, and billing allowed, how do the generalists and specialists work in ways that are financially sustainable in the practice? How are their varying types of work and workload supported? How does the practice pay for some of the non-reimbursable activities, such as cross-education, consultation, and care management?

[Note that all of the above points are discussed in greater detail later in the toolkit, including strategies, since they apply to nearly all forms of integration, not just to co-location.]

***SBIRT (Screening, Brief Intervention, Referral to Treatment)***

*SBIRT* is a model originally developed to identify individuals who could benefit from alcohol and substance abuse treatment and link them to care. The *SBIRT* model might be seen as a special application of the Chronic Care Model as the two models have very similar elements. The core components of *SBIRT* are discussed in Table 5.

**Table 5: Core Components of SBIRT**

<b>1) Universal screening in primary care</b>
<b>2) Identification of a specific problem</b> <ul style="list-style-type: none"><li>a) Provider and patient agree that there is an issue</li><li>b) They work to develop a shared understanding of why the issue requires help and why now is a good time to act</li></ul>
<b>3) Brief counseling specific to the problem</b> <ul style="list-style-type: none"><li>• What might the patient do about the problem now – including seeking more specialized treatment</li></ul>
<b>4) Long-term tracking of the issue since</b> <ul style="list-style-type: none"><li>a) Many patients may not immediately want to seek care</li><li>b) Even those who seek additional care may give it up</li><li>c) Many problems are recurring, even if successfully addressed in the short term</li></ul>

### ***Task Shifting***

*Task shifting (or sharing)* is a term for strategies that try to move tasks usually delivered by specialists (who are in short supply) to less-specialized health workers who are more easily accessible. For example, in some systems, mental health professionals deliver all depression care. A task-shifting plan would move some first-line depression treatments to primary care. Ideally, task shifting always involves sharing – the specialist and generalist are really sharing responsibilities. Specialists support generalists by providing training, advice to specific patients, and by collaborating in the care of patients with greater levels of need. The main motivations for task shifting are listed in Table 6 below.

**Table 6: Promising and Challenging Aspects of Task-Shifting**

	Motivation/promising aspects	Drawbacks/challenges
<b>Lack of specialists</b>	If there are long wait times for specialist care, task shifting can help address the lack of specialists.	May be most suited to care of mild/moderate severity problems or interventions that can be relatively standardized; risk that generalists will be overloaded with new tasks
<b>Reduces barriers to access</b>	Moving the services to the place where they are needed or where clients are more comfortable receiving them reduces the barriers to accessing care.	Some clients may still prefer to see specialist or separate specialty and general care
<b>Possible reducing costs</b>	Costs may be reduced by shifting some tasks to workers who are more numerous, can be trained more rapidly, or whose services are less expensive.	Lack of business models for specialists who provide initial training and ongoing coaching/supervision for generalists (time, methods of communication)
<b>Knowledge of families</b>	Less specialized workers may have more local knowledge, or, in the case of primary care providers, more in-depth knowledge of families and their communities. Task shifting can thus build upon the existing, established, trusting relationships that families and children often have with their primary care providers.	For sensitive issues, residents of some communities may prefer seeking care outside the community; concerns about ability to maintain confidentiality especially in small or closely-knit communities

Task shifting happens all the time in primary care as new campaigns attempt to include more preventive services (for example, asking pediatricians to apply fluoride varnish to protect teeth, shifting that task from specialty dental providers). There seem to be some key points to successful task shifting:

#### ■ **Redesign task**

Often the tasks cannot simply be moved – they have to be redesigned to fit the context of the more general care setting. For example, pediatricians cannot deliver lengthy protocols for treatment of children’s anxiety, but they can effectively deliver suggestions to parents for modeling and rewarding brave behavior.

### ■ **Modify diagnostic process**

The kind of meticulous diagnoses made in specialty care may not be necessary to offer patients a first-line treatment. Specialists need to use their expert knowledge to design effective and safe but simple interventions for generalists to use, based on the specific problems for which families ask for help, while the diagnostic process unfolds.

### ■ **Training on new ways to deliver care**

Generalist providers need training to deliver new forms of care, but they also need ongoing support to become confident and competent in delivering that care.

### ■ **Integrate new process**

The new care has to complement and fit well into the work the generalists are already doing. It cannot simply add another task to a list of responsibilities that already is too long for the time allocated for primary care visits.

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## CHAPTER III. KEY FACTORS IN PEDIATRIC INTEGRATED CARE

### Five Key Factors in Pediatric Integrated Care

- ❖ Team based approach
- ❖ Involve families and communities
- ❖ Use data to monitor progress
- ❖ Where possible build on existing capabilities rather than start from scratch
- ❖ Incorporate sustainability from the beginning (integrate the integration)

While there are many models of integration, there are several overarching factors essential for developing pediatric integrated care programs across all models. Integrated care for young children and their families who have experienced chronic stress or trauma depends upon human relationships: how families and providers interact; how providers interact with each other; and how the staff and leadership of organizations come together around common goals. Accordingly, programs need to be customized to fit the unique resources, talents, and goals at each site (Butler, 2008).

In this chapter we briefly set out some foundational elements of creating integrated care for all patient populations. These elements stem from the challenge of making change in any system that involves human interactions around complicated and sometimes emotion-laden issues:

The following five elements can aid in the establishment (implementation), replication (spread), and maintenance (sustainability) of integrated care:

1. Team based approach
2. Family involvement
3. Data-driven
4. Adapted strategies
5. Sustainability built in from the beginning

### The Essential Role of Teams

People often think that systems change is a leadership decision alone. Moreover, many times people expect leaders to mandate a change without consultation or involvement of the people who implement and experience the changes. A multi-level, multi-perspective, high-functioning team is essential to accomplishing effective and sustainable change in systems.

### ***Who should be part of the team?***

Leadership is essential, but leaders cannot do it alone. Similarly, one group of professionals cannot do it without the collaboration of others. Making change in complex organizations is an exercise in coalition building and requires the active participation of people with various perspectives and roles, from different (usually nearly all) levels of the organizational hierarchy. Ideally, any given site would have representatives of staff from each clinical (e.g. physician, nurse, medical assistant) and non-clinical (e.g. front desk, billing/coding, office manager) roles. We have found that teams involving the following members, at a minimum, can be effective at implementing and sustaining integrated care:

- **Senior Leader:** High-level administrator or leader from a primary care practice; responsible for providing leadership, support, and advocacy on behalf of the team. Ideally, someone who has a pre-existing working relationship with a counterpart at the corresponding trauma/MH center or practice.
- **Day-to-Day Manager:** High-level manager from the primary care practice who will oversee the activities of the team and actively guide the work of the Core Team. This person must have easy access to the Senior Leader and will have primary responsibility for overseeing and managing all work in this project.
- **Trauma Expert:** At least one member of the team should have expertise in providing trauma services for children 0-6.
- **Primary Care Expertise:** At least one member of the team should have expertise in primary care for children 0-6.
- **Family Advocate:** A family consumer who will represent family perspective on care needs and have expertise on family engagement strategies.

### ***Team building***

A group of people in the same room does not magically become a team. Facilitated activities, discussions, common language, group rules, and mutual respect help to build long-term teams that can lead, manage, and drive this work. Teams work best when there is a deliberate effort to make every member's voice equal – the team's power comes from its ability to legitimately represent and reflect the wisdom of everyone involved and the needs of those they represent.

## Involving Families and Community is Essential

In the end, families and communities provide most of the care that children receive, especially young children. Involving families and communities in system change acknowledges their critical role in children's development and ensures that the new system effectively meets the families/patient's needs. Not engaging families as consultants and partners risks missing out on key insights that can make projects successful, especially regarding the range of experiences and

preferences that families bring. Family involvement is critical to closing the gap between what providers think a family needs and what the family actually wants and will use.

### Family and Community Engagement

Use families' perspectives to inform plans and system changes

- Families should have input on tools, practice, and policies
- Families can be champions and messengers
- Communities can promote resilience and help address trauma exposure

### *Race and Culture*

Incorporating families and community is particularly critical in clinics where providers are of a different race or culture than the patients. Every person has different expectations of and experiences with healthcare. We range in our level of trust in a health system and provider: in our attitudes towards medications; in our beliefs around other medical traditions; or concern about stigma associated with mental health care. Race or culture shape our healthcare system in general as well as individual's interactions with providers. Being open to these differences is critical to delivering effective care. With luck, it will be possible to avoid awkward errors and harmful misunderstandings; but even when these occur, comfort with differences offers a better chance that problems will be resolved with grace and respect.

### *Family as Advisors and Advocates*

Adding a family advocate to an advisory committee or a team is a good first step but may not be sufficient to capture the range of family experiences. Rather, family or client/patient opinions need to inform tools, policies, and practices. In addition, family or client/patient opinions can be powerful tools for change within organizations, and families can also serve as both champions and messengers.

There are many ways to engage with families to elicit feedback and collaborate with community organizations. Specific strategies are outlined in Section 5, Theme 2: Providing Family Informed Services. Throughout this toolkit we will talk about the closely related need to be family and parent-inclusive in the care that is offered – what some call the “two generation” approach to child health.

## Be Data-Driven

Data is useful and important, as it can inform choices in program design. It can help us (and our stakeholders) understand if what we are doing is making a difference, and thus help us advocate for the resources that we need to carry out effective programs.

### ***Data to Inform Program Design***

At the very beginning of your efforts to transform your system, take time to think through what data you already have available to you. What are your existing data sources – medical records, patient surveys, and provider surveys? These data can give information about:

- Quantity of care/services for patients (children and adults)
- Quality of clinical care for patients (children and adults)
- Quantity of work done by providers
- Quality of work done by providers
- Population-level generalizations / impact
- Financial implications

Use your data and the readiness assessment (Section 4) to determine your team's priorities.

### ***Data to Monitor Progress***

*To the greatest extent possible, make sure that the work is driven by the best data possible.* At the very beginning of your work, take the time to think through what data you need to monitor your progress. If possible, consult with data experts in your office to review your data collection plans. Having data that demonstrates your success will enable you to develop support for your efforts and sustain the work over time.

Data that tracks outcomes can also sometimes come from existing sources, but often it has to be collected in a new way. Maybe this new way – a survey of family needs or preferences, an attempt to track completion of referrals – can eventually be built into day-to-day operations or maybe it only happens periodically or with a small sample of patients.

Data need not always be big, especially in the planning stages of your work. You can try a new screening tool or a way of talking about concerns with a handful of families and ask for their feedback; based on the results you can try something else or move to a larger scale.

## **Adapting Treatment, Interventions, and Supports to Meet the Context/Environment of the Clinic**

Re-hauling a system to be integrated and trauma-informed can be overwhelming. It is a daunting task to change systems, implement new trainings, and develop tools. However, it is not necessary to “recreate the wheel.” This toolkit provides examples of evidence-informed tools, practices, and processes implemented successfully by more than twenty teams in their efforts to deliver trauma-informed integrated care. For example, your team might be interested in instituting developmental screenings but another team may have already established mechanisms and provided training on how to use screening tools and how to provide counseling about the results. Many of these strategies and tools are incorporated into the supplementary materials and you will be directed to these tools throughout the toolkit.

### ***Evidence-Informed Treatments***

Over the last few decades there has been a growing emphasis on providing medical care that is based on solid research findings – often referred to as “evidence-based care.” Closely related is the idea that the best medicine happens when we are able to make a firm diagnosis and then apply the evidence-based treatment that fits that diagnosis.

Using evidence-based care is a wonderful idea, and a worthy goal, but it turns out to have a number of limitations. First, the range of problems that individuals and families encounter is much greater and more diverse than the body of research on effective treatments. There are many conditions and combinations of conditions for which there is no definitive research on which to base care.

Second, the kinds of people involved in research are frequently not the same as those who come to clinics or doctors’ offices needing treatment. “Real” patients may have different preferences for alternative treatments, and they are more likely to have multiple other problems than the ones presented by patients involved in research.

Finally, the care given in research projects is usually different from what happens in regular medical care. Supports for patients and the extent of clinician training are often much greater in research, and thus the impact of treatments in research projects is often greater than the impact of the same treatments when used in regular care.

Thus, in day-to-day care, we often hope more to be “evidence-informed.” We look for information from research, and from the opinions of experts, and try to be clear about why we are offering a particular type of care in our system. Ideally, we pair evidence-informed care with consistent efforts to monitor how well our patients do and whether there is any new information that might lead us to new treatments.

### ***Adapting Materials to Fit Specific Populations***

Each clinic has a unique setting and therefore the most successful idea from one site will need some adapting to use at another location. Again, in the world of evidence-based care, scientists and policy makers often worry that if there is too much “adaptation” then the care could differ drastically from the original, losing its effectiveness. This is a real concern, but it is balanced by the concern that the original version might not be feasible or effective at the new site because of differences in patient needs or staff expertise. There are at least two ways of striking this balance:

- When adapting material, understand what your source thinks are the most important aspects of the process or treatment – then make sure to try your best to keep those aspects intact.
- Figure out how you will know if the adaptation is successful – be data driven!

The following table lists some of the possible aspects of a strategy or treatment that might need to be adapted to fit in different sites.

**Table 7: Adapting Models for New Settings**

Issues Related to:	Considerations
<p><b>Adapting content to patients &amp; populations served</b></p>	<ul style="list-style-type: none"> <li>• Extent of cultural and linguistic diversity likely to be encountered</li> <li>• Coverage of mental health topics as it relates to local needs and priorities based on clinical data (versus staff perceptions)</li> <li>• Manifestations of clinical problems described match local language and idioms of distress</li> <li>• Selection of mental health topics and treatments tailored to local treatment resources (including medications available)</li> <li>• Locally-relevant variation in the prevalence of related somatic conditions (both as co-morbidities and as causes of mental health problems)</li> <li>• Within each symptom/condition cluster:               <ul style="list-style-type: none"> <li>○ Suggested case-finding and outcome measurement questions and tools appropriate to local language, culture</li> <li>○ Menu of possible brief interventions chosen for appropriateness</li> </ul> </li> </ul>
<p><b>Structure &amp; culture of the health care system</b></p>	<ul style="list-style-type: none"> <li>• Visit characteristics – length, expectations of patients and providers, usual communication style; who, in addition to the patient, usually comes to the visit</li> <li>• Physical settings available for visits – relative privacy, possibilities for safety</li> <li>• Possibilities for follow-up visits related to cost, distance</li> <li>• Availability of complementary and competing community resources (including traditional care)</li> <li>• Extent of specialist mental health consultation likely to be available</li> </ul>
<p><b>Training staff &amp; clinicians</b></p>	<ul style="list-style-type: none"> <li>• Making training materials accessible (technical level, language, pace, format) to varying staff levels</li> <li>• Adapting training topics to coordinate with other training and capabilities that might be available</li> <li>• Shifting the order or emphasis of coverage of topics to be responsive to local priorities as perceived by staff</li> <li>• Developing training case examples that reflect local populations and providers</li> <li>• Finding or writing clinical aids (screeners, patient education materials) in the proper language and that are culturally appropriate, and thinking about how to proceed when they don't seem to be available</li> <li>• Understanding clinical culture with regard to training or working in teams with clinicians from other professional backgrounds or levels</li> </ul>

*Adapted from Wissow et al. (2014)*

## Sustainability Built Into Work from the Beginning

Sustainability has many dimensions. We often think about it from a financial point of view, but it also has components at the emotional, quality, and workforce levels. Thinking about sustainability from the beginning can help avoid:

- **Emotional burnout** – Designing new systems can be stressful and overwhelming
- **One-shot interventions** – One-shot trainings/orientations to new processes/skills rarely have sustained impact, even though they are important to get things started. Follow-up is needed to help people solidify their understanding and work out inevitable problems
- **Loss of trained professionals** – Good integrated care probably helps with burnout and may reduce turnover, but people’s lives are always changing. Changes you test and implement must be sustainable in the broader organization and include plans for training new staff
- **Lack of funding** - Be ready (eventually) to quantify the time and materials required for what you are proposing. Are there possibly direct financial benefits?

### *How to Build Sustainability into the Work*

Sustainability can be a broad and poorly defined term. Using the acronym ‘LADDERS’ is one way to think about sustainability through an action-oriented lens. LADDERS stands for Leadership, Agency fit and capacity, Documentation, Data, Expectations, Replacement, and Staffing. Table 8 outlines key ingredients and guiding questions to help you think about the sustainability of tools, practices, and processes:

**Table 8: The Elements of Sustaining Work: LADDERS**

LADDERS	Guiding Questions
<b>1. Leadership</b>	<ul style="list-style-type: none"> <li>▪ Who are the leaders we need on board?</li> <li>▪ What do we need them to do?</li> <li>▪ How can we help them do it?</li> <li>▪ What would happen if a key leader leaves? Is there a broad base of champions?</li> </ul>
<b>2. Agency Fit and Capacity</b>	<ul style="list-style-type: none"> <li>▪ How does this tool, practice, or process support the overall direction of the organization? How can it be seen as essential to the agency’s core mission?</li> <li>▪ What resources are needed to do this, in terms of technology, documentation, or internal infrastructure, and how will these resources be obtained?</li> </ul>
<b>3. Documentation</b>	<ul style="list-style-type: none"> <li>▪ How will this work be documented, managed, and monitored to ensure it occurs consistently and with the desired intent?</li> <li>▪ Can this documentation be built into existing systems of reporting or patient care (for example, easily extracted from electronic medical records)</li> </ul>
<b>4. Data</b>	<ul style="list-style-type: none"> <li>▪ What data will be collected to monitor the fidelity of this work and how will they be used?</li> <li>▪ Can data relating to these efforts be made part of routine monitoring or feedback to providers or clinical sites?</li> </ul>
<b>5. Expectations</b>	<ul style="list-style-type: none"> <li>▪ What will happen as leadership changes, staff turns over, technology changes, or fidelity begins to drift?</li> <li>▪ Are there realistic expectations about how long change will take, how soon results will be apparent or how big an impact will be seen?</li> </ul>
<b>6. Replacement (Integrate the Integration)</b>	<ul style="list-style-type: none"> <li>▪ Most of all, how will the new program make existing burdens lighter and benefit seemingly unrelated programs?</li> <li>▪ What existing tools, practices, or processes are these practices or processes replacing or improving? How is the new work building on and combining with existing practices to ensure it is not just ‘layering’ something new on top of what is already being done?</li> </ul>
<b>7. Staffing</b>	<ul style="list-style-type: none"> <li>▪ What staff is needed to do this work and how are they being prepared to do it?</li> <li>▪ If existing staff are being given new roles, have they been involved in the process and do they see the new roles as positive?</li> <li>▪ How will ongoing needs for training and supervision, be assessed and met?</li> <li>▪ For new or existing positions involved in the program, is there a career path that will promote retention of skilled team members but allow them to grow and continue to find the job satisfying?</li> </ul>

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## CHAPTER IV. DEFINING PRIORITIES

### Key Ideas

- ❖ Defining goals around trauma-informed integrated care
- ❖ Assessing readiness
- ❖ Implementing change through PDSAs

### Why Are You Working for Pediatric Integrated Care?

There are many possible rationales for integrating pediatric care – most of which can be applied more specifically to programs targeting trauma/stress and families with young children. Different rationales may appeal to different stakeholders. Being able to articulate your rationales to various audiences will help gain support, keep the team together, and help you decide what to prioritize in your work now and what to address later.

Clear rationales can be especially important when it seems unlikely that programs will pay for themselves or save money. Systems are often willing to make new investments if the product is clear and if the program aligns with the mission and core values of a system.

It is also important to distinguish between rationales and goals, as both are important to consider (though we recognize that terms such as rationale, vision, and goals are often used in confusing and overlapping ways – the exact terms are less important than the concepts):

- **Rationale or motivation:** These are usually more general or are statements of values, mission, or guiding principles – for example, every family has a right to access quality care.
- **Goals:** These are usually more specific and ideally associated with something you can measure – for example, in order to give every family access to quality care, we will develop a business model allowing us to provide preventive care for all families in our community regardless of insurance status.

**Table 9. Rationales and Goals for Articulating Impact of Integrated Care**

<b>Rationales</b>	<b>Goals</b>
<b>Increase access to behavioral health services /number served</b>	<ul style="list-style-type: none"> <li>• Better detection of mental health trauma</li> <li>• Less loss from referral to follow-up</li> <li>• Reduce disparities, equalize opportunities for access to quality care</li> </ul>
<b>Increase quality</b>	<ul style="list-style-type: none"> <li>• More expert service at point of first access and ongoing</li> <li>• Reduced time to service once in system</li> <li>• Better match of need to referred service</li> </ul>
<b>Increased choice/better fit with patient preferences</b>	<ul style="list-style-type: none"> <li>• Family satisfaction with point of entry, place of care, locus of coordination</li> <li>• Reduction in “no-show” or treatment drop-out rates</li> </ul>
<b>Improved clinical outcomes</b>	<ul style="list-style-type: none"> <li>• At the individual level</li> <li>• At the population level</li> </ul>
<b>Reduction in costs attributable to:</b>	<ul style="list-style-type: none"> <li>• Delays in receipt of any or optimal treatment</li> <li>• Inappropriate or avoidable use of emergency facilities or inpatient stays</li> <li>• Use of expensive medications when there are alternative psychosocial or medication therapies</li> <li>• Disruption to unrelated services</li> <li>• Low rates of provider productivity because of missed appointments or premature termination of treatment</li> <li>• Time lost from work (among patients and staff)</li> </ul>
<b>Reduction in future illness, disability, and suffering through prevention and early intervention</b>	<ul style="list-style-type: none"> <li>▪ Better coordination with community services and linking patients to community resources</li> <li>▪ Greater proportion of children participating in Early Head Start or pre-K programs</li> <li>▪ Greater proportion of children considered ready for primary school at the appropriate age</li> </ul>

## **Readiness and Where to Start**

The families, providers, and systems you work with are likely being asked to consider many other causes or projects at the same time. In the world of health services research this is often referred to as “competing demands” – different causes and priorities compete for attention and resources, and sometimes contribute to what staff members call “initiative fatigue.”

Integrating care requires a careful assessment of competing demands. You don’t want to implement a program at the expense of another that could be equally important; you don’t want your initiative to fail because everyone is too busy with other things; you don’t want to be forgotten when a new concern arises tomorrow; you don’t want to add to everyone’s burdens; and you don’t want this work to become focused on compliance rather than values and system change.

To see if your team is ready to plan, implement, and practice trauma-informed integrated care, we recommend that you examine your existing data sources and complete the Readiness Assessment, based on the Collaborative Change Framework (Appendix B). Completing this Readiness Assessment with your team will allow you think about *if* you are ready to start this work and help you identify *where* to start – by identifying the themes prioritized by your team.

## How to Implement Change through PDSAs

This work isn't about a one-time change, rather developing sustainable and effective practices in your clinic. Small tests of change are known as PDSA cycles – “Plan-Do-Study-Act” cycles. The PDSA Cycle is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a product or process PDSAs work best when you decide ahead of time what questions the process will evaluate and how the answers will help you decide your next steps. You should always circle back to your higher-level data to ensure that these small tests are resulting in the types of improvements you intended (Section 4). For example, if you are interested in improving the screening of mental and behavioral health problems, a series of PDSAs could help you to select the best screening tool for use in daily practice. A PDSA could test the effectiveness of the selected tool in promoting the assessment of children’s behavior during primary care visits, greater parent interest in behavioral and emotional issues, both, or neither.

For each theme, teams should identify PDSAs to try in their offices or agencies. This strategy can facilitate small and simple changes that are more easily incorporated into existing systems. PDSAs offer a compelling way of building consensus and accelerating the process of moving forward with new ideas. When several possible paths present themselves, a simple test helps to weigh the pros and cons of each option based on data. To use the example from above, rather than debating the merits of various screening tools, or guessing which one might work best, try out the leading candidates with a few families who are willing to give you their opinion. Use the new information to move your decision-making to a next stage, which is often to make some adjustments and, again, do a quick test of the new version.

Most teams will not start work on all themes at once, so start with PDSAs that create “ah-ha” moments to inspire motivation and support for future changes. For example, you may want to test strategies to develop a trauma-informed office early in the process to foster positive attitudes towards assessment and treatment of trauma-related problems.

Within each theme of the Collaborative Change Framework, there are steps you can take to make your first small tests of change. Below is a guide to help your team move from a strategy to a PDSA and develop metrics to assess progress toward your goals.

**Table 10. Steps for Planning and Implementing PDSAs**

<b>PLAN</b>
⇒ What is the objective for this PDSA cycle?
⇒ What do you predict will happen?
⇒ What is the plan for the cycle? What are the steps to execute the cycle, including data collection (who, what, where, when)?
<b>DO</b>
⇒ Carry out the cycle. In brief terms, did it work as you expected?
<b>STUDY</b>
⇒ Summarize and analyze the observed results. What did you learn from this cycle? Include descriptions of successful interactions, unexpected challenges, and other special circumstances that may or may not have been part of the plan.
<b>ACT / ADJUST</b>
⇒ What actions are you going to take as a result of this cycle? (Check one) <input type="checkbox"/> Adapt the Test <input type="checkbox"/> Expand the Test <input type="checkbox"/> Abandon the Test
⇒ Plan for the next cycle. What changes are needed? If expanding or adapting, what will you do to continue your learning while beginning to spread the successes?

### Change through Non-PDSAs

Not all improvement strategies will be in the form of Plan-Do-Study-Act cycles. Sometimes you don't have a question about how to address a challenge (no need to test a hypothesis); or there's only one way to do something; or you have a task or work plan to execute rather than something to *test*. In these cases, you probably have an improvement *task* rather than an improvement *test*. Although they are not PDSAs, these are important parts of your system improvement plan. You'll find several sample PDSAs and a few examples of non-PDSAs as we move step by step through the collaborative change framework themes in chapter five.

## CHAPTER V. STEP BY STEP THROUGH THE COLLABORATIVE CHANGE FRAMEWORK THEMES

### Key Ideas

- ❖ Review of Collaborative Change Framework: Six key themes
- ❖ Sample PDSAs for each theme
- ❖ Strategies to assess your progress toward each goal
- ❖ Resources and references

### Introduction

This chapter reviews the six themes in the Collaborative Change Framework (CCF):

- Developing a trauma-informed office
- Providing family informed services
- Collaborating and coordinating with mental health/trauma services
- Promoting resilience: primary prevention of trauma and chronic stress
- Assessing trauma-related somatic and mental health issues
- Addressing trauma-related somatic and mental health issues

The aim for any organization striving to integrate trauma and primary care is to make changes within all of these themes in ways that make the most sense for the individual providers, agencies, and families being served. To support customization, a brief narrative explaining its importance, what it involves, and how sites can assess their progress toward achieving the objective follows each objective below. Possible strategies and small tests of change (PDSAs) that you could consider testing or adapting in your own site are included as well. At the conclusion of each theme section, you will find a list of resources, references, and documents for more information. These are organized by objective, whenever possible, as well as by resource type.

As many strategies may cross over multiple theme areas, we have tried to place them in the single “best fit” theme to minimize duplication, providing cross-references to other sections where possible and appropriate. Of course, the distinctions are sometimes artificial, but conceptual clarity can feed real improvements in practice.

The Collaborative Change Framework acknowledges that a family’s past experiences can affect its members’ ability to work effectively with and engage healthcare providers, social service systems, and of course, how they interact with each other. Parents’ experiences (and possibly ongoing trauma-related symptoms) may influence how they view and talk about their children’s behaviors, in both positive and negative ways. Parents who have experienced abuse or neglect as

children, discrimination, economic insecurity, or emigration may be more concerned than other parents for their children's safety; they may feel that they lack role models for meeting children's needs; they may find that situations with their child trigger emotional responses from their past. By recognizing that families bring past experiences to each new encounter, providers can deepen their support for parents and avoid misunderstandings that deter families from seeking help.

In U.S. healthcare, the separation of child and adult care can make it hard to provide care to families. Parents and children may not have the same insurance coverage. Doctors who see only or mostly adults may not be comfortable or able to help with children's problems, and vice versa. Regardless of specialty, however, doctors can play a role in helping parents find the mental health and social resources they need to best care for their children. Ideally, internists, family practitioners, and gynecologists caring for adults who are thinking of having children or who seek prenatal care will systematically ask their patients about their general family resources and specifically about depression, anxiety, substance use, and trauma exposures, to help patients find care before they become parents. During pregnancy, obstetricians, midwives, and family physicians can ask their patients about their own experiences as children in addition to discussing how well prepared they feel to cope with the stresses of parenting. Also, pediatricians can continue this process once children are born, inquiring about parental health as well as that of the child and being prepared to offer advice and connect parents to needed services. Thus, throughout the Collaborative Change Framework, we use the language of "patients" and "families" interchangeably, reflecting the notion that our patient in pediatric integrated care is not just the young child, but also the child's caregivers.

## Theme 1: Developing a Trauma-Informed Office

### An Overview and Rationale

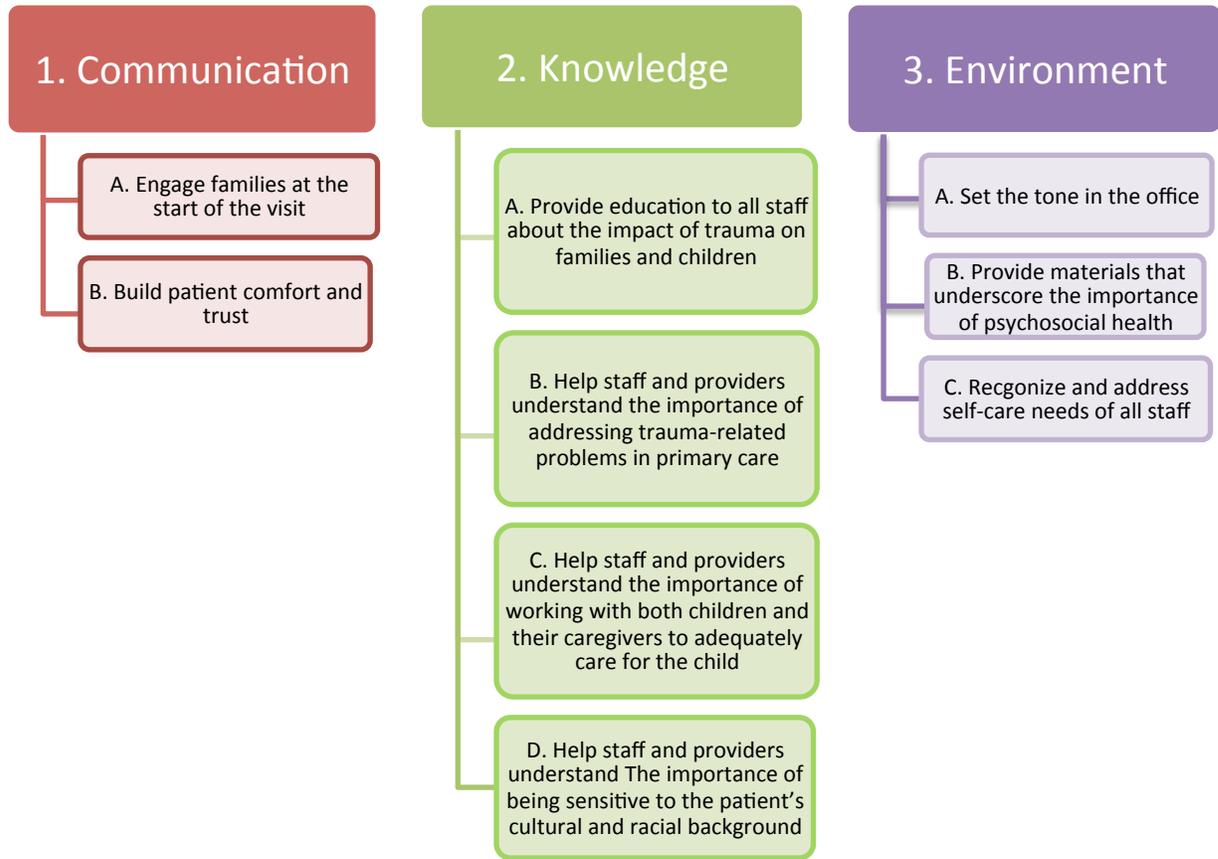
Provider/staff knowledge of the prevalence and impact of trauma can improve sensitivity to and recognition of family needs and improve communication between staff and families. A *trauma-informed office* is one in which the environment—both physical and human— is supportive, fosters patient comfort and trust, and promotes the health and effectiveness of staff, improved staff knowledge, better staff-staff and staff-family communication, and a more welcoming environment will improve patient engagement, satisfaction, and ultimately clinical outcomes.

### Objectives and Strategies for Creating a Trauma-Informed Office:

**Objective 1: Communication:** Increase staff (at all levels) ability to establish supportive relationships with patients, particularly those who have experienced trauma. Why is this important? So that patients and families feel safe and empowered to express their needs and plan their care. This also requires the ability of staff members to communicate empathetically and effectively with each other.

**Objective 2: Knowledge:** Educate staff (at all levels) about the prevalence of trauma in children, families, and communities and its impact on behavior and health. Again, this includes recognition of possible trauma experiences of fellow staff members, and of the impact of working with families with trauma experiences.

**Objective 3: Environment:** Improve office environment so that it is more welcoming, promotes emotional wellness for staff and families, and respects families of different backgrounds and cultures.



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1. Improving Staff/Provider-Patient Communication

### Why is it important?

Effective communication with patients is always important. A successful provider engages children and families during the visit and encourages them to invest in a long-term relationship. Respectful and non-judgmental communication encourages patients to trust their providers and disclose their concerns. Following trauma, it is even more critical that patients feel safe and remain in control of the care process. A staff that takes time to listen to patient needs, explain a diagnosis, and explore care options empowers that individual to collaborate in and engage with a course of action.

There is evidence that a patient-provider relationship in primary care that fosters trust and empowers the patient/family can:

- **Influence clinical outcomes** above and beyond the effect of specific medical treatments.
- **Reduce barriers to mental health care** - Some parents report concerns about biased labeling of children as mentally ill and fear that voicing concerns will lead to inappropriate use of medications. This can be especially relevant to minority parents.
- **Improve identification of mental health issues** – When patients and families feel comfortable expressing mental health concerns, providers can better identify and address these issues.

### What is involved?

Providers can improve communication on a number of fronts to create a welcoming office environment and convey trustworthiness, accessibility, and respect throughout the care experience.

#### ***Strategy A: Engage Families at the Start of the Visit***

As soon as the family walks into the office, there are numerous ways to welcome them and convey respect and sincere interest. Remember that families and patients who have experienced trauma may be anxious or on their guard (without necessarily showing it) or purposely unclear or indirect because what they are trying to express causes them distress, seems shameful, or remains confusing to them.

Every member of the clinical team - from front desk receptionists to medical assistants and providers – plays an important role in making families feel welcome and empowered. *All staff and providers* can help engage families at the start of the visit. Example strategies include:

■ **Greet everyone**

- ✓ Use patients' names during conversations and greet them individually

■ **Be self aware**

- ✓ Be self aware of your own mood and responses (tone and content)
- ✓ Show that you are giving this family your full attention, even if you are busy

■ **Develop supportive techniques**

- ✓ Use an empathetic tone
- ✓ Summarize what you are saying in clear language
- ✓ Ensure patients understand you by checking in on their understanding

Additionally, there are skills that providers can use during the visit to engage families and make them feel more comfortable including:

■ **State your role**

- ✓ Explain your relationship with the family. When you can, emphasize that you are committed to working with them over the long term
- ✓ Be clear about what you will cover in the visit and check if the family has any additions, questions, or changes they'd like to make
- ✓ Explain confidentiality clearly and get verbal or nonverbal confirmation that they understand.

■ **Ask open ended questions**

- ✓ Start with open-ended questions about concerns and the visit agenda
- ✓ Be clear about why you are asking and what you will do with the information

■ **Recognize stress**

- ✓ Acknowledge if your questions seem to be triggering or distressing
- ✓ Recognize and honor that some patients do not like to discuss things in front of other family members
- ✓ Be familiar with and sensitive to the broad range of responses to stress

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your parent advocate, or a sample of parents from your community to get a sense of what strategies they find most engaging, supportive, and respectful.

## **PDSA Example**

### **Improving Patient-Provider Communication**

- Plan:** Develop a script that uses words that are calming, respectful, and empathetic (including some open ended questions) to introduce the link between emotional health and child’s development.
- Do:** One provider tests using the script with one family during a visit.
- Study:** Observe how parents react to the information and if the questions help facilitate conversation. Ask the parents if the information is helpful and easy to understand.
- Act:** Use provider observations/experience along with the feedback provided by the parents to revise the script and make it even more helpful, engaging, and meaningful for parents. Get ready to test it with additional parents – and by additional providers – in your next PDSA cycle.

### ***Strategy B: Build Patient Comfort and Trust***

In the effort to develop relationships with families and foster engagement, it is important to focus on family strengths as well as problems or concerns. Specific skills to build patient comfort and trust during the clinical visit include:

#### **■ Build comfort**

- ✓ Ask for permission along the way to remind the family that they are in control – questions can be deferred if this is not the right time
- ✓ Find non-stigmatizing words to ask about delicate subjects
- ✓ (e.g., “feeling overwhelmed” can be a good word for discussing stress)
- ✓ Offer empathy and assurance of partnership, even if you don’t agree or aren’t yet sure of what to do
- ✓ Refrain from making judgments. Instead, generate hypotheses that help you seek better understanding
- ✓ Give choices by explaining options for both assessment and treatment throughout the visit

#### **■ Focus on family strengths**

- ✓ Ask parents what they do to sustain themselves

- ✓ Ask what parents see as strengths of themselves, their children, and family, and what is going well for them
- ✓ Build on existing assets and give permission to scale back goals
- ✓ Provide advice on actions that are positive and health enhancing, such as behavioral activation and self-care (sleep and diet)

■ **Address stressors**

- ✓ Help with stress reduction
- ✓ (e.g., help with calendar planning/scheduling – this may reduce a host of other family problems)
- ✓ Have referrals ready for housing, food, and other basic needs when they are lacking
- ✓ Transition from talking about child to talking about parent
- ✓ (e.g., “you have a lot on your plate” or “your child’s health is connected to your health”)

■ **Agree on next steps**

- ✓ Make a plan with the patient for the next steps in care
- ✓ Sum up the visit – give advice verbally and in writing
- ✓ (note: some individuals in risky relationships may not want to have something written or easily findable)
- ✓ Ask about possible barriers to follow-up and help troubleshoot
- ✓ Do a warm handoff if you are linking the patient to further care, even within your own office
- ✓ Share contact information to reconnect with you or the office

**PDSA Example**  
**Building Patient Comfort and Trust**

- Plan:** Plan to give parents options about treatment to help build their comfort and trust in you.
- Do:** Share clear options with one parent for treatment. Call it “next steps” and “follow up” instead of “treatment” to make it feel more supportive. Be clear about the benefits and rationale for each of the options and make sure they know the differences.
- Study:** Observe how the parent responds to the options, especially around the language you use to describe each. Ask the parent if the options were helpful, clear, and easy to understand. Ask if there are other questions they wish you had addressed.
- Act:** Use your observations and the feedback from the parent to revise the way in which you share options. Try again with more

## Assess your Progress on Improving Staff/Patient-Provider Communication

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### *Strategy A. Engage Families from the Start of the Visit*

- What communication approaches are currently being used by frontline staff to greet and engage patients/families?
- What communication trainings are offered to staff?
- How do staff help families understand who they are and what they do?
- How do staff understand their own and honor different races and cultures as they strive to engage families?

### *Strategy B. Build Comfort and Trust*

- What communication approaches are currently being used by frontline staff to greet and engage patients/families?
- What communication trainings are offered to staff?
- How do staff help families understand who they are and what they do?
- How do staff understand their own and honor different races and cultures as they strive to engage families?

## Additional Resources for Improving Staff/Patient-Provider Communication

The resources listed below can be found in **Appendix A.1**

### ***Communication Background***

1. A Common Factors Approach to Improving the Mental Health Capacity of Pediatric Primary Care. (Wissow et al., 2008)
2. . Health Information Technology to Facilitate Communication Involving Health Care Providers, Caregivers, and Pediatric Patients: a scoping review. (Gentles, SJ, Lokker C, McKibbin, AK)
3. Communicating With Children and Families - From Everyday Interactions to Skill in Conveying Distressing Information
4. Doctor-Patient Communication: A Review (Ha, Anat, Longnecker, 2010)

### ***Communication Strategies***

1. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

## Objective 2. Improving Staff Knowledge

### Why is it important?

A deeper understanding of trauma should increase support for program changes and improve the quality of care. In order for an office to be trauma-informed, staff at all levels needs to understand what trauma is, how it affects health and behavior, and why it is important to identify and treat trauma-related problems. Education about trauma will not only improve knowledge of the symptoms, potential complications, and needed services, but it will also help staff understand why it is important to address trauma-related problems in primary care with sensitivity and empathy.

### What is involved?

Many staff and providers minimize the extent to which children and families are exposed to trauma, the possible negative impact of childhood trauma exposure, and the importance of early identification and intervention. Staff education can be one tool to overcome this knowledge gap. When providing staff education there are several important things to remember:

- **One-time trainings are not sufficient to maintaining a trauma-informed office.** To integrate trauma-informed practice into daily routines, information must be continually reinforced. Various activities can be put in place to reinforce education over time, such as:
  - Continuing education on trauma as it relates to patients and families
  - Performance expectations and reviews
  - Reflective supervision on complex cases
  - Ongoing training and awareness on the impact of trauma on providers
- **Some providers may have concerns about receiving trauma training.** They may feel that they don't have time to inquire about trauma or that they do not have the skills and resources to address trauma if it is identified. A trauma-training program can address these concerns and acknowledge them as valid. The process can mirror interactions with families – concerns are respected and, rather than being met simply with assurance and being set aside, are taken as a starting point for problem solving once there is agreement on goals.
- **Some providers may themselves have experienced trauma or feel affected by the stories they hear from their patients.** It is important for providers to recognize how their own exposure to trauma may affect their patient and staff interactions. This recognition and self-awareness helps providers cope with negative feelings and burnout. Training should include strategies for staff to support each other.

***Strategy A: Provide education to all staff about the impact of trauma on families and children***

Training on the high prevalence of trauma exposure in children and families, can help staff and providers understand that trauma exposure is wide spread. Training about trauma must emphasize that each individual (depending on ethnicity, culture, and past experience of discrimination and trauma) may experience the impact of trauma differently (see Appendix A.2; Training Resources, PowerPoints). Trainings about the impact of trauma on families and children can include the following components:

- Sources of trauma; definitions of trauma
- Prevalence of trauma exposure and related problems
- Somatic and mental health problems related to trauma

There are many strategies that can be used to provide education to staff include:

■ **Have formal staff training days**

- ✓ Develop and deliver formal training on trauma and the topics described above
- ✓ Include all levels of staff, including front desk staff, nurses, administrators, physicians, etc.
- ✓ Ensure that the training provided is meaningful and accessible to all who are involved

■ **Share educational materials at previously scheduled staff meetings**

- ✓ Use existing meeting times to incorporate in education about trauma
- ✓ Dedicate a specific block of time at each existing meeting for initial and ongoing education

■ **Use staff newsletters, bulletin boards, and communications**

- ✓ Reinforce education and provide new information in written communications you have with staff
- ✓ Have a dedicated section of a staff newsletter or bulletin board to focus on trauma-related issues

■ **Have optional or informal times for discussion**

- ✓ Invite staff to host or facilitate informal discussions about trauma-related issues
- ✓ Have periodic “brown bag lunches”

**PDSA Example**  
**Provide Education on the Impact of Trauma  
for Families and Children**

- Plan:** Plan to share information with other primary care staff (e.g. nurses) about toxic stress and how screeners can be used to help support families and build their comfort and trust in you.
- Do:** Find resources on toxic stress and the benefits of using screeners to provide education for primary care staff.
- Study:** Ask staff for feedback about educational content and learning formats. Give the team an opportunity to ask questions, request additional training, and how they would like to receive it, etc.
- Act:** Use your observations and the feedback from staff to revise the way in which you provide resources and education. Encourage other providers to try it as well.

***Strategy B: Help staff and providers understand the importance of addressing trauma-related problems in primary care***

Education about the impact of untreated trauma-related problems and the effectiveness of early interventions can motivate providers to ask and talk with patients about potential and actual traumatic experiences in a thoughtful way (see Appendix A.2; Training Resources, PowerPoints). Trainings on the importance of addressing trauma-related problems in primary care can include the following training components:

- Impact of untreated trauma-related problems
- Effectiveness of early intervention
- Important role of primary care in preventing and treating trauma

Consider using the strategies listed in Strategy A to provide initial and ongoing training for these topics.

## PDSA Example

### Help Providers Understand the Importance of Addressing Trauma-Related Problems in Primary Care

- Plan:** Plan to implement a process for trauma screening at the practice.
- Do:** Review a completed trauma screening tool with a primary care provider, discussing the new information that was gathered and how it impacted the engagement, planning, care, and treatment for the patient and family.
- Study:** Gather feedback on the conversation. More specifically, find out what aspects of the conversation helped her best understand the importance of addressing trauma in primary care.
- Act:** Use your observations and the feedback from the primary care providers to tailor the screening process.

#### ***Strategy C: Help staff and providers understand the importance of working with both children and their caregivers to adequately care for the child***

Staff and providers must be aware that the mental health and experiences of parents/caregivers can seriously impact their children's development. Education on the importance of working with whole families – not just children -- can motivate providers to ask and talk with patients' parents about their own potential and actual traumatic experiences. Trainings on the importance of working with families can include the following training components:

- Connection between parent/caregiver mental health and parenting capacity
- Connection between parent/caregiver mental health and child development
- Incidence and prevalence of adult mental health issues (e.g., ACEs study)
- Reminders about wide range of trauma exposure, incidence of trauma exposure, and impacts when trauma remains untreated into adulthood

Consider using the strategies listed in Strategy A to provide initial and ongoing training for these topics.

## PDSA Example

### Help Providers Understand the Importance of Addressing Trauma-Related Problems in Primary Care

- Plan:** Plan to implement a process for trauma screening at the practice.
- Do:** Review a completed trauma screening tool with a primary care provider, discussing the new information that was gathered and how it impacted the engagement, planning, care, and treatment for the patient and family.
- Study:** Gather feedback on the conversation. More specifically, find out what aspects of the conversation best helped providers understand the importance of addressing trauma in primary care.
- Act:** Use your observations and the feedback from the primary care providers to tailor the screening process.

#### ***Strategy D: Help staff and providers understand the importance of being sensitive to patients' cultural and racial backgrounds***

A person's race and culture can influence their views of trauma, mental health, and medical care. In clinics where the provider and patient come from different racial and cultural backgrounds, being aware and sensitive of the patients' background is particularly important (see Appendix A.2; Training Resources, Marginalized Populations). Staff trainings about race and culture can include:

- Knowing who you are and how that impacts your work with others of other races and cultures
- Knowledge of patients' racial and cultural background
- Importance of being sensitive a patients race and culture
- Understanding of implicit bias, micro aggressions, historical trauma, personal biases, institutional racism, and structural/systemic racism

For this topic in particular, however, in-office staff training is often insufficient. In addition to the strategies in Strategy A focused on various ways to provide initial and ongoing training, you may consider some of these strategies that are specific to race and culture:

#### ■ **Build knowledge of the community**

- ✓ Go on community tours
- ✓ Talk directly with community members about their race, culture, values, beliefs about family, etc.
- ✓ Read narratives about patients' experiences

■ **Create safe and supportive spaces**

- ✓ Ensure staff develop comfort with the conversations about race and culture through group agreements, especially agreements focused on creating a non-judging, non-blaming environment
- ✓ Share office values and ensure they include clear statements about respect, openness, and lack of judgment
- ✓ Model safety and support at all levels of the organization, particularly at the leadership and supervisory levels

■ **Facilitate and engage in challenging conversations**

- ✓ Bring in facilitators who are experienced and skilled in challenging conversations
- ✓ Ensure that the conversations are ongoing and not one-shot trainings
- ✓ Validate and honor different voices and perspectives

■ **Collect and use data**

- ✓ Collect data by race and culture to see if there are disparities
- ✓ Review data and have discussions about any differences you see (if any) by race and culture
- ✓ Identify opportunities and challenges that may be specific to race or culture

**PDSA Example**

**Help Staff and Providers Understand the Importance of Being Sensitive to Patients' Cultural and Racial Backgrounds**

**Plan:** Plan to talk about race and culture in all staff training

**Do:** Outline a staff training that engages staff in talking about their own and their patient's race and culture. Consider having a family or community member talk about their experience with race, culture, and primary care. Discuss how race and culture can affect engagement, planning, care, and treatment for the patient and family.

**Study:** Gather feedback on the staff training. More specifically, find out what aspects of the staff training helped staff and providers become more aware of the importance of being sensitive to a patient's race and culture

**Act:** Use your observations and the feedback from staff to plan additional conversations and experiences centered on race and culture.

## Assess your Progress on Improving Staff Knowledge

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### *Strategy A. Provide Education to Staff about the Impact of Trauma*

- What is the general understanding of and attitude about addressing trauma-related issues in the office?
- How is training provided about trauma and resilience?
- What is covered in the trainings and what do you feel is most effective?

### *Strategy B. Help Staff/Providers Understand the Importance of Addressing Trauma in Primary Care*

- How do you know if providers and staff are applying the training to their everyday work with children and families?
- What do you have in place to support, reinforce, and strengthen the training content?

### *Strategy C. Help Staff/Providers Understand the Importance of Working with Parents & Caregivers*

- How are staff and providers taught to work with parents and caregivers?
- How are staff and providers supported in working with parents and caregivers?

### *Strategy D. Help Staff/Providers Understand the Importance of Honoring Patients' Races and Cultures*

- How are staff and providers taught to honoring racial and cultural differences?
- How are staff and providers supported in honoring racial and cultural differences?

## Additional Resources for Improving Staff Knowledge

The resources listed below can be found in **Appendix A.2**.

### ***Toxic Stress Background***

1. Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician (Garner et al., 2011)
2. The Lifelong Effects of Early Childhood Adversity and Toxic Stress (Shonkoff et al., 2011)
3. AAP - Toxic Stress Threatens Kids' Long-term Health
4. Adverse Childhood Experiences and the Lifelong Consequences of Trauma

5. Neuroception - A Subconscious System for Detecting Threats and Safety (Porges, 2004)
6. The Science of Early Life Toxic Stress for Pediatric Practice and Advocacy (Johnson et al., 2013)
7. Study: Nearly half of US Kids Exposed to Traumatic Social or Family Experiences
8. Accumulated Childhood Trauma and Symptom Complexity
9. Child Sexual Abuse: Consequences and Implications
10. A Reporter at Large: The Poverty Clinic

***Training Resources: PowerPoint***

1. It's Just Good Medicine: Trauma-Informed Primary Care
2. Trauma Informed Care in Medical and Behavioral Settings
3. ACES and Integrated Care
4. Toxic Stress Overview
5. Elizabeth Hudson's Slide Set from WI Trauma-Informed Care Training

***Training Resources: Marginalized Populations***

*Native Americans*

1. Historical Trauma of the Original Peoples of North America (Canada)
2. Traditional Interpretations of PCIT

*Migrants*

3. Trauma-Informed Care for Displaced Populations- A Guide for Community Based Service Providers

*Foster Kids*

4. The Invisible Suitcase - Behavioral Challenges of Traumatized Children (NCTSN)
5. Helping Foster and Adoptive Families Cope with Trauma

## Objective 3. Improving Office Environment

### Why is it important?

The physical space and cultural tone of an office plays an important role in putting patients at ease. Patients and their families will feel more comfortable if the office has a calm, welcoming atmosphere, demonstrating a respect for diversity and an interest in emotional health. The office should have private space for confidential conversations at each stage of a visit including patient registration, documentation of vital signs and concerns, screening, and post-visit interactions for laboratory work and referral/follow-up planning.

Other environmental factors that can affect patient comfort and satisfaction are scheduling time lags, waiting time between registration and visit, visit length, processes for scheduling follow-up visits, and referral processes. A long wait could discourage a patient from keeping the visit or it could reduce their interest in discussing their concerns. Short visits in primary care may hinder or limit conversation of family needs. Thus, it is important to try to reduce wait time and allow sufficient visit length to discuss patients' psychosocial concerns.

Trauma-informed care includes a focus on office staff. While caring for children can be deeply satisfying, it can also lead to compassion fatigue, which in turn may result in burnout and secondary traumatic stress. In order to support staff's professional and emotional well-being, it is important to recognize and address the emotional needs of all staff.

### What is involved?

Improving the office environment requires attention to the physical space, its contents, as well as to the people who work in that space.

#### ***Strategy A: Set the tone in the office***

Offices can be the source of stress to many families – scheduling appointments and interruptions during visits can cause stress for patients and their families. Offices can minimize the stress associated with visits by creating an office tone that is trauma informed. Strategies to improve the tone of the office include:

#### ■ **Make the office inviting**

- ✓ Use fun colors
- ✓ Have interactive materials for children
- ✓ Have materials for parents (see Strategy B)
- ✓ Reflect the communities and families served in terms of posters, books, toys, languages used

#### ■ **Offer flexibility in scheduling**

- ✓ Have options available to meet the needs of patients
- ✓ Create office procedures to address patient preferences

■ **Make patient time “sacred”**

- ✓ Instill policies that allow for an uninterrupted patient visit
- ✓ Allow for time in all visits to discuss some psychosocial issues
- ✓ Create mechanisms that allow providers to offer longer visits when they might be needed

**PDSA Example**  
**Set the Tone in the Waiting Room**

- Plan:** Plan to make changes in the waiting room atmosphere.
- Do:** Make concrete changes in the waiting room (e.g. small Zen waterfall with calm music).
- Study:** Track comments from patients, observe impact on patient comfort, and impact on office staff.
- Act:** Use the feedback and observations from patients and staff to make additional changes.

***Strategy B: Provide materials to underscore the importance of psychological health***

Waiting rooms can prime families to start thinking about mental health, trauma, and resilience by displaying materials about mental health and child development. Posters and pamphlets can both educate families about the importance of mental health and strategies to promote well-being through different stages of development. To ensure that families can relate to the material, it is important that materials depict people of diverse backgrounds and are available in different languages (see Appendix A.3; Fact Sheets/Posters). Materials on mental health include:

- Table top materials with strategies to deal with stress
- Family-friendly posters on trauma-related health and mental health conditions.
- Fact sheets about mental health across developmental stages

These materials can be shared with families in a variety of ways, including:

■ **Have materials available in the waiting area**

- ✓ Have posters that normalize the importance of mental health and emotional well-being for children and families
- ✓ Develop or adapt existing handouts and have them available in the waiting room

### ■ Share during visits

- ✓ Give materials to all parents (normalizing the process) and use them as opportunities for conversation
- ✓ Do talk-backs with parents based on the materials to ensure they understand them and can make meaning of them

### ■ Send as follow-up

- ✓ Develop materials that are intended to follow-up on the visit in positive, supportive ways
- ✓ Use as link to or rationale for follow up with specialists, if needed

### PDSA Example

#### Provide Materials that Underscore the Importance of Psychosocial Health

**Plan:** Plan to give parents options about treatment to help build their comfort and trust in you.

**Do:** Test the use of a brief family-friendly brochure focused on psychosocial health by placing it at the front desk for parents to look at upon arrival.

**Study:** Note changes in inquiries on the topic and comments from parents. Ask a few parents what they like and dislike about the brochure. Ask if there are other questions they wish it had addressed.

**Act:** Use your observations and the feedback from parents to revise the brochure.

#### ***Strategy C: Recognize and address self-care needs of staff***

Helping families work through trauma and illness can be draining on staff and providers. When working towards trauma-informed integrated care, it is important to support staff wellness as well as recognize signs of compassion fatigue, secondary traumatic stress, and burnout (see Appendix A.3; Secondary Traumatic Stress, Surveys and Self-Care Strategies). Strategies to recognize and address staff self-care include:

### ■ Survey staff

- ✓ Invite regular feedback from staff on compassion fatigue, secondary traumatic stress, and burnout
- ✓ Have staff complete compassion fatigue “tool,” such as the ProQuOL.

- ✓ Be transparent about how the survey results will be used. Use the survey results to inform policies and practices.

■ **Build staff self-care into office**

- ✓ Build conversations about self-care into regular meetings and supervision
- ✓ Include self-care activities as part of regular meeting agendas
- ✓ Have a self-care station or wellness room in the office for staff with items such as green tea, yoga mat, de-stress balls, etc.

■ **Actively support self-care**

- ✓ Have staff include self-care strategies in their own employee/personnel evaluations and plans
- ✓ Follow up with staff about their own self-care
- ✓ Ensure that leadership and managers model “good behavior” related to self-care

**PDSA Example**  
**Recognize and Address Self-Care Needs of Staff**

- Plan:** Plan to survey staff about compassion fatigue
- Do:** Test the use of a brief compassion fatigue survey with a couple of staff
- Study:** Ask staff what they like and dislike about the survey. Ask staff what additional questions they would like to be asked and what support they would like to have from the clinic,
- Act:** Use the feedback from staff to adapt the survey to meet the needs of your clinic staff.

## **Assess your Progress on Improving the Office Environment**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### ***Strategy A. Set the Tone in the Office***

- What have you done to make offices/exam rooms more conducive to discussion and demonstrative of respect?
- What policies are in place to reduce interruptions and maintain privacy during visits?
- How have you created flexibility in schedules to allow for longer discussions of psychosocial concerns?
- How have you made it less difficult for patients to schedule follow-up visits?

### ***Strategy B. Provide Materials that Underscore the Importance of Psychological Health***

- What materials are available in the office to explain mental health in child-friendly and parent-friendly language?
- What materials are available with strategies to reduce stress?
- How are these materials shared with families in open, non-threatening, non-blaming ways?
- How do materials, posters, and your office environment reflect children and families from the diverse backgrounds and languages you serve?

### ***Strategy C. Recognize and Address Self-Care Needs of Staff***

- What trainings are in place to educate staff about emotional fatigue?
- What materials are available with self-care strategies?
- What do you have in place to support staff who may have experienced their own trauma or are affected by their work in trauma care?
- How does your office environment support and promote staff wellness and self-care?

## **Additional Resources for Improving the Office Environment**

The resources listed below can be found in **Appendix A.3**

### ***Fact Sheets/Posters***

1. After the Hospital - Helping My Child Cope
2. Things That Help Babies Wind Down (CHADIS)
3. Mental Health Poster Children (AAP)
4. Mental Health Poster Children- Spanish (AAP)
5. Mental Health Poster Adolescents- Spanish (AAP)
6. Posters on Resilience (AAP).

### ***Secondary Traumatic Stress: Surveys***

1. Building Your Bounce Adult Resilience Survey
2. Compassion Fatigue Self-Test
3. Professional Quality of Life Scale Self-Score
4. The Concise Professional Quality of Life Scale Manual
5. Short Life Stress Test
6. Secondary Traumatic Stress-Informed Organizational Assessment

### ***Secondary Traumatic Stress: Self-Care Strategies***

1. Building Initiative
2. Ideas for Self Care-Fill Ups Handout

## **Theme 2: Family-Informed Practices, Services, and Support/Resources**

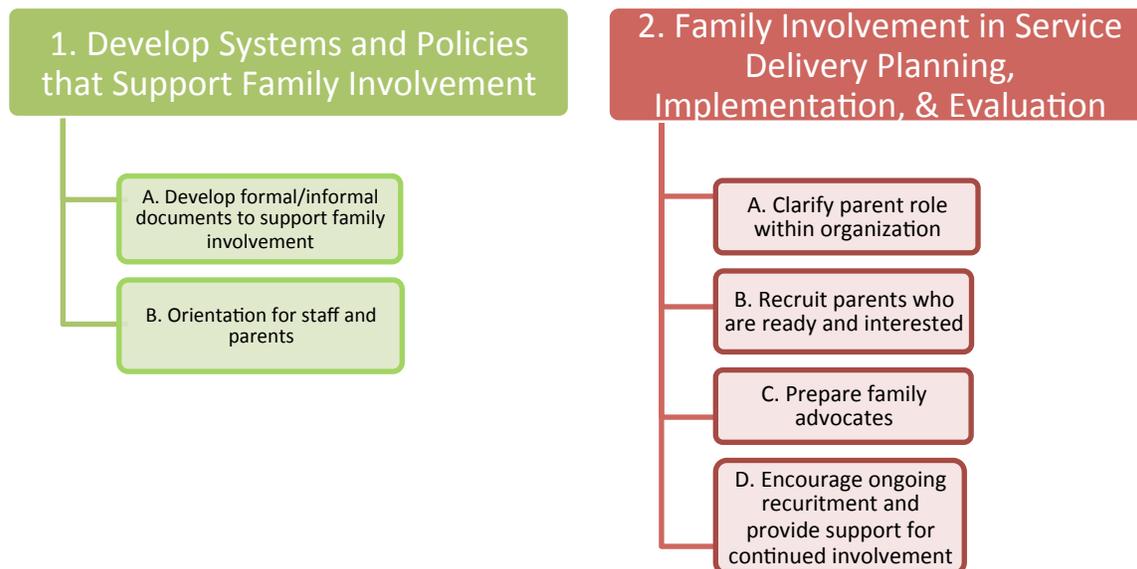
### **An Overview and Rationale**

For a program to be successful, it must meet patients' and families' needs in ways that they find welcoming and supportive. Many clinics and agencies already actively partner with families on a case-by-case basis, and some have family and patient representatives on advisory boards. Going a step further, involving patients and families in the planning, execution, and evaluation of programs speeds the development process and ensures that what the programs, practices, and/or clinics do actually meets the needs of those that it is intended to serve. Moreover, this type of engagement demonstrates that provider-family partnership is a true value and is honored and supported at all levels of the practice. Authentic partnership between providers and families can also be essential to helping sustain what is implemented as families often are the best champions and advocates at the practice, policy, and funding levels.

### **Objectives and Strategies for Creating Family-Informed Services, and Support/Resources**

**Objective 1:** Develop systems and policies that support family involvement.

**Objective 2:** Involve families in service delivery planning, implementation, and evaluation



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1. Developing Systems and Policies to Support Family Involvement

### Why is this important?

Several structural components should be in place to foster and sustain successful family involvement in your organization. Institutionalizing systems and policies ensures readiness, implementation, fidelity, and sustainability.

### What is involved?

#### ***Strategy A: Develop formal/informal documents to support family involvement***

There are a number of documents that can be developed to support family involvement at the organizational level. These documents not only guide the operations, but they confirm the office's goal to involve families. Other structural pieces that can facilitate family involvement include statements (written or verbal) of commitment and support from leadership and staff. Training for staff on the importance of family involvement is useful when attitudes need to be shifted. Strategies for formal/informal documentation can include:

- **State your commitment to support parent involvement**
  - ✓ Include language about the office commitment to family involvement in office goals, value statement, or missions
  - ✓ Make these commitment statements visible, e.g., on all practice documents, as posters in the office, etc.
  - ✓ Ensure that all staff know about this language and parent involvement as a value
  - ✓ Include family partners in the development of these commitment statements
  
- **Include in staff job descriptions**
  - ✓ Include mention of staff roles in helping family team members (e.g., buddy role, reminder calls, confirmation of child care needs, transportation, preparing parents before meetings, etc.) in staff job descriptions
  - ✓ Include families and providers in helping craft the language for these staff roles
  - ✓ Make sure these roles aren't simply added to a long list of other responsibilities without shifting or removing tasks. Staff will not appreciate the roles if they are perceived as "just another thing to do."
  - ✓ Ensure that staff are clear about these roles and connect them to the values of family involvement
  
- **Develop clear reimbursement policies for families**
  - ✓ Allocate or dedicate funds to support family involvement
  - ✓ Include specific guidelines on reimbursement for parent/family

volunteer expenses (e.g., gas, tolls, transportation, meals, stipends, and child care).

- ✓ Ensure that the reimbursement methods are simple for parents to use (see Appendix B.2; Parent Compensation)

■ **Ensure active leadership support for parental involvement**

- ✓ Involve leaders to ensure that staff have dedicated time to support parents
- ✓ Make sure that parents are included at the leadership level in meetings, on teams, and in decision-making
- ✓ Ensure that the involvement of parents is validated and celebrated in visible ways

**Non- PDSA Example**  
**Develop Documents Showing Support for Family Involvement**

Test job description of parent role and responsibility by having one or two families review it and provide feedback.

***Strategy B: Orientation for staff and parents***

Orientation for both staff and the family advocates themselves is important for ensuring the family advocates' role is a positive and productive experience for everyone. Orientation needs to include how to handle personal information – both the family advocate's and that of other clients or patients. It can be particularly delicate if a family advocate is actively receiving care at the site at the same time as serving as a member of the team. In that case, the potential family advocate and her or his primary provider may want to talk about the implications and what is in the family's (or child's) best interests. Staff members also may need to be reminded that their general privileges to access medical records do not extend to viewing the records of patients (in this case, those of the family team member) for whom they do not provide direct care.

It is also critical that certain assurances are made to the parents up front:

- ✓ No parent is required to volunteer, and volunteering will not influence future treatment in any way.
- ✓ Being involved does not require constant retelling of parents' personal trauma history.
- ✓ Scheduling is flexible.
- ✓ Expenses will be reimbursed.

Strategies for orienting parents and staff for their respective roles in family involvement include:

■ **Orient parents to the organization**

- ✓ Give family advocates an orientation to the organization itself. Include a tour and introductions to key individuals they may not have already met
- ✓ Make the family advocate feel like a true part of the organization by giving them their own identification badges, so they can come and go freely
- ✓ Try to give the family advocate an organization email so they can keep up on the organization's internal communications and issues in real time

■ **Orient parents about their role at the agency/system level**

- ✓ Reinforce the importance and value of parent voice, perspective, and expertise. Use language like "lived experience" to validate what family advocates bring to the table
- ✓ Help family advocates understand how to handle personal information – both the family advocate's and that of other clients or patients
- ✓ Remind parent advocates that they do not need to share their story or experience unless they truly feel as if they want to – and this decision may change with the group and the situation
- ✓ Provide clear descriptions to family advocates about their role (see objective below for more details)

■ **Orient staff about the role of family advocates at the agency/system level**

- ✓ Organize a "reverse" orientation in which family advocates or community representatives set up visits to key community sites or organizations
- ✓ Invite clinic/agency team members to sit in as guests at meetings of other community groups to help the clinic team members gain a better feel for how issues are raised when community members are in the majority at a meeting
- ✓ Invite family advocates talk directly to staff about their roles in their own words

### **PDSA Example Orientation for Staff and Parents**

- Plan:** Plan to implement an orientation that supports family involvement.
- Do:** Test the orientation by sharing the outline with a few parents.
- Study:** Ask for specific feedback on content, tone, length, language, planned messengers, etc.
- Act:** Use the feedback from the parents to revise the outline and implement an orientation.

### **Assess your Progress on Developing Systems and Policies that Support Family Involvement**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

#### ***Strategy A. Develop Formal/Informal Documents to Support Family Involvement***

- How does the agency demonstrate support for family involvement?
- What structures are in place to facilitate and support family involvement (e.g., time, staff, budget, guidelines)
- How does leadership demonstrate support for family involvement?

#### ***Strategy B. Institutionalize Orientation for Staff and Parents***

- How are family partners oriented to the agency, including staff and policies?
- How are family partners trained on their roles?
- How is staff trained on the value of parent involvement?
- How is staff trained and supported on how to best work with family partners?

## Additional Resources for Developing Systems and Policies that Support Family Involvement

The resources listed below can be found in **Appendix B.1**

### ***Parent Compensation***

1. FAQs on Compensation for Family, Youth, and Consumer Involvement

### **Parent Feedback Forms**

1. [The NHS Friends and Family Test- Implementation Guide: www.nhs.uk](http://www.nhs.uk)

### ***Toolkits***

1. Strategies to Increase Birth Parent Engagement – *Foster Care*
2. Family Engagement Resources – *Foster Care*
3. Meaningful Parent Leadership- A Guide for Success
4. Pathways to Partnerships with Youth and Families
5. *This document addresses youth and family involvement at both the clinical and organizational levels. A self-assessment tool for each level is included, with specific objectives and activities organizations can use to increase engagement.*
6. Growing and Sustaining Parent Engagement
7. *This toolkit is a quick guide to implementing three strategies for supporting sustained parental engagement in the care and services provided to their children. The strategies include a roadmap for agencies and communities to define their goals and approaches, a checklist to assess the effectiveness of engagement efforts, and a network of different groups dedicated to supporting parent engagement. Available at:*  
<http://www.cssp.org/publications/growingandsustainingparentengagementtoolkit.pdf>
8. NAMI Family Guide- Integrating Mental Health and Pediatric Primary Care

## Objective 2. Involving Families in Service Planning, Implementation, and Evaluation

### Why is it important?

Patients and their families are a clinic or agency's primary stakeholders, and their experiences and opinions ultimately determine the success of proposed services and programs. Thus, they should be involved with planning, implementation, and evaluation, providing important suggestions on a range of issues, including office design, scheduling, staff knowledge, attitudes, communication styles, cultural responsiveness, and care.

Family participation helps assure that services are responsive to family needs, culturally sensitive, feasible for patients, appealing and acceptable, and thus promote long-term engagement in care and better outcomes. The family members involved can gain new skills, which can open doors for them in the community. Many come with skills and knowledge that make them valuable potential staff members of the agency/clinic. Finally, patient and family opinions can be powerful forces for system change – their involvement can legitimize key choices in program design and help prioritize the changes the program seeks to make. And as advocates, they can be essential for the sustainability of improved systems.

#### Benefits of Involving Families

- Assure that services are responsive to families' needs
- Improve quality of care
- Increase patient satisfaction
- Strengthen cultural competence
- Empower parents to create change
- Develop advocates for your

### What is involved?

#### *Strategy A: Clarify parents' role within organization*

There are different ways to get input from families on existing and/or proposed organizational practices. Families can help with planning, implementation, and evaluation, and they can serve as advocates. Strategies for how family advocates can be engaged in different roles include, but are not limited to:

#### ■ Assist with staff training

- ✓ Invite parents and families to provide their input on what should be incorporated into staff training
- ✓ Have them help deliver content to staff directly -- personal narratives from families can demonstrate the need/effect of protocols and interventions on patients

#### ■ Engage as team member for specific project

- ✓ Invite family members to be part of teams for specific projects,

such as Learning Collaboratives. Remember that this may require flexibility about the timing and location of meetings.

#### ■ **Test and Assess PDSAs**

- ✓ Encourage family team members to help select, design, and test tools, resources, materials, process, and practices (e.g., script for talking with parents about resilience, poster in the waiting room, screening tool, parent satisfaction survey).
- ✓ Ask families for impressions and observations as part of the “Study” of the PDSA when the small changes are tested

#### ■ **Participate as Board Member**

- ✓ Serve formal standing groups, such as advisory board, planning committees, or task forces. By having family boards or family representation on your standing boards, you can obtain regular input on programs and develop a relationship with the family members over time (see Appendix B.1; Parent Advisory Board).

#### ■ **Advocate for programs with funders/policy makers**

- ✓ Engage parent advocates to advocate for your program with organizational leadership, funders, and policy makers
- ✓ Help parent advocates tell their personal stories and testimony in ways that augment the data, facts, and figures you may already have
- ✓ Encourage parent advocates to take a lead role in identifying individuals and organizations that may be important to support and sustain your work

### **Non- PDSA Example Clarify Parent Role within Organization**

Talk to parents to invite general feedback on what the role, responsibilities, and expectations should be. Conduct a focus group to help inform the role description from various perspectives.

#### ***Strategy B: Recruit families who are ready and interested***

Not all families will be interested in getting involved, nor are all families ready to do so. Family members who are likely to do well as team members are those who have shown some initiative and understanding of larger needs of all families. However, many people who may be wonderful team members may not step forward or be those who have been the most vocal. Consider strategies to assess readiness and interest and actively recruit them.

■ **Think broadly in your outreach efforts**

- ✓ Consider those in your clinic or agency who have different kinds of contacts with families – nurses, front desk staff, outreach workers or home visitors
- ✓ Invite staff to consider family members who have seemed particularly thoughtful or dedicated, or who have a skill set (sometimes from a prior stage in life or in another country) that could be helpful
- ✓ Encourage staff to consider not only those who have been positive about their experiences – bringing in families who have had differing experiences (both positive and negative) can offer invaluable feedback to system change efforts
- ✓ Make sure to explain to prospective family advocates how valuable their personal experiences are and can be to inform this work and validate how crucial their role is to the organization, especially if they seem hesitant to step into the role

**Characteristics of Family Advocate Who Are Ready and Able to Help (From NCTSN)**

Enthusiasm  
Acceptance  
Ability to listen  
Ability to think analytically  
Commitment to excellence  
Caring  
Ability to inspire  
Competence  
Willingness to help others  
Confidence

■ **Seek out family members who express interest**

- ✓ Look for family members who ask questions about the organization’s operations and policies, who offer to take on various responsibilities, who are interested in other families’ concerns, and who have ideas for activities and services (NCTSN)
- ✓ Develop a brief checklist or “readiness assessment” based on the NCTSN characteristics in the box above
- ✓ Raise awareness among staff at all levels about the characteristics they should be looking for in their interactions with families

## **PDSA Example**

### **Recruit Parents who are Ready and Interested**

- Plan:** Plan to test a recruitment script that will be used to bring in parent volunteers.
- Do:** Share the recruitment script with a few parents who are already volunteers or may be interested.
- Study:** Ask parents what they like and dislike about the script. Also, make sure to ask them what else they would like to include.
- Act:** Use the parent feedback to revise the script and include their suggestions.

#### ***Strategy C: Prepare family advocates***

Preparing the family member(s) you have recruited as family advocates can take many forms, ranging from formal orientations to informal conversations and follow-up. Many family representatives may not know the clinic staff or facility, therefore it is important to build the family advocates rapport with the staff and comfort in the clinic setting. Being clear about expectations, providing an orientation, and a staff buddy are the foundation to make family advocates more comfortable. Strategies for doing this include:

- **Set clear expectations**
  - ✓ Be clear and honest in what you expect from families and what they can expect from you
  - ✓ Create these mutual expectations in partnership with families, using language that is meaningful to them
  
- **Provide orientation**
  - ✓ Provide an orientation to family representatives about the clinic's mission, values, as well as a tour of the facilities (see strategy A)
  - ✓ Ensure the staff feels welcomed by the staff by using first names at meetings (try not to use titles for some people, but first names for others), being informal, and taking the time to get to know one another and appreciate the different perspectives at the table
  
- **Use a buddy system**
  - ✓ Pair the family advocate with a staff "buddy" who will serve as the point person for the family representative
  - ✓ Ensure the staff buddy will provide regular follow-up with the family advocates and be a regular point of contact when questions or concerns arise

- ✓ Make sure the staff buddy is comfortable and excited about the role and is willing to make the long-term commitment to the parent buddy

### **PDSA Example Prepare Family Advocates**

- Plan:** Plan to share information about the organization in order to prepare family advocates.
- Do:** Test an information packet with a few parents. In the information packet, include facts about the staff, organization, and clients served.
- Study:** Ask parents if the information is helpful and easy to read. Probe to assess if it helps them understand the organization. Make sure to also ask them what other information they need before stepping into the volunteer role.
- Act:** Use the parent feedback to revise the information packet.

#### ***Strategy D: Encourage ongoing recruitment and provide support for continued involvement***

Being a family advocate is a huge commitment. On the other hand, empowered family advocates can be impassioned members of your team and they often report satisfaction and personal growth with the role. To ensure sustained family involvement, it is important to recruit potential family advocates on an ongoing basis and provide continued support. Strategies include:

- **Look for potential new family advocates**
  - ✓ Ensure that you have multiple positions allocated and that the position(s) are filled
  - ✓ Ensure that there is more than one parent engaged with the team at any given time -- having multiple family advocates spreads out the responsibilities, provides the advocate with a support network of other families, and ensures that multiple voices, perspectives, and experiences are represented.

■ **Provide support for existing family advocates to sustain their involvement**

- ✓ Review The FRIENDS National Resource Center for Community-Based Child Abuse Prevention’s guide entitled “Meaningful Parent Leadership: A Guide for Success” (Appendix B.1), which outlines strategies to sustain family advocate involvement. Ideas include:
  - Hold meetings at times that are convenient for families
  - Ask how best to stay in contact (text, calls, or email)
  - Ensure that families’ input is being heard with verbal acknowledgement and documentation in meeting notes
  - Define acronyms that only clinic staff understand
  - Continually check-in with the parent advocate to see if the workload is manageable, troubleshoot when necessary
  - Provide training on topics related to the program or on leadership skills
  - Recognize and celebrate family representative’s for their role and contributions
  - Where possible, consider providing concrete support for families’ involvement in the form of childcare when necessary as well as stipends for their time.

**PDSA Example**

**Encourage ongoing Recruitment and Provide Support for Continued Involvement**

- Plan:** Plan to test a recruitment script that will be used to bring in parent volunteers.
- Do:** Share the recruitment script with a few parents who are already volunteers or may be interested.
- Study:** Assess increased participation and ask for direct feedback from those parents who were part of the test. Remember that different people may have different preferences, so it will be important to test a range of options
- Act:** Use the parent feedback to revise the script and include their suggestions.

## Assessing your Progress on Improving Family Involvement

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### ***Strategy A. Clarify Parents' Role within Organization***

- How does the organization get input from families on existing and/or proposed practices and policies?
- How are families engaged in planning, implementation, and/or evaluation efforts?
- How are families engaged as advocates for the work of the organization?

### ***Strategy B. Recruit Families Who Are Ready and Interested***

- What criteria are used to recruit families to serve in family partner roles?
- What type of outreach efforts do you use to identify and recruit potential family partners?

### ***Strategy C. Prepare Families Who Have Volunteered***

- What type of formal preparation do you provide to family partners?
- What type of informal preparation do you provide?

### ***Strategy D. Encourage Ongoing Recruitment and Provide Support for Continued Involvement***

- How are you engaging in ongoing recruitment of family partners?
- If you already have parent partners, how do you support them in using their experiences and expertise to enhance your work?

## Additional Resources for Improving Family Involvement

The resources listed below can be found in **Appendix B.2**

### ***Parent Advisory Board***

1. Parent Advisory Groups in Pediatric Practices: Parents' and Professionals' Perceptions (Young, McMenemy, & Perrin, 2001)

*This article reports the results of a survey asking parents and providers about their experiences with parent advisory groups. Overall, both describe the groups as beneficial, with each group emphasizing specific aspects of the experience.*

2. Tips for Developing an Effective Advisory Board

*A quick two-page summary of the role of an advisory board, recruitment of members and planning meetings. Includes a case example. Available at:*

[http://www.nctsn.org/sites/default/files/assets/pdfs/Pathways\\_AdvisoryBdTipsheet.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/Pathways_AdvisoryBdTipsheet.pdf)

## **Theme 3: Collaboration and Coordination—Mental and Physical Health Services**

### **An Overview and Rationale**

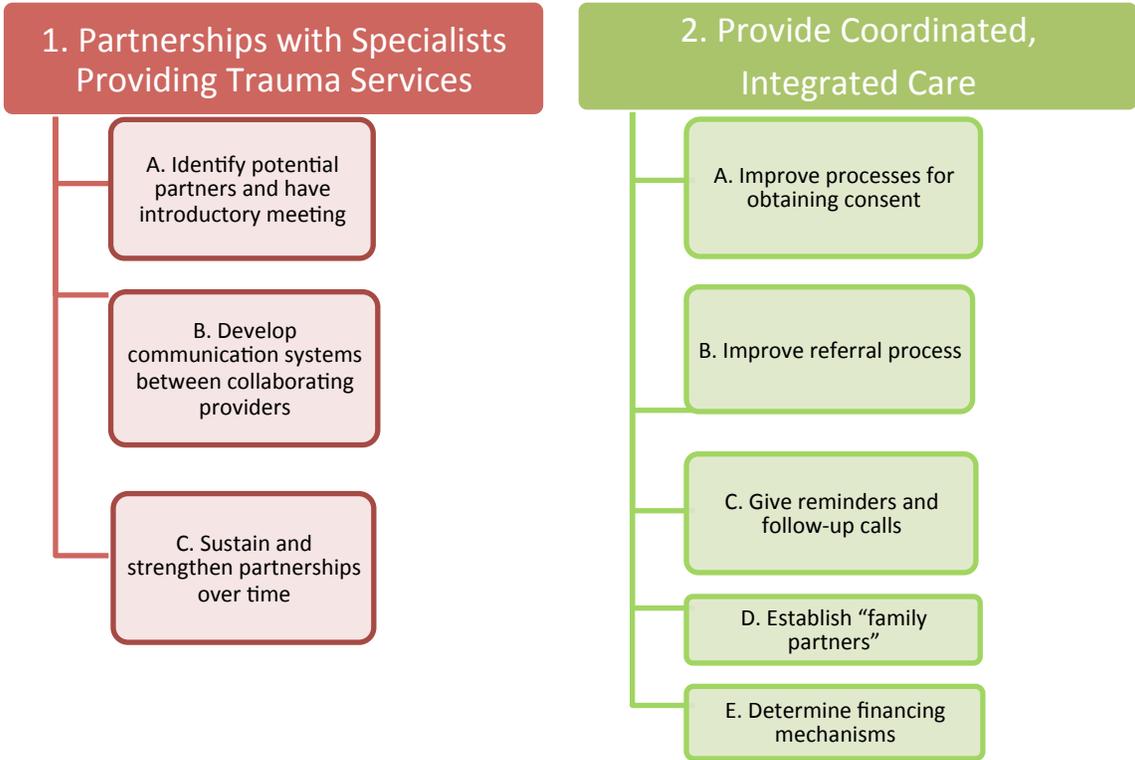
Collaboration and coordination with community mental health services, specialty mental health, and medical care is essential for improving primary care capacity to help families experiencing early childhood trauma and stress. The primary care provider (PCP) is the child’s regular care provider, and children typically see their PCPs at least once a year. This gives PCPs a unique role in serving as coordinators of the child’s overall care within and outside of the primary care setting. When PCPs identify the need for mental health specialty care for trauma-related issues, they can identify the best source of care for the child, introduce the child to the specialist, manage overall treatment, and monitor progress over time.

The idea that primary care can help provide and coordinate an array of services that meet a child and family’s needs, help children and families understand and navigate systems of care, and follow progress over time, dates back several decades (See *Models of Integrating Services, Families, and Communities* in Chapter 2). Though there are many possible models that PCPs might use to achieve these goals – medical homes, comprehensive clinics, collaborative or integrated care – evidence suggests that a necessary, and, in some cases, sufficient, ingredient is the ability of PCPs to form personal, trusting relationships with the specialists and organizations with whom they collaborate. The relationships among providers create the pathways across which information can flow safely and efficiently, so that services are most likely to meet patients’ needs and preferences.

### **Theme 3 Objectives and Strategies for Collaboration and Coordination Between Mental and Physical Health Services**

**Objective 1:** Develop partnerships with specialists providing trauma services

**Objective 2:** Provide coordinated, integrated care



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1: Develop partnerships with specialists providing trauma services

### Why is it important?

Partnerships between primary care and specialists providing trauma services are good for patients and their families. Partnerships can make it easier to obtain needed care, as it is rare that any single provider can provide all that a family might need in terms of expertise or services. They also ensure that care is coordinated in ways that make sense for families. Partnerships are also good for providers and the organizations in which they work. Partnerships can improve quality of care, efficiency, reduce duplication of effort or services, and make work more satisfying and, ultimately, more successful.

To provide coordinated care, providers need to *know what types of expertise and services best meet the different needs of their patients and their families*. From the primary care perspective, that means understanding the community, school, or mental health services for which there is evidence of effectiveness (whether that is known formally from studies or from the recommendations of other families or from colleagues).

In addition, providers need to know that the necessary expertise, services, and providers exist in their community, and they need to know *how to contact them*, details of the services available, any relevant financial or insurance information, and the logistics of families receiving services (where they are located, hours of availability, etc.).

Partners need to establish *mechanisms for transfer of information* in both directions at the initiation of care, periodically during care, and when care ends. Ideally there are opportunities for actual discussions among providers that inform each of these decision points. The steps to identify partners, develop communication systems, build on existing relationships, and sustain relationships overtime are discussed below.

### What is involved?

#### ***Strategy A: Identify potential partners and have introductory meeting***

While there are many concrete ways in which partnerships might be structured, the intent remains mostly the same: two or more providers or organizations recognize that they have overlapping goals and offer complementary services – and thus in working together they can better serve their clients/patients as well as meet their own needs. Partners commit to the up-front effort of articulating their common goals, figuring out how to work together, and sustaining the efforts required in making the relationship work. Primary care providers have a role in initiating and supporting the ongoing shared care of a patient or family among different specialty providers (especially mental health or trauma-focused services).

Partnerships can develop among individual providers or among organizations. Partnerships, both new and existing, must be built on the foundations of knowledge and trust.

- **Identify families' needs**
  - ✓ Recognize the specific mental health and trauma needs of families and children that are not currently being met in the PCP visit
  
- **Identify providers of services**
  - ✓ Know local providers of those services that are needed, including services for parents
  
- **Understand access issues**
  - ✓ Recognize those issues that impact or impede families' abilities to access services, including linguistic and cultural needs
  
- **Provide cross-education**
  - ✓ Share information about themselves and their services as well as about the population being served with potential partners -- this can be in writing, in a face-to-face meeting, a "lunch and learn," etc.
  
- **Ensure clarity about expectations and opportunities**
  - ✓ Be clear about what PCP wants/needs from partnership as well as the opportunities for partners

### **Non- PDSA Example** **Identify Potential Partners and Have Introductory Meeting**

Invite providers to a lunch or other meeting where you can share information about collaborating and coordinating with mental health services.  
Use this time to brainstorm on how to partner in care.

#### ***Strategy B: Develop communication systems between collaborating providers***

There are four key elements of partnership and coordinated care: 1) knowledge of partner's service; 2) trust in partner's clinical judgment; 3) information sharing; and 4) collaborative delivery of care. The knowledge of a partner's services is the focus of the first strategy; the remaining three elements are connected to developing communication systems. From a practical perspective, partnerships between mental health/trauma specialty and primary care providers can develop into coordinated care plans that monitor and support patient care over time.

Partnerships can allow for co-management between behavioral and medical providers who consider themselves a team and work as colleagues. In order to coordinate care in this way, partners must discuss how they will share information and collaborate to deliver care.

■ **Develop trust in partner’s clinical judgment**

- ✓ Share decisions and rationales for decisions openly across partners
- ✓ Ensure that all partners are as transparent as possible about their clinical practice and work

■ **Share information openly**

- ✓ Agree on a mechanism to contact each other for advice and to share information about mutual patients (e.g. telephone calls, meetings, email, or text). Sharing patient information with the purpose of coordinating care is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), permitting medical providers to share protected health information without an individual’s authorization with another health provider treating the individual. (*HIPAA Privacy Rule and Provider to Provider Communication* see Appendix C.1).
- ✓ Although it’s not required, make sure patients know you are working in partnership and sharing information as part of your service

■ **Provide collaborative delivery of care**

- ✓ Consider various types of collaboration that promote true integration (shared information, decision-making, and co-management. For example, shared electronic medical records, joint visits, morning huddles to discuss patients, or in-office consultations.

## PDSA Example

### Develop Communication Systems between Collaborating Providers

- Plan:** Plan to test a means of increasing collaboration with mental health providers.
- Do:** Test a one-page referral/feedback/consent form that can be signed by the patient at the time of referral and shared with collaborating provider through multiple means (mail, fax, carried by the family). Test this for a week.
- Study:** See how regularly it gets through, how you receive information back, and what information seems most important to you and to the other provider.
- Act:** Use the observations to revise the document and manage the workflow.

#### ***Strategy C: Sustain and strengthen partnerships over time***

To sustain partnerships over time, it's important to keep in contact with partners and have regular meetings – either in person or by phone – to talk about shared patients as well as to address organizational issues that may arise.

#### **■ Talk about shared patients**

- ✓ Have clearly established organizational ways of sharing information about patients. This requires more than a common EMR; it requires actual communication, either in person, via phone, or by email, in order to make joint decisions.

#### **■ Review patient outcomes**

- ✓ Review patient outcomes jointly.
- ✓ Include individual patient outcomes as well as population-level outcomes in the review
- ✓ Use these discussions to help strengthen partnerships as providers can see and evaluate the impact of their collaboration

#### **■ Identify organizational improvements**

- ✓ Include discussions about IT, EMRs, billing, reimbursement, service availability and access, staffing, etc.
- ✓ Talk openly with one another about organizational strengths and challenges across organizations

■ **Conduct joint trainings**

- ✓ Continue to deepen trust and enhance their joint expertise by providing clinical training to one another in their own specialty areas

■ **Provide leadership and organizational support**

- ✓ Ensure leaders and the overall organizations to which the providers belong also partner.
- ✓ Help leadership actively support the collaboration by understanding productivity and workload requirements, technology needs, staffing support, etc.

**PDSA Example**  
**Sustain and Strengthen Partnership Overtime**

- Plan:** Plan to have a weekly phone call between primary care and mental health providers to talk about shared patients.
- Do:** Try this phone collaboration once and see how the collaboration works.
- Study:** Reflect on what information gets shared, how it improves patient care, how long it takes, and what guidelines might be developed to add structure to the call.
- Act:** Use the observations to make changes for a more productive, effective, and efficient call.

## Assess your Progress on Developing Partnerships

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### *Strategy A. Identify Potential Partners and Have Introductory Meeting*

- What type of provider lists do you have for the full range of community, school, and specialty expertise and services that might be needed or that are recommended by treatment guidelines?
- What types of specific types of expertise or services are needed based on the unique needs of your patient population, including specific cultural or linguistic needs?
- What relationships do you already have with specialty providers or organizations?
- How can existing partnerships be expanded in some way, or used to understand how to build new partnerships?

### *Strategy B. Develop Communication Systems between Collaborating Providers*

- How do you and your staff currently communicate with specialists with whom you hope to partner in ways that are as simple as possible?
- How do you and your partner document your communication in ways that are feasible, simple, helpful, and minimally intrusive?
- How are EMRs and other existing data systems used to support the communication and collaboration across partners?
- How is your open communication shared with families?

### *Strategy C. Sustain and Strengthen Partnerships Over Time*

- How do you keep in touch with existing partners about shared patients?
- How do you keep in touch with existing partners about shared patient population outcomes?
- How do you address and resolve challenges as they arise within the partnership?
- How do the organizations' leadership support the partnership?

## Additional Resources for Developing Partnerships

The resources listed below can be found in **Appendix C.1**

### *Developing Partnerships*

1. Developing Effective Child Psychiatry Collaboration with Primary Care (Sarvet and Wegner, 2009)

*This article encourages collaboration between pediatricians and child psychiatrists, acknowledging both the benefits and the barriers. It also offers strategies for collaboration, including communication between services, structuring a psychiatric service to meet the referral needs of primary care, and an example of embedding collaboration within the region's healthcare system.*

2. Confidentiality Laws Tip Sheet
3. HIPPA Privacy Rule

### *Select Links*

- AAP Mental Health Initiatives (Available at: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health>)  
*Resources from the American Academy of Pediatricians focused on mental health efforts in a pediatric context.*
- SAMHSA Integrated Care Models. (Available at: [www.integration.samhsa.gov/integrated-care-models](http://www.integration.samhsa.gov/integrated-care-models))  
*General information and resources from SAMHSA regarding behavioral and primary healthcare integration.*

## Objective 2. Provide coordinated, integrated care

### Why should care be coordinated and integrated?

When the primary care and mental health providers coordinate care across sites, it helps ensure the patient receives the type and quantity of care that is needed. Services are more efficient and effective when providers know what services families are already receiving, how much help they can absorb now, and how needs might be prioritized so that services can be sequenced in the most effective or acceptable way. Coordination of care may also reduce no-show rates and encourage patients to follow-up with specialists, while reducing duplication of services.

### What is involved?

In order to provide coordinated, integrated care, mental and physical health providers must first have partnerships based on the foundations outlined in Objective 1: (1) Knowledge of partner's service, (2) Trust in partner's clinical judgment (3) Systems to share information and, (4) Collaborative delivery of care.

Once these partnerships and communication systems are in place, coordinated and integrated care can be explained and delivered to patients and families following the strategies outlined below.

#### ***Strategy A: Improve processes for obtaining consent***

While HIPAA allows for the sharing of protected health information to coordinate care, some providers desire an additional consent form. Additionally, as you strive to engage families as authentic partners in their own care, it is good practice to let them know your plans to share their information. This can be especially important if they specific concerns related to culture, beliefs, or safety.

#### ■ **Integrate into routine paperwork**

- ✓ If you are going to use a consent form, try to integrate it into your routine paperwork for new patients
- ✓ For existing patients, ask parents for permission right up-front

#### ■ **Explain purpose of sharing to families**

- ✓ Take time to explain how the sharing of information will contribute to their families' care.
- ✓ Understand and respect their reluctance, if they have any, especially based on possible cultural concerns. Most of the time when providers help families understand that the sharing of information is intended to provide them the best, most seamless care possible, families will value both the coordination of care and the transfer of information that they will not have to repeat.

■ **Ensure consistency across providers**

- ✓ Make sure that partners use the same – or at least consistent – consent forms and language around information sharing. Families may find it confusing if the language is different.

(Note: In situations where there is a concern for family violence, special care has to be taken that disclosures are not documented in a portion of a child’s record to which a potentially violent partner may have access.)

**PDSA Example**  
**Improve Processes for Obtaining Consent**

- Plan:** Plan to test using a “parent permission form” with parents at intake
- Do:** Test a script with a few families. Include verbal or written scripts that explain why mental health is part of total care and how the primary care provider will work with the behavioral health provider and family as a team. Include mention of communication and record sharing between providers so that the parent does not have to be a coordinator of information.
- Study:** Ask parents for feedback on the form and processes.
- Act:** Use the feedback from the parents to make changes to the “parent permission form.”

***Strategy B: Improve process of making referrals***

Recognize that some patients/families may be reluctant to leave the primary care setting for new services. To address this issue it is important the primary care providers provide meaningful referrals by stating their plans to stay involved in the care. They should also “introduce” patients/families to the specialty care providers whenever possible. There are number of ways to improve the process of making referrals:

■ **Involve families**

- ✓ Ask families for permission to offer advice
- ✓ Explore the pros and cons of involving specialty care
- ✓ Be willing to consider alternatives
- ✓ Explore barriers.
- ✓ Rely on relationship with provider to further help coordinate care across members of the family
- ✓ Recognize when multiple family members, including parents, have needs and, to the extent possible, leverage the work in individual

treatment of each member to inform the care of the family as a whole.

■ **Make a clear plan for continued involvement**

- ✓ Facilitate the specialist’s involvement by making a clear plan for staying involved in the family’s care
- ✓ Clearly communicate this plan with the family.

■ **Know the specialists**

- ✓ Cite a true personal relationship with the specialist
- ✓ Share in-depth knowledge of specialty treatment

■ **Use “Warm handoffs”**

- ✓ Introduce the patient directly to the specialist to help the patient feel comfortable with the new provider
- ✓ Take the time for both providers and the family to be virtually or literally in one place
- ✓ Talk together about how everyone – including the family -- will work together going forward

Once a referral has been made, the “referring” provider doesn’t drop out of the picture; he or she maintains a role in either in actually providing an essential part of the treatment or by supporting and monitoring progress. For example, primary care providers may prescribe medications that complement the work of a mental health therapist, or they may be able to troubleshoot if the patient’s relationship with the therapist breaks off or can’t be sustained.

**PDSA Example**  
**Improve Referral Process**

- Plan:** Plan to test a script with a family about introducing the family to the mental health provider onsite (warm handoff)
- Do:** Include words that are comforting and reassuring. Let the patient know you and your office will continue to monitor his/her care.
- Study:** Ask family how they feel about the process and get feedback for improvement
- Act:** Use the family feedback to make changes in the script.

### ***Strategy C: Give reminders and follow-up calls***

Understand and respect that there are many reasons patients don't follow up with specialty care. As part of this understanding, put into place systems for improving patient follow up and show rates at appointments with mental health specialists. Consider integrating these follow-up strategies into your systems:

- **Text reminders**
  - ✓ Include the provider name, location, date, time, contact information, and reason for visit to ensure the family remembers the importance of the appointment
  
- **Ask for updates**
  - ✓ Request text or phone updates from patients after their visits with specialists to help them put the visit into their own words.
  
- **Make follow up calls**
  - ✓ After the day of the scheduled appointment with the specialist, call the patient to see if they showed up
  - ✓ Ask the patient how it went. This can also help with planning next steps in the patient's care.

#### **PDSA Example Give reminders and Follow-Up Calls**

- Plan:** Plan to test sending a follow-up appointment reminder to families in order to monitor no-show rates.
- Do:** Send a text message as a reminder to several families.
- Study:** Ask the families if they appreciated the reminder and if it helped them to show up for their appointment. Also, study the no-show rates for these families. Lastly, study how long this process takes the staff to complete in addition to their existing work.
- Act:** Use your observations and the feedback from the families and staff to revise the way in which your follow-up affects the workflow

***Strategy D: Establish “family partners”***

Some families may feel uncomfortable seeking mental health treatment and be apprehensive to voice their concerns to their primary care providers. A family navigator or “partner” from the community can help to bridge the gap between the patients and provider.

- ✓ Engage parent advocates as “greeters” for other families who are new to the clinic or community to ease their transition
- ✓ Have parent advocates run support groups
- ✓ Engage parent advocates serve as one-to-one mentors (for tips on incorporating peer-to-peer support into your program see Appendix C.2).

**PDSA Example  
Establish “Family Partners”**

- Plan:** Plan to test involving family partners.
- Do:** Test referring one family to a family navigator at the primary care site.
- Study:** Ask for feedback about the experience from both the family member and the family navigator.
- Act:** Use the feedback to revise the family navigator process.

***Strategy E: Determine funding and financing mechanisms to support coordination and integration***

Primary care and mental health services have specific reimbursement limitations, often related to face-to-face visits with patients. To support coordinated and integrated care, however, funding and financing mechanisms need to be developed and identified to support those other activities that providers will be doing, such as peer consultation, care coordination, warm hand-offs, care management, and follow-up.

■ **Identify possible billing codes**

- ✓ Know the specific billing and reimbursement codes for your state
- ✓ Use existing resources, such as the helpful guides developed by the national American Academy of Pediatrics, for ideas on how various services and supports can be effectively billed
- ✓ Review and use these guides to support care reimbursement

■ **Create dedicated positions**

- ✓ Create specialized positions, such as care coordinators/navigators, peer consultants, cultural brokers, and care managers
- ✓ Base these positions on salary rather than fee-for-service or productivity requirements so they can attend fully to the needs of supporting coordinated, integrated care

■ **Advocate for improved reimbursement options**

- ✓ Invite leaders and other partners (including family partners) to serve as advocates in the policy realm
- ✓ Use stories and data of improved patient care
- ✓ Develop a case for overall cost-benefit savings

**Non- PDSA Example**

**Determine Financing Mechanisms to Support Coordination**

Determine if non face-to-face services, such as attending team meetings, conferring with a consultant, or referring provider can be reimbursed by relevant insurance plans.

## Assess your Progress on Providing Coordinated, Integrated Care

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### ***Strategy A. Improve Processes for Obtaining Consent***

- What policies and mechanisms do you have in place for obtaining consent to share information?
- How readily is information received and incorporated into medical records?
- How is the rationale for consent communicated with families?

### ***Strategy B. Improve Process of Making Referrals***

- How are families being prepared for and linked to specialists?
- How are primary care providers sharing information about specialists with families?
- How is care continuity being maintained when referrals are made?

### ***Strategy C. Give Reminders and Follow-Up Calls***

- How are the outcomes of referrals being tracked?
- What is the current rate of successful linkages?
- What are the best ways to reach families and ensure follow through?

### ***Strategy D. Establish “Family Partners”***

- How are family partners used to help families understand the need for specialty mental health services?
- How are family partners used to help engage families in accessing or receiving specialty mental health services?

### ***Strategy E. Determine Funding and Financing Mechanisms for Coordinated, Integrated Care***

- What billing systems are in place to support coordinated, integrated care?
- What billing systems need to be added to support coordinated, integrated care?
- What positions have been or need to be created and funded to support coordinated, integrated care?

## Additional Resources for Providing Coordinated, Integrated Care

The resources listed below can be found in **Appendix C.2**

### ***Providing coordinated, integrated care***

1. Enhancing Pediatric Mental Health Care- Strategies for Preparing a Primary Care Practice (Foy et al., 2014)
2. Integrating Behavioral Health and Primary Care Services- Opportunities and Challenges for State Mental Health Authorities
3. Integrating Child Psychiatry Into the Pediatric Medical Home (Keller and Sarvet, 2013)  
*A short article advocating for the integration of child psychiatry and pediatrics in a Patient-Centered Medical Home model, with a focus on consultation services and specialized care coordination.*
4. Integration of Mental Health, Substance Use, and Primary Care Services (2011)
5. The Integration of Behavioral Health Interventions in Children's Health Care: Services, Science and Suggestions
6. Best Principles for Integration of Child Psychiatry into the Pediatric Health Home
7. Ten Key Principles for Successful Health Systems Integration (Suter et al., 2009)  
*A review identifying ten principles of successful integration efforts, regardless of the integration model, population served, and healthcare context.*

### ***Peer to Peer Support***

1. Tips for Incorporating Peer-to-Peer Support into Your Program  
*A brief summary of the value of linking new clients with those who have been through treatment, different forms of peer-support and tips for implementation within a program.*  
Available at:  
[http://www.nctsn.org/nctsn\\_assets/pdfs/Pathways\\_PeertoPeerTipsheet.pdf](http://www.nctsn.org/nctsn_assets/pdfs/Pathways_PeertoPeerTipsheet.pdf)

## **Theme 4: Preventing Trauma and Promoting Resilience**

### **Why Is This Theme Essential for Trauma-Informed Integrated Care? An Overview and Rationale**

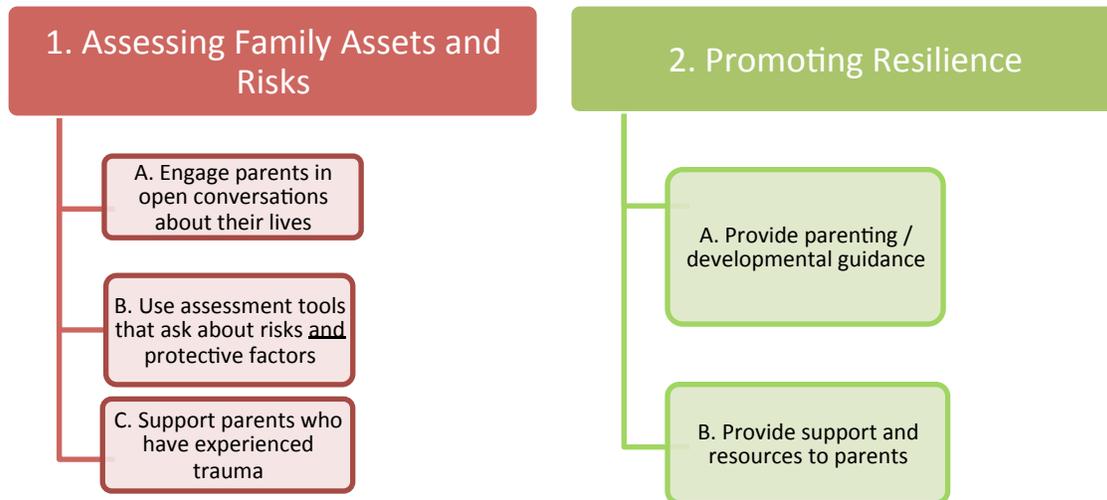
Primary care and behavioral health providers cannot prevent families from being exposed to trauma and stress, but building on families' strengths may help families avoid the negative impacts of that exposure and better cope with those that are unavoidable. As in all of the other sections of the toolkit, we think about children and parents individually but also as a family, knowing that, in multiple ways, the strengths and challenges of one family member can be transmitted to others, especially when considering the connection between positive caregiving relationships and social-emotional development, resilience, and learning in young children.

In this section of the toolkit we think of prevention in two ways: 1) ways to help families avoid exposure to stress and trauma; and 2) how to help families build resources so that if they encounter stress and trauma in the future they will feel less of an impact, and more quickly return to feeling well and secure. The medical and mental health systems are not the only resources families have to achieve these goals, but there is good evidence that they can play an important role. This section focuses on interventions that are universal – meant to be of help to all families that a provider encounters – and that build both strengths and a willingness to seek help in future times of need.

### **Theme 4 Objectives and Strategies for Full Implementation**

**Objective 1:** Assess family risks for potential exposure to trauma and stress as well as family assets, such as sources of support for child and parent.

**Objective 2:** Provide guidance that promotes development of resilience and wellness and provide support for families seeking to reduce stress



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1. Assessing Family Assets and Risks

### Why is it important to identify assets and risks?

To prevent trauma-related challenges and promote resilience, it is important to assess exposure to adversities that might cause trauma or stress (or to help anticipate possible exposures and head them off). This is similar to the discussion of identifying trauma exposure provided in Theme 5, but in this section we focus primarily on having brief discussions with all families either as a first stage in assessment or as a follow-up, even when screening questionnaires are “negative.”

Families may be exposed to stress and trauma in a variety of ways. In today’s society with historically high levels of household debt, and the decline in wages and benefits relative to the cost of living, many families may be in precarious financial situations, with trauma related to providing basic needs for their families. They may be unable to cope with a serious illness or job loss. They may live in settings where exposure to community violence is high on a regular basis. Substance abuse, intimate partner violence, and parental mental health issues also contribute to possible exposures to violence. Additionally, for children and families of color, racism experienced in daily life, whether implicit or explicit, may increase stress and exposure to trauma.

Children can be a cause of stress for parents. As most parents can attest, children can vary enormously in their personalities and what professionals call temperaments – the extent to which they react to change, are easy going or fussy about food or clothes, are predictable or unpredictable about sleep or hunger, and being bold or shy with new people and situations. Parents may feel more or less prepared to manage children’s personalities, and nearly all parents will feel challenged at some point. Stress can be even greater if a parent feels criticized by other family members – often the child’s father, or a grandparent – for their ability to manage the child’s behavior or meet what seem to be the child’s needs. Children with potentially serious medical or developmental problems create even more stress, both because of worry for their health and because of uncertainty about how to be a good parent for them.

However, all families possess competencies and psychological resources that can mitigate the response to and impact of trauma exposure. Identifying these family strengths, or protective factors, can protect children and families from long-term harm. We can think of these exposures to adversity and family protective factors for families with young children in several categories.

**Table 11. Family Risk and Protective factors**

Risk Factors	Protective Factors
<ul style="list-style-type: none"><li>• Basic needs</li><li>• Threats to personal safety</li><li>• Threats to the family’s mental and physical health</li><li>• Preparation for parenting</li><li>• Parenting skills and child characteristics</li></ul>	<ul style="list-style-type: none"><li>• Successes with past challenges</li><li>• Role models for coping with challenges</li><li>• Participation in community groups (service, religious, school-related)</li><li>• Feelings of confidence about meeting the child’s emotional, behavioral, and educational needs</li><li>• Feeling supported in parenting by spouses, partners, other family members or friends</li><li>• Feeling capable of balancing childcare needs with work or other adult responsibilities.</li></ul>

Moreover, primary care providers have significant opportunities to help teach families how to positively respond to potentially stressful and traumatic experiences by identifying, developing, and supporting parents’ protective factors.

### What is involved?

#### ***Strategy A: Engage parents in open conversations about their lives***

It is important to ensure that parents’ own concerns and issues are heard, not just those of the child. Asking *all* parents how they doing and if they have any concerns opens up the dialogue to discuss possible stressors. Talking about potential stressors for parents at every visit helps to normalize this discussion, demonstrates that it is universally done, recognizes that family situations can change, and respects the fact that children present greater or lesser challenges as they develop.

#### ■ **Make conversation universal**

- ✓ Engage in the conversation with all families at every visit
- ✓ Do not use a screening or assessment tool to decide whether or not to open the discussion
- ✓ Do not ask just once and never again
- ✓ Make it routine so that parents realize they aren’t being singled out in some way.

#### ■ **Honor cultures, beliefs, and family structures**

- ✓ Use language and engage in ways that demonstrate respect for different life experiences, beliefs, cultures, and family structures
- ✓ Ask inviting sensitive questions that show you respect various ways of child rearing and living in families

■ **Normalize daily stressors**

- ✓ Recognize that all families face stressors in their daily lives
- ✓ Talk about these stressors and show families that you relate to, respect, and/or understand the challenges they may face

■ **Acknowledge child development as stressor**

- ✓ Use the conversation as an opportunity to educate parents about child development
- ✓ As you talk about different stages of development, help parents understand the stresses each can place on the parent and the family

**PDSA Example**

**Engage Parents in Open Conversations about their Lives**

**Plan:** Plan to test ways to ask parents what they want.

**Do:** Ask directly, “What do you want to achieve by improving your child’s behavior?” or “What are you doing for YOU?”

**Study:** Get feedback from the parents. Also, observe if parent engagement improves with these families.

**Act:** Use your observations and feedback from the families and staff to revise the way in which your follow-up affects the workflow.

***Strategy B. Use assessment tools that ask about risks and protective factors***

In addition to engaging parents in discussions about their lives, you can use a tool that asks about exposure to stressors and availability of protective factors. For example, the ACEs questionnaire has items that ask about exposure to adversity, and the Center for Study of Social Policy (CSSP) provides indicators of protective factors. (Appendix D.1)

■ **Identify potential screening tools**

- ✓ Review the many tools that exist and identify those that would work best with your children and families
- ✓ Consider those that have questions, language, format, style, and validity that are consistent with the way your practice and providers operate

■ **Avoid duplication**

- ✓ Review other screeners that you use and ensure you are not duplicating effort.
- ✓ If you find, through a review process, that other screening tools you use are already asking some questions about risk and

protective factors, figure out how you will use these existing questions, or add to them as needed

■ **Integrate into existing tools and processes**

- ✓ Consider how you can integrate these questions or tools into other screening tools or processes
- ✓ Think about whether there are any existing tools these new screening tools may replace so that you don't overwhelm providers or partners with new requirements

■ **Introduce the tools with family-friendly language**

- ✓ Try using scripts or family-friendly language to introduce the screening tools so that parents understand why the questions are being asked and how the responses will be used to help their family's care

Assessment of these risks and assets can be done in the regular visit. Possible questions are listed in Table 12.

**Table 12: Questions to Assess Families Risks**

Risk Factor	Possible Questions
<b>Basic needs</b>	<ul style="list-style-type: none"> <li>✓ Is there, or has there been, insecurity about having housing, food, clothing and the support of family or friends?</li> </ul>
<b>Threats to personal safety</b>	<ul style="list-style-type: none"> <li>✓ Does the family, or did it at one time, live in or have to travel to a neighborhood where they feel unsafe?</li> <li>✓ Do family members feel unsafe or wary because of their ethnicity, race, immigration status, gender, or sexual orientation?</li> <li>✓ Do school-aged children feel safe traveling to and attending school?</li> <li>✓ Is there a concern for emotional or physical violence between partners, or emotional or physical punishment of children?</li> </ul>
<b>Threats to the family's mental and physical health</b>	<ul style="list-style-type: none"> <li>✓ Does someone in the family work in a particularly dangerous or stressful job?</li> <li>✓ Is there anyone in the family with a serious medical or mental health problem, including problems with alcohol or drugs?</li> </ul>
<b>Preparation for parenting</b>	<ul style="list-style-type: none"> <li>✓ Do young parents – often young mothers – feel confident in their parenting knowledge and in having the support and resources they will need to care for an infant?</li> </ul>
<b>Parenting skills and child characteristics</b>	<ul style="list-style-type: none"> <li>✓ Does the child have behavior that the parent finds hard to deal with?</li> <li>✓ What skills does the parent have to deal with their children's behavioral issues?</li> </ul>

## PDSA Example

### Use Assessment Tools that Ask about Risks and Protective Factors

- Plan:** Plan to test implementing an assessment tool into the workflow.
- Do:** Test an existing or modified tool that assesses risk and protective factors with a few families.
- Study:** Ask the families for detailed feedback on the questions, how they were asked, when they were asked, etc. Also ask providers how valuable the experience was for them and how much time it took.
- Act:** Use your observations and the feedback from the families and providers to modify the tool and the process of implementation.

#### ***Strategy C: Support parents who have experienced trauma***

If parents discuss their exposure to trauma in a conversation with you or through a screener, make sure to follow up. While the parent explains his/her traumatic situation make sure to listen attentively and withhold judgment. If the situation seems complex, don't worry about doing everything — go for what the family values most. Leave the door open for future care, respecting concerns or hesitation. Steps to support parents and families who have experienced trauma are listed below:

- **Provide in-office intervention as appropriate**
  - ✓ When disclosures and conversations indicate an interventions that can take place in the moment, ask families if they have supports in place, how the PCP can help, and if it is okay to offer advice and ensure you understand the issues at hand
  
- **Honor the families' feelings about help**
  - ✓ Take time to make the case for and understand the family's feelings toward seeking help from a social worker or other provider when it might help
  - ✓ Talk about the possible benefits while acknowledging that there might be financial or other costs
  - ✓ Help parents make decisions about when those costs are justified. If not now, ask, "What would it take?"
  
- **Consult with in-office specialist**
  - ✓ Rely on the partnerships you've developed to receive real time consultation
  - ✓ Talk to your partner about options and recommendations

- ✓ Have your partner talk directly to the parents
- ✓ Bring in your peer support person or family advocate

■ **Refer parents for additional help or support**

- ✓ If you are unable to address concerns in the office or with the support of in-office consultation, consider referring the parent for specialized services or supports, including family education and support programs, community programs, etc.
- ✓ Engage your care navigator
- ✓ Engage your care coordinator to ensure follow up as needed
- ✓ Try to ensure there aren't barriers to access these supports
- ✓ Ask if help is needed to access or navigate services

■ **Follow up with the family**

- ✓ Offer a means of follow-up with you – a phone call, a visit
- ✓ Check in to see how the family is doing
- ✓ Ask about roadblocks to referrals

### **PDSA Example**

#### **Support Parents Who Have Experienced Trauma**

**Plan:** Plan to test supporting and connecting with parents.

**Do:** Test using empathy to connect with parents and try acknowledging their stress and intense emotions with language such as “It sounds as if you have a lot going on in your life. I’m sorry if I’m rushing you.”

**Study:** Observe the reactions of parents and see whether there is an improvement in communication.

**Act:** Use your observations to modify the provider-patient communication by showing empathy towards parents.

## **Assess your Progress on Assessing Families Assets and Risks**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### ***Strategy A. Engage Parents in Open Conversations about Their Lives***

- How do you ask parents about their exposure to stress and trauma?
- What types of questions do you ask to identify family assets and strengths?
- How do you help them understand why you are asking the questions?

### ***Strategy B. Use Assessment Tools that Ask About Risks and Protective Factors***

- What screening of child and parent exposure to stress and trauma is already taking place? How is it documented?
- How do you identify family assets and strengths in a structured and systematic way?
- What tools fit best with your office's culture and existing processes?

### ***Strategy C. Support Parents Who Have Experienced Trauma***

- How do you use information that is gathered about families' assets and risks?
- How do you engage parents in next steps?
- How do you support parents to address their own needs?
- How do you follow up with parents?

## Additional Resources for Assessing Families Assets and Risks

The resources listed below can be found in **Appendix D.1**

### Assessing family risks and assets

1. Applying Surveillance and Screening to Family Psychosocial Issues: Implications for the Medical Home (Garg & Dworkin, 2012).  
*This article emphasizes the importance of a physician identifying and intervening on psychosocial issues that affect a child's home life, and offers strategies to incorporate screening into pediatric practice.*
2. CSSP The Protective Factors Framework and Survey
3. CSSP A Protective Factors Framework PowerPoint
4. Life Stressors Checklist-Revised.  
*This self-report checklist includes stressful life events (such as natural disasters, assault, death in the family, etc.) and questions about the meaning and impact of the events on the individual's life. Available through the VA at: <http://www.ptsd.va.gov/professional/assessment/te-measures/lsc-r.asp>*
5. Childhood Trust Events Survey (CTES).  
*This survey is available in different forms: Two examples include one to ask a parent about events their child has experienced and one to ask an older child or adolescent about events they have experienced. Both versions cover the same twenty-six distressing events, with slightly altered wording.*  
Adult caregiver version available at:  
[http://www.depts.ttu.edu/hs/icfs/ACEClinic/docs/Childhood\\_Trust\\_Events\\_Survey.pdf](http://www.depts.ttu.edu/hs/icfs/ACEClinic/docs/Childhood_Trust_Events_Survey.pdf)  
Older child/adolescent version available at:  
[http://drjenna.net/wp-content/uploads/2013/07/trauma\\_events\\_survey\\_for.pdf](http://drjenna.net/wp-content/uploads/2013/07/trauma_events_survey_for.pdf).

### Select Links

1. ACEs questions.  
*There are questions about childhood trauma available through the Adverse Childhood Experiences Study. While these questions do not include trauma experienced after childhood, they can serve as a conversation starter for what childhood trauma(s) may still be affecting the parent. Available at: [www.cestudy.org](http://www.cestudy.org)*
2. Adverse Childhood Experience (ACE) Study.  
*The ACE Study examines the links between adverse childhood experiences, including maltreatment, and adult health. Available at: <http://www.cdc.gov/violenceprevention/cestudy/>.*

## Objective 2. Promoting Resilience

### Why is it important to promote resilience?

Providing guidance on parenting, healthy emotional development, and ways to meet families' basic needs can help families avoid the negative impacts that exposure to stress and trauma may have. Helping families build their own capacity so that if they encounter stress and trauma in the future they will feel less of an impact, and more quickly return to feeling well and secure, is an important role that primary care providers can play in families' lives.

### What is involved?

#### ***Strategy A: Provide parenting / developmental guidance***

Fortunately, most pediatricians and family doctors have good advice to give about parenting challenges – assuming that they have been able to help parents feel comfortable and supported while discussing the situation.

#### ■ **Provide training to providers**

- ✓ Ensure that you share information with providers and provide appropriate trainings to help them recognize how important family strengths, parenting help, resilience, and prevention are to child health

#### ■ **Share written materials about parenting**

- ✓ Most families will benefit from materials about parenting that they can use at home. A number of parenting resources are listed in the Appendix. A few examples of developmental resources include:
  - **“Reach Out and Read” program** – many pediatricians participate in this program that distributes age-appropriate books to families without charge.
  - <http://www.cdc.gov/parents/> - The Centers for Disease Control's newly enhanced website targeted directly to families with downloadable materials for children of all ages and videos about parenting young children.
  - **Parenting books** for example, Penelope Leach's “Your Baby & Child” and T. Berry Brazelton's “Touchpoints.”

#### ■ **Be aware of in-office interactions and environments**

- ✓ Remember that a family's interaction with the health care system can be therapeutic in itself, providing a source of respect and a place of safety and education.

- ✓ Ensure the office environment plays a role in whether families choose to disclose their concerns or experiences and the extent to which they will consider a health care provider’s advice.
- ✓ Be aware that interactions between parents and providers (as well as with entire office staff) can serve as a model for parents’ interactions with other adults in their lives or even with their children. They can directly experience positive ways of discussing difficult topics, showing respect even in the context of disagreeing with someone, and managing relationships even when one is busy and stressed.

### **PDSA Example**

#### **Provide Parenting/Developmental Guidance**

- Plan:** Plan to test giving brief advice during regular health care visits. This includes bringing up issues that predictably arise as a child grows, especially patterns of sleep, feeding, and crying.
- Do:** Provide suggestions for management and when to seek help. This also includes talking about infants’ responsiveness to stimulation, including talking, face-to-face contact, showing things in the environment, and naming them. As infants get older, it’s important to discuss reading, simple toys, and limiting “screen time.”.
- Study:** Observe family reactions to the advice; consider how it affects provider communication with the family; note any needed workflow changes.
- Act:** Use your observations to modify information for families and plan next steps such as creating brochures on these topics.

#### ***Strategy B: Provide support and resources to parents***

Knowledge is power. The more that parents are aware of and realize they have access to supports and resources in their own community the stronger they can be. Making sure this information is presented in ways that are useful, meaningful, and accessible to parents is essential.

#### **■ Provide resource lists**

- ✓ Make sure that parents are aware of community resources by providing up-to-date and readily available resource lists.
- ✓ Distribute resource lists in the waiting room, exam room, and online

- ✓ Have frontline staff and providers develop a system for distributing or directing families to the resource list
- ✓ Ensure the lists include up-to-date resources for the range of community services that can help with income, housing, employment, transportation, developmental services, Head Start, family violence, and substance/alcohol abuse (make sure to include location, cost, and transportation options).

■ **Offer your own classes or programs**

- ✓ Offer parenting classes or refer to community-based programs. Examples of community based parenting programs include groups sponsored by the YM/WCA, religious groups, or employers
- ✓ Consider using evidence-based parenting programs such as, Triple P, Circle of Security, Motherwomen, Systematic Training for Effective Parenting (STEP). It is important to note that a review of parenting programs found that the most effective were those that allowed parents to practice and get feedback and pointers (versus just receiving advice or reading).

**PDSA Example**

**Provide Support and Resources to Parents**

- Plan:** Plan to test using “behavioral activation.”
- Do:** Talk with parents about things that bring them happiness or pleasure. With the help of your parent team members and advisors, try different ways of asking this question, making suggestions, and asking about it at follow-up. Responses may vary among different cultural groups and family structures.
- Study:** Observe the family’s reactions and the difference in reactions when varying how the question is presented.
- Act:** Use your observations to modify how you communicate with the parents.

## Assess your Progress on Promoting Resilience

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### *Strategy A. Provide Parenting / Developmental Guidance*

- What training have staff/providers had on resiliency and its promotion?
- What training has staff/providers had on working with parents and caregivers?
- What written materials do you have for parents specifically about parenting?
- In what ways do your physical environment and office culture offer a supportive space for parents?

### *Strategy B. Provide Support and Resources to Parents*

- What supports does your office have for parents who are trying to cope with stress and trauma?
- What resources are currently available at your site or in the community that support parenting or early childhood development?
- In what ways are they accessible and culturally responsive for the families your agency serves?
- How is your resource list developed and kept up to date?
- In what ways is it distributed to parents? How do you ensure it remains relevant and helpful for parents?

## Additional Resources for Promoting Resilience

The resources listed below can be found in **Appendix D.2**

### Parent Mental Health Resources

1. A Parent's Self-Care and Self-Reflection
2. Before You Talk to Your Children- How Your Feelings Matter
3. Birth Parents with Trauma Histories- A Guide for Mental Health Professionals
4. Birth Parents with Trauma Histories- A Guide for Parents
5. Birth Parents with Trauma Histories- A Guide for Resource Parents
6. Taking Care of Yourself is Just as Important as Taking Care of Your Family

### Promotion and Prevention

#### Early Childhood

1. Ages and Stages – Learning Activities
2. Purposeful Parenting - First visit
3. Purposeful Parenting - 36 month visit
4. Purposeful Parenting - 18 month visit
5. Purposeful Parenting - 9 month visit
6. Tips to Promote Social-Emotional Health Among Young Children
7. The First 1,000 Days - Bright Futures Examples for Promoting EBCD  
*This grid was developed by the American Academy of Pediatrics, and it provides examples of evidence-informed activities that promote the parent-child relationship and child development in line with guidelines from Bright Futures.*  
Available at: [www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD\\_Well\\_Child\\_Grid.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf)
8. Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years (Regaldo & Halfon, 2001).
9. Healthy Steps- An Approach to the Primary Care of Children from Birth to Three

#### Adolescent

1. Tips to Promote Social-Emotional Health Among Teens
2. Adverse Childhood Experiences: Assessing the Impact on Health And School Engagement and the Mitigating Role of Resilience
3. Primary Prevention Programs for Children and Adolescents: A Meta-analytic Review (Durlak & Wells, 1997)
4. This review of preventive interventions directed at children under age 18 indicates that the majority of interventions reviewed have significantly positive effects on emotional and behavioral outcomes, supporting continued primary prevention efforts for children and youth.
5. Primary Prevention of Child Physical Abuse and Neglect: Gaps and Promising Directions (Klevens & Whitaker, 2012)
6. The goal of this review was to identify gaps in the literature on prevention of child maltreatment. Additionally, promising programs targeting different levels of the socioecological model (societal, community, and general population) were identified and described.
7. U.S. Department of Health and Human Services (DHHS). Administration on Children, Youth, and Families (ACYF). Emerging practices in the prevention of

child abuse and neglect. Washington (DC): Government Printing Office; 2003.

10. This report covers childhood maltreatment and the results of a national survey of prevention efforts with select successful programs described in detail.

**All Ages**

1. AAP Bring Out the Best in Your Children
2. AAP When Things Aren't Perfect: Caring for Yourself and Your Child
3. Practitioner Review: Diagnosing Childhood Resilience- a systematic approach to the diagnosis of adaptation in adverse social and physical ecologies
4. Child and Family Resilience: A Call for Integrated Science, Practice, and Professional Training
5. Interdisciplinary and Innovative Approaches to Strengthening Family and Individual Resilience: An Introduction to the Special Issue
6. Detection, diagnosis, and prevention of child abuse: the role of the pediatrician
7. Practitioner Review: Children in foster care- vulnerabilities and evidence-based interventions that promote resilience processes

**Select Link:**

Families Overcoming Under Stress (*Project FOCUS*) is a resilience-building program, initially designed for military families. The training includes skills for increasing closeness, support, adaptability and communication within the family. Available at: [www.focusproject.org/](http://www.focusproject.org/)

## **Theme 5: Assessing Trauma-Related Somatic and Mental Health Issues**

### **An Overview and Rationale**

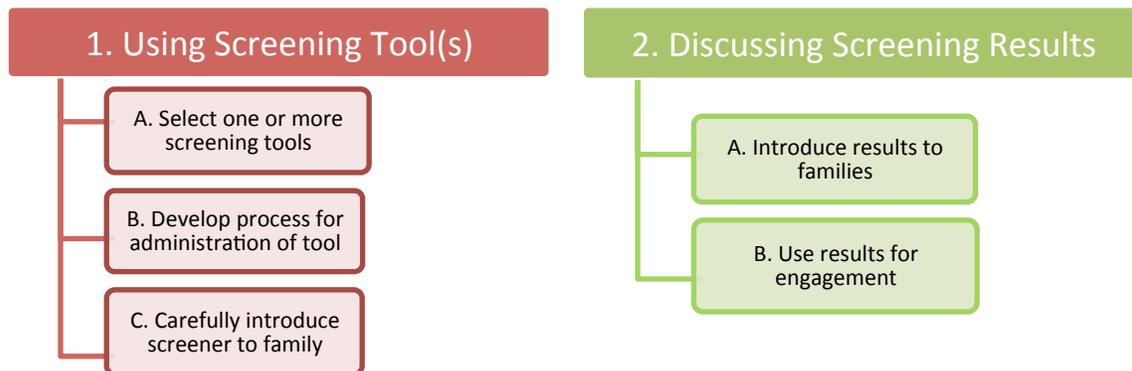
Detection of somatic and mental health problems related to exposure to trauma and stress among young children is critical to ensure their healthy physical and emotional development. Pediatric primary care providers, who focus on the development of children and typically have an ongoing, trusting relationship with families, are well suited to assess problems related to exposure to trauma and stress among young children. An assessment for trauma exposure at health maintenance visits helps to identify health problems related to trauma and organize the discussion around family concerns.

In general, the assessment of trauma-related problems among young children should involve a balanced approach that incorporates screening, activation, and communication. More specifically, assessing trauma-related problems is as a process that is likely to involve some combination of a) use of a screening tool, b) discussion about the results, c) collaborative planning to address any concerns identified through the screening or discussion and d) agreement to check in again about this area if there are no concerns at present.

### **Objectives and Strategies to Assess Trauma-Related Somatic and Mental Health Issues:**

**Objective 1:** Include the systematized assessment of trauma-related somatic and mental health problems as part of a holistic assessment of the child's well-being.

**Objective 2:** Complement screening with a discussion that engages the family and facilitates the assessment of trauma-related problems.



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1. Using Screening Tool(s)

### Why is it important?

The identification of trauma-related somatic and mental health problems is part of a holistic assessment of the child's well-being. Use of a screening tool at health maintenance visits with young children ensures that every parent is asked the same set of questions, including questions about problems that could be related to trauma. Routine assessment addresses two important issues: first, that it is impossible to guess which families may have experienced trauma, and second, that routine and universal assessment makes it normal to address a potentially stigmatized topic.

Screening tools can efficiently identify the family's concerns and make sure these issues are discussed in the visit. Prior research about health maintenance visits – not directly related to trauma—found that comprehensive, pre-visit screening with parents of children 4-10 enhanced:

- Parent engagement
- Parent-provider communication
- Agenda setting
- Visit efficiency
- Acceptability of discussing topics believed to be out of the scope of a pediatric visit
- Routine nature of a screener helped parents feel comfortable bring up sensitive issues without feeling targeted or stigmatized.

We know less about screening specifically for trauma exposures or other life stresses than for other issues. There is no reason to think that screening for trauma will be different from screening for other sensitive but important issues, but families and providers should choose screeners that are sensitive and relevant to the community they serve.

### What is involved?

#### ***Strategy A: Select one or more screening tools***

In general, providers should ask about the child's own and the family's exposure to trauma and stress and then about somatic, behavioral, and emotional symptoms that could be a result of exposure to trauma. It is critical to include strengths and factors that may promote resiliency as part of your assessment. Trauma screening may not be viewed as a priority in pediatric practice when it is competing with screening for other issues, such as developmental delays, safety, and nutrition. Therefore it is important to be clear about your purpose for screening and your capacity to implement a new screener into your workflow. The selection of an approach to trauma and stress depends on the individual needs and capacity of each site. Key considerations when choosing a screener include:

- **Purpose:** Is your goal to screen for trauma *exposure* and/or how the patient *responds* to trauma exposure?
- **Capacity:** Implementing a trauma screener can result in “new” problems that need to be addressed. What is the capacity of the primary care clinic to address mental health issues? Are local mental health facilities and community resources equipped to handle increased patient loads?
- **Current Systems:** What systems can be adapted to in order to effectively administer a screen? What are your available means of deployment? Can you integrate a trauma screen with other screening and EMRs?
- **When will the screener be administered:** Some topics are routinely asked as new families come into care; others might be routinely asked at all health maintenance visits, while others might be asked only annually (or some other interval) unless a change in a child or family’s status raised a concern. The below highlights the connection between screening timing and content (though these are only suggestions to start discussion)

**Table 13. Screening for Trauma and Stress-Related Issues: Considerations**

Timing of Screening	Possible Topics
At start of relationship	<ul style="list-style-type: none"> <li>• Prior history of mental health problems (or only maternal depression?)</li> <li>• Past exposure to violence, major loss, life threatening situations (medical or otherwise)</li> <li>• Parents’ own childhood experiences</li> <li>• Survey of family supports and strengths, perceptions of child’s strengths and positive attributes</li> <li>• Any current concerns (as per annual and every visit routines)</li> </ul>
“Annual” or at some interval other than every health maintenance encounter	<ul style="list-style-type: none"> <li>• Family economic security (including security of food, housing, employment)</li> <li>• Broad-range inquiry about child emotional, behavioral, developmental issues</li> <li>• Updates on family accomplishments, changes that family reports as positive</li> <li>• Updates on challenges related to health, support, parent mental health</li> <li>• Exposure to violence</li> </ul>
At every encounter	<ul style="list-style-type: none"> <li>• Brief inquiry or short screen about parent and child emotional/behavioral/functional problems</li> <li>• “Anything new?”</li> </ul>

There are a number of screening tools available to assess physical and emotional development as well as different aspects of trauma exposure and trauma-related problems among children of various ages. Each screener has different strengths and weaknesses, and the choice of screeners will depend on your office structure and systems, other screeners already being used, patient flow, and co-located resources. When choosing a screener it is important to consider the time and effort needed to complete, administer, score, and interpret the results.

Common *trauma-related* screening tools include: the SEEK, SWYC, and the ACES checklist, and the protective factors checklist to assess resilience. The table on the next page lists major characteristics of each and pros and cons.

**Table 14: Overview of Common Trauma-Related Screeners**

Screener	Source(s)	Domains, age, target population	Pros	Cons
<p><b>ACES Checklist</b> (Various versions derived from original Adverse Childhood Events study)</p>	<p>acestudy.org and <a href="http://www.cdc.gov/nccdphp/p/ace">www.cdc.gov/nccdphp/p/ace</a> for original version; adaptations from Center for Youth Wellness (centerforyouthwellness.org) and others</p>	<ul style="list-style-type: none"> <li>• Parent’s childhood maltreatment and family dysfunction</li> <li>• Adaptations to refer to children/youth up to 18 and outside family including abuse, discrimination, medical trauma, food and housing insecurity</li> </ul>	<ul style="list-style-type: none"> <li>• Asks about parent’s childhood exposure to trauma</li> <li>• Covers wide variety of stresses (depending on version)</li> </ul>	<ul style="list-style-type: none"> <li>• Sensitive items. Some families wary of answering.</li> <li>• Some versions involve disclosing actual traumas versus count of domains experienced</li> <li>• Does not ask about parent’s current exposure.</li> <li>• As yet no data/consensus on scoring or optimal clinical use</li> </ul>
<p><b>Protective Factors Survey</b></p>	<p>National Center for Community-Based Child Abuse Prevention <a href="http://www.friendsmc.org/p/protective-factors-survey">www.friendsmc.org/p/protective-factors-survey</a></p>	<ul style="list-style-type: none"> <li>• Based on protective factors framework (<a href="https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/">https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/</a>; <a href="http://www.cssp.org/reform/strengthening-families">www.cssp.org/reform/strengthening-families</a> (parental resilience, social connections, concrete support, parenting/developmental knowledge, child social and emotional competence)</li> </ul>	<ul style="list-style-type: none"> <li>• Questions phrased to cover both strengths and risks</li> <li>• Used in agency evaluations</li> <li>• Sensitive to change; considered evidence-based instrument</li> </ul>	<ul style="list-style-type: none"> <li>• Few questions specifically tap child development</li> <li>• Does not explicitly ask about most current or past traumas/stresses</li> </ul>
<p><b>SEEK (Safe Environment for Every Kid)</b></p>	<p><a href="http://theinstitute.uma.ryland.edu/seek/">http://theinstitute.uma.ryland.edu/seek/</a></p>	<ul style="list-style-type: none"> <li>• Parents asked about household risk of poison, fire, smoking exposure, lack of food</li> <li>• Possible physical abuse</li> <li>• Parent depression, stress, substance use, parenting difficulties,</li> <li>• Domestic violence</li> </ul>	<ul style="list-style-type: none"> <li>• Efficient</li> <li>• Screener is part of suggested implementation program for which training and support available including parent handouts, clinician decision algorithms, possible links to EMRs, QI and MOC programs</li> <li>• Impact of program tested in RCTs</li> </ul>	<ul style="list-style-type: none"> <li>• Does not cover development.</li> <li>• Smaller range of stresses, child traumatic exposures covered compared to ACES</li> </ul>
<p><b>SWYC (Survey of Well-Being of Young Children)</b></p>	<p><a href="http://www.theswyc.org">www.theswyc.org</a></p>	<ul style="list-style-type: none"> <li>• Age-specific forms and specific forms for post-partum depression</li> <li>• Developmental Milestones: Gross Motor, Fine Motor, Language and Communication</li> <li>• Infant/Preschooler social-emotional development</li> <li>• Family psychosocial: (Depression, SA, DV, socioeconomic)</li> <li>• Open question for parent concerns about child development or behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Covers several screening recommendations: developmental and behavioral screening; autism screening; and parental mental health, SA, DV, food availability</li> <li>• Incorporates evidence-based tools</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively more time to administer (author estimate 15 minutes) and score (sections of form have their own scoring guides), but meets other screening needs simultaneously so overall may contribute to efficiency</li> <li>• Doesn’t ask about the parent’s own childhood</li> </ul>

## PDSA Example

### Select One or More Screening Tools

Review a number of different screening tools at a team meeting with various perspectives present. Discuss the pros and cons of each, including how long it would take to administer a tool, when it might be used, who might be responsible for administering the tool, and how it might be integrated with other screening requirements, etc.

#### ***Strategy B: Develop process for administration of tool***

If you recognize the challenges involved with screening, you can select the process that best suits your practice. With less than 20 minutes typically allotted to a pediatric well-child visit, screening during the visit cuts the time for discussion considerably. Screening prior to the visit helps with this problem, but there may still be concerns that discussing concerns identified on a pre-visit screener will take too much time.

Furthermore, you must consider how to document screening results. The American Academy of Pediatrics supports the inclusion of trauma screening results in the health record. In primary care, when you take a social history, it is documented in the notes. In general, facts relevant to the child's health should be in the record. Provider speculation or personal comments should not go in the record. There may be other considerations, however, that can be discussed with families. For example, concerns about family violence might not be documented if a potentially violent partner could access them. Details about parental mental health problems might be omitted and reserved for the parent's own medical record.

Mental health professionals often make a distinction between the medical record and their "psychotherapy notes." The latter often contain much detail that is helpful to the therapist in thinking through care, but is not essential to documenting the content and appropriateness of care. This distinction may be helpful in deciding what to include in a child's medical record and what to retain in a provider's personal notes.

## PDSA Example

### Develop Process for Administration of Tool

- Plan:** Plan to test distribution of an assessment tool in the waiting room versus distribution in the exam room.
- Do:** Try distributing the tool in both locations.
- Study:** Ask the families what they thought about completing the screener in each setting. Pay particular attention to privacy concerns among those who completed screeners in the waiting room. For those who answered in the exam room, find out if they felt they had adequate time to complete it before speaking to the provider. Also, ask if they felt comfortable seeking assistance if necessary.
- Act:** Use your observations and feedback from families and staff to select a location and continue development of the processes.

#### ***Strategy C: Carefully introduce screener to family***

The acceptability of trauma screening may vary among families, and all will require some explanation of why the questions are being asked and who will see the answers.

There are a number of possible points to make in introducing screening – the following list represents points that may vary in their importance to families in different settings – you can ask the families you work with which are the ones that most need emphasis.

- **Screening is universal:** Families may be concerned that they are being targeted for a screen, so it is helpful to explain that you screen all families routinely because these issues are common and can be helped.
  
- **Screening will give more time for discussion:** It may also be useful to explain to families that you are using a formal screening tool in order to optimize attention to patient concerns in the visit. They may appreciate that you are trying to spend less time on question asking and more time discussing concerns.
  
- **Screeners ask about all aspects of health that affect a child’s development:** Families may not be used to seeing questions about sensitive topics like trauma and mental health, so it’s important to explain up front that you are doing a comprehensive assessment of both physical

and mental health concerns because all areas of health are important for a young child's development.

- **Screening is confidential:** It is also helpful to explain your confidentiality protocols. When possible, the provision of a private space to complete the screener may help assure confidentiality and increase disclosure.
- **Staff are available to answer questions:** Some families may need help understanding certain questions or the response options, so it is useful to let families know that staff are available to answer questions and explain how families can obtain this assistance.
- **Responses are optional:** You might include that answering any of the questions is optional – any question can be skipped and discussed during the visit instead.

### **PDSA Example** **Carefully Introduce Screener to Family**

- Plan:** Plan for the front desk staff to test use a verbal introduction script to introduce a screener.
- Do:** Ask front desk staff to introduce the screener using the script with a few families. The script can explain the purpose of the screener, that it is a universal, confidential, and part of a comprehensive well-child visit that assesses both physical and emotional health. You may need to test a written preamble on top of your screener that covers the same points.
- Study:** Ask the families through a one-page survey or in a brief meeting what they thought about how the screener was introduced and what they would have liked to know in advance.
- Act:** Use the feedback from the families and front desk staff to improve the implementation process.

## Assess your Progress on Using Screening Tools

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### *Strategy A. Select One or More Screening Tools*

- What screenings are already being carried out either pre-visit or included in EMR or other systems?
- How do these screenings include exposure to trauma, impact of trauma, parental experiences, and family strengths?

### *Strategy B. Develop Process for Administration of Tool*

- How is screening for these issues incorporated into existing workflows, expectations, and requirements?
- Who is currently responsible for administering the various screenings done in your office and how are they oriented to the purpose and value?

### *Strategy C. Carefully Introduce Screener to Family*

- What is the environment for screening about sensitive issues?
- How are the screening questions presented to parents in ways that are supportive and engaging?
- How are the screening questions perceived by parents with different life experiences and concerns?

## Additional Resources for Using Screening Tools

The resources listed below can be found in **Appendix E.1**

### *Assessment of trauma-related problems*

#### ○ **Screeners**

##### ▪ **Primary Family Psychosocial**

1. Bright Futures Pediatric Intake Form
2. Combined SWYC forms
3. Edinburgh Postnatal Depression Scale
4. SEEK- The Parent Screening Questionnaire (PSQ)
5. The Patient Health Questionnaire-2 – Overview
6. The Patient Health Questionnaire-9 – Questions

##### ▪ **Family Strengths and Risk Profile**

1. Protective Factors Self-Assessment
2. Protective Factors Overview

##### ▪ **Young Child**

1. Ages & Stages Questionnaire – Social-Emotional
2. Young Child PTSD Checklist
3. Young Child PTSD Screen

##### ▪ **School-Age**

1. Center for Epidemiological Studies Depression Scale for Children
2. Early Childhood Screening Assessment - 401
3. Early Childhood Screening Assessment -Manual
4. Pediatric Symptom Checklist
5. Self-Report for Childhood Anxiety Related Emotional Disorders
6. Early Development Instrument: A Population-Based Measure for Communities (EDI)

##### ▪ **Adolescent**

1. Bright Futures Supplemental Questionnaire for Adolescents
2. ACES- During Your Child’s First 18 Years
3. PHQ-9 Modified for Adolescents
4. The CRAFFT Screening Interview
5. The Patient Health Questionnaire-2 – Overview
6. CANS-Trauma Exposure and Adaptation Search CANS at [www.learn.NCTSN.org](http://www.learn.NCTSN.org)
7. FANS More information: [www.fans.umaryland.edu](http://www.fans.umaryland.edu)
8. CES-DC

#### ○ **Screening – Additional Information**

1. AAP Healthy Development Chapter-Promotion Screening Chart for CCNC Workgroup
2. ACE Nonspecific Rating Scale
3. Identifying and Caring for Child Victims of Violence
4. Improving the Adverse Childhood Experiences Study Scale (Finkelhor et al., 2013)

5. Pediatric Primary Care to Help Prevent Child Maltreatment - The SEEK Model (Dubowitz et al., 2010)
6. Screening & Surveillance
7. Screening Tool Rating Summary
8. The SEEK Model of Pediatric Primary Care (Dubowitz et al., 2012)
9. Trauma Screening Identification and Referral
10. Trauma Screening
11. Enhancing Developmentally-Oriented Primary Care: An Illinois Initiative to Increase Developmental Screening in Medical Homes (Allen et al., 2010).  
*This describes the successful implementation of training programs to address barriers that pediatric physicians experienced in administering screeners for a variety of developmentally important topics, including violence*
12. Implementation of a Program to Teach Pediatric Residents and Faculty about Domestic Violence (Berger, Bogen, Dulani, & Broussard, 2002).  
*This article demonstrates that a brief education program is effective at improving violence screening practices among physicians and other medical professionals.*
13. Assessing the Impact of a Web-Based Comprehensive Somatic and Mental Health Screening Tool in Pediatric Primary Care (Fothergill et al., 2013).  
*This study demonstrates the utility of a comprehensive pre-visit screener for well-child visits. Both parents and providers reported that the screener improved parent engagement, communication, agenda setting, and visit efficiency.*
14. Improving the Management of Family Psychosocial Problems at Low-Income Children's Well-Child Care Visits: The WE CARE Project  
*This article describes a randomized controlled trial demonstrating the effectiveness of an easily-implemented psychosocial screener in urban pediatric practice. The use of this screener was shown to increase discussion of psychosocial topics and parental engagement with community family support resources.*
15. Universal Mental Health Screening in Pediatric Primary Care: A Systematic Review (Wissow et al., 2013).  
*This review focuses on how patients and parents engage with screeners in pediatric primary care and how the results are evaluated and used by providers in determining care for their patients.*
16. Adverse childhood experiences of low-income urban youth (Wade et al. 2014).

#### Select Links:

- [Healthcare Toolbox. A collection of training resources for healthcare providers, including slides on providing trauma-informed care and reducing medical traumatic stress in pediatric settings.](http://healthcaretoolbox.org/index.php/tools-and-resources/training-tools) Available at: <http://healthcaretoolbox.org/index.php/tools-and-resources/training-tools>

## Objective 2. Discussion of Results

### Why is it important?

Screening is incomplete without a conversation between the doctor and the family about the screening results. Implementing screening without discussing the patient/parent's responses seriously undermines the intent and can create additional burdens to families and providers. Without discussion, the screener becomes just another administrative requirement. Discussion should be used to better understand family concerns (including exploring topics suggested by but not covered by the screening) and planning how those concerns can be addressed.

#### Why Discuss Screening Results?

- Foster disclosure of concerns
- Tease out serious concerns from moderate concerns
- Learn more about context of problems identified
- Discuss ways to prevent exposure to trauma
- Discuss methods to cope with trauma

Both “negative” and “positive” screens need follow-up. Screens may be negative because: the family truly senses that there are no difficulties to discuss; they are not comfortable disclosing difficulties; they don't understand the questions being asked; or they don't see their problems reflected in the questions on the screen. Thus, a negative screen can confirm that there are no problems but it can also create an opening for families to disclose related issues. Screens can be positive because the family in fact has difficulties to discuss or because they misinterpret questions or the directions for completing the form. The conversations between provider and patient that emerge from the use of the screener are even more important than the positive/negative results of the screening tool itself. It is also important to remember that the positive/negative cut-points in “validated” tools may not be applicable to the population for which you are caring. Scores below but close to the cut-point may be significant, as positive scores just above the cut-point may not be.

#### ***Strategy A: Introduce results to families***

Given the cautions noted above, it is best to start the discussion by:

- ✓ Thanking the patient/parent for completing the screen
- ✓ Asking for permission to discuss the results
- ✓ Explaining that the screener is meant to help decide what might be important to talk about at this visit
- ✓ Explaining that the responses make it seem as if there might/might not be something to add to the agenda, pending what the patient or parent thinks

If items are checked as “positive” or cause distress to a family, you can ask for permission to talk more about the answer. It remains important to get a full

agenda before circling back to these topics – the trauma/stress screen still is only one of many topics that may be important to the family at this time.

### **PDSA Example** **Introduce Results to Families**

- Plan:** Plan to test different ways to verbally introduce screening results in the visit.
- Do:** Test using different scripts with language that conveys compassion, empathy, and support. Re-state that the goal of screening is to identify family strengths and concerns and improve discussion of these factors.
- Study:** Ask the families and providers who tried using the scripts for feedback.
- Act:** Use the feedback to modify the script.

***Strategy B: Use results for engagement.*** It is important that the family not feel judged for their problems or overwhelmed by possible courses of action. Overall, the discussion between the provider and the family should focus on family strengths and engaging the parent and child in a discussion about the patient's wellbeing.

- ✓ Review the strengths and supports in the family
- ✓ Clarify the family concerns identified on the screener
- ✓ Learn more about the child's needs
- ✓ Learn about the context of problems identified
- ✓ Discuss ways to prevent exposure to trauma
- ✓ Discuss methods to cope with trauma

## PDSA Example Use Results for Engagement

- Plan:** Plan to test questions you can ask to bring attention to positive aspects in the family's life.
- Do:** Try asking questions like “*Who or what do you consider to be your sources of support?*” or “*What beliefs do you have that help provide you with guidance in your daily life?*”
- Study:** Observe how these affect the conversation and if anyone expressions appreciation for being asked about these assets.
- Act:** Use your observations and comments from the families to modify the questions that you ask.

### Assess your Progress on Discussing Screening Results

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

#### ***Strategy A. Introduce Results to Families***

- How do providers currently engage families in the initial discussion of screening results?
- What training do providers need to improve their understanding and the purpose of trauma-informed screeners and associated results?

#### ***Strategy B. Use Results for Engagement***

- What training do providers need to improve their ongoing communication of screening results to ensure families are engaged?
- How do providers use families' strengths as identified through the screening process for engagement?

## **Theme 6: Addressing Trauma-Related Health and Mental Issues**

### **An Overview and Rationale**

Many children suffer from trauma-related problems that go untreated, which can affect both physical and emotional development. Primary care providers who identify trauma-related problems should be well prepared to respond in order to assure patients receive quality care. The choices of intervention are a continuum from what can be done in the office visit to what can be done outside the office after the visit, either in specialty care or in the community. There is much that a primary care provider can do in the context of the office visit. This is the “primary care advantage.” PCPs can build upon their relationships with families and on the trust families have in the providers. Addressing trauma-related health and mental health issues does not always require psychotherapy or referral. Often times, the thoughtful, sensitive, and intentional interactions between provider and family are the intervention that the family needs most and finds most helpful.

### **Objectives and Strategies for Addressing Trauma-Related Health and Mental Issues**

- Objective 1:** Help families become aware of the links between trauma/stress and health.
- Objective 2:** Help families develop plans for needed care or monitoring.
- Objective 3:** Provide brief services within the practice.
- Objective 4:** Coordinate referrals to specialty trauma care and co-manage ongoing treatment.



### A Closer Look at Each Objective

The goal for anyone striving to achieve the overall mission of this work is to implement these objectives in ways that are appropriate for the individual providers, agencies, and families being served. The strategies for implementation will differ depending on the practice and the patient population. Below you'll find each objective followed by a brief narrative explaining its importance, what it involves, possible strategies, and small tests of change (PDSAs) that you could consider testing or adapting in your own site. After the narrative descriptions, you'll find questions to assess your progress toward achieving the objective.

## Objective 1: Help Families Become Aware of the Links Between Trauma/Stress and Health

### Why is it important?

Some families recognize that they have experienced something stressful or traumatic, but not be able to connect that experience to changes in their children's behavior or health status. However, many families experiencing trauma recognize its impact. Some will already be obtaining help; others will feel that given the resources they have available, or the potential risks of seeking help, that they are doing all that is possible. As with any educational process, it is important to start by understanding what families already know and what they might like to learn. Remember that key parts of being "trauma informed" include demonstrating respect, recognizing strengths, and promoting feelings of self-control and self-determination. These goals are served by listening and by asking for permission to provide information.

### What is involved?

#### ***Strategy A: Share information with families about trauma, stress, and health***

Research on early childhood trauma provides extensive data on the impact of trauma in early childhood. Even if they do not have the words to communicate their feelings or reactions, children are affected and they may need extra support—both from their parents, and on some occasions from professionals. As discussed in the first section, not all stress is negative. Stress can be positive, tolerable or toxic. Positive and tolerable stresses are buffered by a supporting relationship. In toxic stress there is prolonged activation of the stress-response system in the absence of a protective relationship. It is important to support parenting because a caring adult, parent, or family member can buffer a child's experience when exposed to a traumatic event.

Children who have experienced trauma and stress may experience disrupted sleep and eating patterns, leading to parent-child conflict and to the child not feeling well. Trauma and stress can make children irritable, impatient, angry, or aggressive. Children may show increased worry about being separated from a parent or losing their parents or other adults who are close to them. Worry can be expressed as changes in behavior or avoidance of reminders about the traumatic events.

Providing concrete information about how trauma can affect a child's physical and mental health, and what the common behavioral responses are can help families make sense of what is happening. Strategies to raise awareness of trauma and its impact include:

- **Introduce the relationship between trauma and health:**
  - ✓ Discuss links between trauma and health
  - ✓ Discuss links between trauma and child development
  
- **Consider the family’s perspective:** Always be aware of, and acknowledge, that you don’t know what the situation looks like from the parent’s perspective
  
- **Reassure the family:** Explain that children’s reactions to extremely frightening or overwhelming events are usually normal responses to abnormal events. Both children and adults experience physical and emotional reactions to trauma and stress, and there are things that can be done to help.

**PDSA Example**  
**Share Information with Families about Trauma, Health, and Stress**

- Plan:** Plan to test a brief family-friendly brochure focused on psychosocial health.
- Do:** Give it to a few parents when they first arrive in the office.
- Study:** Ask the families for feedback on content and format.
- Act:** Use feedback from the families to modify the content, format, and placement of the brochure.

***Strategy B: Guide families about how they can help support the child***

For young children, parents or primary caregivers can minimize the impact of trauma as well as help children recover more quickly. Some of the factors that promote resiliency (or effective coping) include:

- ✓ Continuity in basic needs (food, housing, security)
- ✓ Information that helps the child make sense of what is happening and restore a feeling of predictability to life
- ✓ Key personal relationships, care, or activities that help the body’s regulatory systems to return to normal
- ✓ The naming of feelings and guidance on how to manage them
- ✓ Support positive development and remediate problems that could interfere with a child’s ability to cope with trauma

### **PDSA Example**

#### **Guide Families to Help Support the Child**

- Plan:** Plan to test using talking points to give parents information on what they can do to help their own child.
- Do:** Be as concrete, family-friendly, and strengths-based as possible when engaging in this conversation based on the child's experience with trauma or stress.
- Study:** Ask the parents for feedback. Find out if they found the information helpful, if they want additional information, when it would be most helpful, and if talking points changed how they interacted and supported their child.
- Act:** Use the parent feedback to modify talking points and processes.

### **Assess your Progress on Helping Families Become Aware of the Links Between Trauma/Stress and Health**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

#### ***Strategy A. Share Information with Families about Trauma, Stress, and Health***

- How do you educate providers about the connections between trauma exposure, health, and child development?
- How do you educate parents about trauma, health, and child development?

#### ***Strategy B. Guide Families about How They Can Help Support the Child***

- How do you help families identify strategies and supports for their child?
- How do you provide guidance to families in ways that are engaging?

## **Additional Resources for Helping Families Become Aware of the Links Between Trauma/Stress and Health**

The resources listed below can be found in **Appendix F.1**

1. Understanding the Behavioral and Emotional Consequences of Child Abuse (Stirling et al., 2014)  
*This reviews the impact trauma can have on a child and offers general guidance for pediatricians advising parents and considering interventions.*
2. Social-Emotional Problems in Preschool-Aged Children (Brown et al., 2012)  
*This study showed that parents were generally open to referrals from their child's pediatrician to other mental health services.*
3. Resources for Soothing
4. Primary Care Doctors are Critical to Detecting Mental Illness in Children (NAMI)

## Objective 2: Help Families Develop Plans for Needed Care or Monitoring

### Why is it important?

Partner with parents/families in discussing and developing a plan to help their child after exposure to a trauma. Young children often look to their caregivers first for information and reassurance. The parent's ability to cope with stress is a key indicator of the child's response. Perhaps the single most important thing to remember about working with families who have experienced trauma or stress is that they often experience loss of control over key aspects of their lives – the aspects that help them feel safe and valued as people. Our goal, first and foremost, is to help them regain a sense of safety and control. The parents' experience of being heard, respected, and valued, is the essential first step of collaboration, and will increase the likelihood that they will follow-through with a treatment/monitoring plan.

### What is involved?

#### ***Strategy A: Review options for care***

Take time to talk with families about their various options for care and review their options. Parents and providers may not always agree on the best first step – either may have strong feelings about pursuing a particular treatment path (for example, using or not using a medication). Fortunately, if there are good opportunities for partnership over time, the plans can be revisited and adjusted as needed. Restoring a sense of security and control may be the most powerful treatment that can be provided; the goal is for families to feel respected and to regain confidence in their ability to take charge of their lives.

#### ■ **Collaborate with the family and encourage questions:**

- ✓ Listen to and learn from parents' observations and questions about how their child is responding to stress.
- ✓ “Wondering together” is often a helpful and respectful approach.
- ✓ Check in with family about whether they would like to know more about something.
- ✓ Ask parents if they would like to hear your thoughts
- ✓ After you have spoken, ask them what they think and if the information makes sense to them

- **Review options:** The provider can review a number of options from which the parent might choose, and discuss which options are most feasible. (Options are listed under Objective 3).

Keep in mind that not every child who has been affected by a traumatic experience will need a referral. In some cases, families may identify a concern that they and their child are already addressing. This is a good opportunity to see

if they have any questions and to offer to check in about this at the next visit, (as described more fully in theme 5).

Patients may already be in care for the identified problem. If so, you can ask about their care and see if they are satisfied or have any concerns. This way, you learn which services in the community are working well and which are not. If you find good services, reach out and partner with other providers who are providing services or care for the family (as discussed in theme 3).

### **PDSA Example Review Options for Care**

- Plan:** Plan to test asking parents to summarize the options for care you have presented.
- Do:** Have parents describe which ones are appealing and why. Try this with a few parents as a strategy to ensure that they are part of the planning team.
- Study:** Ask the parents how they felt when being asked to share this way. Get their feedback and input on effective ways to involvement without making them feel on the spot or tested.
- Act:** Use the parent feedback to modify communication with parents.

#### ***Strategy B: Discuss competing priorities and make plan***

The provider can help the family discuss and prioritize other stressors within the family. This step may raise awareness of other stressors that could be addressed or identify barriers to the family's seeking help. Some families will not feel ready for treatment—either psychologically or logistically. With these families, it is important to:

- ✓ Convey support
- ✓ Offer to help when they are ready
- ✓ Use motivational interviewing techniques to help convince the family to seek care now or in the future

It is important to note that responding to these cases is different from “wait and see” as you want to make a concrete follow-up plan

### **PDSA Example**

#### **Discuss Competing Priorities and Make a Plan**

- Plan:** Plan to test discuss care priorities with families.
- Do:** Try using a script to guide this conversation and document the families' responses.
- Study:** Get feedback from families on the conversation. Take note of how the structure and work flowed, whether you were able to achieve the outcome of making a plan, and what you would do differently next time.
- Act:** Use your observations and the feedback from the families to make changes to the processes and work flow.

### **Assess your Progress on Helping Families Develop Plan for Needed Care or Monitoring**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

#### ***Strategy A. Review Options for Care***

- How are treatment plans typically completed in partnership with families?
- How do providers currently identify options for intervention in partnership with families?
- What training do your providers need to conduct this type of collaborative planning?

#### ***Strategy B. Discuss Competing Priorities and Make Plan***

- How are competing priorities discussed with families?
- How are plans made in partnership with parents when there are competing priorities?
- How are benefits and challenges identified and weighed by providers and parents to inform these choices?

## **Additional Resources for Helping Families Develop Plan for Needed Care or Monitoring**

The resources listed below can be found in **Appendix F.2**

1. Pediatric Primary Care to Help Prevent Child Maltreatment: The Safe Environment for Every Kid (SEEK) Model (Dubowitz, Feigelman, Lane & Kim, 2009).
2. Optimizing the Early Parent- Child Relationships: windows of opportunity for parents and pediatricians (Shah, Muzik, & Rosenblum, 2011).

## Objective 3: Provide Services within Primary Care Practice

### Why is it important?

Depending on the case, PCPs may opt to provide brief counseling and treatment during the visit before or instead of referring the patient for specialty care. This could be for a number of reasons: the patient prefers not to see a specialist, the provider feels confident the in-office treatment will be helpful, or there are not community services available for the problem identified.

### What is involved?

Primary care practices can provide a variety of services addressing trauma-related problems, ranging from the PCP providing general information about child responses to traumatic stress and developmental guidance to referrals for specific evidence-based treatments. The selection of approach will depend on the child's needs and the provider's skills and comfort.

The PCP will work with the parents to determine which services are most responsive to their concerns and most likely to prevent escalation of any problems. The primary care providers should be aware of the interventions being offered by specialists in order to determine what approach might be most effective.

#### *Strategy A: Providing developmentally-keyed guidance*

Providing education about typical responses to trauma and stress at various developmental stages can reassure parents and increase their confidence in helping their children. It also helps them understand their child's behavior. Strategies to support development include:

- **Emphasize the importance of maintaining routines/relationships** as a way to stabilize children. Routines to consider include bed and mealtimes for children, regular parent-child time together, taking care of the household – cleaning, laundry, shopping – and visits with relatives or friends. Providers can ask families to think about what might be different since the trauma occurred or the stress has worsened. For example, providers can ask:
  - ✓ Are there changes that impact basic needs – such as where the family is living, changes to income, or the absence of someone on whom the family depends?
  - ✓ Are the adults in the family feeling and acting differently – are they distracted, worried, depressed, and possibly behaving differently toward each other and toward children in the family?
  - ✓ How have family routines changed? Has there been a loss of predictability or activities that children, in particular, had come to count on (such a time with parents)?

- **Support parental mental health:** Young children look to their parents for reassurance and comfort. Children’s post-traumatic problems may be triggered by changes in the emotions and actions of their adult caretakers. As noted in other sections, supporting parent self-care and, when needed, specific treatment can be helpful.
  
- **Review standard child behavior advice**
  - ✓ Acknowledge and name children’s emotions and then offering comfort
  - ✓ Find brief but stimulating activities to do together (reading, cooking, cleaning, following the child’s lead to play a game)
  - ✓ Trouble-shooting mealtime and bedtime issues
  
- **Follow-up:** The most important step is arranging for follow-up. Trauma and stress will not be “fixed” with a single consultation, and it can take time to develop trusting relationships in which the extent of the trauma and its meaning can be discussed. Whatever the initial treatment plan, make concrete plans to have either a return visit or telephone call.

***Strategy B: Implement evidence-based practices***

Generally, primary care providers may want to implement promising practices that have an accepted theoretical foundation, are manualized, are widely utilized, and have insignificant negative outcomes. For example, these may be useful for stress-related behavior, sleep, anxiety, depression, attention-control, endocrine problems, immunity, and nutrition/growth. (See Appendix F.3 for examples of evidence-based practices PCPs can consider implementing within their practice or via referral.)

## **Assess your Progress on Providing Services within Primary Care Practices**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

### ***Strategy A. Providing Developmentally-Keyed Guidance***

- What role do providers currently see themselves playing relative to trauma and mental health concerns?
- What training do providers have on general ways to address mental health concerns?
- What training, resources, or tools exist to help providers provide guidance to parents during the office visit?

### ***Strategy B. Implement Evidence-Based Practices***

- What evidence-based trauma practices do providers have the skills and knowledge to provide in the office?
- What knowledge do primary care providers have about evidence-based trauma care available in the community so that they can make effective and appropriate referrals?

## Additional Resources on Providing Services within Primary Care Practices

The resources listed below can be found in **Appendix F.3**

1. Addressing Adverse Childhood Events and Other Types of Trauma in the Primary Care Setting – AAP.  
*A brief introduction to reasons and strategies for incorporating trauma assessment and response into primary care.* Available at: [http://www.aap.org/en-us/Documents/ttb\\_addressing\\_aces.pdf](http://www.aap.org/en-us/Documents/ttb_addressing_aces.pdf)
2. Identifying, Treating, and Referring Traumatized Children (Cohen, Kelleher, & Mannarino, 2008).  
*This review emphasizes the role a pediatrician is well-positioned to fulfill in terms of identifying and treating traumatized children, and further describes optimal office-based interventions and community-based interventions for referral purposes.*
3. Improving the Management of Family Psychosocial Problems at Well-Child Care Visits (Garg et al., 2007)
4. Effects of a Primary Care-Based Intervention on Violent Behavior (Borowsky et al., 2004)
5. Pediatric Primary Care to Help Prevent Child Maltreatment (Dubowitz et al., 2009)
6. Policy Statement -- Mental Health Competencies for Pediatric Primary Care
7. Primary Care Services Promoting Optimal Child Development (Regaldo et al., 2001)
8. Physician-reported practice of managing childhood posttraumatic stress in pediatric primary care
9. The Current and Ideal State of Mental Health Training: Pediatric Program Director Perspectives
10. The Medical Home Approach to Identifying and Responding to Exposure to Trauma – AAP.

## Objective 4: Provide Referrals to Specialty Trauma Care and Manage Ongoing Treatment

### Why is it important?

The primary care provider can address not all patient concerns and problems. Indicators that a family might benefit from more specialized or intensive treatment include:

- The family would like it or feels that they benefited from it in the past
- Family members are struggling at home, work, school, or the community to carry out their day-to-day functions
- There is ongoing worry about personal safety
- Family members have mental health needs that can't be met by the primary care provider
- A referral might offer more comprehensive care in a more convenient form – for example, easier access to adult and child services, better links with social supports.

Referrals should always be discussed with parents (and adolescents). Parents may see this as a command or as an indication that the pediatric provider no longer wishes to be involved. The decision to seek additional care should be a joint one made with the family, and the referring provider should have an ongoing role collaborating in the family's care. Referring primary care providers can coordinate care at multiple sites and manage ongoing treatment so that patients have one provider who is overseeing their care and making sure they are receiving the treatment they need.

### What is involved?

#### ***Strategy A: Use warm hand offs with co-located mental health personnel***

When a mental health or behavioral health provider is located on site, this person provides a bridging role between primary care and specialty care. Ideally, having a co-located mental health provider will facilitate referrals, record sharing, and communication between providers, billing, and collaborative management of patient care.

Despite the advantages of co-location, it does not guarantee provider-to-provider communication, and it does not always improve patient willingness to follow through with referrals. It can also be a challenge for everyone in a clinical setting to understand what each other does and how to best access each other's expertise. Therefore, practices with co-located professionals must pay attention to these factors to ensure patient needs are addressed.

#### ***Strategy B: Coordinate referrals to community-based specialist***

If there is not a co-located mental health provider on site, then the primary care provider can make a referral to a specialist in the community. As discussed earlier in the section on collaboration, there are a number of challenges to

managing patient care when making referrals. It may be difficult to communicate with separate agencies, and primary care providers often don't know if the patient followed through with the referral or what treatment was provided. In some cases, the sharing of information or patient records is prohibited. It is important to develop relationships with specialty services in the community and develop systems of communication and information exchange that facilitate management of patient care. This is especially true when the referral is for a parent, requiring involvement of the adult mental health service system.

Providers should familiarize themselves with the local resources for behavioral health services, and what kinds of treatments are offered by these services. Knowledge of evidence based treatment resources will help the primary care provider identify the best place for the patient to go.

### **Assess your Progress on Improving Staff/Patient-Provider Communication**

Below are some key questions to help you assess how you are doing in each of the strategies in this objective.

#### ***Strategy A. Use Warm Hand Offs with Co-Located Mental Health Personnel***

- How do you help parents feel comfortable with co-located or in-office mental health specialists?
- How do you make introductions to co-locate or in-office mental health specialists?

#### ***Strategy B. Coordinate Referrals to Community-Based Specialists***

- How are providers connected to various community mental health providers (both pediatric and adult) and the kinds of interventions and evidence-based practice they provide?
- How do you coordinate referrals to these mental health specialists?

How do you manage ongoing treatment when external referrals are made?

## Additional Resources on Improving Staff/Patient-Provider Communication

The resources listed below can be found in **Appendix F.4**

### **Therapies**

1. Behavioral Interventions and Counseling to Prevent Child Abuse and Neglect (Selph et al., 2013)  
*This recent review found that risk factor assessment, behavioral interventions, and counseling in the pediatric setting all decreased child abuse and neglect. Home visitation interventions were also reviewed, with mixed results.*
2. NCTSN Knowledge Bank- Intervention and Manual
3. Comparative Effectiveness of Interventions for Children Exposed to Nonrelational Traumatic Events

### *Select links*

4. Circle of Security  
*This is an early intervention program designed to enhance secure attachment between parents and very young children. Secure attachment is generally linked to healthy child development. More information:*  
<http://circleofsecurity.net/resources/treatment-assumptions/>
5. Attachment and Biobehavioral Catch-Up (ABC)  
*This intervention is designed to help caregivers provide nurturing and structured care to children who have experienced maltreatment. More information:* [www.infantcaregiverproject.com](http://www.infantcaregiverproject.com).
6. Alternatives for Families: A Cognitive Behavioral Treatment (AF-CBT). .  
Available at: [www.afcbt.org](http://www.afcbt.org)  
*AF-CBT is an intervention designed for families with frequent conflict, anger/aggression difficulties, behavioral problems, harsh punishment, and other patterns related to trauma. This intervention specifically targets the child-caregiver relationship.*
7. Trauma-Focused Cognitive Behavior Therapy. *An evidence-based intervention that has been shown to help children, adolescents, and their caregivers overcome challenges related to trauma.* Available at:  
<http://tfcbt.musc.edu/>

### **Referral Templates**

1. Supplemental Appendix S11: Primary Care Referral and Feedback Form (Pediatrics)
2. Visit Discharge and Referral Summary for Family (AAP)