WHAT YOU NEED TO KNOW: This report describes how one Federally Qualified Health Center located in a mixed neighborhood in Portland and serving a high percentage of patients with chronic illness and/or mental health and substance abuse challenges used the Standards of Practice for Trauma Informed Care as an assessment and planning tool. In addition, we provide examples of how the TIC workgroup organized and presented the assessment results and their recommended priorities to various clinic audiences.

Applying Standards of Practice for Trauma Informed Care in a Primary Healthcare Clinic: The OHSU Richmond Clinic Demonstration Project

Background

In early 2016, the Department of Family Medicine at the Oregon Health & Science University (OHSU) formed a partnership with Trauma Informed Oregon (TIO) to initiate an implementation project for trauma informed care (TIC) at the department's clinic in the Richmond neighborhood of SE Portland. OHSU Family Medicine at Richmond (Richmond) is a Federally Qualified Health Center and serves individuals and families in its catchment area regardless of ability to pay, income, insurance, language, or background. The clinic is located in a mixed neighborhood and serves a high percentage of patients with chronic illness and/or mental health and substance abuse challenges. Providers and clinic staff are strongly committed to patient-centered care and are organized in teams to support comprehensive and coordinated care as well as to encourage continuity of relationship between patients, staff, and providers.

The goal of the TIC project was to create a more trauma informed context for patients, caregivers, and the workforce at Richmond through a shift in the organization's culture, policies, practices, and procedures. At the same time, TIO and the OHSU departmental staff, as well as strong advocates at the clinic, wanted our work locally to contribute to discussion in the broader health care field. We decided to test the Standards of Practice for Trauma Informed Care (Standards)[1] that had been developed by TIO but not yet adapted for healthcare. The purpose was to determine the extent to which the Standards applied to a healthcare setting, make adaptations as needed, test the tool, and create a version that would be available and useful for other interested partners.

This report briefly describes the early planning process at Richmond, but focuses primarily on our experience working with the Standards. Aspects of this process are included and may be helpful for other primary care groups to consider. In addition, we provide examples of how

[1] Standards of Practice for Trauma Informed Care https://traumainformedoregon.org/standards-practice-trauma-informed-care/faqs/

the workgroup organized and presented the assessment results and their recommended priorities to the various clinic audiences.

Getting Started

Our initial work at Richmond included engaging all of the clinic staff through information sessions and foundational training on trauma, its impact, and the principles of TIC. By offering two, half-day training options in March of 2016, we were able to include nearly 100% of staff (providers, nurses, medical assistants, office and administrative). Following the training, the planning team was opened to new members; additional staff volunteered or were recruited in an effort to include representation from each role in the clinic, and the resulting workgroup began meeting soon after to start the assessment and planning process.

The process of forming a workgroup and moving through the early planning stages has been similar across many organizations, and some of the many issues involved are documented elsewhere.[2] In the primary healthcare setting, scheduling can be particularly difficult and it also can be difficult to include staff in certain clinic roles because of particular constraints (at Richmond, it was particularly challenging to include front office staff, for example, who play a key role but do not have flexibility in their work schedules). We planned workgroup meetings at Richmond for the noon hour and staff initially gave up personal time to participate. Almost immediately, however, clinic management agreed to provide lunch and made it possible to extend the meeting to one and a half hours.

As has been common across organizations, the first priorities for TIC action steps came from the needs identified during training and from direct input of workgroup members and other staff. The very first concerns at Richmond focused on the experience of the workforce with respect to activated patients in the waiting room, exam rooms, the pharmacy, the entryway, or the parking lot. The need for protocols to ensure staff safety and a request for de-escalation training surfaced very quickly. The group prioritized a number of other immediate and concrete safety concerns as well. These were addressed quickly and successfully, getting the group off to a strong positive start (examples are included in Table 2).

The workgroup continued meeting monthly, working its way through the list of identified issues as well as new ones that emerged on an ongoing basis. Because this work is ongoing,

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[2] Central Oregon Trauma Informed Care Project: Progress Report 2015-2017
https://traumainformedoregon.org/wp-content/uploads/2017/02/LCHC-TIC-Implementation-Progress-Report-July-2017.pdf
Clackamas County Behavioral Health Centers Trauma Informed Care Initiative 2012-2016
https://traumainformedoregon.org/wp-content/uploads/2016/01/Clackamas-County-Behavioral-Health-Clinics-Trauma-Informed-Care-Initiative-Final-Report.pdf
Yatchmenoff, D., Sundborg, S., & Davis, M. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work, 18*(1), 167-185

within a few months, a subcommittee formed to review the TIO Standards of Practice and begin using them at the clinic.

Working with Standards of Practice in a Healthcare Setting

The initial Standards were created with community-based mental health or family support organizations in mind. We weren't sure how well they would apply to primary care—both conceptually and with respect to the specific terminology and use of language in the tool. However, given the heightened interest in the healthcare field in operationalizing the principles of TIC, we felt it was important to offer this resource to healthcare providers if we could.

Adapting the TIO Standards

The Standards subcommittee at Richmond, which included a lead social worker, supervisor, nursing staff, quality assurance manager, and others agreed to review the Standards and make any adaptations that seemed appropriate before applying them to the clinic. Over two meetings, we went through each individual item, looking at the applicability of the content to primary care as well as any issues with terminology. In the end, we made only a few changes, most of them nominal, such as changing "agency" to "clinic" and "client" to "patient," etc. Substantively, most of the standards were easily applicable, particularly given that the tool provides guidelines, not prescriptions. We encourage organizations to focus on those items that are most relevant and useful and set others aside or defer for later consideration.

We found that including multiple roles and perspectives on the standards sub-committee resulted in maintaining a broader set of standards than might have been endorsed if the review committee had not been as heterogeneous. For example, there was considerable discussion about whether items relating to peer support applied in a clinic setting. In the end the standard remained, despite the fact that the practice of routinely offering peer support is not yet in place at Richmond, nor in many other primary care settings.

In a similar process, healthcare providers at the Oregon Pediatric Society undertook a second review of the instrument and suggested further modifications to some of the language. These revisions did not alter in concept how we were using the tool at the Richmond Clinic, but were helpful input for the current version now available on the TIO website.[3]

Using TIO Standards as benchmarks in primary care

Once the Standards had been approved for use at the clinic, the sub-committee moved into the assessment process. The group met for approximately one and a half to two hours on six occasions over a seven-week period, working systematically through the five domains (see

[3] Standards of Practice for Trauma Informed Care – Healthcare Settings
https://traumainformedoregon.org/resource/healthcare-standards-practice-trauma-informed-care/

Appendix A) to document strengths, identify areas in which improvements could be made, and generate agreed-upon ratings as a baseline for monitoring progress.

In general, the process was smooth and highly productive. However, there were challenges that surfaced as well. Some of what we learned that may be helpful to other organizations includes the following:

- The commitment to meet weekly and to move quickly and efficiently through the Standards created a momentum that was helpful. It also meant that information, ideas, and common understanding were not lost from one meeting to the next.

- For the same reasons, consistency in subcommittee membership also helped. We had a core group that participated in all of the meetings, along with a few additional staff who came to observe or participate once or twice. However, this meant that only a small number of staff were familiar with our work on the Standards, which was occurring parallel but separate from the process in the larger TIC workgroup. Eventually, we needed to address this potential disconnect.

- It was also helpful to have guidance on the Standards from TIO staff as the group moved through them. The subcommittee spent a fair amount of time discussing the meaning and interpretation of some items. Although the tool explicitly invites individualized interpretation and adaptation as needed, the group was more comfortable when TIO staff could explain and provide examples of what was intended. As we have revised the Standards for the website, we have considered where additional information might be helpful to make this easier for workgroups that are operating without outside technical assistance.

- One of the largest challenges was the natural impulse to move towards numerical ratings on individual Standards (see the Standards of Practice for Trauma Informed Care - FAQs for more information about this[4]) before fully exploring what may already be in place at the clinic that addressed a particular area. TIO staff helped to keep the discussion open-ended and to encourage dialogue and reflection on each of the individual Standards. Whether an outside consultant or a staff member facilitates the process, this "slowing down" and listening is an important function. At Richmond, it led to a richer and fuller discussion of various aspects of clinic culture that are experienced differently by staff in different roles and at different levels of authority. This greater understanding, as well as cross-fertilization of ideas, is ideally an outgrowth of the assessment process, however it occurs.

[4] Standards of Practice for Trauma Informed Care - FAQs https://traumainformedoregon.org/standards-practice-trauma-informed-care/faqs/

- A related challenge was the impetus to move immediately to solutions. We discouraged the subcommittee from problem-solving as they went through the Standards (though also suggested tracking any ideas that surfaced so they could be brought forth later). We felt it was important that the results of the Standards-based assessment (the strengths and weaknesses identified as well as the resultant ratings) be presented to the larger TIC workgroup for feedback and input before moving too quickly to priorities and action steps. Ideally, the results would also be presented to leadership, the patient advisory council, and potentially to all staff—again, with the possibility of additional input or feedback. This not only improves the assessment, but also can help strengthen and sustain buy in.

- However, as in nearly every other situation we've encountered, the ideal of wide dissemination and engagement of multiple perspectives at every step in the process has been difficult if not impossible to achieve, given the complex and intense work that is ongoing at the clinic. It is hard to engage broader participation in a timely fashion. In the end, there is a balance to be found between inclusiveness and the need to keep moving forward rather than stalling out. Both are important.

- It was also important to conceptually link the original concerns generated in the all-staff training that were driving the efforts on the TIC workgroup with the results of the Standards-based assessment, which addressed many of the same concerns but at a slightly higher or more abstract level. We were concerned that the two processes were operating independently and could be confusing both to staff and to clinic leadership. Jointly we worked on a graphic presentation of this two-pronged or "hybrid" approach—that is, addressing immediate "micro" concerns in the workplace (tied to the principles of safety, power, and self-worth) while simultaneously working on "mezzo" level aspects of practice and policy (in the five domains covered by the Standards). One version of this graphic representation is included in Appendix B to this document. It includes a few specific changes that were initiated to address safety concerns early on at Richmond. These appear under "Trauma Informed Practice on the Ground" The point of the graphic is to show the interrelationships between the micro and mezzo-level efforts.

- In the end, however, organizing the data from the workgroup and the Standards subcommittee into a manageable and readable format was the key to moving forward. Two documents provided as tables proved helpful.

    - The first is Table 1 listing the five Standards domains in one column. A second column reflects the Areas of Strength noted by the subcommittee, with specific details on action steps that have been taken. The third column

indicates Standards that the subcommittee felt had not yet been sufficiently addressed. Again, these are not yet action steps—merely areas where work is needed. They form the basis for the larger TIC workgroup to prioritize and brainstorm solutions.
    - The second is Table 2 details the specific issues related to safety, power, and self-worth that the TIC workgroup took on, listing the concern and how it relates to trauma informed care, along with the recommended action step, the result (completed, in process, or deferred), and any particular barriers to the recommended action. Note that some of the completed action steps also appear as examples in the Standards document since they directly address one or more of the domains.
    - Together these documents form the basis for more systematic planning, with action steps coming out of the Standards-based review as well as immediate concerns from the workgroup linking back to the larger key domains of clinic operation.

- One of the advantages of benchmarks or standards is the possibility of using the initial review as a baseline against which progress can be gauged (though the tool was not designed to provide precise quantifiable measures, so caution is always required in interpretation of results).[5] It has been approximately one year since the Standards assessment was completed at Richmond, and as this document is in production, the subcommittee is planning to reconvene to revisit the results and to identify areas where progress has been made, establish new priorities, and suggest next steps.

Beyond assessment, the work to implement TIC at Richmond clinic has continued and there is much more to be learned from their efforts, the strategies that have been effective in surmounting barriers, and specific achievements, including considerable progress in areas of clinic practice and management as well as the initiation of training and TIC implementation efforts at other primary care clinics in the OHSU system.

Interested partners are encouraged to contact Joan Fleishman, Psy.D. (fleishma@ohsu.edu) at the Department of Family Medicine at OHSU for updates and to learn about their plans to disseminate information on the TIC initiative at Richmond and the rollout to other clinics.

[5] Standards of Practice for Trauma Informed Care - FAQs https://traumainformedoregon.org/standards-practice-trauma-informed-care/faqs/

Table 1
Standards of Practice for Trauma Informed Care: December 2016 Results and Recommendations

Standard Domain	Areas of Strength	Priority Areas/ Recommendations
Organizational Commitment Clinic leadership acknowledges that understanding the impact of trauma is central to effective service delivery and makes operational decisions accordingly.	**1. Trauma Informed Care (TIC) efforts are a part of the clinic strategic plan.** **2. Clinic prioritized training for all staff.** **3. Clinic has agreed to have line in budget for TIC efforts, provides lunch for committee meetings, allows committee chairs to devote one to two hours/week to work as well as allows committee members to work on TIC work outside of the meetings.**	**1. Need a process in place for regular feedback and suggestions from staff and patients related to TIC.** **2. Leadership regularly visits with staff across the clinic.** **3. Decisions about changes in policy, practices, procedures, and personnel are made in a way that minimizes negative impact on workforce and patients receiving services.** **4. Workforce wellness for all employees is a priority and is addressed.**
Environment and Safety Demonstrated commitment to creating a welcoming environment and addressing safety concerns.	**1. Clinic has addressed safety in and outside the clinic. Examples include: Security during all clinic hours, safety assessment of clinic, improved lighting and safety of bike shed.** **2. Clinic has a space committee where concerns are brought about safety and how to create a welcoming environment.**	**1. There is a designated "safe space" for staff to practice self-care.** **2. Physical safety and crisis protocols are in place and are regularly practiced, including debriefing and care of staff.**

Standard Domain	Areas of Strength	Priority Areas/ Recommendations
Workforce Development Human resources policies and practices reflect a commitment to TIC for staff and patients/caregivers.	**1. Everyone in the clinic has had training in TIC.** **2. Committee sends clinic updates via email every two months.** **3. Clinic staff feel safe bringing up concerns/questions/feedback to the committee.**	**1. Core training is offered at least annually** **2. Training is provided for all staff on supporting, managing, and responding to reactivity.** **3. Clinic is building internal capacity to ensure that ongoing training and education for staff on TIC is available.** **4. Screening and interviewing protocols include applicants understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of TIC.** **5. New employee orientation and training includes the core principles of TIC, which affirms the agency's commitment to ongoing trauma awareness and education.**
Services and Service Delivery Service delivery reflects a commitment to trauma-informed practices.	**1. Health Literacy workgroup is alive and well.** **2. Patient Advisory Council is being used appropriately.** **3. Clinic uses Press Ganey surveys to collect patient feedback. Hospital uses patient advocates to help support patients.**	**1. Clinic needs easy to read documentation that explains core services, key rules and policies, and process for concerns/complaints.** **2. Policies related to treatment services have been reviewed and modified as needed to reflect an understanding of trauma and its impact.** **3. Clinic procedures reflect an understanding of the potential triggers.**

Standard Domain	Areas of Strength	Priority Areas/ Recommendations
	4. Naloxone is being prescribed to everyone who is prescribed opiates, regardless of risk. **5. Clinic is supporting an Intimate Partner Violence initiative.** **6. Clinic provides services to everyone.**	**related to physical touch and close contact for patients affected by histories of trauma.** **4. If/when clinic services are denied, patients are provided assistance in connecting with other resources in the community.**
Systems Change and Progress Monitoring There is demonstrated commitment to ongoing planning, implementation, and continuous improvement.	**1. The clinic has a TIC committee that is active.** **2. TIC subcommittee is looking at universal standards of TIC and assessing greater clinic needs/strengths.** **3. TIC created a staff survey to assess baseline data of staff's awareness of TIC and staff burnout/wellness.** **4. TIC committee has created a safe avenue for staff to offer regular feedback and opportunities to learn and grow.**	**1. Clinic policies have been reviewed through a trauma informed-lens and modified to meet TIC principles.** **2. Leadership receives regular updates on progress and priorities for systems change to ensure TIC.**

Table 2

Richmond Clinic Action Steps: April 2016-May 2017

Hotspot	Why	Action Steps	Result	Barriers
Bike Shed	Not safe at night and door does not stay open.	Sensor light added inside and out. Hook to keep door open when needed and door stop available.	Completed. Completed.	None and low cost.
Parking	Staff parking lot a block away from clinic.	Buddy System put in place to walk to car. Inform staff with quarterly email message and at huddles that security guard can walk staff members to their car and remind them to move their car into clinic lot after 5 p.m.	Completed. Completed.	Ran into issues with security company and safety concerns with one guard. Guard was replaced after talking with security company.
Lobby	Music has been an issue in the lobby and currently not being played there. Security desk is the first thing seen when entering the clinic. Lobby needs to be assessed. Only one entrance/exit door for staff and the back emergency exit is locked.	Research music that is not stimulating and increases a sense of calm in the lobby. Check to see if it can be moved away from the door. Environmental Scan completed and making some low cost, high impact changes (paint, chairs, furniture repaired, music, etc.). Look into cost of electronic chips on badges to access exit door.	In Process. Not possible right now. In process. Not completed.	 Needs to be there for safety purposes. Too expensive so not possible.

Hotspot	Why	Action Steps	Result	Barriers
Safety	Clinic only pays for security until 8:30 p.m. and security guards often leave early. Staff and patients are alone in the clinic late at night.	Security is now present during all hours clinic is open. Management is working with security company so there is consistency among the security staff.	Completed.	
	Create closing procedure that includes security checking the whole clinic before leaving and informing staff.	Security does walk thru before leaving	Completed.	
	No safety protocol in place for activated patients in the clinic.	Install panic button upstairs.	In process.	
	Multiple hotspots around safety that are difficult to organize.	Make a list of what hotspots the workgroup gives to the safety committee and send in advance.	In process.	
X-ray room	Procedures and language do not feel trauma informed (TI) and include a lack of privacy and activating language.	Scripts developed on how to ask patients to remove clothing and other instructions in a TI way.	Completed.	
Signage	Sign needed to inform patients about REFRESH and what to expect when they go upstairs.	Signage ideas given to safety and space committee.	In process.	
	Signs need improvement to convey a more welcoming environment.			
	Signs on cell phone use needed for patients in lobby and other rooms.	Workgroup created ideas and ran them by the Patient Advisory Committee (PAC) for feedback.	In process.	
	No inclusive signs present for bathrooms.	All bathroom signs in clinic are now ADA/all gender inclusive on bathroom doors.	Completed.	

Hotspot	Why	Action Steps	Result	Barriers
Training	Want to become a TI agency. Threatening/escalated patients in lobby and on phone.	Two days of trainings on TIC for all staff. De-escalation training for front office and pharmacy. Met with Clackamas Behavioral Health Center. Training developed by behavioral health team. Crisis protocol in place Suicide Intervention Protocol developed that is patient centered and has staff debriefing component.	Completed Completed de-escalation training. Working on this and looking at OHSU's internal resources.	
Communication	Issues of disruption at front desk with lobby improvements. How to respond to community about national and local tragedy. How to inform staff on TIC happenings (newsletter was suggested). No safe feedback loop for staff.	Script for desk staff to inform patients on construction. TIC committee has collective effort to respond by memo with resources. Bring it to workgroup and someone will volunteer to take the lead on it. Workgroup members attend PAC, staff and leadership team meetings are held regularly to update staff on TIC activities, and TIC monthly memo goes out to all staff. Safe process developed for staff to offer regular feedback and opportunities for learning through the TIC committee.	Completed. Completed. Completed. Completed.	

Hotspot	Why	Action Steps	Result	Barriers
Workgroup	Recruitment, charter, and mission statement needed.	Developed charter and budget that were approved by leadership and are in strategic plan. Recruitment for the workgroup came from all areas of the clinic and Cascadia site. Facilitator chosen and given time to manage the workgroup. Lunch for the workgroup is provided and members are paid for one to two hours to attend meeting. Committee is allowed to work on TIC outside of meetings. Line in clinic budget for TIC efforts	Completed. Completed/On going. Completed. Completed.	
Rooms	Rooms needs improvement. Second floor is not a secure patient area; doorways and doors are an issue.	Pumping room has new paint, refrigerator, and new chair. Other rooms have new carpet, paint, more lift equipment, and increased janitorial services. Second floor safety evaluated by public safety during safety and threat assessment. Recommendations made to leadership and will keep the clinic updated on changes.	Completed. In process.	
Security Guards	Location of security desk is activating for patients. Security guard leaves before clinic closes.	Move desk away from door Paying security guards to stay from open to close and do a walk through before they leave. Security guards are present during all clinic hours.	Not possible right now. Completed.	Needs to be there for safety purposes.

Hotspot	Why	Action Steps	Result	Barriers
Clinic	Clinic is not TI in many areas.	Charter for TIC workgroup committee approved to address hotspots. Physical environment reviewed.	Completed.	
		Standards of practice completed by sub-workgroup and presented to leadership with recommendations.	Completed.	
		Clinic staff survey created and sent out to all staff to assess baseline data of staff awareness of TIC and staff wellness. Data results presented to leadership team.	Completed.	
	Issues with building construction disrupting service.	Scripts developed for front desk staff to inform patients about lobby spruce up project and construction.	Completed.	
	Policies/forms outdated and not TI.	Clinic polices reviewed and revised the non-violence and patient dismissal policies. Registration/intake form updated to include trans language and gender choice.	In process.	
Staff break room	No space available that is safe and calm for taking care of oneself.	TIC Committee handed it to the Wellness Committee	In Process.	
Water	No accessible water stations	Filter water downstairs on first floor and upper second floor has water bottle fill station.	Completed.	

Hotspot	Why	Action Steps	Result	Barriers
Staff	Staff being asked to work before being clocked in.	Reminder memos to all staff about when to approach incoming staff about patient needs.	Completed.	
	Being disrupted during break or being paged while on lunch.	On TIP of The Week suggested using Smart Web meal break and changing status to be blocked. Remind staff paging is for urgency only. Routing Guide sent to staff		
	Staff voiced concerns about events not being culturally sensitive.	Workgroup addressed culturally themed events through writing letter to leadership.	Completed.	
	Medical assistants (MA) are concerned about being disrespected by providers.	Workgroup brought this to the attention of providers and MAs report providers have been friendly and more respectful.	Completed.	
	Staff have only one door to enter/exit and are interrupted by staff and patients.	Using fire exit (backdoor) for staff exit or enter by key card. TIC workgroup submitted SBAR proposal to clinic leadership.	Not possible now.	Leadership determined cost is too high.
	Issues with escalated/angry patients.	Workflow developed for how staff can engage with patients and how to care for staff afterwards.		
Patients	Staff activated by having to weigh patients every time.	Want to make it optional for patient	Not possible now. Maybe move scale to more private area.	Weight info needs to be collected for a quality measure.
	No data about patient experience.	Generated patient hotspots at the PAC meeting.	Completed	
	Issues with patient policies not being TI.	Presented abbreviated TIC training at PAC.	Completed	
	Dismissal Polices not TI.	Revised the non-violence and patient dismissal policies	Completed	

Completed Action Steps by Date

Action Step	Date Completed
Bike Shed Improvements	April 2016
De-escalation training and scripts	May 2017
Signage walk through and improvements, all gender/ADA inclusive signs on bathrooms	April 2017
Standards completed by sub-workgroup and presented to leadership	December 2016
TIC trainings	March 2016
Communication improvements	Continuous
Clinic electronic survey and presented highlights to leadership	August 2016
Lobby improvements	In Process
Newsletter/memo from TIC workgroup with a suggestion loop	On going
Informing patients about weighing and touching	In process
Second floor improvements	In process
X-Ray room improvements	In Process
Security improvements	January 2017
Building improvements (paint, filtered water, chairs)	In process
Local/National Tragedy Response memo protocol	June 2016
Charter for workgroup created and approved	December 2016
Created Culture of Wellness, Space and Safety committees	July 2016
TIC Booth with resources at Parking Lot Event	July 2016
Environmental scan completed by workgroup	February 2017
Addressed culturally themed events	December 2016
Revised the non-violence and patient dismissal policies	April 2017
Second floor safety and parking lot was evaluated by public safety, and recommendations made to the clinic	December 2016
Health Literacy workgroup developed	May 2017

Appendix A

The Standards of Practice for Trauma Informed Care

Agency Commitment

- Leadership invested in learning
- Budget for TIC
- Feedback sought and used
- Workforce wellness a priority
- Commitment to equity and diversity

Physical Environment and Safety

- Environmental Scan
- Staff and consumer experience
- Safe space
- TI crisis protocols in place

Workforce Development

- Training
- Hiring and onboarding
- Supervision
- HR policies and practices
- Workforce wellness

Service Delivery

- Welcoming environment
- Intake process
- Staff skill set
- Transparent program rules
- TSS available or referred
- Peer support

Systems Change and Monitoring

- Sustained process for TIC
- Self-assessment
- Communication
- Evaluation, feedback loop

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Committee to Wellnes

Appendix B

Organizational Efforts

What Organizations can do to Create a Culture of Trauma Informed Care

Standards of Practice