WHAT YOU NEED TO KNOW: Every organization that embarks on the journey to implement trauma-informed care will have its own set of motivators, conditions, and challenges. However, we have also found strikingly common themes across a wide range of agencies, systems, and fields of practice. Several partners around the state have allowed us to document their ongoing process and results in the hope that the information might be useful to others. Below is a progress report from a rural community health center in Central Oregon.

Central Oregon Trauma-Informed Care Project
Progress Report
2015-2017

Introduction

In the fall of 2015, La Pine Community Health Center (LCHC) and Trauma Informed Oregon (TIO) formed a partnership to create the Central Oregon Trauma-Informed Care Project. The goal of the project was to explore implementation of trauma-informed care (TIC) in a rural community healthcare setting. Recognizing that many patients have complex circumstances, including histories of trauma, LCHC believed that this effort could help staff better understand and respond effectively to the root causes involved in many of the social and health challenges experienced by clinic patients. The Central Oregon Trauma-Informed Care Project was officially launched with a daylong all-staff training in October 2015.

Purpose

The collaboration between TIO and LCHC serves two purposes. First, LCHC has gained guidance from TIO staff, increasing the knowledge and capacity of providers and staff to incorporate an understanding of the impact of adversity and trauma in providing care. Second, the partnership has enabled TIO to document the process and results of the initiative, while learning more about the barriers and facilitating factors involved in implementing TIC in a rural health care setting.

Methods

LCHC formed a TIC work group (TIC-WG) in November, 2015, and this group has been meeting monthly since that time. A TIO staff member has facilitated this work group over the past 18 months. The progress toward implementation has primarily been documented through the meeting notes and input from the TIC-WG. In addition, TIO has met with clinic management and the LCHC data analyst in order to establish clinic-wide data that can be used to track impact. Feedback has been gathered from service recipients as part of a survey about their clinic experience, and from staff as part of the annual staff satisfaction survey.

Sharing the Findings

This report is part of the ongoing documentation of progress at LCHC and reflects the current status of the initiative. It is intended to be a resource for other organizations as they work to implement TIC.

Background and Context

LCHC is a Federally Qualified Health Center (FQHC) that serves a rural area of Central Oregon spanning 2,500 square miles (parts of which are designated as frontier) and two counties. The main

clinic is located in La Pine, Oregon; however, LCHC comprises several additional clinics in order to meet the needs of the approximately 20,000 residents living in this catchment area[1]. These include two clinics, one located in Christmas Valley and one located in Sunriver, and two school-based health centers (SBHC), one located in La Pine and one located in Gilchrist, Oregon.

External Conditions

Adults and children served by LCHC have higher rates of many demographic risk factors compared to Deschutes County or Oregon as a whole. Poverty is a common concern across all age groups. According to 2015 census data, 17% percent of the population for whom poverty data is available (n=18,000) lives below the federal poverty level (FPL) with the rate slightly more than 18% in the most densely populated area. Of the approximately 3,500 children in this region, 23% live below the federal poverty level (FPL). Comparatively, the rate for children under the age of 18 living below the FPL is 20% in Deschutes County and 21% in Oregon. Other risk factors in the population include lower rates of education among adults 25 years and older (47% have a high school diploma or less), single parent households (21% of families with children under 18), and high unemployment (9.5% among those for whom documented employment is known, n=7,896). The percentage of individuals age 62 or older in this region (32%) is also higher compared to overall rates in Deschutes County or Oregon (21.6% or 19.4%, respectively).

Physical and mental health issues are common among those living in LCHC's catchment area, and the demand for services is high. In 2016, LCHC reported 31,584 encounters from 8,431 patients across the five clinic sites[2], an average of 3.75 visits per patient. Of these, 4,847 encounters were walk-ins.

Clinic staff note that many LCHC patients struggle with mental health and substance use challenges. As a percentage of the population, the rate of suicide attempts and completions is high. While effort has been made to increase resources to this area, including the recent addition of behavioral health therapists at LCHC, county mental health providers located in La Pine, and specialty care offered by visiting physicians, available services do not meet the need. Moreover, travel in this part of the high desert can be problematic, with icy and snowy winter conditions and many unpaved roads, creating isolation and difficulty accessing care.

The need for services and the stress experienced by residents can be challenging for LCHC staff and add to their sense of intensity. As a result, the TIC-WG has prioritized staff wellness in order to prevent burnout and vicarious trauma (see Action Steps for additional discussion).

Internal Conditions

In addition to the external factors affecting LCHC, clinic staff note several internal factors that support the need for TIC. Staff turnover is frequent, particularly for medical providers, occurring on average every two years. With a designation as an FQHC, there is educational loan repayment offered through National Health Service Corp if providers locate at LCHC. This can lead some to consider LCHC as a stepping stone and/or experiential learning opportunity (See Action Steps for discussion of TIC-WG efforts focused on ensuring good communication and support for staff when changes occur). It's worth noting that in order to minimize the sense of loss among staff, LCHC leadership positively reframes this situation pointing to the benefit of having talented new providers. Additionally, knowing that

[1] When the project began in October, 2015, LCHC had the main clinic in La Pine, Oregon and two school-based health centers, one located on the campus of La Pine High School and the other located in Gilchrist, Oregon. A satellite clinic had recently opened (August 2015) in Christmas Valley, Oregon. Since that time, an additional clinic has opened in Sunriver, Oregon.

[2] The following is 2016 patient and encounter data from each site: LCHC main location in La Pine 19,229 encounters, 4,650 patients; Christmas Valley 3,779 encounters, 892 patients; Sunriver 621 encounters, 211 patients; La Pine SBHC 1902 encounters, 405 patients; Gilchrist SBHC 1,209 encounters, 298 patients.

transitioning to new medical staff can cause a sense of loss or anxiety for patients, many of the providers make a point to offer warm hand-offs or introductions via skype. Another internal factor affecting LCHC has been rapid expansion and growth. In August 2015, the clinic in Christmas Valley opened, followed by the clinic in Sunriver opening in 2016. Also in 2016, the main clinic in La Pine initiated a clinic addition and remodel. While these moves are positive overall, they can stress an organization in the short term. Onboarding new staff and working through the complexity of multiple locations can be a strain, especially when workloads are high. Dealing with the noise and inconvenience of construction is also difficult and has been discussed by TIC-WG members. Finally, state and federal expectations, for example integrated care with behavioral and physical health, can create internal challenges. Although these major policy shifts may be beneficial in the long run, they often bring additional responsibilities and tasks and can create significant challenges and unforeseen barriers. As one example, the integration of disciplines might involve the use of more than one electronic health record (EHR). Frustratingly, EHR systems are often unable to communicate with each other and share data, causing duplicate entry and problems for staff and patients.

Change Agents and Facilitating Conditions

Providing healthcare in a rural setting is inherently challenging. Patients often have complex situations and unmet needs. Accessing care can be difficult for many, and engaging in services may not be a priority. This was a familiar situation for LCHC's Medical Director, Dr. Laura Pennavaria, who had been thinking about a positive way to broach the subject of complex health conditions with her patients. Dr. Pennavaria was intrigued by the research on Adverse Childhood Experiences (ACEs)[3] and the idea that these health struggles could be related to early trauma. At conferences, she learned about trauma-informed care, an approach to service delivery that is based on the understanding of the impact of trauma and a desire to ensure clinic policies and practice reflect that knowledge. Given an opportunity to partner with TIO to pilot TIC at the clinic, she and the others on the management team were immediately on board.

> "We are all about the patients and the employees. I knew right away this was not just another program that would be here today and gone tomorrow. It was really more a matter of - *how do we do this*" (as stated by Charla DeHate, LCHC's Chief Executive Officer in *Central Oregon Medicine*).

Several other factors contributed to the staff's eagerness for TIC. The community showed *Paper Tigers*, a documentary about ACEs and a Washington State high school's effort to understand the impact of trauma on students. This inspired community interest and awareness of ACEs, which contributed to a shift in understanding. It is worth noting that *Paper Tigers* was brought to the community by the La Pine High School Care Team. A showing of the film had already taken place in Bend and Anne Marie Schmitt, Assistant Principal of La Pine High School, wanted South County to have the same opportunity as the other schools in the Bend-La Pine School District. La Pine area schools were also interested in TIC and this event underscored the possibility for cross-sector collaboration in the future.

Several clinic staff served as early adopters and champions of the effort. In particular, Beth Erickson, a behavioral health consultant at LCHC, has significantly contributed to the interest and work towards

[3] https://www.cdc.gov/violenceprevention/acestudy/about.html

the TIC implementation project. In her role at the clinic, and with her knowledge of the community and commitment to TIC, she has been an enthusiastic and effective champion.

Other staff share this enthusiasm and were happy to form the TIC-WG to shepherd the initiative. The effort of the TIC-WG has been the most notable outcome of the project thus far, and this work is described below.

Assessment and Planning

The process of implementing TIC will vary across organizations and fields of practice. However, identifying a core group that will move the process forward and monitor progress and outcomes is a key component to successful implementation.

The TIC Work Group

Following the all-staff training in October 2015, the clinic formed a work group that represents the diversity of roles in the clinic. This group has eagerly embraced TIC and is taking on the role of modeling and promoting TIC within the clinic. Following, are some of the strategies practiced by the LCHC work group:

- ***Have frequent and predictable meetings***. The TIC-WG meets monthly on the same Wednesday of each month. This consistency has ensured good attendance given such a busy clinic setting (approximately 10-12 staff at each meeting). Further, the meetings are limited to one hour, which creates a need to stay focused and productive.
- ***Meet at a convenient time and offer food***. The TIC-WG meets at noon and lunch is provided. Not only is this a convenient time for staff, but the provision of food reflects a commitment to self-care.
- ***Provide flexible facilitation for the meetings.*** Over the past year, TIO staff has helped provide guidance and facilitation for many of the meetings. Given that TIC was new to many of the LCHC staff, outside expertise and guidance has been helpful during the initial stages of the project. From a practical standpoint, TIO support has reduced the burden on already busy staff. However, the facilitation has been flexible (i.e., the agenda is altered as needed and discussion reflects the present concerns/interests of the work group) in order to be mindful of the dynamic environment of the clinic. Currently, TIC-WG members rotate taking and disseminating meeting notes. As TIC knowledge continues to increase and a work plan is outlined, it will be beneficial to transition the facilitation role to clinic staff. Although the group currently gives input to the monthly agenda, having clinic facilitation will increase staff buy-in and sustainability.
- ***Identify clinic contacts and leads.*** From the beginning of the project, the LCHC management team has provided guidance, support, and clinic-related information. At least one member of the management team has attended each TIC-WG meeting, which has been helpful as the TIC-WG discusses the feasibility of changes to policy or practice. Moreover, an internal "point person" to help coordinate meetings, set agendas, and provide information specific to the clinic context has been important.
- ***Prioritize the most immediate needs***. One of the most important opportunities for TIC, and an early focus of the TIC-WG, was the clinic's critical incidence response. Staff members frequently encounter upset and/or activated patients, which can be stressful for other patients in the clinic as well as the staff. The TIC-WG has been a great source of stability and problem-solving as the clinic considers trauma-informed ways to handle these situations. Over the past year, staff have received two trainings in de-escalation, a training in nonviolent communication, and a training in customer service. Additionally, TIC-WG has encouraged the revision of clinic protocols for handling these situations, including a practice of debriefing with clinic staff and, when

appropriate, patients. Furthermore, the sensitivity with which these situations are handled has become more trauma-informed. Activated patients are offered a safe space to regain a sense of calm or, when appropriate, are gently and discretely encouraged to leave. When law enforcement becomes involved, they now enter the building from a back entrance, away from the patients and staff in the front lobby. These changes have improved staff's feelings of safety and control, decreasing the negative impact. In the past, these stressful situations often affected a large portion of the clinic; now it is not uncommon to find that many TIC-WG members had no idea an incident had occurred.

- ***Create a culture of TIC.*** Open communication and transparency were seen by the work group as critical to a culture of TIC. The TIC-WG sends email updates to keep staff informed of TIC progress and has worked to obtain regular feedback from staff not directly involved in the TIC-WG. It is worth noting that open communication can be challenging as the organization balances staff's need to know with privacy and confidentiality considerations. The TIC-WG has grappled with this issue.
- ***Structure the process.*** TIC involves a shift in organizational culture, process, and approach rather than a specific model for service delivery. For this reason, it can be difficult to translate principles into practice. One of the recent challenges for the TIC-WG is switching gears from a focus on crisis incidents to the development of a longer-term strategic plan for implementing TIC. To guide and structure the process, the TIC-WG is using an assessment tool (in this case the TIO Standards of Practice for Trauma Informed Care[4]) in addition to addressing the concrete needs and priorities that emerged from the initial all-staff training. Although it may take a number of months to complete the Standards and work through emergent needs, together these will form the basis of a work plan.

Progress Monitoring and Outcome Assessment

There are several strategies for gathering information and feedback to assess progress. Some strategies have been used by the TIC-WG while others are yet to be developed. Methods for assessing impact will be an important consideration during the next phase of the project.

- ***Staff survey.*** LCHC administers an annual staff climate survey from the National Association of Community Health Centers. This survey includes questions about how employees feel and the support they receive. It is one of the more trauma-informed standardized instruments available for medical settings. However, clinic leadership plans to review the survey questions using a trauma lens and potentially supplement with a set of question focused specifically on TIC. In addition to the climate survey, in the future staff, will likely be asked about specific TIC efforts at LCHC. This process is yet to be developed but could provide valuable information about the reach and impact of specific action steps of the TIC-WG and/or policy and practice changes that have been initiated.
- ***Client survey.*** In January 2016, a short client survey was administered to learn how patients experience the clinic waiting area. Specifically, the TIC-WG was interested in feedback about whether the waiting area is welcoming and comfortable and how the patient experience might be improved (see Appendix A for the survey).
- ***Standards of Practice.*** In February 2017, the TIC-WG started working through TIO's Standards of Practice for a Healthcare Setting. Although there was discussion about forming a subcommittee to work through the Standards, the group decided to tackle the process as a whole. They plan to address one section of the Standards each meeting (there are five domains)

[4] See Resources for Organizations at www.traumainformedoregon.org.

until they have worked through the entire tool. This will provide an assessment of the current status, highlighting existing strengths as well as identifying opportunities for improvement that will inform the work plan.

- ***Output from training sessions.*** TIC training at LCHC included a chance for staff to work in small groups identifying "hot spots", i.e., circumstances, situations, or conditions in the agency that could activate a trauma response in staff or clients. These "hot spots", or emergent needs, have helped inform immediate priorities and will also be included in the work plan.
- ***Work group input.*** As the work group has become more knowledgeable and versed in TIC, potential action steps emerge from the monthly meetings. Typically, these relate directly to "hot spots" that were identified in training and one or more of the specific Standards that are currently under review. As one example, staff wellness has become a priority as the TIC-WG connect the impact of stress and trauma on staff well-being.

Action Steps to Date

As the clinic has moved forward implementing TIC, action steps can be described as both abstract and concrete. Some of the strategies have represented tangible changes, such as word choice on written communications shared with patients, e.g., "If you have mental health problems" became "If you are experiencing mental health challenges." Other efforts are harder to capture as they involve changes to culture and climate.

Changing Clinic Culture

From the start of the project, the TIC-WG has tried to create a culture in the clinic that feels trauma-informed by identifying (and highlighting to others) situations that reflect TIC, and looking for opportunities to use a trauma lens. Each work group meeting begins with a discussion of TIC "sightings." Members also problem solve situations that could have been handled in a more trauma-informed way. In order to continue building TIC knowledge, the group is encouraged to discuss how what they observed reflects the impact of trauma and/or the principles of TIC. In other words, what about this situation might threaten one's sense of safety, power, or self-worth? How did the staff either mitigate (or not) the individual's traumatic reaction? Time is also allocated (when available) at all-staff meetings to mention a TIC sighting or two. When time is not available, the group can send the TIC sighting via email. Following is an example of the type of TIC sighting that is discussed by the group.

> "*Kathy prepared for her day by letting Tom, Sheri, and I [Brenna] know that she was concerned a patient would arrive at his appointment activated, since she had had a previous encounter with this patient who came across as having an aggressive behavior. Good job Kathy for commencing this type of communication for everyone's safety! We did a run through of what time the patient was scheduled and who would be where in the building. We also discussed where our panic buttons are located at Gilchrist Clinic SBHC. I was planning on heading back to La Pine later in the afternoon, but since I was part of the communication, I arranged my schedule to support my fellow co-workers. Overall, everyone was 'all on board' with the TIC message*."

Supervision and Staff Wellness

Initial work with the TIO Standards of Practice has focused on the area of Workforce Development, specifically supervision and the standards related to staff wellness. Each work group member anonymously indicated where on the continuum of progress they believed the clinic was in terms of regularity of supervision and emphasis on staff self-care and wellness (from "*we haven't started yet*" to "*we've done a little"* to "*we've done quite a bit"* to "*we're stellar"*). The work group members felt that

the clinic has "*done quite a bit*" in providing regular supervision. When considering whether supervision includes discussion of self-care and wellness, however, members agreed that the clinic has only "*done a little*." Some specific strategies generated by the group included

- Having staff create self-care plans;
- Creating a self-care wellness survey for staff; and
- Working toward consistent and reflective supervision (for example, as outlined in, *Interactional Supervision* by Lawrence Shulman).

Staff Appreciation and Team Building

In addition to workforce wellness, the TIC-WG has prioritized staff appreciation. After a visit at Clackamas Behavioral Health Clinic in Oregon City to gain ideas for TIC, the work group established the Sunshine Committee, comprised of a cross-section of clinic staff. The intention is to create and promote activities that will encourage the staff to feel appreciated and valued. For instance, the Sunshine Committee created a bulletin board to be used by staff to write small notes of gratitude and recognition for coworkers. Another example is a matching game (otherwise known as "a little-known fact game") used as a way for staff to get to know each other better. The goal is to match the fact to the right staff person, with a prize for the most correct matches. Participation has been excellent; approximately 2/3 of the staff have been involved. Feedback has been positive, with staff members expressing their enjoyment.

Integrated Care

An effort that falls outside the TIC-WG purview but that coincides with the Central Oregon TIC Project is a pilot program LCHC is involved in with Johns Hopkins called the Pediatric Integrated Care Collaborative (PICC). A small team from LCHC recently traveled to Maryland to learn more about the project. While in Maryland, each team was asked to pilot a TIC strategy, called a PDSA (plan-do-study-act). The PICC team will be testing the impact of having a quick behavioral health visit included in every well-child check. This will be a chance for behavioral health (BH) staff to introduce themselves and answer any questions. The hope is this will increase the number of BH referrals that are actually pursued, but the team is still determining how to measure success. One of the PICC members is a provider, and the pilot will focus on her patient load first. LCHC will provide data for Johns Hopkins, which may also support evaluation of the TIC project. According to the team, there are two more centralized collaborative sessions: one in October in Denver, and one in April in Denver. The collaborative ends sometime before summer 2018. Although more clarity will be given in the coming weeks, the team feels that this year-long collaborative will help take TIC to a deeper level.

Other Action Steps

Other examples of trauma-informed strategies during this past year include

- Creating a new position (Satellite Site Clinic Manager) to ensure all sites feel supported;
- Hosting an annual open house (with a meal) for patients;
- Using a trauma lens during the clinic remodel/building project for decisions such as paint colors and use of space; and
- Adding employee photos to emails so staff feel connected.

Next Steps

The work plan that will be developed in the coming months will focus on

- Priorities identified in the "hot spots" from the all-staff training;

- Support for staff wellness activities;
- Opportunities for feedback from staff and patients; and
- Training on trauma, vicarious trauma, and TIC.

Although LCHC policy is reviewed by outside parties, clinic leadership believe the TIC-WG will be valuable in reviewing policy using a trauma lens, particularly policies that address safety concerns on the part of staff and patients. This local TIC-focused policy review will be included in the workplan.

Assessing Impact

As LCHC continues to initiate changes in practice and policy to reflect the principles of TIC, it will be important to assess not only the results (what is accomplished) but the impact (what is different because of the effort). Both qualitative and quantitative evaluation methods will be needed to help answer these questions. Potential methods might include

- Focused discussion with work group members about their experience of the process, their impression of the results, and their sense of impact;
- Brief anonymous staff survey that the TIC-WG could develop to gather similar process information from the entire staff;
- Analyzing staff wellness, morale, and job satisfaction questions from the existing staff survey or from questions that may be added; and
- Anonymous patient surveys with specific questions related to feelings related to safety, empowerment, and connection (feeling valued and cared for).

Additionally, clinic-level data could help assess impact linked with the implementation of TIC-specific policies and practices at LCHC. With anticipated improvement in staff morale and patient experience, data might show reduction in staff absenteeism and/or turnover. Indicators of increased patient engagement might show up over time as

- Reduction in non-indicated use of emergency room services;
- Reduction in No Shows for appointments;
- Improved rates of adherence to child immunization rates;
- Increase adherence to recommended colorectal screenings and other preventive services; and
- Increased rates of follow through on referrals.

Numerous factors could affect these quantitative outcomes, so it is critical to develop ongoing methods for direct feedback from staff and patients about their experiences to help interpret and provide context for any findings.

Lessons from the LCHC Experience

We asked the TIC-WG members what they've learned about the implementation process. Some of the responses included:

- TIC is an evolving process that takes time, commitment, and patience.
- We can work together to overcome barriers within the clinic and among community resources.
- Handing the Kleenex to someone is more important than keeping a schedule.
- It's important to not take things personally.
- We need to think about disruptive patients differently, with a different lens.
- Addressing the whole person is important.
- We need to meet patients and staff where they are.
- Empathy and sensitivity are necessary.
- The environment plays a big role and it's important to eliminate as many barriers as possible for patients and families.

- We need to use a nonjudgmental approach.
- It's important to use a broader lens and look beyond what's just in front of you. Think about the context.

In summary, it is evident that despite a lack of formal data to inform progress, there clearly has been learning at LCHC. Moreover, the consensus of the TIC-WG is that the efforts to implement TIC at the clinic are making a difference and that the effort will continue and grow over time.

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Appendix A
Waiting Room Survey for Patients

We are looking for your feedback! In an effort to make LCHC the best it can be, please take a few minutes to complete this brief survey regarding our waiting room. Please rate the following statements on a scale of 1-5 (1=strongly disagree, 5=strongly agree).

Which location are you completing this survey for (circle one): La Pine main clinic La Pine school-based clinic Sunriver clinic Gilchrist school-based clinic Christmas Valley clinic

	Disagree 1	2	Neutral 3	4	Agree 5
My experience in the waiting room was welcoming.	○	○	○	○	○
The seating in the waiting room was comfortable.	○	○	○	○	○
The waiting room has a comfortable amount of space.	○	○	○	○	○
Music in the waiting room would improve my experience.	○	○	○	○	○
The magazines, photos and posters in the waiting room were appealing to me.	○	○	○	○	○
I was acknowledged and addressed in a timely and courteous manner.	○	○	○	○	○
I was informed of approximate wait time to see my provider or receive services if delayed.	○	○	○	○	○

Do you have any other comments or suggestions on how we can improve your waiting room experience?

Comment Box