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

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We are especially grateful to the participants in the initial PICC Breakthrough Series (2013-14) and two subsequent Learning Collaboratives (2014-16). 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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SECTION I: 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 future Learning Collaboratives or (2) as a stand-alone guide to support the implementation of trauma-informed pediatric integrated care. We have intentionally called it a “toolkit” rather than a “guide” as we believe the content is rich with concrete tools you can use to support your implementation efforts.

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 implement 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. Following is a brief summary of each of the sections contained in this toolkit.
NOTE: Sections I, II, and III focus on the WHAT IS and WHY of trauma-informed care. Sections IV and V focus on the HOW you can get there.

<table>
<thead>
<tr>
<th>Section</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toolkit Overview</td>
<td>Describes the creation, purpose, audience, and organization of the toolkit</td>
</tr>
<tr>
<td>Section I. Trauma in Early Childhood</td>
<td>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</td>
</tr>
<tr>
<td>Section II. Key Factors in Pediatric Integrated Care</td>
<td>Provides an overview of the critical elements to implement integrated care</td>
</tr>
<tr>
<td>Section III. Trauma-Informed Integrated Care</td>
<td>Defines trauma-informed integrated care and explains why it is a goal, including example success stories from the previous Collaboratives</td>
</tr>
<tr>
<td>Section IV. Trauma-Informed Integrated Care Foundations</td>
<td>Discusses four key foundations of trauma-informed integrated care; includes how to make the business case for trauma-informed integrated care</td>
</tr>
<tr>
<td>Section V. Step-by-Step Guide to Implementing Trauma-Informed Integrated Care</td>
<td>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</td>
</tr>
</tbody>
</table>

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 a 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 and sustain them in their everyday practice.

This toolkit was developed from the collective input of participants in PICC’s Breakthrough Series Collaborative and two subsequent Learning Collaboratives. PICC began with a “Breakthrough Series Collaborative” (BSC) that ran from 2013-2014. The BSC encouraged participating teams from across the U.S. to test practical, sustainable processes of integrating trauma/chronic stress prevention, detection, and early intervention into primary care for young children. The ten 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 called Plan-Do-Study-Act cycles (PDSAs), 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.

In 2014-2015, ten 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 an updated version.

From 2015-2016, the final Learning Collaborative was conducted (LC2), and included six teams. These teams once again used the lessons learned and compiled in the Toolkit as a foundation, and deepened the work by focusing more deeply on prevention, resilience, and in-office interventions. The lessons learned from this cohort have also been incorporated into this version of the toolkit. (A complete list of teams that participated in the BSC, LC1, and LC2 is provided in Appendix A.)

Despite the fact that the practical work of twenty-six teams from across the country have informed the development of this toolkit, what you are holding now continues to be a work in progress. This toolkit may never be fully finished. In fact, 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. Wellness is more than the absence of disease or disorder. To support mental and behavioral wellness, we 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.
SECTION II: UNDERSTANDING CHILDHOOD TRAUMA

CHAPTER I. TRAUMA IN EARLY CHILDHOOD

IN THIS CHAPTER

- Childhood Trauma & Traumatic Stress Defined
- 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 family member, bullying, or medical procedures can also be traumatic.

What Is Child Traumatic Stress?
While many children experience one or more traumatic event, 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.

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](image)

**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 known that experiences can change the ways that genes regulate key processes within our bodies.

**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).
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.
Promoting Resiliency Through Early Intervention

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.

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 Section III, Element VI: 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>
<thead>
<tr>
<th>Program</th>
<th>Target Age</th>
<th>Impact</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Foundations</td>
<td>0-2</td>
<td>Antisocial-aggressive Behavior, Conduct Problems, Depression, Externalizing, Internalizing, Prosocial with Peers</td>
<td>A universal prevention program to improve mother, child, and birth outcomes through promoting co-parenting quality among couples who are expecting their first child.</td>
</tr>
</tbody>
</table>

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


- 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
II. TRAUMA-INFORMED INTEGRATED CARE

IN THIS CHAPTER:

- Trauma Informed Care Defined
- 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 caregivers.
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.

**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)

<table>
<thead>
<tr>
<th>Element of the CCM</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient self-management support</td>
<td>Develops patient skills through coaching, education, and problem solving. <em>(e.g. Psychotherapy and psycho-education to promote self-management and engagement in care)</em></td>
</tr>
<tr>
<td>Clinical information systems use</td>
<td>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; <em>(e.g. “patient portal” with ability for families to access and track their own information; update system with progress reports or follow-up surveys)</em></td>
</tr>
<tr>
<td>Delivery system redesign</td>
<td>Re-definition of physician and staff work roles to facilitate anticipatory or preventive rather than reactive care <em>(e.g. screening, discussing concerns, prevention counseling)</em></td>
</tr>
<tr>
<td>Provider decision support</td>
<td>Facilitated provision of expert-level input to generalists to reduce need for consultation separated in time and space from clinical needs <em>(e.g. telephone consultation services for primary care doctors or easy ways to contact specialists)</em></td>
</tr>
<tr>
<td>Community resource linkage</td>
<td>Support for family needs from resources outside the health care organization <em>(e.g. resource box in clinic for community support organizations)</em></td>
</tr>
<tr>
<td>Health care organization support</td>
<td>Organization leadership and tangible resources to support goals and practices of the CCM</td>
</tr>
</tbody>
</table>

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.
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 3. Levels and Degrees of Integration

<table>
<thead>
<tr>
<th>Degree of Integration</th>
<th>Organization</th>
<th>Facility</th>
<th>Records and Scheduling</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Separate</td>
<td>Separate</td>
<td>Separate</td>
<td>Sporadic</td>
</tr>
<tr>
<td>Basic distance</td>
<td>Separate</td>
<td>Separate</td>
<td>Separate</td>
<td>Periodic</td>
</tr>
<tr>
<td>Basic on-site</td>
<td>Separate</td>
<td>Co-located</td>
<td>Separate</td>
<td>?</td>
</tr>
<tr>
<td>Close partly</td>
<td>Same</td>
<td>Co-located</td>
<td>Some shared</td>
<td>Regular</td>
</tr>
<tr>
<td>Close fully</td>
<td>Same</td>
<td>?</td>
<td>Shared</td>
<td>Team meetings</td>
</tr>
</tbody>
</table>

Adapted from Doherty (1995)
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 will the specialist 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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Pitfalls</th>
</tr>
</thead>
<tbody>
<tr>
<td>“One stop shopping” 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</td>
<td>Does not ensure communication: 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</td>
</tr>
<tr>
<td><strong>Reduce stigma:</strong> 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</td>
<td>Diverts responsibility: 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</td>
</tr>
<tr>
<td><strong>Personalized referrals:</strong> Offers the opportunity for personalized referrals – specialist and generalist providers can meet together with a family to jointly plan how they will work together</td>
<td>Overload specialists’ capacity: 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)</td>
</tr>
<tr>
<td><strong>Increase consultations:</strong> 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</td>
<td>Budget: 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</td>
</tr>
</tbody>
</table>
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? 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

<table>
<thead>
<tr>
<th><strong>Universal screening in primary care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider and patient agree that there is an issue</td>
</tr>
<tr>
<td>They work to develop a shared understanding of why the issue requires help and why now is a good time to act</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Identification of a specific problem</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What might the patient do about the problem now – including seeking more specialized treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Brief counseling specific to the problem</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Many patients may not immediately want to seek care</td>
</tr>
<tr>
<td>b) Even those who seek additional care may give it up</td>
</tr>
<tr>
<td>c) Many problems are recurring, even if successfully addressed in the short term</td>
</tr>
</tbody>
</table>

### 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.
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 caregivers for modeling and rewarding positive behavior.

- **Modify diagnostic process**

---

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

<table>
<thead>
<tr>
<th>Motivation/promising aspects</th>
<th>Drawbacks/challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of specialists</strong></td>
<td>If there are long wait times for specialist care, task shifting can help address the lack of specialists.</td>
</tr>
<tr>
<td><strong>Reduces barriers to access</strong></td>
<td>Moving the services to the place where they are needed or where clients are more comfortable receiving them reduces the barriers to accessing care.</td>
</tr>
<tr>
<td><strong>Possible reducing costs</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Knowledge of families</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
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.
Core Readings and Resources


III. PRINCIPLES OF PEDIATRIC INTEGRATED CARE

IN THIS CHAPTER:

- Use a team based approach.
- Involve families and communities.
- Use data to monitor progress.
- Where possible build on existing capabilities rather than starting 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 principles for creating integrated care for all patient populations. These insights stem from the challenge of making change in any system that involves human interactions around complicated and sometimes emotion-laden issues.

The following five ingredients 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 wants and will use.

**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 input need to inform tools, policies, and practices. In addition, family or client/patient feedback can be powerful tools for change within organizations. Families can also serve as champions for the program.

There are many ways to engage with families to elicit feedback and collaborate with community organizations. Specific strategies are outlined in Section III,
Element II: Providing Family Informed Services. Throughout this toolkit we will talk about the closely related need to be family and caregiver-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, make adjustments, or move to a larger scale.

Meeting the Needs 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 treatment.

**Adapting Materials to Fit Specific Populations**

Each clinic has a unique setting and therefore the most successful idea from one site may 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>
<thead>
<tr>
<th>Issues Related to:</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| Adaptating content to patients & populations served | Extent of cultural and linguistic diversity likely to be encountered  
Coverage of mental health topics as it relates to local needs and priorities based on clinical data (versus staff perceptions)  
Manifestations of clinical problems described match local language and idioms of distress  
Selection of mental health topics and treatments tailored to local treatment resources (including medications available)  
Locally-relevant variation in the prevalence of related somatic conditions (both as co-morbidities and as causes of mental health problems)  
Within each symptom/condition cluster:  
Suggested case-finding and outcome measurement questions and tools appropriate to local language, culture  
Menu of possible brief interventions chosen for appropriateness |
| Structure & culture of the health care system | Visit characteristics – length, expectations of patients and providers, usual communication style; who, in addition to the patient, usually comes to the visit  
Physical settings available for visits – relative privacy, possibilities for safety  
Possibilities for follow-up visits related to cost, distance  
Availability of complementary and competing community resources (including traditional care)  
Extent of specialist mental health consultation likely to be available |
| Training staff & clinicians               | Making training materials accessible (technical level, language, pace, format) to varying staff levels  
Adapting training topics to coordinate with other training and capabilities that might be available  
Shifting the order or emphasis of coverage of topics to be responsive to local priorities as perceived by staff  
Developing training case examples that reflect local populations and providers  
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  
Understanding clinical culture with regard to training or working in teams with clinicians from other professional backgrounds or levels |
Sustainability 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

<table>
<thead>
<tr>
<th>LADDERS</th>
<th>Guiding Questions</th>
</tr>
</thead>
</table>
| 1. Leadership | Who are the leaders we need on board?  
What do we need them to do?  
How can we help them do it?  
What would happen if a key leader leaves? Is there a broad base of champions? |
| 2. Agency Fit and Capacity | 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?  
What resources are needed to do this, in terms of technology, documentation, or internal infrastructure, and how will these resources be obtained? |
| 3. Documentation | How will this work be documented, managed, and monitored to ensure it occurs consistently and with the desired intent?  
Can this documentation be built into existing systems of reporting or patient care (for example, easily extracted from electronic medical records) |
| 4. Data | What data will be collected to monitor the fidelity of this work and how will they be used?  
Can data relating to these efforts be made part of routine monitoring or feedback to providers or clinical sites? |
| 5. Expectations | What will happen as leadership changes, staff turns over, technology changes, or fidelity begins to drift?  
Are there realistic expectations about how long change will take, how soon results will be apparent or how big an impact will be seen? |
| 6. Replacement (Integrate the Integration) | Most of all, how will the new program make existing burdens lighter and benefit seemingly unrelated programs?  
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? |
| 7. Staffing | What staff is needed to do this work and how are they being prepared to do it?  
If existing staff are being given new roles, have they been involved in the process and do they see the new roles as positive?  
How will ongoing needs for training and supervision, be assessed and met?  
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? |

Adapted from Agosti (2014)
Core Readings and Resources


- Glasgow RE, Lichtenstein E, Marcus AC. Why don’t we see more translation of health promotion research into practice? Rethinking the efficacy-to-effectiveness transition. AJPH 2003;93:1261-67.


IV. DEFINING PRIORITIES

IN THIS CHAPTER:

- Define goals around trauma-informed integrated care.
- Assess readiness.
- Implement 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

<table>
<thead>
<tr>
<th>Rationales</th>
<th>Goals</th>
</tr>
</thead>
</table>
| Increase access to behavioral health services /number served | → Better detection of mental health trauma  
   → Less loss from referral to follow-up  
   → Reduce disparities, equalize opportunities for access to quality care |
| Increase quality                                     | → More expert service at point of first access and ongoing  
   → Reduced time to service once in system  
   → Better match of need to referred service |
| Increased choice/better fit with patient preferences  | → Family satisfaction with point of entry, place of care, locus of coordination  
   → Reduction in “no-show” or treatment drop-out rates |
| Improved clinical outcomes                           | → At the individual level  
   → At the population level |
| Reduction in costs attributable to:                  | → Delays in receipt of any or optimal treatment  
   → Inappropriate or avoidable use of emergency facilities or inpatient stays  
   → Use of expensive medications when there are alternative psychosocial or medication therapies  
   → Disruption to unrelated services  
   → Low rates of provider productivity because of missed appointments or premature termination of treatment  
   → Time lost from work (among patients and staff) |
| Reduction in future illness, disability, and suffering through prevention and early intervention | → Better coordination with community services and linking patients to community resources  
   → Greater proportion of children participating in Early Head Start or pre-K programs  
   → Greater proportion of children considered ready for primary school at the appropriate age |

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 elements prioritized by your team.

How to Implement Change through PDSA Cycles

Although this work is comprehensive, as described in the next chapter, it is not about making a massive one-time change that will take years to plan. Instead it is about developing effective practices and tools in your clinic that are realistic for you, your staff, and your families.

In order to ensure the practices and tools will be effective and have the results you want, we encourage teams to begin testing changes on a small scale using the Plan-Do-Study-Act / Adjust (PDSA) method. This method uses a series of very small, systematic, and rapid steps that allow you to gain valuable learning and knowledge as you continually improve the practice or process and let it grow and spread in natural ways that will be able to be sustained.

There are many benefits of implementing changes using PDSAs. First, PDSAs rely on an inclusive change process. Those who are closest to the work (including front desk staff, medical assistants, care coordinators, patient navigators, family advocates, providers, etc.) come up with their own ideas of what they’d like to do and then try them out. This is the opposite of organizational change that originates in a meeting room far from where providers interact with actual patients and changes are “rolled out” via email, policy change, or memorandum.

Second, because the tests are done first on a very small scale (with one family or one provider) results of the test are available quickly. There is no need to wait for a month – or even a week – before knowing if the idea is promising.

Third, many ideas can be tested simultaneously, as various team members can try the ideas that resonate with them most. This empowers team members and other staff to do what they know best, take initiative, and apply their own expertise to areas they want to improve.
Fourth, the successes and lessons learned even from these small tests are powerful motivators in bringing others on board. Rather than trying to convince a colleague that an idea has merit in concept, you have experience and some data to share about what it actually might look like in practice. This offers 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 real data, rather than assumptions. For example, instead of spending months around a table debating the merits of various screening tools, or guessing which one might work best, you can simply try out the leading candidates with a few families who are willing to give you their opinions. This feedback can then help move your decision-making to the next stage, which is often to make some adjustments and, again, do a quick test of the revised version.

And fifth, the lessons learned when testing on a small scale first have minimal impact on the rest of the organization in terms of time and cost. The entire program or clinic isn’t required to shift to a major new tool, method, or practice all at once before you have a very high level of confidence that it will actually work in your organization.

We have learned that PDSAs work best when you decide ahead of time what questions you are trying to answer. It helps to formulate a hypothesis about what you think might happen. And then 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. 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, based on family and provider feedback. The higher-level data you will want to review might include whether the tool is effective in promoting the assessment of children’s behavior during primary care visits (how often it’s getting used), how providers are using the information, and whether the tool improves caregiver interest in behavioral and emotional issues. While the “S” (Study) for the first small cycle may be primarily qualitative and anecdotal in nature (e.g., Did the caregiver understand the questions? How long did it take to administer? Was there anything missing from the questions asked?), the data that is collected as part of the study also grows as more cycles are tested. Thus, as a PDSA cycle moves from a small initial test to full implementation, your study phase will become more intensive and evaluative. Before you decide to make something standard practice, you will want to be certain that it is resulting in true improvements based on clear data and outcomes.
When using PDSA cycles, it is essential to realize that they are not intended to be once-and-done tests. Instead, teams use PDSA cycles in which each “A” (Act or Adjust) becomes the “P” (Plan) for the next cycle. In doing this, each subsequent cycle becomes slightly larger, involving more families or more providers. This expansion that occurs as the learning is continually applied helps ensure that the idea has merit across a variety of conditions, audiences, and providers. Moreover, it allows you to work out any “kinks” in the process along the way, further increasing the likelihood of being able to replicate and sustain the work.

Most teams will not start PDSAs on all elements at once. We suggest you consider starting with PDSAs that create “ah-ha” moments, focusing on elements that 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 element of the Collaborative Change Framework, there are Change Strategies you can test using PDSAs. Below is a PDSA guide to help your team move from a broader Change Strategy to a PDSA that you could “test by next Tuesday.”
Table 10. Steps for Planning and Implementing PDSAs

<table>
<thead>
<tr>
<th>PLAN</th>
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<tbody>
<tr>
<td><strong>What is the goal for this PDSA cycle?</strong></td>
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<tr>
<td><strong>What do you predict will happen?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What is the plan for the cycle? What are the steps to execute the cycle, including data collection (who, what, where, when)?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DO</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Carry out the cycle. In brief terms, did it work as you expected?</strong></td>
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</table>

<table>
<thead>
<tr>
<th>STUDY</th>
<th></th>
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<tbody>
<tr>
<td><strong>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.</strong></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ACT / ADJUST</th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What actions are you going to take as a result of this cycle? (Check one)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapt the Test</td>
<td>Expand the Test</td>
<td>Abandon the Test</td>
<td></td>
</tr>
<tr>
<td><strong>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?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 other improvement strategies as we move step by step through the Collaborative Change Framework elements in chapter five.
SECTION III: THE TOOLKIT

Toolkit Overview

The Collaborative Change Framework (CCF) was designed by a multi-disciplinary, inclusive group of experts to serve as the foundation for the first Breakthrough Series Collaborative. The goal of the CCF was to identify the key areas in which teams would need to do work in order to achieve trauma-informed integrated care for children and families exposed to trauma or chronic stress. This chapter reviews six elements in the Collaborative Change Framework (CCF) with a focus on how to translate these elements into concrete and sustainable practice in everyday work. To support customization and honor the unique strengths and needs of each clinic, organization, agency, and community, each section begins with a brief narrative explaining the CCF element’s importance and ingredients necessary for implementation. Possible strategies that you could consider testing or adapting in your own site are included as well to further translate the elements and change concepts into small tests of change (PDSAs). At the conclusion of each element section, you will find a list of resources, references, and documents for more information. These are organized by goal, whenever possible, as well as by resource type. Thus, for each section, you will see the following:

- **ELEMENTS** are the overarching themes in the CCF

- **GOALS** outline specific objectives under each ELEMENT

- **CHANGE CONCEPTS** clarify the mechanisms through which GOALS are achieved

- **CHANGE STRATEGIES** test CHANGE CONCEPTS through Small Acts of Change (PDSAs)
The Collaborative Change Framework is divided into six **ELEMENTS**. Although these elements are inter-related and inter-connected, for the purposes of the LC they have been separated into distinct areas as a way of organizing implementation into manageable pieces. Some elements are relatively specific to trauma/chronic stress, but others could apply to all interactions in the primary care setting. For example, practices that have already committed to attaining “medical home” status may find that they have already built mechanisms to address several of these elements, though perhaps not with some specific trauma/stress or early childhood emphasis. Under each element is a brief list of more specific areas in which changes may be tested by participating teams to achieve the goals of this LC. These areas are intended to provide guidance, but not specific steps to take, as the specific steps will be determined by each individual site based on its unique organizational strengths, needs, and challenges. These elements are:

1. **Oe**
   - Office Environment
2. **Fi**
   - Family Involvement
3. **Cc**
   - Coordinate & Collaborate
4. **Pr**
   - Promote Resilience
5. **As**
   - Assess Health Issues
6. **Ad**
   - Address Health Issues
GOALS outline specific objectives in service of each ELEMENT. The goal for anyone striving to achieve the overall mission of this work is to implement these goals in ways that are appropriate for the individual providers, agencies, and families being served. Thus, strategies for implementation will differ depending on your practice and the patient population. As you move through the toolkit, you’ll find a number of goals that have been identified under each of the six elements. Each goal will be introduced with by a brief narrative explaining its importance, what it involves (the change concepts), and possible strategies that you could consider testing or adapting in your own site (PDSAs). Last, you’ll find questions to help you assess your progress toward achieving the overall goal.
CHANGE CONCEPTS clarify the mechanisms through which GOALS are achieved. A change concept is an idea that has been found useful in transforming goals into specific strategies to achieve your goals. A team may desire to make their office environment trauma-informed but what exactly does that entail? Change concepts are intended to stimulate reflection about the changes in office workflow and culture that would indicate a positive transformation towards becoming trauma-informed.

GOAL 1. COMMUNICATE WITH FAMILIES IN RESPECTFUL, OPEN, SUPPORTIVE WAYS

- Engage Families at the Start of the Visit
- Build Patient Comfort and Trust

Improving communication with families, educating staff and partners, and creating a healthy office environment are all goals that remain somewhat abstract. Change concepts can be used to break goals down into more specific targets by identifying mechanisms for change that can be further parsed into small tests of change. To achieve respectful, open, and supportive communication with families, teams must develop hypotheses about the mechanisms that will bring about good communication. Engaging families from the start of the visit is not yet a strategy but it focuses team attention on one way to strengthen communication with families.
CHANGE STRATEGIES are used to test CHANGE CONCEPTS through small acts of change. For each change concept, there are many strategies that can be tested and ultimately implemented. We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. You may notice that many strategies cross over multiple element areas. We have tried to place them in the single “best fit” theme to minimize duplication, providing cross-references to other sections where possible. Of course, the distinctions are sometimes artificial, but conceptual clarity can feed real improvements in practice. Change strategies demonstrate how you might consider testing and ultimately implementing change in your own daily work.

1.1.A. ENGAGE FAMILIES AT THE START OF THE VISIT

1. GREET EVERYONE

2. BE SELF-AWARE

3. DEVELOP SUPPORTIVE TECHNQUES
Important Note on the Collaborative Change Framework

We also want to note that in U.S. healthcare, the separation of child and adult care can make it particularly hard to provide care to families. Caregivers 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 families 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 caregivers. 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 caregivers to needed services.

Thus, throughout the Collaborative Change Framework, we use the language of “patients,” “caregivers,” 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. This multi-generational approach is yet another critical aspect of becoming a trauma-informed integrated care practice.
ELEMENT I: 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, and improves staff knowledge of trauma and its impact on families. The trauma informed office encourages better staff-staff and staff-family communication and a welcoming environment will improve patient engagement, satisfaction, and ultimately clinical outcomes.

GOAL 1: Communicate with Families in Respectful, Open, Supportive Ways

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. Developing authentic, respectful, open relationships with patients and families in ways that respect their life experiences is at the core of trauma-informed work.

Goal 2: Educate Staff and Partners about Trauma and Trauma-Informed Care

Educate staff (at all levels), as well as partners, about the prevalence of trauma in children, families, and communities and its impact on behavior and health and about factors that promote resilience and recovery from traumatic events. Again, this includes recognition of possible trauma experiences of fellow staff members, and of the impact of working with families with their own trauma experiences.
Goal 3: Create and Support a Healthy Office Environment

Ensure that the office environment is welcoming, promotes emotional wellness for staff and families, and respects families of different backgrounds and cultures.
Goal 1. Communicate with Families in Respectful, Open, Supportive Ways

Why Is This Goal Important for Trauma-Informed Integrated Care?

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.

Caregivers’ 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. Caregivers who have experienced abuse or neglect as children, discrimination, economic insecurity, or emigration may be more concerned than other caregivers 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 caregivers and avoid misunderstandings that deter families from seeking help.

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 caregivers 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 caregivers.
• **Improve identification of mental health issues** – When patients and families feel comfortable expressing mental health concerns, providers can better identify and address these issues.

This goal encompasses two key change concepts: A) engaging families at the start of the visit; and B) building comfort and trust with families. As soon as a family walks into the office, there are numerous ways to welcome them and convey respect and sincere interest. 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 these families feel welcome and empowered. *All staff and providers* can help engage families at the start of the visit. And as an essential part of this, 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.

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. The strategies listed below are based on the work of participating Collaborative teams along with other work going on nationally related to trauma-informed integration. While we have tried to be comprehensive with our ideas, this list is by no means exhaustive.
Change Concept A. Engage Families at the Start of the Visit

As soon as a family walks into the office, there are numerous ways to welcome them and convey respect and sincere interest. 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 these families feel welcome and empowered. All staff and providers can help engage families at the start of the visit. And as an essential part of this, 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.
Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.

<table>
<thead>
<tr>
<th>Change Concept A. Engage Families at the Start of the Visit</th>
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<tbody>
<tr>
<td><strong>Change Strategies</strong></td>
<td><strong>Small Tests of Change</strong></td>
</tr>
<tr>
<td>Greet everyone</td>
<td>→ Use patients’ names during conversations and greet them individually.</td>
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</tbody>
</table>
| 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. |
| 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. |
Change Concept B. Build Comfort and Trust with Families

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical, specific and testable – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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<tr>
<th>Change Concept B. Build Comfort and Trust with Families</th>
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<tbody>
<tr>
<td><strong>Possible Strategies</strong></td>
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</table>
| **Build comfort**       | → Remind the family that they are in control by seeking their permission to ask questions or to make a suggestion. 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 caregivers what they do to sustain themselves.  
→ Ask what caregivers 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. streamlining scheduling 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 caregiver, 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 family 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th>Serious Concerns/Challenges</th>
<th>1</th>
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<th>3</th>
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<th>5</th>
<th>Very Strong, Positive</th>
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**Change Concept A. Engage Families from the Start of the Visit**

- What communication approaches are being used by frontline staff to greet and engage patients/families?
- What communication trainings are offered to staff?
- How do families understand staff roles (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?

**Change Concept B. Build Comfort and Trust**

- What communication approaches are 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?
Goal 2. Educate Staff and Partners about Trauma and Trauma-Informed Care

Why Is This Goal Important for Trauma-Informed Integrated Care?
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 need 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.

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.

This element relies on four change concepts: 1) provide education to all staff about the impact of trauma on families and children; 2) help staff and providers understand the importance of addressing trauma-related problems in primary care; 3) help staff and providers understand the importance of working with both children and their caregivers to adequately care for the child; and 4) help staff and providers understand the importance of being sensitive patients’ cultural and racial backgrounds.
Change Concept 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 widespread. Training about trauma must emphasize that each individual (depending on ethnicity, culture, past experience of discrimination, trauma, and resilience) 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

Change Concept B. Understanding 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
Change Concept C: Understanding the Importance of Working with Both Children and Their Caregivers to Adequately Care for the Child

The mental health and experiences of caregivers/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’ family members about their own potential and actual traumatic experiences. Trainings on the importance of working with families can include the following training components:

- Connection between caregiver mental health and caregiving capacity
- Connection between 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

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to translate change concepts A, B, or C. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.

- Have formal staff training days
- Share educational materials at staff meetings
- Use staff newsletters, bulletin boards, and communications
- Have optional or informal times for discussion
Implementing Change Strategy through Small Tests of Change (PDSAs)

For all of these change concepts, there are clearly limitless changes that can be tested and ultimately implemented, as evidenced by the long list above. We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

<table>
<thead>
<tr>
<th>Change Concepts A, B, and C. Provide Education to All Staff</th>
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<tr>
<td><strong>Possible Strategies</strong></td>
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<tr>
<td>Have formal staff training days</td>
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Change Concept 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 persons of other races and cultures
- Knowledge of patients’ racial and cultural background
- Importance of being sensitive to a patient’s race and culture
- Understanding of implicit bias, micro aggressions, historical trauma, personal biases, institutional racism, and structural/systemic racism
- Important role of primary care in preventing and treating trauma

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to test change concept D. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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

| Change Concept D. Help Staff and Providers Understand the Importance of Being Sensitive to Patients’ Cultural and Racial Backgrounds |
|---------------|----------------------------------------------------------------------------------|
| **Possible Strategies** | **Specific Ideas to Test** |
| 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

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**Change Concept 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?

**Change Concept 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?

**Change Concept 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?

**Change Concept 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?
Goal 3. Create and Support a Healthy Office Environment

Why Is This Goal Important for Trauma-Informed Integrated Care?

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. It is therefore essential to recognize and address the emotional needs of all staff.

This goal includes three change concepts: 1) set the tone in the office; 2) provide materials to underscore the importance of psychological health; and 3) recognize and address self-care needs of staff.
Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to test change concept A. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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<tr>
<td>Possible Strategies</td>
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| Make the office inviting | → Use fun colors.  
→ Have interactive materials for children.  
→ Have materials for caregivers (see Strategy B).  
→ Reflect the communities and families served in terms of posters, books, toys, languages used.  
→ Play calm, welcoming music. |
| 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. |
Change Concept 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

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to test change concept B. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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

| Change Concept B. Provide Materials to Underscore the Importance of Psychological Health |
|-----------------------------------------------|-----------------------------------------------|
| Possible Strategies                           | Specific Ideas to Test                          |
| 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 caregivers (normalizing the process) and use them as opportunities for conversation.  
   ➔ Do talk-backs with caregivers 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. |
Change Concept 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).

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to test change concept C. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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community to get a sense of what strategies they find most engaging, supportive, and respectful.

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<thead>
<tr>
<th>Change Concept C. Recognize and Address Self-Care Needs of Staff</th>
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<tbody>
<tr>
<td><strong>Possible Strategies</strong></td>
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</table>
| Survey staff | → Invite regular feedback from staff on compassion fatigue, secondary traumatic stress, and burnout.  
→ Have staff complete compassion fatigue “tool,” such as the ProQOL.  
→ 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

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<tr>
<th>Serious Concerns/Challenges</th>
<th>Very Strong, Positive</th>
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**Change Concept 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?

**Change Concept 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 caregiver-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?

**Change Concept 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?
Element I: For More Information

Goal 1. Communicate with Families in Respectful, Open, Supportive Ways
The resources listed below can be found in Appendix A.1. The resources below include references, guidelines, and tools that may be helpful as you test ideas in this area.

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, McKibbon, AK)
3. Communicating With Children and Families - From Everyday Interactions to Skill in Conveying Distressing Information

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

Goal 2. Educate Staff and Partners about Trauma and Trauma-Informed Care
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
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: PowerPoints**
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 Americas*
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

**Goal 3. Create and Support a Healthy 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
ELEMENT II. INVOLVING FAMILIES

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 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.

Goals and Strategies for Creating Family-Informed Services and Support/Resources

Goal 1: Develop systems and policies that support family involvement.

Goal 2: Involve families in service delivery planning, implementation, and evaluation
Goal 1. Develop Systems and Policies to Support Family Involvement

Why Is This Goal Important for Trauma-Informed Integrated Care?
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.

This goal includes two change concepts: 1) developing formal / informal documents to support family involvement; and 2) providing orientation for staff and caregivers.

Change Concept A: Develop Policies and Practices 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.
Below, you will see examples of how this change concept could be tested as concrete strategies. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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

- Support Caregiver Involvement
- Include in Staff Job Descriptions
- Develop Reimbursement Policies for Families
- Ensure Active Leadership Support for Family Involvement
<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State your commitment to support caregiver involvement</strong></td>
<td>➔ Include language about the office commitment to family involvement in office goals, value statement, or missions.</td>
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<tr>
<td></td>
<td>➔ Make these commitment statements visible, e.g., on all practice documents, as posters in the office, etc.</td>
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<td></td>
<td>➔ Ensure that all staff know about this language and caregiver involvement as a value.</td>
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<td></td>
<td>➔ Include family partners in the development of these commitment statements.</td>
</tr>
<tr>
<td><strong>Include in staff job descriptions</strong></td>
<td>➔ Include mention of staff roles in helping family team members (e.g., buddy role, reminder calls, confirmation of child care needs, transportation, preparing caregivers before meetings, etc.) in staff job descriptions.</td>
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<tr>
<td></td>
<td>➔ Include families and providers in helping craft the language for these staff roles.</td>
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<td></td>
<td>➔ 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.”</td>
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<tr>
<td></td>
<td>➔ Ensure that staff are clear about these roles and connect them to the values of family involvement.</td>
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<tr>
<td><strong>Develop clear reimbursement policies for families</strong></td>
<td>➔ Allocate or dedicate funds to support family involvement.</td>
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<td>➔ Include specific guidelines on reimbursement for caregiver/family volunteer expenses (e.g., gas, tolls, transportation, meals, stipends, and child care).</td>
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<td>➔ Ensure that the reimbursement methods are simple for families to use (see Appendix B.2; Caregiver Compensation).</td>
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<tr>
<td><strong>Ensure active leadership support for parental involvement</strong></td>
<td>➔ Involve leaders to ensure that staff have dedicated time to support families.</td>
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<td>➔ Make sure that families are included at the leadership level in meetings, on teams, and in decision-making.</td>
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<td>➔ Ensure that the involvement of families is validated and celebrated in visible ways.</td>
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</table>
Change Concept B: Provide Orientation for Staff and Caregivers

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 families up front:

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

Moving from Change Concept to Concrete Strategy

Below, you will see examples of how this change concept could be tested as concrete strategies. Each of these possible strategies is detailed further – making them even more practical and specific—in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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<th>Change Concept B. Provide Orientation for Staff and Caregivers</th>
<th>Specific Ideas to Test</th>
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</thead>
<tbody>
<tr>
<td><strong>Possible Strategies</strong></td>
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</tr>
<tr>
<td>Orient caregivers to the organization</td>
<td>→ Give family advocates an orientation to the organization itself. Include a tour and introductions to key individuals they may not have already met.</td>
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<td></td>
<td>→ 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.</td>
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<td></td>
<td>→ 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.</td>
</tr>
<tr>
<td>Orient caregivers about their role at the agency/system level</td>
<td>→ Reinforce the importance and value of family voice, perspective, and expertise. Use language like “lived experience” to validate what family advocates bring to the table.</td>
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<td></td>
<td>→ Help family advocates understand how to handle personal information – both the family advocate’s and that of other clients or patients.</td>
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<tr>
<td></td>
<td>→ Remind caregiver advocates that they do not need to share their story or experience unless they truly want to – and this decision may change with the group and the situation.</td>
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<td></td>
<td>→ Provide clear descriptions to family advocates about their role (see goal below for more details).</td>
</tr>
<tr>
<td>Orient staff about the role of family advocates at the agency/system level</td>
<td>→ Organize a “reverse” orientation in which family advocates or community representatives set up visits to key community sites or organizations.</td>
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<td></td>
<td>→ 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.</td>
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<td></td>
<td>→ Invite family advocates to talk directly to staff about their roles in their own words.</td>
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</table>
Assessing Your Progress
As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

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<thead>
<tr>
<th>Serious Concerns/Challenges</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>Very Strong, Positive</th>
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**Change Concept 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?

**Change Concept B. Provide Orientation for Staff and Caregivers**
- 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 family involvement?
- How is staff trained and supported on how to best work with family partners?
Goal 2. Involve Families in Service Planning, Implementation, and Evaluation

Why Is This Goal Important for Trauma-Informed Integrated Care

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 or develop 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.

This goal includes four change concepts: A) clarify caregivers’ role within the organization; B) recruit families who are ready and interested; C) prepare family advocates; and D) encourage ongoing recruitment and provide support for continued involvement.


**Change Concept A: Clarify Caregivers’ 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.

**Moving from Change Concept to Change Strategy**

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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

### Change Concept A. Clarify Caregivers’ Role within Organization

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<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
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<tbody>
<tr>
<td>Assist with staff training</td>
<td>→ Invite families to provide their input on what should be incorporated into staff training.</td>
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<td></td>
<td>→ Have them help deliver content to staff directly -- personal narratives from families can demonstrate the need/effect of protocols and interventions on patients.</td>
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<tr>
<td>Engage as team member for specific project</td>
<td>→ Invite family members to be part of teams for specific projects, such as a Learning Collaborative or community outreach campaign. Remember that this may require flexibility about the timing and location of meetings.</td>
</tr>
<tr>
<td>Test and Assess PDSAs</td>
<td>→ Encourage family team members to help select, design, and test tools, resources, materials, process, and practices (e.g., script for talking with caregivers about resilience, poster in the waiting room, screening tool, caregiver satisfaction survey).</td>
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<td>→ Ask families for impressions and observations as part of the “Study” of the PDSA when the small changes are tested.</td>
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<td>Participate as Board Member</td>
<td>→ 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; Caregiver Advisory Board).</td>
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<tr>
<td>Advocate for programs with funders/policy makers</td>
<td>→ Engage parent advocates to advocate for your program with organizational leadership, funders, and policy makers.</td>
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<td>→ Help family advocates tell their personal stories and testimony in ways that augment the data, facts, and figures you may already have.</td>
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<td>→ Encourage family advocates to take a lead role in identifying individuals and organizations that may be important to support and sustain your work.</td>
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Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to recruit families who are interested and ready. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your
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<tr>
<th>Change Concept B. Recruit Families Who Are Ready and Interested</th>
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<tr>
<td><strong>Possible Strategies</strong></td>
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<tr>
<td>Think broadly in your outreach efforts</td>
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<tr>
<td>Seek out family members who express interest</td>
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Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to prepare family advocates. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
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</table>
| 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. |
Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to prepare family advocates. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
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<tbody>
<tr>
<td>Look for potential new family advocates</td>
<td>→ Ensure that you have multiple positions allocated and that the position(s) are filled.</td>
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<td>→ Ensure that there is more than one caregiver 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, ensures that multiple voices, perspectives, and experiences are represented, and guarantees substitutes when people move on.</td>
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</table>
| 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 caregiver 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th>Serious Concerns/Challenges</th>
<th>Very Strong, Positive</th>
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</thead>
</table>

**Change Concept A. Clarify Caregivers’ 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?

**Change Concept 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?

**Change Concept 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?

**Change Concept D. Encourage Ongoing Recruitment and Provide Support for Continued Involvement**
- How are you engaging in ongoing recruitment of family partners?
- If you already have caregiver partners, how do you support them in using their experiences and expertise to enhance your work?
Element II. For More Information

**Goal 1. Develop Systems and Policies that Support Family Involvement**

The resources listed below can be found in [Appendix B.1](#).

**Caregiver Compensation**

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

**Caregiver Feedback Forms**


**Toolkits**

1. Strategies to Increase Birth Parent Engagement – *Foster Care*
2. Family Engagement Resources – *Foster Care*
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 goals 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:*
8. NAMI Family Guide- Integrating Mental Health and Pediatric Primary Care

Goal 2. Involve Families in Service Planning, Implementation, and Evaluation

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

Caregiver Advisory Board

1. Parent Advisory Groups in Pediatric Practices: Parents’ and Professionals’ Perceptions (Young, McMenamy, & 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
ELEMENT III: Collaboration and Coordination of 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.

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

**Goal 2:** Provide coordinated, integrated care
Goal 1: Develop Partnerships with Specialists Providing Trauma Services

Why Is This Goal Important for Trauma-Informed Integrated Care?

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 over time are discussed below.

This goal includes three change concepts: A) identify potential partners and have introductory meeting; B) develop communication systems between collaborating providers; and C) sustain and strengthen partnerships over time.
Change Concept A: Identify and Meet with Potential Partners

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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to identify and meet with potential partners. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

<table>
<thead>
<tr>
<th>Identify Families' Needs</th>
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<tr>
<td>Identify Providers Of Services</td>
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<tr>
<td>Understand Access Issues</td>
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<td>Provide Cross-education</td>
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<td>Ensure Clarity About Expectations And Opportunities</td>
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Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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

<table>
<thead>
<tr>
<th>Change Concept A. Identify Potential Partners and Have Introductory Meeting</th>
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<tr>
<td><strong>Possible Strategies</strong></td>
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<td>Ensure clarity about expectations and opportunities</td>
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</table>
Change Concept B: Develop Communication Systems Between Collaborating Partners

There are four key elements of partnership and coordinated care: 1) knowledge of partner’s service; 2) cultivating trust in partner’s clinical performance; 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to develop communication systems between collaborating providers. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

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<tr>
<td><strong>Possible Strategies</strong></td>
</tr>
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</table>
| Cultivating trust in partner’s clinical performance | ➔ 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. |
SUSTAIN AND STRENGTHEN PARTNERSHIPS

Change Concept C: Sustain and Strengthen Partnerships

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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to sustain and strengthen partnerships. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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### Change Concept C. Sustain and Strengthen Partnerships Over Time

<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk about shared patients</td>
<td>➔ 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.</td>
</tr>
</tbody>
</table>
| 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th>Serious Concerns/Challenges</th>
<th>1</th>
<th>2</th>
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<td>Very Strong, Positive</td>
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</table>

**Change Concept 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?

**Change Concept 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?
Change Concept 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 partnerships?
Goal 2. Provide Coordinated & Integrated Care

Why Is This Goal Important for Trauma-Informed Integrated Care?

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.

In order to provide coordinated, integrated care, mental and physical health providers must first have partnerships based on the foundations outlined in Goal 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.

This goal includes five change concepts: A) improve processes for obtaining consent; B) improve process of making referrals; C) give reminders and follow-up calls; D) establish “family partners”; and E) determine funding and financing mechanisms to support coordination and integration.
Change Concept A: Improve Processes For Obtaining Consent For Exchange Of Information

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. (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.)

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to improve processes for obtaining consent for exchange of information. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Integrate Into Routine Paperwork

Explain Purpose of Sharing to Families

Ensure Consistency Across Providers

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you
might consider testing and ultimately implementing these strategies in your own daily work.

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

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<td>Possible Strategies</td>
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</table>
| 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 caregivers 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                       | → Understand 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.  |
Change Concept 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 provides whenever possible.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to improve processes for improving the referral process. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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<td><strong>Possible Strategies</strong></td>
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</table>
| Involving 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 caregivers, 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. |
Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to improve processes for reminders and follow-up calls. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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### Change Concept C. Give Reminders and Follow-Up Calls

<table>
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<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
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<tbody>
<tr>
<td>Text reminders</td>
<td>➔ Include the provider name, location, date, time, contact information, and reason for visit to ensure the family remembers the importance of the appointment.</td>
</tr>
<tr>
<td>Ask for updates</td>
<td>➔ Request text or phone updates from patients after their visits with specialists to help them put the visit into their own words.</td>
</tr>
</tbody>
</table>
| 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. |
Change Concept 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to establish family partners. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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<tr>
<td>Welcome families to the clinic</td>
<td>Engage family advocates as “greeters” for other families who are new to the clinic or community to ease their transition.</td>
</tr>
<tr>
<td>Run or serve as site for support groups for families</td>
<td>Develop family advocates as leaders of support groups.</td>
</tr>
<tr>
<td>Provide peer mentors for families</td>
<td>Engage family advocates serve as one-to-one mentors (for tips on incorporating peer-to-peer support into your program see Appendix C.2).</td>
</tr>
</tbody>
</table>
Change Concept E: Secure Funding To Support Coordination & 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to establish family partners. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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<th>Change Concept E. Determine Funding and Financing Mechanisms to Support Coordination and Integration</th>
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<tr>
<td>Possible Strategies</td>
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</table>
| 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. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

| Serious Concerns/Challenges | 1 | 2 | 3 | 4 | 5 | Very Strong, Positive |

**Change Concept 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?

**Change Concept 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?

**Change Concept 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?

**Change Concept 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?

**Change Concept 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?
Element III. For More Information

Goal 1. Develop Partnerships with Specialists Providing Trauma Services

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
  General information and resources from SAMHSA regarding behavioral and primary healthcare integration.

Goal 2. Provide 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
ELEMENT IV: Preventing Trauma And Promoting Resilience

An Overview and Rationale

Preventing Trauma and Promoting Resilience are essential activities for improving population health in the context of limited and expensive resources for individual healthcare interventions and the increasing difficulty of successfully intervening as a child or problem develops. It also supports consumer and healthcare provider stress management by offering a wellness focus to complement the more traditional and stressful illness care.

Although it is challenging for primary care and behavioral health providers cannot to prevent families from being exposed to trauma and stress, but building on families’ strengths may help families avoid the negative effects of experiencing such impacts that exposure and to better cope with those that are unavoidable. (citation) As in all of the other sections of the toolkit, we think about children and caregivers individually but also as a family, knowing that, in multiple ways, the strengths and challenges of one family member can influence strengths and challenges of 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 of trauma effects 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 and can partner with community resources to help families achieve these goals. This section focuses on interventions that are universal – meant to be of help to all families that a provider encounters.
In the context of the other elements and their goals, element IV by current goals

1. Further develops resources, activities and conversations introducing psychosocial health in a Trauma Informed Office and promotes the development of health and resilience across the population served, by ..

2. Affirms the role of Families in preventing and soothing child stress and the engagement of families in integrated care teamwork, by mobilizing resources to support family strengths and protective factors

3. Coordination

4. Element IV Prevention of exposure, experience and effects of trauma and Promotion of resilience .. by… universal conversation, resource, guidance, etc. and providing resilience-experiences within service settings. In order to more directly address improvement in population health.

5. Focuses on universally surveying trauma exposure, in observation and conversation, to triage need for more resource-intensive and specialized individualized Screening and Assessment

6. Focuses on universally supporting response to trauma exposure, hopefully prior to development of trauma effects, and before providing or referring for more intensive (and less available) individualized Intervention for complications in recovery

**Element IV Goals and Strategies for Full Implementation**

**Goal 1:** Assess Survey (i.e. be informed and alert for) family risks for potential exposure to trauma and stress as well as family assets, such as sources of support for child and caregiver.

**Goal 2:** Provide guidance that promotes development of resilience and wellness and provide support for families seeking to reduce cope with stress.
Goal 1. Assess Family Assets and Risks

Why Is This Goal Important for Trauma-Informed Integrated Care?

To prevent trauma-related challenges and promote resilience, it is important to identify and anticipate both the assess exposure to adversities that might cause risk leading to trauma or stress and the assets that could provide protection from adversity. (or to help anticipate possible exposures and head them off). This is similar to the discussion of In contrast to discussion of identifying trauma exposure provided in Element V, 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.” about the potential health effects of stress and resilience.

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 caregivers ( ). As most caregivers can attest, children can vary enormously in their personalities( ) and 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. Caregivers may feel more or less prepared to manage children’s personalities, and nearly all caregivers will feel challenged at some point. Stress can be even greater if a caregiver 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 caregiver 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

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs</td>
<td>Successes with past challenges</td>
</tr>
<tr>
<td>Threats to personal safety</td>
<td>Role models for coping with challenges</td>
</tr>
<tr>
<td>Threats to the family’s mental and physical health</td>
<td>Participation in community groups (service, religious, school-related)</td>
</tr>
<tr>
<td>Preparation for parenting</td>
<td>Feelings of confidence about meeting the child’s emotional, behavioral, and educational needs</td>
</tr>
<tr>
<td>Parenting skills and child characteristics</td>
<td>Feeling supported in parenting by spouses, partners, other family members or friends</td>
</tr>
<tr>
<td></td>
<td>Feeling capable of balancing childcare needs with work or other adult responsibilities.</td>
</tr>
</tbody>
</table>

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 caregivers’ protective factors.

This goal includes three change concepts: A) engage caregivers in open conversations about their lives; B) use assessment tools that ask about risks and protective factors; and C) support caregivers who have experienced trauma.
Change Concept A: Engage Families at the Start of the Visit

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.
### Change Concept A. Identify Potential Partners and Have Introductory Meeting

<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>➔ Identify families’ needs</td>
<td>➔ Recognize the specific mental health and trauma needs of families and children that are not currently being met in the PCP visit.</td>
</tr>
<tr>
<td>➔ Identify providers of services</td>
<td>➔ Know local providers of those services that are needed, including services for caregivers.</td>
</tr>
<tr>
<td>➔ Understand access issues</td>
<td>➔ Recognize those issues that impact or impede families’ abilities to access services, including linguistic and cultural needs.</td>
</tr>
<tr>
<td>➔ Provide cross-education</td>
<td>➔ 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.</td>
</tr>
<tr>
<td>➔ Ensure clarity about expectations and opportunities</td>
<td>➔ Be clear about what PCP wants/needs from partnership as well as the opportunities for partners.</td>
</tr>
</tbody>
</table>
Change Concept B: Use Assessment Tools to Identify Risks And Protective Factors

In addition to engaging caregivers 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)

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to identify risks and protective factors. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

- Identify Potential Screening Tools
- Avoid Duplication
- Integrate Into Existing Tools
- Introduce Tools with Family-Friendly Language

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

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Possible Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs</td>
<td>Is there, or has there been, insecurity about having housing, food, clothing and the support of family or friends?</td>
</tr>
</tbody>
</table>
| Threats to personal safety                      | Does the family, or did it at one time, live in or have to travel to a neighborhood where they feel unsafe?  
Do family members feel unsafe or wary because of their ethnicity, race, immigration status, gender, or sexual orientation?  
Do school-aged children feel safe traveling to and attending school?  
Is there a concern for emotional or physical violence between partners, or emotional or physical punishment of children? |
| Threats to the family’s mental and physical health | Does someone in the family work in a particularly dangerous or stressful job?  
Is there anyone in the family with a serious medical or mental health problem, including problems with alcohol or drugs? |
| Preparation for parenting                        | Do young caregivers – often young mothers – feel confident in their parenting knowledge and in having the support and resources they will need to care for an infant? |
| Parenting skills and child characteristics       | Does the child have behavior that the caregiver finds hard to deal with?  
What skills does the caregiver have to deal with their children’s behavioral issues? |

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.
<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
</table>
| 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 caregivers understand why the questions are being asked and how the responses will be used to help their family’s care. |
Change Concept C: Support Caregivers Who Have Experienced Trauma

If caregivers discuss their exposure to trauma in a conversation with you or through a screener, make sure to follow up. While the caregiver 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.
<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide in-office intervention as appropriate</td>
<td>→ 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.</td>
</tr>
<tr>
<td>Honor the families’ feelings about help</td>
<td>→ 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 caregivers make decisions about when those costs are justified. If not now, ask, “What would it take?”</td>
</tr>
<tr>
<td>Consult with in-office specialist</td>
<td>→ 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 caregivers. → Bring in your peer support person or family advocate.</td>
</tr>
<tr>
<td>Refer caregivers for additional help or support</td>
<td>→ If you are unable to address concerns in the office or with the support of in-office consultation, consider referring the caregiver 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.</td>
</tr>
<tr>
<td>Follow up with the family</td>
<td>→ 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.</td>
</tr>
</tbody>
</table>
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Concerns/Challenges</td>
<td></td>
<td></td>
<td></td>
<td>Very Strong, Positive</td>
</tr>
</tbody>
</table>

**Change Concept A. Engage Caregivers in Open Conversations about Their Lives**

- How well do you ask caregivers 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?

**Change Concept B. Use Assessment Tools that Ask about Risks and Protective Factors**

- What screening of child and caregiver 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?

**Change Concept C. Support Caregivers Who Have Experienced Trauma**

- How do you use information that is gathered about families' assets and risks?
- How do you engage caregivers in next steps?
- How do you support caregivers to address their own needs?
- How do you follow up with caregivers?
Goal 2. Promote Resilience

Why Is This Goal Important for Trauma-Informed Integrated Care?

Resilience helps determine how families and children experience their exposure to stress and to what extent stress leads to negative effects. Being resilience-informed includes awareness of how social determinants can support protective/promotive childhood experiences that nurture resilience expectations underlying healthy coping strategies that can result in wellness. Building competence and resilience in children and families should result in improved population health.

Providing guidance on parenting, healthy emotional development, and ways to meet families’ basic needs response to trauma 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 integrated care teams can play in families’ lives.

This goal includes two change concepts: A) provide parenting / developmental guidance; B) provide support and resources to caregivers.
Change Concept A: Provide Parenting & Developmental Guidance About Preventing and Soothing Child Stress Response

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

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.
## Change Concept A. Provide Parenting / Developmental Guidance

<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training to providers</td>
<td>→ 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.</td>
</tr>
</tbody>
</table>
| 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 caregivers and providers (as well as with entire office staff) can serve as a model for caregivers’ 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. |
**Change Concept B: Provide Support & Resources to Parents**

Knowledge is power. The more that caregivers 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 caregivers is essential.

**Moving from Change Concept to Change Strategy**

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

1. **Provide Resource Lists**
2. **Offer Your Own Classes or Programs**

**Implementing Change Strategy through Small Tests of Change (PDSAs)**

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.
**Change Concept B. Provide Support and Resources to Caregivers**

<table>
<thead>
<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
</tr>
</thead>
</table>
| **Provide resource lists**           | → Make sure that caregivers 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 caregivers to practice and get feedback and pointers (versus just receiving advice or reading).  
   → Offer space and family access to community groups with useful programs. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Concerns/Challenges</td>
<td></td>
<td></td>
<td></td>
<td>Very Strong, Positive</td>
</tr>
</tbody>
</table>

**Change Concept 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 caregivers and caregivers?
- What written materials do you have for caregivers specifically about parenting?
- In what ways do your physical environment and office culture offer a supportive space for caregivers?

**Change Concept B. Provide Support and Resources to Caregivers**

- What supports does your office have for caregivers 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 caregivers? How do you ensure it remains relevant and helpful for caregivers?
Element IV. For More Information

Goal 1. Assess Family Assets and Risks

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

Assessing family risks and assets

   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 caregiver 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
   Older child/adolescent version available at:

Select Links

1. Essentials for Childhood Framework: Steps to Create Safe, Stable, Nurturing Relationships and Environments for All Children
   The framework illustrates “strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens so that they, in turn, can build stronger and safer families and communities for their children.”
   https://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html

2. 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 caregiver. Available at: www.acestudy.org

3. 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/acestudy/.

Goal 2. Promote Resilience
The resources listed below can be found in Appendix D.2

Caregiver 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
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 caregiver-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

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
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.
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.
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
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

Program Links:
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/

Fussy Baby Network The Facilitating Attuned INteractions (FAN) approach “focuses on the caregiver’s concerns and uses five core processes to match interactions to what the caregivers are showing they can most use in the moment. The FAN approach also teaches professionals to track, regulate, understand, and use their own responses to families, thus building self-awareness and self-regulation. FAN has proved applicable
beyond issues of infant fussiness and generalizable as conceptual framework and practical tool to support attunement in helping relationships and promote reflective practice.

http://www.erikson.edu/fussybaby/national-network/

Home-Visiting Resources listed in Garner’s article on homevisiting.

Creating Cultures of Trauma-Informed Care A self-assessment and planning tool. This planning tool aims to provide programs guidance on creating an organizational culture of trauma-informed care. It suggests that this can be achieved by incorporating an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery in all aspects of service delivery and the physical setting. Five Key principles are identified: safety, trustworthiness, choice, collaboration, and empowerment. Trauma-informed services are designed specifically to be welcoming and hospitable for all individuals and are designed to avoid trauma-related dynamics that may be retraumatizing for those seeking services.


Community Connections (CCTIC) model
http://www.communityconnectionsdc.org/web/page/673/interior.html

Roadmap to resilience toolkit for community development, developed from a variety of community projects to decrease the impact of adversity and build resilience.

http://www.acesconnection.com/blog/the-roadmap-to-resilience-toolkit-v-1-0-is-here-1
http://communityresiliencecookbook.org/
ELEMENT V: Assessing Trauma-Related 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, d) agreement to check in again about this area if there are no concerns at present and e) promotion to facilitate healthy social-emotional development.

Goals and Strategies to Assess Trauma-Related Health Issues:

GOAL 1: Include the systematized assessment of trauma-related health problems as part of a holistic assessment of the child’s well-being.

GOAL 2: Complement screening with a discussion that engages the family and facilitates the assessment of trauma-related problems.
Goal 1. Use Screening Tools

Why Is This Goal Important for Trauma-Informed Integrated Care?

The identification of trauma-related health problems is part of a holistic assessment of the child’s well-being. Considering what is known about early brain development, toxic stress, the impact of poverty and resilience, the AAP and Bright Futures (4th Edition) recommend routinely screening for Social Determinants of Health (includes ACE’s), maternal depression, and development and behavior, including social-emotional development. Use of a screening tool at health maintenance visits with young children ensures that every caregiver 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 caregivers of children 4-10 enhanced:

- Caregiver engagement
- Caregiver-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 caregivers feel comfortable bring up sensitive issues without feeling targeted or stigmatized.

Families and providers should choose screeners that are sensitive and relevant to the community they serve. 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? Has the primary care clinic identified mental health resources that have experiences with infant and early childhood mental health? Is the primary care practice familiar with other support resources for families of young children? 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 table below highlights the connection between screening timing and content (though these are only suggestions to start discussion).

<table>
<thead>
<tr>
<th>Timing of Screening</th>
<th>Possible Topics</th>
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</table>
| At start of relationship | Prior history of mental health problems (or only maternal depression?)  
Past exposure to violence, major loss, life threatening situations (medical or otherwise)  
Caregivers’ own childhood experiences  
Survey of family supports and strengths, perceptions of child’s strengths and positive attributes  
Any current concerns (as per annual and every visit routines) |
| “Annual” or at some interval other than every health | Family economic security (including security of food, housing, employment)  
Broad-range inquiry about child emotional, behavioral, developmental issues and use of formal, validated tools for development and behavior, and autism at recommended visits |
**maintenance encounter** Updates on family accomplishments, changes that family reports as positive

Updates on challenges related to health, support, caregiver mental health (and use of formal tool for maternal depression at recommended infant visits)

Exposure to violence

**At every encounter** Brief inquiry or short screen about caregiver and child emotional/behavioral/functional problems

“Anything new?”

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, the family questions section of the SWYC, the Kemper-Kelleher Family Psychosocial Screener, the ACES checklist, and the protective factors checklist to assess resilience. The table in the appendix (table 14 Overview of trauma related screeners) lists major characteristics of each and pros and cons.

This goal includes three change concepts: A) select one or more screening tools; B) develop process for administration of tool; and C) carefully introduce screener to family.
Change Concept A: Select One or More Screening Tool

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 is a priority in pediatric practice as a key part of overall screening processes, along with maternal depression, developmental and behavioral, social-emotional, and autism screening. In fact, a trauma screen may identify risk and provide opportunity for intervention before an issue is identified on a later developmental screen. 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to select one or more screening tools. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

- Identify Gaps and Needs for Screening
- Get Input Directly from Pediatric Providers
- Know the Community and Family Needs

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you
might consider testing and ultimately implementing these strategies in your own daily work.

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

<table>
<thead>
<tr>
<th>Change Concept A. Select One or More Screening Tools</th>
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<tbody>
<tr>
<td>Possible Strategies</td>
<td>Specific Ideas to Test</td>
</tr>
</tbody>
</table>
| Identify gaps and needs for screening | ➔ Conduct a workflow review focused on screening to understand the various conditions and factors currently being screened for by the office.  
 ➔ Survey pediatric providers about how (if) they identify exposure to trauma and stress.  
 ➔ Survey pediatric providers about how (if) they identify child and family strengths and resilience factors. |
| Get input directly from pediatric providers | ➔ Talk to pediatric providers about what information they would like to have about children and families related to trauma and stress exposure.  
 ➔ Host discussion at staff meeting or as a breakfast to talk about the need to screen for trauma, stress and resilience, and how it impacts child development and health. (Use as a quasi-training opportunity while getting information about screening needs.) |
| Know the community’s and families’ needs | ➔ Bring information about screening and possible screening tools to the Caregiver Advisory Council, family advocates, or community partners for input and feedback.  
 ➔ Try using various screeners with diverse families (of various races, socioeconomic status, cultures, and languages) and invite their feedback and recommendations.  
 ➔ Invite a family member or community partner to share their perspectives on trauma and resilience screening tools. |
Change Concept B: Develop Process for Administration of Tool

Pediatric visits are already stretched thin. The primary care clinician may have only 20 minutes with a child and family. Identifying parental strengths and discussing social determinants of health is a major focus of Bright Futures guidelines, and using this screening tool is a way to facilitate these conversations with families. Thus, finding ways to work this tool into existing workflows is essential.

Furthermore, you must consider how to document the results of the screening tool. The American Academy of Pediatrics supports the inclusion of trauma screening results in the health record and in primary care, when you take a social history, it is documented in the notes. This is documentation of risk for the benefit of the child. In general, facts relevant to the child’s health should be in the record.

There may be other considerations, however, related to documentation that should be discussed with families. For example, concerns about family violence might not be documented if a potentially violent partner could access them. In such instances it is useful to understand the EHR capacity to designate material as confidential and to use that function. Details about parental mental health problems might be omitted and reserved for the caregiver’s own medical record as 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.
Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.
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</table>
| Understand existing office workflows | ➔ Map the flow of existing screening tools from the time they are handed to a family and the time the provider reviews and uses them.  
➔ Try handing out the selected screening tool at various points in the visit to determine which makes the most sense for patients and providers. This can include sending it prior to the visit, handing it out when the patient first checks in, when they are first roomed, or when the provider comes in for the visit.  
➔ Ask caregivers when the screener would be best/easiest for them to complete.  
➔ Offer to sit with families to answer questions, read, and/or translate the screening tool. |
| Develop clear expectations for how, when, and by whom the screener is administered | ➔ Test out having the screener distributed by various roles in the office to determine which will work best. Consider front desk staff, medical assistants, physician’s assistants, nurses, and doctors.  
➔ Print the screener on a brightly colored paper so it is obvious to staff and providers.  
➔ Use reminders (post-it notes, emails, etc.) to help staff remember to distribute the screener to all families.  
➔ Provide brief training to staff who will be distributing the screener to ensure they understand its purpose, value, and importance. |
Change Concept C: Carefully Introduce Screener to Family

Asking about trauma and exposure to trauma can be extremely sensitive for families. The questions themselves could be triggers. Moreover, some families will worry about why the questions are being asked and how their responses will be used, for example if certain answers will result in child protective services being called. Regardless of how families feel about being asked these questions, we know that they are still critically important to ask. So rather than avoiding the questions, we need to find ways to explain to families why the questions are being asked, who will see the answers, and how they will be used.

There are a number of possible points to make as you introduce 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 to determine the most effective messages.

- **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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

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</table>
| Use written explanation of screener | ➔ Develop language that is included at the top of the screener itself – a “preamble” – that explains the purpose and use of the screener in family-friendly terms. (Have caregiver representatives help develop the language.)  
 ➔ Create a one-pager in the office that is distributed to all families about the new screener and why it is now being used.  
 ➔ Put up posters or other information in the waiting area to normalize and explain the use of the tool.  
 ➔ Develop a short Q&A about the tool to dispel any myths or misperceptions about its use. |
| Talk to families before they complete the screener | ➔ Develop talking points for all staff involved in distributing the screener to use when explaining the screening tool to families.  
 ➔ Do role plays in the office to practice having the conversation with families.  
 ➔ Offer to help families complete the tool so that they don’t feel isolated or confused. |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

<table>
<thead>
<tr>
<th>1</th>
<th>Serious Concerns/Challenges</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Very Strong, Positive</th>
</tr>
</thead>
</table>

**Change Concept Strategy A. Select One or More Screening Tools**

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

**Change Concept 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?

**Change Concept C. Carefully Introduce Screener to Family**

- What is the environment for screening about sensitive issues?
- How are the screening questions presented to caregivers in ways that are supportive and engaging?
- How are the screening questions perceived by caregivers with different life experiences and concerns?
Goal 2. Discuss Screening Tools With Families

Why Is This Goal Important for Trauma-Informed Integrated Care?

The fundamental purpose of screening is to learn information about children and families that you might not already know. It is not to get a score or rating, but instead to identify information and experiences that may require further conversation or some sort of follow-up intervention.

Thus, screening is incomplete without a conversation between the primary care clinician and the family about the screening results. Implementing screening without discussing the patient’s/caregiver’s responses seriously undermines the intent and can create additional burdens to families and providers. Without discussion, the screener becomes just another administrative requirement or, worse yet, a potential trigger for families. 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.

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, even though a negative screen may suggest there are no problems, it can also create an opening for families to disclose related issues and to identify strengths/protective factors.

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 that are below but close to the cut-point may be significant, just as positive scores just above the cut-point may not be.

This goal includes two change concepts: A) introduce results to families; and B) use results for engagement.
Change Concept A: Introduce Results to Families

With the time limitations of a pediatric well-child visit, screening can help focus the time for discussion. Completion of the screening tool prior to the visit helps with timing, but some clinicians may still have concerns that discussing the results of the screener will take too much time.

Additionally, some clinicians may feel they don’t have the skills or expertise to discuss the results of a trauma exposure screener. Clinicians may fear “opening a can of worms,” from both a time perspective as well as a content perspective.

Keep in mind that if items are checked as “positive” or may cause distress to a family, you can ask for permission to talk more about the answer. It remains important to plan the visit 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.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

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<tbody>
<tr>
<td>Possible Strategies</td>
</tr>
</tbody>
</table>
| Lead with appreciation and engagement, not just results | → Thank the patient/caregiver for completing the screen.  
   → Ask for permission to discuss the results.  
   → Explain that the screener is meant to help decide what might be important to talk about at this visit.  
   → Explain that the responses make it seem as if there might/might not be something to add to the agenda, pending what the patient or caregiver thinks.  
   → Ask if the caregiver has any questions about the screener before you start talking about what you learned. |
| Normalize the results | → If you are using a validated instrument, you may share some of how the screener is typically used and what it tells you generally. If you are not, you might remind the family that this screener is used with all patients; they have not been “singled out.”  
   → Use empathetic and compassionate language, such as “all caregivers experience stress,” and “our goal is to help address and alleviate stressors in your life, wherever possible.”  
   → Avoid using judgmental or blaming language or jargon such as “this screen was positive” or “you screened positive for stress and trauma exposure.” |
Change Concept 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 caregiver and child in a discussion about the patient’s well-being.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

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</table>
| **Focus on strengths**                     | ➔ Point out the areas where the caregiver or child demonstrates strengths or resilience factors. Even if they have experienced trauma or stress, it is likely that they have had positive, resilient responses.  
  ➔ Ask the family where they get their strength and support. Invite broad thinking about positives and support systems.                                                                                     |
| **Use the questions to go deeper**         | ➔ Clarify the family concerns identified on the screener. Ask deeper questions about those concerns to better understand what might be happening for the family.  
  ➔ Learn more about the child’s needs. Ask direct questions about the impact of these experiences rather than just focusing on the experiences themselves.  
  ➔ Learn about the context of problems identified. Make sure you have a full picture of what these experiences mean to the family.                                                                               |
| **Identify and prioritize solutions and strategies together with the family** | ➔ Use the screener as a teaching opportunity and discuss ways to prevent exposure to trauma in the future. Make the caregiver feel empowered.  
  ➔ Discuss methods to cope with trauma. Remember that just talking about trauma and coping skills is an intervention you can provide in real time.  
  ➔ Ask the caregiver what their primary issues, priorities, or concerns are. Even if the screener is positive and you have some concerns, they may not be the caregiver’s priority at this time.                                                                 |
Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

| Serious Concerns/Challenges | 1 | 2 | 3 | 4 | 5 | Very Strong, Positive |

**Change Concept 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?

**Change Concept 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?
Element V. For More Information

**Goal 1. Use Screening Tool(s)**

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 (Family Questions Section)
    3. SEEK- The Caregiver Screening Questionnaire (PSQ)
    4. Edinburgh Postnatal Depression Scale
    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
  2. Baby Pediatric Symptom Checklist (In SWYC ages 2mos – 15 mos)
  3. Preschool Pediatric Symptom Checklist (in SWYC ages 18 mos – 60 mos)
  4. ECSA (Early Childhood Screening Assessment (for ages 18 – 60 mos)
  5. Young Child PTSD Checklist
  6. Young Child PTSD Screen

- **School-Age**
  1. Center for Epidemiological Studies Depression Scale for Children
  2. Pediatric Symptom Checklist (ages 4-16)
  3. Self-Report for Childhood Anxiety Related Emotional Disorders
  4. 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
7. FANS More information: 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 caregivers and providers reported that the screener improved caregiver 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 caregivers engage with screeners in pediatric primary care and how the results are evaluated and used by providers in determining care for their patients.


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. Available at: http://healthcaretoolbox.org/index.php/tools-and-resources/training-tools

Goal 2. Discuss Screening Results with Families

1. The AAP Resilience Project
   www.aap.org > advocacy and policy > AAP health initiatives > Center on Healthy Resilient Children > The Resilience Project contains articles, training materials, screeners for trauma, ACE’s, resilience
ELEMENT VI: Addressing Trauma-Related Health and Mental Health 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. Interventions form 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,” as primary care providers can build upon their relationships with families and on the trust families have in them. 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.

Goals and Strategies for Addressing Trauma-Related Health and Mental Health Issues

Goal 1: Help families become aware of the links between trauma/stress and health.

Goal 2: Help families develop plans for needed care or monitoring.

Goal 3: Provide brief services within the practice.

Goal 4: Coordinate referrals to specialty trauma care and co-manage ongoing treatment.
Goal 1. Raise Awareness of Links Between Trauma/Stress and Health

Why Is This Goal Important for Trauma-Informed Integrated Care?

Some families recognize that they have experienced something stressful or traumatic, but they are not able to connect that experience to changes in their children’s behavior or health status. While other families who have experienced trauma do recognize its impact. Some will seek help; others will not, perhaps due to a lack of resources, a lack of awareness about how things could be better, other higher priorities, or the stigma of seeking health. 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.

This goal draws from two change concepts: A) share information with families about trauma, stress, and health; and B) guide families about how they can support the child.
Change Concept A: Share Information with Families about the Link between Trauma/ Stress and Health

Research on early childhood trauma provides extensive data on its 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 caregivers, 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. Toxic stress results in prolonged activation of the stress-response system in the absence of a protective relationship. It is important to support parenting because a caring adult, caregiver, 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 caregiver-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 caregiver 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 common behavioral responses that can help families make sense of what is happening.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.
Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.
**Change Concept A. Share Information with Families about the Link between Trauma/ Stress and Health**

<table>
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<tr>
<th>Possible Strategies</th>
<th>Specific Ideas to Test</th>
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| Introduce the relationship between trauma and health | ➔ Discuss links between trauma and health in family friendly ways. Avoid judgmental or blaming language.  
 ➔ Discuss links between trauma and child development.  
 ➔ Discuss resilience and strengths to ensure the family recognizes the opportunity to buffer the experience and feels reassured that there is hope for change. |
| Be respectful of the family and their context    | ➔ Consider the family’s perspective. Always be aware of, and acknowledge, that you don’t know what the situation looks like from the caregiver’s perspective.  
 ➔ Ask the family questions about their understanding of what has happened and how it has impacted their family. |
| Provide reassurance by normalizing responses     | ➔ Explain that children’s reactions to extremely frightening or overwhelming events are usually normal responses to abnormal events.  
 ➔ Remind families that both children and adults experience physical and emotional reactions to trauma and stress and there are things that can be done to help. |
Change Concept B: Guide Families to Support Their Children

For young children, caregivers 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 access to 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
- Maintaining structure, rules, and emotional support
- The naming of feelings and guidance on how to manage them; and
- Supporting positive development and addressing problems that could interfere with a child’s ability to cope with trauma.

Moving from Change Concept to Change Strategy

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<tr>
<th>Change Concept B. Guide Families about How They Can Help Support the Child</th>
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<tbody>
<tr>
<td>Provide information and/or access to needed resources</td>
<td>➔ Ask caregivers what they most want and need to support their child. ➔ Develop partnerships with community partners who provide basic needs such as food, housing, diapers, clothing, etc. Be able to link families directly to these needed resources. ➔ Create a resource guide for families. ➔ Honor the connection between having basic needs met (“social determinants of health”) and impacts on health and wellness for the entire family</td>
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<tr>
<td>Teach parenting and coping strategies</td>
<td>➔ Model activities in the office visit that the caregiver can use at home, such as a deep breathing exercise or chair yoga to practice mindfulness. ➔ Share positive parenting strategies and encourage the caregiver to use them at home. ➔ Provide concrete resources and information to caregivers such as they relate to activities and relationship building. ➔ Support caregiver resilience in managing their own trauma history and efectos on parenting</td>
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Assessing Your Progress

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<td>Very Strong, Positive</td>
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**Change Concept 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 caregivers about trauma, health, and child development?

**Change Concept 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?
Goal 2. Plan Collaboratively with Families

Why Is This Goal Important for Trauma-Informed Integrated Care?

It is essential to partner with parents/families to discuss and develop a plan to help their child after exposure to a trauma. Young children often look first to their caregivers first for information and reassurance. The family’s ability to cope with stress is a key indicator of the child’s response. Caregivers 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 caregivers’ experience of being heard, respected, and valued is an essential first step of collaboration, and will increase the likelihood that they will be able to follow through with a treatment/monitoring plan.

This goal includes two change concepts: A) review options for care; and B) discuss competing priorities and make plan.
Change Concept A: Review Options for Care

Caregivers 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). Taking the time up front to talk with families about their various options for care and their priorities and preferences can help reach agreement. The caregiver-provider relationship allows for opportunities to revisit and adjust the plan, as needed. Restoring a sense of security and control may be the most intervention 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.

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. The provider might ask if there are any questions and offer to check in about this at the next visit, (as described more fully in Element V).

Patients may already be in care for the identified problem. If so, you can ask about their care to see if they are satisfied. 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 Element III).

Moving from Change Concept to Change Strategy
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| Collaborate with the family and encourage questions      | ➔ Listen to and learn from caregivers’ 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 caregivers 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                                           | ➔ Review the relevant options from which the caregiver might choose, and discuss which options are most feasible. (Options are listed under Goal 3). |


Change Concept 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 clarify options and priorities

If the family does not wish to pursue treatment, the provider and caregiver should make a concrete follow-up plan.

Moving from Change Concept to Change Strategy

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| Identify and sort through multiple priorities for the family | → Assist families in prioritizing their needs and concerns.  
   → Talk with the family about how the issues you’ve identified “fit” into their existing priorities. Are they more important? Less important? Why?  
   → For each option you’ve identified together, provide feedback on the pros and cons. Ask the caregivers to share their perspective on pros and cons as well, as they may be different.  
   → Ask the caregivers to share their perspective on pros and cons as well, as they may be different. |
| Help family make a plan | → Ask the caregivers to select from the options presented. Identify obstacles, for pursuing the option, such as accessibility or transportation.  
   → Put the plan in writing using family-friendly language. Make sure the family has a copy and that it is documented in the patient records  
   → Make sure you have timeframes and resources available to maximize the success of the plan for the family. Be realistic and honest about expectations. |
Assessing Your Progress

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**Change Concept 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?

**Change Concept B. Discuss Competing Priorities and Make Plan**

- How are competing priorities discussed with families?
- How are plans made in partnership with caregivers when there are competing priorities?
- How are benefits and challenges identified and weighed by providers and caregivers to inform these choices?
Goal 3. Provide Services at Visit

Why Is This Goal Important for Trauma-Informed Integrated Care?

Primary care providers can provide a variety of services addressing trauma-related problems, ranging from 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 primary care providers should be educated about the interventions being offered by specialists in order to determine what approach might be most effective.

This goal includes two change concepts: A) provide developmental guidance; and B) implement evidence-based practices.
Change Concept A: Provide Developmental Guidance

Providing education about typical responses to trauma and stress at various developmental stages can reassure caregivers and increase their confidence in helping their children. It also helps them understand their child’s behavior.

Caregivers may need support in terms of their own mental health. Young children look to their caregivers 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 caregiver self-care and, when needed, specific treatment can be helpful.

Follow up is important. 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.

Moving from Change Concept to Change Strategy

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| Emphasize the importance of maintaining routines/relationships | ➔ Teach, or remind, caregivers about the importance of routines, such as bed and mealtimes for children, regular caregiver-child time together, taking care of the household – cleaning, laundry, shopping – and visits with relatives or friends.   
➤ 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 caregivers)? |
| Support caregiversal mental health                      | ➔ Know the adult mental health system in your community. Develop connections and relationships with adult providers to whom you can refer caregivers.   
➤ Engage the office social worker or mental health specialist as a “warm hand-off” for caregivers with possible mental health needs. |
| Review standard child behavior advice                  | ➔ Acknowledge and name children’s emotions and then offer comfort.   
➤ Share ideas for brief but stimulating activities that caregivers and children can to do together (reading, cooking, cleaning, following the child’s lead to play a game).   
➤ Offer advice and trouble-shoot on routines such as mealtime and bedtime issues. |
| Provide follow-up                                       | ➔ Ask the family when they would like to follow up with you, or have your office follow up with them.   
➤ Make concrete plans for either a return visit or follow up phone call or text. Create reminders to ensure that the family is contacted. |
Change Concept B: Implement Evidence-Informed Practices

Primary care practices may wish to train their staff in specific treatments for child trauma. There are a growing number of group and individual or family focused interventions for children affected by trauma. Some (described as “evidence-based treatments”) have been extensively evaluated, using randomized trials with different populations. Others, often described as “evidence-informed practices” or “promising practices” use an accepted theoretical foundation, are widely used, but have not yet been evaluated with randomized trials. Many of these interventions require master’s level or higher degrees in counseling. Some are available for non-clinicians. More information can be found at the National Registry of Evidence-based Programs and Practices (NREPP). (See Appendix F.3 for examples of evidence-based practices PCPs can consider implementing within their practice or via referral.)

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to engage families at the start of a visit. Each of these possible strategies is detailed further – making them even more practical and specific – in the sample PDSAs that follow.

Identify evidence-based practices for office

Train providers
Implementing Change Strategy through Small Tests of Change (PDSAs)

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<th>Change Concept B. Implement Evidence-Based Practices</th>
<th>Specific Ideas to Test</th>
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<tbody>
<tr>
<td>Possible Strategies</td>
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<tr>
<td>Identify key evidence-based practices for the office to learn</td>
<td>→ Identify the highest priority issues and concerns related to stress and trauma that your office would like to be able to address through in-house interventions.</td>
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<td>→ Review research to determine what evidence-based practices may be available and best suited to meet your needs.</td>
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<td>→ Compare the evidence-based practices you like with the training, supervision, clinical, resource, and implementation requirements to make sure they are feasible in your current office environment.</td>
</tr>
<tr>
<td>Train providers in identified evidence-based practices</td>
<td>→ Identify providers to be trained in identified evidence-based practices. (Make sure they meet the clinical requirements prior to training.)</td>
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<tr>
<td></td>
<td>→ Provide protected time for identified providers to receive training.</td>
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<tr>
<td></td>
<td>→ Share information with entire office to ensure everyone knows who has the skills and training to provide specific interventions.</td>
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**Strategy A. Provide Developmental 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 caregivers 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?
Goal 4. Connect with Specialty Care

Why Is This Goal Important for Trauma-Informed Integrated Care?

The primary care provider cannot address 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; or
- 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.
- Recovery process appears to be complicated, e.g. by family system issues, intensity of trauma, substance misuse, milieu, developmental level, etc.
- Screening process (Element V) has identified potential value of further assessment and/or intervention

The decision to seek additional care should be a joint one made with the family, and the provider should have an ongoing role collaborating in the family’s care. Whenever possible, the provider should connect the family to a specialty caregiver directly, so that the family is personally introduced to the specialty provider. When this is not possible, it is helpful if the referring provider knows the clinician and could say something like “this is someone with whom I’ve worked closely for the last several years and we’ll continue to work closely around your care.”

Referrals should be discussed with caregivers (and adolescents) prior to them being made. Otherwise, caregivers may see this as a command or as an indication that the pediatric provider no longer wishes to be involved. Once the referral is
made, the referring primary care provider should follow up to ensure that the patient has been successfully referred and engaged in treatment.

This goal includes two change concepts: A) use warm hand-offs with co-located mental health personnel; and B) connect with community-based specialists.
Change Concept A: Use Warm Hand-Offs with Co-Located Mental Health Personnel

Having a co-located mental health provider will facilitate coordinated care, making referrals for additional services, record sharing, and communication between providers, billing, and other providers of the patient’s care.

Co-location, however, does not guarantee provider-to-provider communication, and it does not always improve patient willingness to follow through with referrals. It can be a challenge for providers to understand each other’s role and how to best access each other’s expertise. Practices with co-located professionals must pay attention to these factors to ensure patient needs are addressed.

Moving from Change Concept to Change Strategy

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<tr>
<td><strong>Possible Strategies</strong></td>
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<tr>
<td>Develop shared understanding of expertise</td>
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| Bring partners “into the room”                         | → Develop loose guidelines for when a mental health partner should be brought into a visit. These should be developed jointly between the primary care and mental health providers.  
→ Develop process for how this will happen to ensure access, availability, and the appearance of seamlessness for patients.  
→ Ask the family's permission before inviting in someone else. |
| Continue to facilitate relationship building with the family | → Develop clear ways of talking about one another to families. Find ways to introduce partners in ways that feel supportive and help facilitate the relationship.  
→ Clearly describe the relationship with your clinical partner is clear to the family so that it reinforces the sense of team and coordination.  
→ Remind the family that you are still part of the care team. This hand-off isn’t simply passing them off to another “professional.” |
Change Concept B: Connect with Community-Based Specialists

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. Off-site referrals can present challenges. It may be difficult to communicate with separate agencies. The primary care providers may not know if the patient followed through with the referral or what treatment was provided. It may be difficult to share information or patient records. It is important to develop systems of communication and information exchange with outside referral sources that facilitate management of patient care. This is especially true when the referral is for a caregiver, 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.

Moving from Change Concept to Change Strategy

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### Change Concept B. Connect with Community-Based Specialists

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<tr>
<td>Know local resources and providers</td>
<td>➔ Host an open house in which you invite community-based specialists in as a way to develop relationships and understand your shared patient population. ➔ Get to know resources, in terms of evidence-based practices, so that you know what and who might be a good fit for your patients. ➔ Develop referral protocols in which personal connections are used to facilitate connections, rather than just giving families a name and number to call.</td>
</tr>
<tr>
<td>Coordinate care in real time</td>
<td>➔ Have social worker or care coordinator in the office make appointments with specialty providers before the families leave. ➔ Reassure caregivers that you will remain involved even if the provider isn’t in your office.</td>
</tr>
<tr>
<td>Plan for follow-up</td>
<td>➔ Develop protocols or plans to follow up with the specialty provider after referral. Make sure the family knows you plan to do this. ➔ Follow up with the family with a call or text to check in and see how the initial appointment went.</td>
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**Change Concept A. Use Warm Hand-Offs with Co-Located Mental Health Personnel**

- How do you help caregivers 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?

**Change Concept B. Connect with 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?
Element VI: For More Information

**Goal 1. Raise Awareness of 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 caregivers and considering interventions.*

2. Social-Emotional Problems in Preschool-Aged Children (Brown et al., 2012)
   *This study showed that caregivers 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)

**Goal 2. Plan Collaboratively with Families**

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).


**Goal 3. Provide Services at Visit**

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.

   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.

**Goal 4. Connect with Specialty Care**

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 caregivers and very young children. Secure attachment is generally
linked to healthy child development. More information:
http://circleofsecurity.net/resources/treatment-assumptions/

5. Child Caregiver Psychotherapy
http://nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf
http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed

6. Caregiver Child Interaction Therapy
http://www.pcit.org/
http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf
http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed

7. Preschool PTSD Treatment
http://www.infantinstitute.org/MikeSPDF/PPTversion7.pdf
http://www.cebc4cw.org/program/preschool-ptsd-treatment/

8. Trauma Systems Therapy
http://www.med.nyu.edu/child-adolescent-psychiatry/research/institutes-and-
programs/trauma-and-resilience-research-program/trauma-systems-therapy
http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/TraumaSystems
TherapyTST_fact_sheet_3-21-07.pdf
http://www.cebc4cw.org/program/trauma-systems-therapy-tst/detailed

9. Child and Family Traumatic Stress Intervention
https://medicine.yale.edu/childstudycenter/cvtc/programs/cftsi/
http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_
Fact_Sheet.pdf
http://www.cebc4cw.org/program/child-and-family-traumatic-stress-
treatment-cftsi/detailed

10. Attachment and Biobehavioral Catch-Up (ABC)
This intervention is designed to help caregivers provide nurturing and
structured cared to children who have experienced maltreatment. More

Available at: 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.

http://learn.nctsn.org/course/index.php?categoryid=70
http://www.cebc4cw.org/program/alternatives-for-families-a-
cognitive-behavioral-therapy/detailed
12. 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/
http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

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