Agenda

1-2:15 – Trauma Informed Care
2:15-2:30 Break
2:30-3:45 – Social Determinants of Healthcare
3:45-4 Break
4-5:15 – Value Based Payment
Our Time Together

- Trauma Overview
- ACE Study
  - History
  - Behavior as Coping
  - Your ACE
- Vicarious Trauma
- Building Resilience
  - In Ourselves
  - In Clients
- Trauma Informed Engagement
- Trauma Informed Care
- OSA
- Q and A/ Thank You!
What is Trauma?

What is trauma?

We become traumatized when our ability to respond to a perceived threat is in some way overwhelmed. Trauma is about loss of connection – to ourselves, to our bodies, to our families, to others, and to the world around us.

WHAT IS TRAUMA?
An experience, situation or event that:
- evokes fear
- changes the individual’s worldview
- changes the individual’s view of themself

@2014 The #NoMoreShame Project
What is Trauma?

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

Draft Definition (SAMSHA, 2012)
Trauma Definition Expanded

- For today, the *trauma* is used to describe those very intense and stressful life experiences and may cause overwhelming fear, anxiety, horror, confusion or helplessness to the point that it harms a person’s physical and emotional health.

- These stressful life experiences may be related to violence and victimization including sexual and physical abuse, rape, or criminal assault (e.g., mugging).

- Trauma may also be experienced when a person sees violence towards others or the devastating results of terrorism or natural disasters.

- For some people, frequent and intense bullying that causes humiliation and fear can be traumatic.

- Living under persisting conditions of intense poverty, discrimination and racism may also be experienced as traumatic.

- Soldiers in combat, refugees from places where war and torture is common and people living in violent neighborhoods may also experience the harmful effects of trauma.
The Three “E’s” of Trauma

- Event(s)
- Experience of Events
- Effect of Experience
### Types of Trauma:

<table>
<thead>
<tr>
<th>Traumatic Experience</th>
<th>Three Types</th>
<th>Neglect Counts</th>
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</table>
| Threatens the life or physical integrity of a child or someone important to that child (parent, grandparent, sibling) | **Acute:** a single event that lasts for a limited time  
**Chronic:** multiple events, often over a long period  
**Complex:** multiple events beginning at a very young age; caused by adults who should have been caring for/protecting child | Failure to provide for basic needs is seen as a trauma by infants or young children, who depend on adults to survive. Neglect also opens door to other traumatic events, and may reduce a child's ability to recover from trauma. |
| Causes an overwhelming sense of terror, helplessness, and horror | | |
| Produces intense physical effects such as pounding heart, rapid breathing, trembling, dizziness, or loss of bladder or bowel control | | |

**Trauma Adds Up**
It is cumulative—each new traumatic event compounds the last

Source: Tullberg, 2011

**Reactions Vary Widely**
Based on the child’s level of exposure to trauma, access to supportive caregivers, previous history of traumatic events, and other factors
Prevalence

- In a recent study, two-thirds of the children reportedly experienced at least one traumatic event by age 16, including 30.8% with exposure to one event and 37% to multiple events. The most common events were witnessing or learning about a trauma that affected others – known as “vicarious” events.
- Children who experience trauma are often those with depressive, disruptive behavior disorders and high anxiety.
- Each year there are about 207,754 victims of sexual assault with someone in the United States being sexually assaulted every 2 minutes.
- In the United States, approximately five million children experience some form of traumatic event each year.
- More than two million children in the US are victims of physical and/or sexual abuse.
- These children often grow up with some kind of emotional and behavioral challenges, sometimes a ‘SMI’.
Common Trauma Reactions

- Emotional
  - Emotional Dysregulation
  - Numbing

- Physical
  - Somatization
  - Biology of Trauma
  - Hyperarousal
  - Sleep disturbance

- Cognitive
  - Feeling different
  - Flashbacks
  - Triggers
  - Dissociation

- Behavioral
  - Reenactments
  - Self-harm and self-destructive behaviors
  - Substance use
  - Avoidance

- Social and Interpersonal
  - Relational issues

- Developmental
  - Delayed development (speech, comprehension, fine or large motor skills)
The Effects of Trauma:

- Trauma may strongly affect a person’s thinking, feeling, behavior, and physical well-being in harmful ways.

- People who have experienced traumatic life events may find it difficult to regulate their feelings and responses to stress. This may cause a person to be...

  - Overly sensitive to common day to day life stressors
    - Seeing neutral situations as threatening (being on guard much of the time)
    - Having feelings that are much stronger or unusual than the situation calls for. For example: rage reactions that go way beyond the situation; feelings of panic in non-threatening situations; or, feeling numb or detached from one’s surroundings
    - Having strong and uncomfortable reactions to people, places and things that remind the person of the original traumatic event

- Physically uncomfortable or ill in response to common life stressors
  - Body tension
  - Rapid breathing
  - Nausea
  - Headaches
  - Restlessness
  - Tics

- Trauma experiences may lead a person to cope in ways that contributes to mental health, substance use and/or physical health problems

- The person who has had trauma experiences may not be aware of how these experiences are contributing to current disappointments and life difficulties.

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Brain Circuitry Involvement in PTSD

SENSORIMOTOR CORTEX
Function: Coordination of sensory and motor functions
In PTSD: Symptom provocation results in increased activation

ANTERIOR CINGULATE CORTEX
Function: Autonomic functions, cognition
In PTSD: Reduced volume, higher resting metabolic activity

THALAMUS
Function: Sensory relay station
In PTSD: Decreased cerebral blood flow

PREFRONTAL CORTEX
Function:
- Emotional regulation
In PTSD:
- Decreased gray and white matter density
- Decreased responsiveness to trauma and emotional stimuli

PARAHIPPOCAMPAL GYRUS
Function: Important for memory encoding and retrieval
In PTSD: Show stronger connectivity with medial prefrontal cortex; decreases in volume

ORBITOFRONTAL CORTEX
Function: Executive function
In PTSD: Decreases in volume

FEAR RESPONSE
Function:
- Evolutionary survival
In PTSD:
- Stress sensitivity
- Generalization of fear response
- Impaired extinction

AMYGDALA
Function:
- Conditioned fear
- Associative learning
In PTSD:
- Increased responsiveness to traumatic and emotional stimuli

HIPPOCAMPUS
Function:
- Conditioned fear
- Associative learning
In PTSD:
- Increased responsiveness to traumatic and emotional stimuli

<table>
<thead>
<tr>
<th>Lizard Brain</th>
<th>Mammal Brain</th>
<th>Human Brain</th>
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<tbody>
<tr>
<td>Brain stem &amp; cerebellum</td>
<td>Limbic System</td>
<td>Neocortex</td>
</tr>
<tr>
<td>Fight or flight</td>
<td>Emotions, memories, habits</td>
<td>Language, abstract thought, imagination, consciousness</td>
</tr>
<tr>
<td>Autopilot</td>
<td>Decisions</td>
<td>Reasons, rationalizes</td>
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</tbody>
</table>
Our Brains on Stress

Stressed Brains Can’t Effectively:

• Respond
• Learn
• Process
Coping and Trauma: Basis of ‘Pathology’

Many individuals have developed extreme coping strategies in childhood, adolescence and adulthood, to manage the impacts of overwhelming traumatic stress, including:

- Suicidality,
- Substance abuse and addictions,
- Self-harming behaviors such as cutting and burning,
- Hallucinations,
- Emotional numbing and dissociation,
- Hyper-vigilance, somatization, aggression and rage,
- Re-enactments such as abusive relationships, and
- Serious health risk behaviors

The following responses to trauma/traumatic events are components of Posttraumatic Stress Disorder (PTSD):

- Hyperarousal: nervousness, jumpiness, quickness to startle.
- Re-experiencing: intrusive images, sensations, dreams, memories
- Avoidance and Withdrawal: feeling numb, shutdown or separated from normal
- Life, pulling away from relationships and/or activities, avoiding things that trigger memories of trauma/s
Why Does It Matter To Providers?

‣ Sometimes, mental health professionals, substance abuse counselors and medical doctors and nurses, and other providers may not always consider the role that trauma may play in a person’s current health/mental health concerns.

‣ When a person and his/her healthcare providers don’t explore the connection between trauma and current life problems, an important opportunity to improve one’s life is missed. For example, not knowing about how trauma has affected a person can lead to:
  • Ineffective treatment or even harmful treatment
  • Wrong diagnosis of a person’s mental health or substance use problem
  • Mismatch between what the person needs and the services they receive
Do Your Clients Have a Trauma History?

› Have they experienced traumatic experiences before the age of 18?
› After the age of 18?
› Are you assessing for this? How and When?
› Are you considering that some of those ‘difficult behaviors’ or challenges are actually coping mechanisms to cope and deal with what they’ve experienced?
The Adverse Childhood Experiences (ACE) Study

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

Of the 17,000 respondents:

- 1 in 4 exposed to 2 categories of ACEs
- 1 in 16 was exposed to 4 categories.
- 22% were sexually abused as children.
- 66% of the women experienced abuse, violence or family strife in childhood.
- Women were 50% more likely than men to have experienced 5 or more ACEs
Childhood Experiences Underlie Chronic Depression
Childhood Experiences Underlie Suicide

% Attempting Suicide

ACE Score

0 1 2 3 4
PEOPLE WHO HAVE EXPERIENCED TRAUMA ARE:

- 15 Times More Likely To Commit Suicide
- 4 Times More Likely To Become An Alcoholic
- 4 Times More Likely To Develop A Sexually Transmitted Disease
- 4 Times More Likely To Inject Drugs
- 4 Times More Likely To Use Antidepressant Medication
- 3 Times More Likely To Be Absent From Work
- 3 Times More Likely To Have Serious Job Problems
- 2.5 Times More Likely To Smoke Tobacco
- Missing Work
- Depression
- Smoking
- Inject Drugs
Multiple trauma experiences raise the risk for........

- **Mental Health Challenges**
  - Alcoholism and alcohol abuse, substance use/abuse
  - Anxiety problems and fears
  - Avoiding people, places and things that are similar to or reminders of the traumatic event(s)
  - Suicide attempts

- **Behavioral Health Challenges**
  - High Risk Behaviors
  - Poor relationships with others
  - Multiple sexual partners
  - Unintended pregnancies
  - Smoking

- **Physical Health Challenges**
  - Obesity
  - Respiratory difficulties and other physical health problems
  - Heart disease
  - Sleep problems
  - Memory problems and flashbacks
Evidence from ACE Study Indicates...

Adverse childhood experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs.
The Challenge: It is difficult to tell if a particular life problem of one of our clients is related to trauma.

We may not know what kinds of experiences our clients have really had when they present for services, so we need to approach them in a universally sensitive manner:

➢ If we assume it is not related to trauma, we miss a great opportunity to help.
➢ If we assume trauma may be playing a role, we begin to pay attention to signs of trauma and ask the right questions.

The steps we take to create a safe and trusting environment benefits everyone.
What can we do?

➢ It would be wise to assume that trauma may play a role in the person’s current life difficulties and that our job is to…

1) Engage the person in exploring his/her life history related to trauma in a way that is respectful and sensitive

2) Insure that our policies, procedures, activities, environment and ways that we relate and talk to each other creates a safe and trusting environment

‣ These experiences may affect participation in treatment and are most important to consider from the very beginning
Let’s complete the ACE Survey!

› Take a few minutes and complete the survey.
› Thoughts?
› Questions or concerns?
Vicarious Trauma
The experiences of our clients may directly impact us.
Compassion Fatigue

“affects those who do their work well” (Figley, 1995)

- Shift in hope and optimism about the value of the work
- Deep physical, emotional and spiritual exhaustion
- Compassion fatigued practitioners continue to give themselves fully to their clients, finding it difficult to maintain a healthy balance of empathy and objectivity.
- Can be a typical response to work overload; can ebb and flow depending on demands

(Mathieu, 2007; Pfifferling & Gilley, 2000)
Risk Factors for Compassion Fatigue

- Personal History of Trauma
- Degree of Exposure
- High Degree of Empathy
- Inexperience Working with Trauma
- Counter-transference
Vicarious Trauma

- Providers working in social service settings face a number of challenges that lead to high rates of burnout and turnover. Working with trauma survivors brings another layer of challenge and stress.
- This phenomenon, known as secondary traumatic stress or vicarious trauma, is defined as “a state of tension and preoccupation with the individual or cumulative trauma of clients.”
- Service providers who work with trauma survivors are at risk of experiencing post-traumatic responses that parallel those of the people being served.
  - Re-experiencing the traumatic events; avoidance/numbing of reminders of the traumatic event; and persistent arousal.
  - Negative changes in the way we make meaning of ourselves and of the world
Vicarious Trauma

› Secondary exposure to extremely stressful events (exposure to others’ trauma or reexperiencing the client’s trauma)

› Symptoms rapid in onset and specific to a particular event

› Symptoms: Afraid, difficulty sleeping, images of upsetting event, avoiding the client and reminders of the event

(Figley, 1995, Stamm, 2012)
Burnout

- Feelings of hopelessness
- Feelings of being emotionally exhausted and overextended by the work.
- Feelings of depersonalization which result in negative, cynical attitudes toward clients.
- Diminished personal accomplishment, reflecting a sense of lowered competence and a lack of successful achievement in work with clients.
- Associated with high workloads and non-supportive work environment

(Maslach & Jackson, 1986; Stamm, 2012)
Burnout and VT: Co-Travelers

• Burnout
  – Work-related hopelessness and feelings of inefficacy

• VT
  – Work-related secondary exposure to extremely or traumatically stressful events

• Both share negative affect
  – Burnout is about being worn out
  – STS is about being afraid
Compassion Fatigue Self-Assessment

1. Personal concerns commonly intrude on my professional role.
2. My colleagues seem to lack understanding.
3. I find even small changes enormously draining.
4. I can't seem to recover quickly after association with trauma.
5. Association with trauma affects me very deeply.
6. My patients' stress affects me deeply.
7. I have lost my sense of hopefulness.
8. I feel vulnerable all the time.
9. I feel overwhelmed by unfinished personal business.

How many of you answered....

- Yes to 1 item
- Yes to 2 items
- Yes to 3 items
- Yes to 4 or more

Yes to 4 or more could be possible indicators of Compassion Fatigue.
What is the ?

Compassion Fatigue → Compassion Satisfaction

Self-Care!
Essential Components of Self-Care

Three essential components, of self-care that effectively address the negative impact of secondary traumatization on therapists: The “ABCs,”

- **Awareness** of one’s needs, limits, feelings, and internal/external resources.
- **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others.
- **Connection** to oneself, to others, and to something greater than the self.

Saakvitne, et. al. (1996)
Building Resilience

Resilient social workers have:

- Work-life balance
- Reflective skills
- Flexible coping styles
- Empathy without over-involvement (emotional boundaries)
- Strong social support networks
- Social confidence

(Kinman & Grant 2011; Grant & Kinman 2012)
What is Resilience?

› The American Psychological Association reports that resilience is “adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress”.

› Resilience is “bouncing back” from difficult and very stressful experiences in childhood or adulthood. It means being protected from the most harmful effects of trauma.

› Resilience also means how we handle and react to the day to day stresses that are just a part of life.
Dimensions of Resilience

- Fitness and stamina
- Nutrition for energy
- Rest and recovery

Physical

- Calming and focusing
- Impulse control
- Emotional regulation
- Positive emotion
- Realistic optimism

Emotional

- Self-belief
- Outlook & perspective
- Thinking traps
- Sustained focus
- Causal analysis
- Control controllables

Mental

- Values and beliefs
- Empathy
- Reaching out

Spiritual
The Three “E’s” of Trauma

Event(s) → Experience of Events → Effect of Experience

Resilience!
An Example!- Has anyone ever been in a car accident?

> Let’s say you always considered your driving time as “your time”—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance.

> How do you react?

> Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is always questioned, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked.

> Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe.

> Many other individuals are able to return to organizing core beliefs that support their perception of safety.
How Resilience Works?

- Resilience is best understood as both transactional and contextual, arising from the reciprocal engagement of persons and contexts. Persons and contexts, individuals and communities, groups and societies, survivors and ecosystems.

- Resilience is also a multidimensional phenomenon, expressed in relative degrees across multiple domains of psychological functioning. Expressions of resilience can co-exist with symptoms of even severe psychopathology.

- A goal of clinical intervention is to help the survivor mobilize his/her resilient capacities.
The 7 Cs: The Essential Building Blocks of Resilience

1. Competence: When we notice what young people are doing right and give them opportunities to develop important skills, they feel competent. We undermine competence when we don't allow young people to recover themselves after a fall.

2. Confidence: Young people need confidence to be able to navigate the world, think outside the box, and recover from challenges.

3. Connection: Connections with other people, schools, and communities offer young people the security that allows them to stand on their own and develop creative solutions.

4. Character: Young people need a clear sense of right and wrong and a commitment to integrity.

5. Contribution: Young people who contribute to the well-being of others will receive gratitude rather than condemnation. They will learn that contributing feels good, and may therefore more easily turn to others, and do so without shame.

6. Coping: Young people who possess a variety of healthy coping strategies will be less likely to turn to dangerous quick-fixes when stressed.

7. Control: Young people who understand privileges and respect are earned through demonstrated responsibility will learn to make wise choices and feel a sense of control.

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The 7 Cs are an adaptation from The Positive Youth Development movement. Rick Little and colleagues at The International Youth Foundation first described the 4 Cs of confidence, competence, connection, and character as the key ingredients needed to ensure a healthy developmental path. They later added contribution because youth with these essential 4 characteristics also contributed to society. The additional two C’s – coping and control – allow the model to both promote healthy development and prevent risk.
An Opportunity to Build Resilience

Trauma Informed Engagement
Phases of Engagement

1. First Contact
2. First Meetings
3. Ongoing Services/ Retention
4. Terminating Services
Summary of Phase One: Engagement at First Contact
First Contact

Objectives:
✓ Be welcoming
✓ Validate the person
✓ Express empathy and understanding
✓ Assess for urgency
✓ Clarify the need
✓ Confirm the next appointment or process and problem solve any presenting barriers
Phase Two: Engagement at First Meetings
First Meetings

Objectives:
✓ Remember the ARCH principles
✓ Focus on immediate concerns and needs
✓ Help participants make informed decisions about treatment and clarify the helping process
✓ Encourage shared decision-making in treatment: set the foundation for a collaborative working relationship
✓ Instill hope, reinforce strength, and foster resilience
✓ Attend to participant’s past experiences with mental health services and problem solve around barriers
✓ Create an opportunity for participants to ask questions and contract for future services
The ARCH Principles

- Acceptance,
- Respect,
- Curiosity, and
- Honesty

Focus on Immediate Concerns and Needs

- Be ready to schedule another appointment sooner than the following week.
- Participants often need help negotiating with other “systems” (healthcare, substance abuse providers, etc.).
- Responding to participants’ concerns provide an opportunity for provider to demonstrate their commitment and potential capacity for help.
Making Informed Decisions About Treatment

- Provide a clear overview of first meetings
- Clarify the helping process…
  - Carefully introduce self, agency intake process, and possible service options.
  - Discuss what is expected of participant and what they should expect from the intake process
- Clarify the need for mental health care - establish the felt need
Encourage Shared Decision-Making in Treatment

- Set the foundation for a collaborative working relationship.
  - Explain roles and responsibilities with the focus on ‘shared’ goals
  - “We” begins to be created
Instill Hope, Reinforce Strength, and Foster Resilience

Empower participants by:
- Providing positive feedback
- Instilling hope
- Reinforcing strengths
- Fostering Resilience
- Helping to identify barriers to implementing change within their day-to-day life and help problem-solve around those barriers

Validate participant and take time to understand participant’s perspective
- Participants may have concerns about privacy and confidentiality
- Participants who do not trust the provider or feel the information shared will not be held in confidence are also at a greater risk for dropout
- Cultural and racial differences between the provider and participant can lead to misunderstanding
Attend to Participant’s Past Experiences With Mental Health Services

- Identify and problem-solve around barriers to help seeking
  - First meetings are most helpful if there is an exploration of potential barriers to obtaining ongoing services
  - Specific obstacles, such as time and transportation must be addressed.
  - Other types of barriers include previous negative experiences with helping professionals; discouragement by others to seek professional help; differences in race or ethnicity between the interviewer and the participant; trauma history
Create an Opportunity for Participants to Ask Questions

- Create a space for participants to feel comfortable to express their concerns and ask questions
- Contract for future services
What Do We Mean By a Trauma-Informed Approach?

- A *trauma-informed approach* refers to how a program, agency, organization, or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma;
- It refers to a change in the organizational culture.
- All components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma.
- A trauma-informed approach is designed to avoid re-traumatizing those who seek assistance.
What is Trauma-Informed Care?

Trauma-informed care refers to how you think about and respond to those who have experienced or may be at risk for experiencing trauma.

“Trauma Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma...that emphasizes physical, psychological, and emotional safety for both providers and survivors...and, that creates opportunities for survivors to rebuild a sense of control and empowerment.”

~(Hopper, Bassuk, & Olivet, 2010, pg. 82)
5 Principles of Trauma-Informed Care

Safety
Trustworthiness
Choice
Collaboration
Empowerment

(Fallot & Harris, 2008)
Systemic Pillars of Healing

3 Pillars of Trauma Informed Care

1. Safety
2. Connections
3. Managing Emotions
<table>
<thead>
<tr>
<th>Common/Traditional View</th>
<th>Trauma Informed View</th>
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</thead>
<tbody>
<tr>
<td>‣ Person chooses behavior and needs consequences</td>
<td>‣ People want to do well but lack the skills or have learned bad behavior patterns</td>
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<tr>
<td>‣ Characterizes a person’s behavior negatively (i.e. manipulative)</td>
<td>‣ Characterizes a person’s behavior constructively (i.e. needs calming strategies)</td>
</tr>
<tr>
<td>‣ Uses labels to describe people (borderline, etc.)</td>
<td>‣ Reframes behavior to identify strengths</td>
</tr>
<tr>
<td>‣ Authoritarian</td>
<td>‣ Collaborative</td>
</tr>
<tr>
<td>‣ Minimizes coping strategies</td>
<td>‣ Behavior is communication and serves a function</td>
</tr>
<tr>
<td>‣ Mental health focused</td>
<td>‣ Whole person focused</td>
</tr>
<tr>
<td>‣ People should already know the expectations</td>
<td>‣ Teaches and re-teaches expectations using differentiation</td>
</tr>
<tr>
<td>‣ Create systems that make people work for support</td>
<td>‣ All people receive support regardless of their needs</td>
</tr>
<tr>
<td>‣ Staff-centered environment</td>
<td>‣ Person-centered environment</td>
</tr>
<tr>
<td>‣ Uses jargon with families and non-providers</td>
<td>‣ Uses language so that all can understand</td>
</tr>
</tbody>
</table>
Infusing Trauma Informed Care

- The program, organization, or system *responds* by applying the principles of a trauma-informed approach to all areas of functioning.
- People in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors, and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services.
- This is accomplished through staff and leadership training on trauma, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve.
- Some organizations have established "trauma work groups", a cross section of staff that strategize how to apply the lessons about trauma into daily program practices.
How we may unintentionally cause our clients to relive their trauma:

The importance of relationships

**What Hurts**
- Interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, judgmental

**What Helps**
- Interactions that express kindness, patience, reassurance, calm and acceptance and listening
- Frequent use of words like PLEASE and THANK YOU
How we may unintentionally cause our clients to relive their trauma: The importance of the physical environment

What hurts

› Congested areas that are noisy
› Poor signage that is confusing
› Uncomfortable furniture
› Separate bathrooms
› Cold non-inviting colors and paintings/posters on the wall

What helps

› Treatment and waiting rooms that are comfortable, calming and offers privacy
› Furniture is clean and comfortable
› No wrong door philosophy: we are all here to help
› Integrated bathrooms (clients and staff)
› Wall coverings, posters/pictures are pleasant and conveys a hopeful positive message
How we may unintentionally cause our clients to relive their trauma:

### Our policies and procedures

<table>
<thead>
<tr>
<th>What hurts</th>
<th>What helps</th>
</tr>
</thead>
<tbody>
<tr>
<td>› Rules that always seem to be broken (time to take a second look at these rules)</td>
<td>› Sensible and fair rules that are clearly explained (focus more on what you CAN DO rather than what you CAN’T DO)</td>
</tr>
<tr>
<td>› Policies and Procedures that focus on organizational needs rather than on client needs</td>
<td>› Transparency in documentation and service planning</td>
</tr>
<tr>
<td>› Documentation with minimal involvement of clients</td>
<td>› Materials and communication in the person’s language</td>
</tr>
<tr>
<td>› Many hoops to go through before a client’s needs are met</td>
<td>› Continually seeking feedback from clients about their experience in the program</td>
</tr>
<tr>
<td>› Language barriers</td>
<td></td>
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How we may unintentionally cause our clients to relive their trauma: Our attitudes and beliefs

<table>
<thead>
<tr>
<th>What hurts</th>
<th>What helps</th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ Asking questions that convey the idea that “there is something wrong with the person”</td>
<td>‣ Asking questions for the purpose of understanding what harmful events may contribute to current problems</td>
</tr>
<tr>
<td>‣ Regarding a persons difficulties only as symptoms of a mental health, substance use or medical problem</td>
<td>‣ Recognizing that symptoms may be a persons way of coping with trauma</td>
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A Framework for Effective Programs

- Uses a research-based risk and protective factor framework that involves families, peers, and communities as partners to target multiple outcomes.
- Is long-term, age specific, and culturally appropriate.
- Fosters development of individuals who are healthy and fully engaged through teaching them to apply social-emotional skills and ethical values in daily life.
- Aims to establish policies, institutional practices, and environmental supports that nurture optimal development.
- Incorporates and adapts evidence-based programming to meet local community needs through strategic planning, ongoing evaluation, and continuous improvement.
- Selects, trains, and supports interpersonally skilled staff to implement programming effectively.
An Example: Seeking Safety

Seeking Safety is an evidence-based, counseling model to help people attain safety from trauma and/or substance abuse. It directly addresses both trauma and addiction. Any clinician can conduct it even without training as it is an extremely safe model; however, there are also many options for training. The Seeking Safety book provides client handouts and guidance for clinicians.

Seeking Safety began in 1992 under grant funding from the National Institute on Drug Abuse. It was developed by Lisa M. Najavits, PhD at Harvard Medical School and McLean Hospital. It has been used in many countries and has been translated into over 8 languages.

The model is highly flexible. It can be conducted in group or individual format; for men and women; adults or adolescents; for any length of treatment; any level of care (e.g., outpatient, inpatient, residential); any type of trauma, any type of substance. Clients do not have to meet formal criteria for PTSD or substance abuse—it is often used as a general model to teach coping skills. Seeking Safety has been successfully implemented for many years across vulnerable populations including homeless, criminal justice, domestic violence, severely mentally ill, veterans and military, and others.

Seeking Safety offers 25 topics that can be conducted in any order and as few or many as time allows: Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices, and Termination. You can read a brief description of all 25 topics.

The key principles of Seeking Safety

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on both trauma and substance abuse at the same time)
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse
4. Four content areas: cognitive, behavioral, interpersonal, case management
5. Attention to clinician processes (clinicians’ emotional responses, self-care, etc.)
The Organizational Self-Assessment (OSA)

› Let’s Review!
Trauma Informed Care Approaches Improve the Experience of Everyone

Trauma informed organizations

- Increase safety for all
- Improve the social environment in a way that improves relationships for all
- Increases the quality of services
- Increases success and satisfaction at work
- Reduces negative encounters and events
- Creates a community of hope and health
Our Quality Improvement Method

- Education/knowledge/awareness
- Self assessment
- Identify an improvement goal
- Create an improvement plan/action plan
- Plan Do Study Act
Videos to Show

- https://www.youtube.com/watch?v=JlRK1vqcuvvg
Resources

- https://www.youtube.com/watch?v=P8nMgY5dkTs&nohtml5=False
- https://www.youtube.com/watch?v=AOOc3VO_Gyg&nohtml5=False
- http://www.fosteringresilience.com/professionals/
- https://hr.ucsf.edu/hr.php?&A=1055&org=c
- https://www.nationalcouncildocs.net/trauma-informed-care-learning-community/resources/additional-resources
PLACE MATTERS
AN OVERVIEW OF THE SOCIAL DETERMINANTS OF HEALTH
AGENDA

- Overview of the Social Determinants of Health
  - Health Disparities
  - Health Inequities
  - Our Role

- Screening: Place Matters

- Reflection

- Q&A
What is the greatest difference in life expectancy observed between counties in the U.S.?

A. 7 years  
B. 15 years  
C. 22 years  
D. 25 years
ANSWER:

B. 15 Years

Populations in some wealthy communities live on average well into their 80s, while others in some inner city neighborhoods and Native American reservations barely scratch 60.
“...the opportunity to be healthy is not equally available everywhere or for everyone.”
A social gradient in health exists
Social Determinants of Health

Those factors that impact upon health and well-being: the circumstances into which we are born, grow up, live, work, and age, including the health system.

Social Determinants of Health

Dramatic inequities dominate global health today.
These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves influenced by policy choices.
Social Determinants of Health

The social determinants of health are prominently responsible for health disparities and health inequities.
Health disparities: differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities

Health inequities: disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity
Consider What Creates Health: Nature and Nurture

- Previously presented as two competing realms at odds, the interplay between biology and the environment is key.
- One cannot understand biology without understanding the socio-environmental context.
- Mechanisms underpinning social factors cannot be understood without considering neurobiology.
Your ZIP code may be more important to your overall health than your genetic code.
Across America, Differences in How Long and How Well We Live
Determinants of Health and Their Contribution to Premature Death

Social Determinants of Mental Health

Not distinctly different from the social determinants of health

But deserve special emphasis, because:

- Mental illnesses and substance use disorders are highly prevalent and highly disabling
- Behavioral health conditions are high-cost illnesses
  - They have been largely neglected
Individuals with serious mental illnesses die, on average, 25 years earlier than the general population.
Culture Counts

“Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”
Disparities in Early Childhood are the Tip of the Iceberg

- Heart disease
- Hypertension
- Cancer
- Alcoholism
- Stroke
- Asthma
- Nephritis
- COPD
- Dementia
- STDs
- Influenza
- Depression
- Injuries
- Unwanted pregnancies
- HIV
- Drug abuse
- Substance Use
- Diabetes
- Homicide
- Tuberculosis
- Malnutrition
- Anxiety
- Malnutrition
- Anxiety

Adverse Early Life Experiences
ACEs are Highly Prevalent

More than 60% of the population surveyed reported one or more ACEs.
Health Problems Associated with ACEs

- Alcohol use disorders
- Depression
- Illicit drug use
- Suicide attempts
- Teen pregnancies
- Smoking
- COPD
- Fetal death
- Ischemic heart disease
- Liver disease
- Hearing voices
- Risk for intimate partner violence
- Multiple sexual partners
- STDs
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Early mortality
Relationship of ACE Score to Having Attempted Suicide in Adulthood

Poverty, Income Inequality, Neighborhood Deprivation
Neighborhood Deprivation

An “extreme poverty” neighborhood is an area/neighborhood where over 40% of households are below the federal poverty line.
The Juvenilization of Poverty

About 40% of children in the United States are poor or near poor.
Income Inequality

2008 data. Includes capital gains. Source: Emmanuel Saez, University of California-Berkeley

### Mental Health Related Outcomes Associated with Poverty and Income Inequality

- Depressive disorders
- Poor self-reported mental health
- Drug overdose deaths
- Juvenile homicides
- Delinquency
- Anxiety disorders
- PTSD
- Increased arrests
- Cognitive, behavioral, and attention-related problems in children
Poor Education
As a child or youth from a family living in poverty, you are 2-3x more likely to have a mental health problem along with poorer academic performance than that of a child from a family that is not living in poverty.
Poor Education

THE ACHIEVEMENT GAP

The achievement gap between children from high- and low-income families is roughly 30 to 40 percent larger among children born in 2001 than among those born twenty-five years earlier.²

“...education is a way out of poverty — but poverty is also a hindrance to education.”²
Poverty and Mental Health

- Poverty has been associated with numerous mental health outcomes.
- Timing, duration, and intensity of poverty matter.
Unemployment, Underemployment, Job Insecurity
"Very Good" or "Excellent" Health

- Under $20K: 37%
- $20-40K: 47%
- $40-60K: 56%
- $60-80K: 62%
- Over $80K: 71%

Source: NHIS 2001-2005
Food Insecurity
Housing Insecurity
Health Impact of Substandard Housing Conditions

- Rodent and cockroach infestation
- Water leaks and resultant mold
- Peeling paint and lead paint
- Exposed wires and uncovered radiators
- Insufficient heat or running water
- Overcrowding
- Increased asthma
- Increased lead poisoning
- Injuries
  - Radiator burns
  - Window falls
  - Fires from improper wiring, lack of smoke detectors, use of space heaters
- Increased infectious diseases
HOMELESS STUDENTS ARE ... 

2 times as likely as their housed peers to score poorly on standardized tests in math and reading.

3 times more likely to be placed in special education programs.

4 times more likely to drop out of school.

8 to 9 times more likely to repeat grades.

SOURCES

and
The Built Environment
On average, how many more supermarkets are there in predominantly white neighborhoods compared to predominantly Black and Latino neighborhoods?

A. About the same
B. 2 times as many
C. 4 times as many
D. 6 times as many
ANSWER:

C. 4 times

Predominantly Black and Latino neighborhoods have more fast-food franchises and liquor stores, yet often lack stores that offer fresh, affordable fruits and vegetables.
Poor Access to Care
WHAT IS OUR ROLE?
Screening for Social Determinants

- Do you Have Enough Food?
- Are your housing conditions safe/Is your housing stable?
- Do you have enough money in the house to pay for basic necessities (food, clothing, shelter, hygiene items?)
- Have you had any problems with your medical insurance (eligibility, denials, rejections, bills, etc.)
- Is your child being properly educated?
- Are there domestic violence issues in your home?
<table>
<thead>
<tr>
<th>Policies</th>
<th>Staffing</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examine agency policies to determine if they may be inadvertently limiting access to the disenfranchised.</td>
<td>Do you recruit, retain, and promote a diverse group of staff with knowledge, skills, and experience in serving diverse populations?</td>
<td>Has your agency identified and articulated engagement practices/standards for staff to utilize when serving hard to reach populations?</td>
</tr>
</tbody>
</table>
Considerations

Improve access to care and services

Examine organizational culture and the programs sensitivity to serving individuals who are economically disadvantaged.

• How are staff encouraged to attend to the concrete needs of those they serve who are burdened with the daily stress of living without?

• Are staff trained on addressing their own biases and judgements in the clinical decision-making process?
Considerations
All Policies are Health Policies

“Housing policy is health policy. Educational policy is health policy. Anti-violence policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy.”
Addressing Public Policies

- Taking action *beyond the walls* of treatment centers
- Advocate for policies and laws that improve education, increase employment opportunities (or extend employment benefits for the unemployed), decrease food insecurity, end discrimination, improve housing standards, etc.
- Offer expertise to your elected officials (individually, or through professional organizations)
- Cross-sector collaborations and relationships are key
Q&A?
Resources

› The Social Determinants of Mental Health 1st Edition
  Michael T. Compton (Author, Editor), M.D. (Author, Editor), Ruth S. Shim (Editor), M.P.H. (Editor)

› Unnatural Causes, [http://www.unnaturalcauses.org](http://www.unnaturalcauses.org)

› World Health Organization, [www.who.int](http://www.who.int)

Value Based Payment Arrangements & Principles
What is Value Based Payment?

† Approach used by payers to promote quality and value of health care services. The goal is to shift from volume-based payment, to payments that are driven by outcomes.

† Value Based Payment is based on population health and not on any individual member.

† Goals (the Triple Aim):
  • Improving Member’s Experience
  • Improving Quality
  • Reducing Costs
Risk and Reward

- VBP arrangements offer different levels of risk and reward built into the provider contract
- Risk Arrangements requires providers to have enough resources in the bank to cover losses if outcomes don’t meet the contract expectations
- Contractors need to take responsibility for a pool of patients large enough to mitigate the impact of outliers
- VBP requires provider to have tools to monitor performance in real time so can correct course based on data and meet targets
What are Risk and Rewards Arrangements?

- In a Value Based Payment providers are expected to participate in reward, risk or both arrangements.
- Reward arrangement refers to an arrangement when savings are shared between providers when agreed upon outcomes are met. Outcome measures usually involves provider processes measures and member outcomes.
- Risk arrangement refers to providers ability to pay penalties when agreed upon outcome measures have not been met and overall healthcare cost were above projected amount.
What is Capitation?

- Is a payment arrangement for providers.
- It pays a provider a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.
- Usually these types of contracts are between the State and Managed Care Organization. Also and independent practice association (IPA) can hold such as contract.
- The amount paid is based on the average expected health care utilization of that group of clients.
- The payment amount is usually referred to as Per Member Per Month (PMPM)
# Types of VBP Arrangements

<table>
<thead>
<tr>
<th>Types</th>
<th>Total Care for General Population (TCGP)</th>
<th>Integrated Primary Care (IPC)</th>
<th>Care Bundles</th>
<th>Special Need Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population</td>
<td>Patient Centered Medical Home or Advanced Primary Care, includes:</td>
<td>Episodes in which all costs related to the episode across the care continuum are measured</td>
<td>Total Care for the Total Sub-pop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Care management</td>
<td>• Maternity Bundle</td>
<td>• HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Practice transformation</td>
<td></td>
<td>• MLTC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Savings from downstream costs</td>
<td></td>
<td>• HARP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contracting Parties</strong></td>
<td>IPA/ACO, Large Health Systems, FQHCs, and Physician Groups</td>
<td>IPA/ACO, Large Health Systems, FQHCs, and Physician Groups</td>
<td>IPA/ACO, FQHCs, Physician Groups and Hospitals</td>
<td>IPA/ACO, FQHCs and Physician Groups</td>
</tr>
</tbody>
</table>

Source: VBP Bootcamp #2
Total Care for General Population (TCGP)

- Contracted entity takes responsibility for all healthcare needs/cost, including emergency room and inpatient cost.

- This arrangement can be upside only, up and down risk, or full capitation.
Integrated Primary Care Bundle

‣ *IPC puts community based professionals in the lead more than other arrangements.*

‣ Primary care groups focused on the spectrum of integrated primary care: population health, routine sick care, and chronic care.
  • Reduce inefficiencies and potentially avoidable complications throughout the entire spectrum.
  • No risk for types of care where specialty and inpatient care is leading (cancer, trauma, surgical care).

‣ Significant opportunity for quality improvement and shared savings.
Integrated Primary Care

- **IPC includes**: Bipolar, Diabetes, Depression, Asthma, Substance Use, etc.

- **IPC does NOT include**: emergency room and/or inpatient cost

- Inpatient and emergency room payments are separate and not the responsibility of the IPC.

- This arrangement can be upside only, up and down risk, or full capitation.
Care Bundle Payments

- A bundled payment is a single payment to providers for all services related to a single condition for a specified period of time (episode of care).

- All services can and probably will include emergency room and in-patient stay related to the condition.

- This arrangement can be **upside only, up and down risk, or full capitation.**
Specialty Needs Population

- Specialty Needs Population is similar to TCGP with focus on identified sub-populations

- Total care for sub-populations, e.g. HIV/AIDS, MLTC, HARP

- Contracted entity takes responsibility for all healthcare needs/cost, including emergency room and inpatient cost.

- This arrangement can be upside only, up and down risk, or full capitation.
What Do I Do Now?
Your Role as a Provider

- Behavioral health providers bring an expertise to the primary health care system that is needed to treat the whole person.

- Purpose of affiliating is to increase your power and influence, not reduce.
What Can You Do?

- Determine what VBP approach(es) make sense for your agency
  - Understand your costs to deliver care
  - Know your population
  - Identify the landscape
- Develop strategic marketing and communication plan
- Demonstrate your value
- Positioning and affiliating
- Need to document what works
- Talk to PPS
Know Your Population

- Get a sense of who you are serving
- The types of services you are delivering
- The types of services individuals with specific diagnoses are receiving
- Breakdown of clients by Insurance Type

Key features: standardization of definitions and terms across organization
Using data to make informed decisions

To succeed in new health care environment, all levels of staff must use the best available data to make informed decisions.

- **Clinical staff** can collect, monitor, and review clinical data to make treatment decisions. For example, seeing which diagnosis corresponds to what type of treatment in order to determine if the appropriate service is being provided.
- **Program directors** can use payer mix data, clinical, claims and payment data for each service and program to understand profitability.
- **Leadership** can use data to make decisions about staffing, and contracting and negotiating leverage.
Using Data To Enhance Your Service Package

› A Value Based Payment environment offers opportunities for expansion and innovation.
› Growth and change require strategic planning and this requires data
› The reports described here today can form the basis of this planning.
› Look not just for what is in the reports but also what the reports do not reflect. Who are you not engaging? How can you enhance access to your services? Engage more individuals in need?
How is this useful in a VBP environment

- Building upon these reports, providers will be better positioned to succeed in the Value Based Payment environment.
- VBP contracts require providers to have the tools to monitor performance in real time and course correct based on that data so that their outcomes can meet the expectations of the contracts.
Stronger Together

To be viable, Behavioral Health providers need to come together in different organizational structures for VBP arrangements:

• Mergers
• IPAs
• Contractual relationships
MCTAC Role

Training & Technical Assistance:

- In-person and web-based offerings
- Information Dissemination
- Tool & Resource Development

All activities informed by ongoing provider/plan/state partner feedback.
Additional Resources

‣ DOH Value Based Payment Page: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

‣ CTAC/MCTAC Website and System Transformation Page: http://ctacny.org/systems-transformation