

PRACTICE PAPER

# Supporting Small but Mighty Practices in Implementing ACE Screening & Trauma- Informed Care

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# Table of Contents

Chapter	Page
<b>1:</b> Background and Introduction to Trauma & Adverse Childhood Experiences	<b>1</b>
<b>2:</b> A Trauma-Informed Approach to Healthcare – How Healthcare Can Help	<b>4</b>
<b>3:</b> Incorporating TI Approaches into the Physical Environment & the Front Desk	<b>8</b>
<b>4:</b> The Trauma-Informed Clinical Encounter: Exams, Tests & Procedures	<b>16</b>
<b>5:</b> Screenings for ACEs and Responding to Trauma	<b>25</b>
<b>6:</b> Staff Wellness - A Critical Aspect of Trauma-Informed Care	<b>36</b>
<b>7:</b> Conclusion: Trauma-Informed Approaches and the Small but Mighty Practice	<b>41</b>

## Definitions

Acronyms	Definition
ACE	Adverse Childhood Experience when referring to only one ACE
ACEs	Adverse Childhood Experiences when referring to more than one ACE
EHR	Electronic Health Record
EMR	Electronic Medical Record
PEARLS	Pediatric ACEs and Related Life-Event Screener
SDOH	Social Determinants of Health
TI	Trauma-Informed
TIC	Trauma-Informed Care

This practice paper was funded by the ACES Aware initiative in California. It was based on a series of online trainings facilitated by the Primary Care Development Corporation (hyperlink to the trainings <https://www.pcdc.org/what-we-do/training-technical-assistance/screening-for-and-addressing-aces-adverse-childhood-experiences-webinar-series/>). A special thanks to Angela Fernandez, Trauma Expert & Consultant, who co-created the content for the trainings and facilitated the trainings with Yael S. Lipton, MPH, MCHES.

# Background and Introduction to Trauma & Adverse Childhood Experiences

**Background:** Recently there has been increased recognition of the role trauma and adverse childhood experiences (ACEs) play in the health of people and populations.

The COVID-19 pandemic has greatly affected the mental and emotional well-being of many people around the world.<sup>1</sup> Healthcare practices and clinics of all sizes, but particularly small and medium-sized practices, should consider ways to incorporate trauma-informed approaches to care in their practices.

This paper is a roadmap to help smaller healthcare practices implement trauma-informed approaches. These recommendations are informed by a year-long series of provider engagement sessions (virtual learning series) conducted between 2020 and 2021 as part of the ACEs Aware initiative, funded and led by the California Office of the California Surgeon General Department of HealthCare Services to give Medi-Cal providers training and support in implementing ACEs screening. For the purposes of this paper, we consider smaller practices as those that employ approximately 6 – 7 or fewer

providers, including Medical Doctors, Nurse Practitioners and/or Physician's Assistants. While all healthcare settings should provide care that is culturally responsive and trauma-informed, smaller practices are positioned to implement trauma-informed approaches as they are often anchor institutions operating within communities that have been typically disinvested and disenfranchised. These practices often serve tight-knit populations and can tap into the needs and insights of their community and families. In California, statewide efforts incentivize the use of TIC by reimbursing screenings for ACEs.

The steps outlined in this paper offer a comprehensive framework to integrating trauma-informed approaches into healthcare practices. It is our hope that through this paper practices can begin integrating trauma-informed approaches.

<sup>1</sup> Tomaz T, Castro-Vale I. Trauma-informed care in primary health settings—which is even more needed in times of covid-19. *Healthcare*. 2020;8(3):340. doi:10.3390/healthcare8030340

## Adverse Childhood Experiences (ACEs):

ACEs are potentially traumatic events that occur when we are young. ACEs and the associated toxic stress they create are the root causes of some of the most common, serious, and costly health and social challenges facing our state (see ACEs Aware website for more comprehensive information about the effects of ACEs).

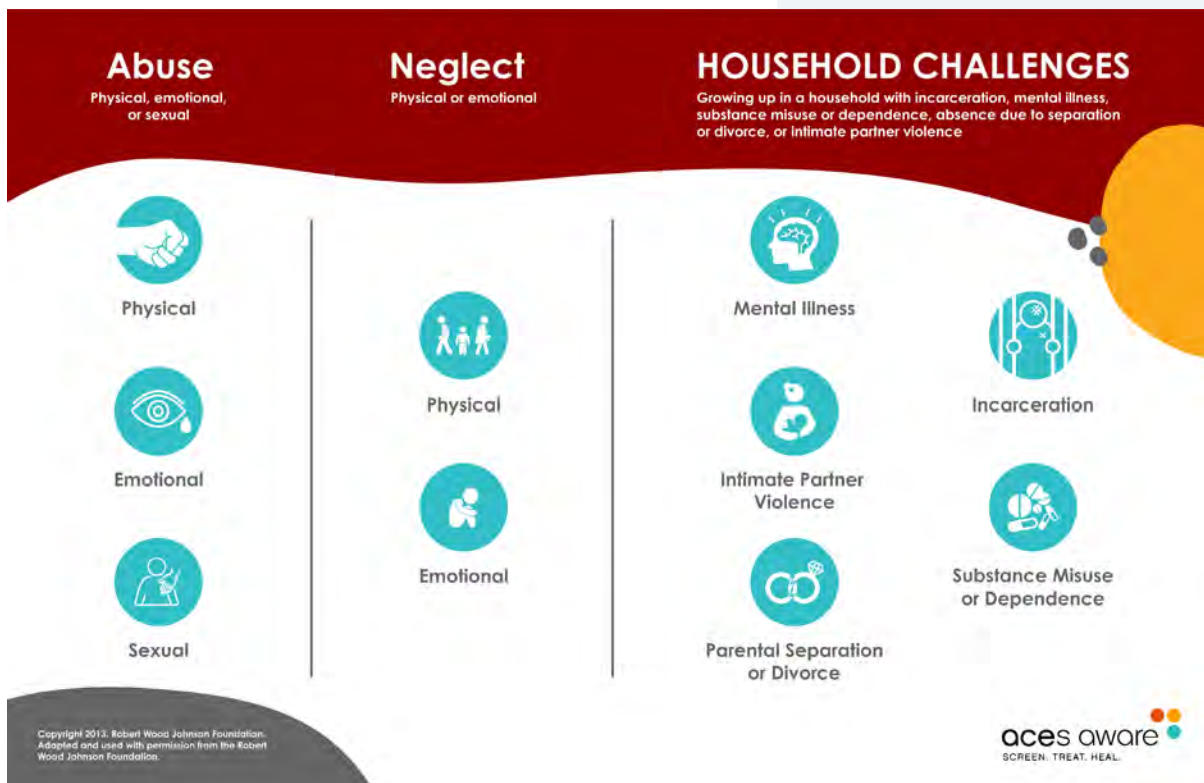
Adverse Childhood Experiences are specific traumatic events that occur in childhood between the ages 0 – 17.<sup>2</sup> There are 10 ACEs that fall into three categories:

- **ABUSE:** Direct physical, emotional and/or sexual
- **NEGLECT:** Physical and/or emotional
- **HOUSEHOLD:** Living with someone with mental illness, incarcerated relative, mother physically and/or emotionally abused, someone with substance abuse disorder, and/or divorced of parents

## What is Trauma?

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

Substance Abuse and Mental Health Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884. Rockville, MD 2014 (Google URL)



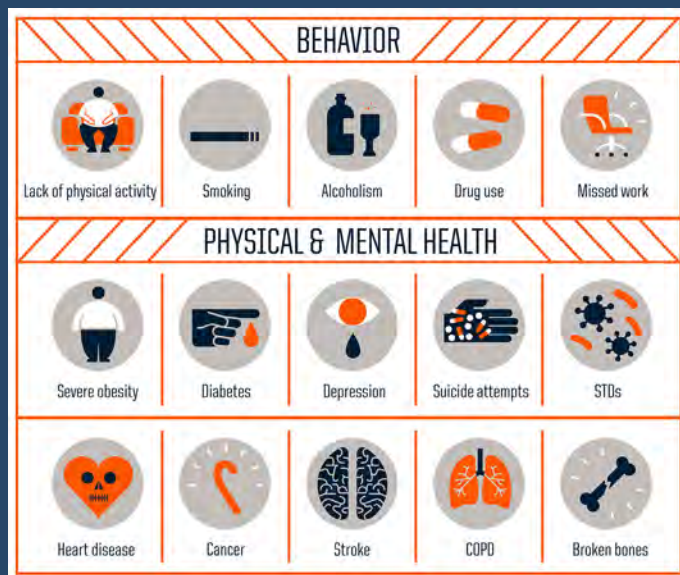
Adverse Childhood Experiences (ACEs). Aces AWARE. <https://www.acesaware.org/ace-fundamentals/> Accessed August 14, 2021.

<sup>2</sup> Preventing adverse childhood experiences. Centers for Disease Control and Prevention. [https://www.cdc.gov/violenceprevention/ACEs/fastfact.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2FACEstudy%2Ffastfact.html](https://www.cdc.gov/violenceprevention/ACEs/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2FACEstudy%2Ffastfact.html). Published April 6, 2021. Accessed August 14, 2021.

## The Effects of ACEs:

The impacts of ACEs may continue to be experienced long after the initial events, and impact one’s health and interactions with the health care system. Research has shown that although trauma survivors and people who have experienced ACEs are high utilizers of sick visits and emergency care, they may avoid seeking preventive medical care, and may not<sup>3</sup> seek mental health services, but rather look for help in primary care settings. Patients with trauma and ACEs may present with common physical symptoms and poorly managed chronic conditions and be unaware of the connection between their experience and health. Trauma or re-triggering of past trauma can also occur in the context of health service delivery itself, driving patients to avoid care or experience fear and anxiety when getting care.

## ACEs can Increase your Health Risks



Centers for Disease Control and Prevention

For more information about ACE-associated health conditions for pediatrics and adults see ACEs AWARE’s [ACE Screening Clinical Workflows](#), [ACEs and Toxic Stress Risk Assessment Algorithm](#), and [ACE-Associated Health Conditions: For Pediatrics and Adults](#).

**62%**  
of California residents have  
experienced at least one ACE



**16%**  
of California residents have  
experienced 4 or more ACEs



California Department of Public Health, Injury and Violence Prevention Branch (CDPH-IVPB) University of California, Davis, Violence Prevention Research Program, California Behavioral Risk Factor Surveillance System, 2011-2017.

<sup>3</sup> Raja S, Hasnain M, Hoersh M, Gove-Yin, S, Rajagopalan, C. Trauma informed care in medicine: Current knowledge and future research directions. *Fam Community Health*; 2015; 38(3): 216-26.

# A Trauma-Informed Approach to Healthcare – How Small Practices Can Help

Healthcare practices and centers can help support patients’ feelings of safety and comfort while obtaining services, and ultimately improve access to quality care for people who have experienced ACEs and/or trauma.

## What is a Trauma-Informed Healthcare Organization:

A trauma-informed approach to clinical care is defined as having these components:

A foundation grounded in trauma-informed principles and a team approach

An environment that is calm safe and empowering

Education about the impacts of current and past trauma (and other adversities) on health

Inquiry about-and response-to recent and past trauma that includes onsite or community based resources and treatments

*Machtiger, E.L., Davis, K.B., Kimberg, L.S., et. al. From treatment to healing: Inquiry and response to recent and past trauma in adult health care. Women’s Health Issues, 2019;29; 97-102. DOI:10.1016-J.WHI.218.11.003*

A trauma-informed framework is a recognition that all parts of the body are interconnected and accounts for the connection between emotional experiences and physical health. Trauma-informed care, which is person-centered by design, brings us back to the framework that bodies, brains, systems, and experiences are all inter-connected and affect one another. This holistic approach to care recognizes that the root cause or exacerbation of physical disease may in fact be emotional and mental.

Still, physicians and healthcare staff may not feel as though they are able to help patients with adverse experience. This can be a potential barrier to implementing TIC, particularly in small healthcare practices. Adopting key ingredients of trauma-informed care in small but meaningful ways, and learning to adapt these efforts through informed-and-collaborative decision making with staff, will allow healthcare practices to continue to support patients without feeling overly burdened by the process.

## The Key Ingredients of Trauma-Informed Organizational Practices:

Adopting trauma-informed approaches begins with incremental steps throughout the organization, starting with basic awareness raising.

### Key Ingredients of Trauma-Informed Organizational Practices

#### **Create a safe physical and emotional environment for both patients and staff**

Feeling physically, socially, and/or emotionally unsafe may cause extreme anxiety and can be potentially triggering and re-traumatizing for people who have experienced trauma. Creating a safe and welcoming environment is a first step to ensuring patients and staff are engaged in TIC.

#### **Develop a trauma-informed front-desk experience**

Taking a trauma-informed design approach not only includes the look and feel of your space, but also how staff operate within that space -- the front desk sets the tone for a patient's whole experience.

#### **Implement trauma-informed clinical encounters**

For people with trauma histories, clinical exams can be especially triggering because of their invasive nature. Implementing trauma-informed approaches can mitigate some triggering experiences by thoughtfully and consistently encouraging a sense of dignity for patients.

#### **Screen for trauma and ACEs**

A critical component of TIC is screening for ACEs and other trauma. The purpose of screening is to identify patients at risk for toxic stress and then implement strategies to reduce the impacts of toxic stress and the risk of negative health and social outcomes.

#### **Prevent secondary traumatic stress in staff**

Working with patients who have experienced trauma can cause "emotional duress that results when an individual hears about the firsthand trauma experiences of another."<sup>4</sup> Support your staff, many of whom may have had their own trauma, or been involved in group traumas.

<sup>4</sup> Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals. National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011. Accessed May 10, 2021 at [http://nctsn.org/sites/default/files/assets/pdfs/secondary\\_traumatic\\_tress.pdf](http://nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf). Published 2011. Accessed August 12, 2021.

## Resources for Trauma-Informed Training and Professional Development:

- [ACESAware.org](https://www.acesaware.org/): ACEs Aware is an initiative led by the Office of the California Surgeon General and the Department of Health Care Services and provides Medi-Cal providers training, clinical protocols, support, and payment for screening children and adults for ACEs.
- [Positive and Adverse Childhood Experiences \(PACES\) Connection: pacesconnection.com](https://www.pacesconnection.com/): A website that is made up of over 400 communities around the world doing trauma work
- [Primary Care Development Corporation \(PCDC\)](https://www.pcfdc.org/): PCDC is a national organization dedicated to supporting clinics and practices through all facets of healthcare implementation. PCDC provides expert technical assistance, training, and coaching to help providers implement trauma-informed approaches to care, and many other topics such as addressing social determinants of health, health plan quality and performance reporting, and launching and funding new programs and practices.
- [Trauma-Informed Care Implementation Resource Center](https://www.healthcarestrategies.org/trauma-informed-care-implementation-resource-center/): This website, developed by the Center for Health Care Strategies, provides resources from trauma-informed care leaders across the country to help improve patient outcomes, increase patient and staff resilience, and reduce avoidable health care service use and costs.

The first and most fundamental element of TIC is to be person-centered. Trauma-informed Care is by nature person-centered because it involves patients in their treatment and the decision-making process.<sup>8</sup> In addition, TIC is culturally responsive and approaches patients and staff with cultural humility. Physicians may be the experts in testing, diagnostics, and treatment, but patients are the experts in how best they can manage their treatments given their particular life and experiences.

A second critical element of TIC is screening for trauma and ACEs. ACEs AWARE focuses on screening for ACEs using specific tools. Trauma-informed practices may also use screening tools to screen for trauma, ACEs, intimate partner violence (IPV), substance use and abuse social needs, and many other issues that may affect adult and young patients.

As noted, staff training is a crucial ingredient for

implementing trauma-informed organizational practices. More specifically, for a healthcare center or practice to be trauma-informed, staff should be trained in trauma-specific treatment approaches. There are several evidence-based trauma-specific approaches available.

A final key element to TIC is engaging referral sources and partnering with outside organizations. As we discuss in Chapter 6, screening for social needs can be an important complement to trauma-informed care. To implement a trauma-informed approach, centers and practices must have strong relationships and partnerships with outside organizations who are equipped to support individuals in trauma recovery, social needs, and more. In other words, practices must be able to refer people out for services they cannot provide internally – whether the referral is to address the trauma itself, or for other critical wraparound services that were identified as part of the screening process. Practices should

<sup>8</sup> Robinson JC, Miller KM. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014;312(16):1663-1669



take steps to address the needs that have been uncovered through screening. Therefore, partnerships to other organizations that specialize in trauma, IPV, depression, substance use, etc. are critical to the holistic support that underlies TIC.

**Small but Mighty - Why Small practices Can and Do Make a Difference:** Smaller healthcare practices are perfectly positioned to implement trauma-informed approaches. Many small and medium-sized practices have been in practice for decades and are trusted partners in their communities. As such, they have uniquely strong relationships with patients and their families, compared to larger practices. This is the perfect foundation for implementing TIC.

Many small and medium-sized practices are also located in historically undeserved areas, serving uninsured and underinsured populations, that are typically affected by poverty and racism. Providers and staff in small practices often share ethnic and cultural backgrounds with their patients which helps promote trust and cultural competency. In fact, studies show that small practices provide high quality care, a greater level of personalization and responsiveness to patient needs with lower average costs per patient,<sup>6</sup> and fewer hospitalizations, compared to larger practices.<sup>7</sup> This gives small practices an advantage towards the successful implementation of person-centered TIC. However, while small and medium-sized practices are perfectly positioned to do this work, there are challenges that require different kinds of solutions compared to bigger health systems. For example, small practices may have limited resources, including limited employees and money to spend

on implementing training and new programs. Of great significance, “Becoming ACEs Aware in California” training is free of cost for providers ([www.training.acesaware.org](http://www.training.acesaware.org)).

“A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.

– SAMHSA, 2012, citing Harris, M. & Fallot, R. (2001). *Using trauma theory to design service systems*

That said, the benefits of implementing trauma-informed approaches greatly outweigh the challenges – both for the practice itself as well as its patients. Implementing TIC offers a huge opportunity to improve the health and well-being of both families and communities by addressing the root causes of illness and is also a great opportunity to re-think the roles of support staff and work in a more team-based approach, which has been shown to increase staff and provider satisfaction.

<sup>9</sup> Robinson JC, Miller KM. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *JAMA*. 2014;312(16):1663-1669.

<sup>10</sup> Casalino LP, Pesko MF, Ryan AM, Mendelsohn JL, Copeland, KR, Ramsay PP, et al. Small primary care practices have low rates of preventable hospital admissions. *Health Aff (Millwood)*. 2014;33(9):1680-1688.

# Incorporating TI Approaches into the Physical Environment & the Front Desk

Effects of Physical Space on Individuals with Trauma Histories: Research has shown that physical space has a profound impact on attitude, mood and behavior due to the strong connection between physiological and emotional states and the physical environment.<sup>8</sup>

Studies evaluating the effects of physical surroundings showed that an agency that was perceived as pleasant, beautiful, well kept, above average, neat, calming, and efficient, was considered more professional, believable, and offers a higher level of customer service in handling customer complaints than one which was perceived as disorganized, unpleasant, etc.<sup>9</sup> Taking steps to make healthcare spaces warm, clean, calming, and well-kept fosters a sense of dignity for both patients and staff.

## 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?

- Comfortable, calming, and private treatment and waiting spaces
- Furniture is clean and comfortable
- No wrong door philosophy
- Integrated restrooms
- Messages conveyed throughout that are positive and helpful

<sup>8</sup> Gill N. Council post: The importance of trauma-informed design. Forbes. <https://www.forbes.com/sites/forbesnonprofitcouncil/2019/12/09/the-importance-of-trauma-informed-design/?sh=18d3664f6785>. Published December 9, 2019. Accessed August 14, 2021.

<sup>9</sup> Berens, MF. A review of research: Designing the built environment for recovery from homelessness. Design Resources for Homelessness. <http://designresourcesforhomelessness.org/wp-content/uploads/2015/11/Orientationreport.pdf>. Accessed on May 13, 2021.

## Trauma-Informed Healthcare Design

For small to medium-sized practices with tight spaces or budgets, incorporating trauma-informed design does not have to be overly expensive or complicated – there is no need to knock down any walls to become trauma-informed! The simple rule of thumb for trauma-informed design is to remove adverse stimuli and environmental stressors. Congested areas that are noisy, confusing or with not enough signs, have uncomfortable and dirty furniture, use cold, non-inviting colors, with nothing on the wall can make for an uncomfortable and unsafe-feeling environment. In contrast, comfortable,

clean, and calming private treatment and waiting spaces, a “no wrong door” philosophy, and messages on the wall that are positive and hopeful can help make patients feel welcome and more relaxed. Remember, though, some of the things that can be traumatizing for some people might not be for others – so trauma-informed design is population-specific, and it’s worth engaging your staff, patients, and community in thinking-through how best to make changes and improvements to your practice’s environment.

### Before Trauma-Informed Design



### After Trauma-Informed Design



Farrell J, and Weeks, R. *Trauma-Informed Spaces & Places*. VT Office of Economic Opportunity Conference. April 3, 2019.

### Consider Patient Culture, Community, and History:

It can be helpful to ask members of your community about what kind of images, art, colors, etc., make them feel happy, calm, and relaxed. In general, avoid abstract art, and have materials and signs in the languages of the patients.

### Multi-Sensory Spatial Layout, Furniture and Sight Lines:

Spaces with clear sight lines, high ceilings, and minimal barriers are usually perceived as being safer and more relaxed. Patients are less likely to feel trapped or confined. Make spaces as easy to navigate as

possible by using clear, consistent signs. This means that signs for things like treatment rooms or restrooms are clearly and consistently labeled throughout the center, and in whatever languages are most common among patients. In addition, furniture should face away from walls, with patients backs against the walls as much as possible. This prevents the feeling of being surprised from behind. Avoid having people in different parties sit face-to-face, which can be perceived as confrontational. Arranging seating in a way where chairs are clustered in groups or via cornered seating that invites socialization and interaction are better choices. These can

be especially good for families who come in together. If possible, also include options for secluded seating so people can choose to be a little further away from others and have more privacy. Finally, furniture should be clean, comfortable, and big enough to accommodate different body sizes.

### **Wall Color, Art, and Connections to the Natural**

**World:** Images of nature are soothing as are earth-toned colors like sky blues and forest greens. According to trauma-informed designers, warm colors should be avoided as they may arouse negative emotions. Cool colors, on the other hand, have a calming effect and make spaces feel more open and less crowded. And avoid stark white walls. They are institutional and can remind people of places like prisons, hospitals, and the like.

“Nature has universally soothing, feel-good properties that can comfort traumatized individuals who may otherwise feel disoriented or disconnected.”

– Soderstrom, 2020

**Engage the Senses - Hearing and Seeing:** People with trauma histories may be triggered by loud,

harsh noises, certain music, and certain smells as well. Therefore, you want to minimize loud and overwhelming noises to the greatest extent possible. Soft, natural sounding music without lyrics is preferable. Some practices have chosen to use TVs to play news stations, soap operas, talk shows, or other daytime TV for those waiting. However, these programs often cover topics like unhealthy relationships, distressing current events, crime, and more, that may have been at the center of many past traumas. Instead, some practices have televisions with health messages on them that can promote things like healthy eating, getting recommended screenings, and other positive health practices. Just remember to think deliberately about what is on the televisions, how loud it is, and who controls it.

**Lighting:** Natural lighting tends to reduce stress and discomfort. Lighting can be changed easily by using a different lightbulb. While natural light is always preferable, it's not always realistic. Spaces with windows that can still maintain privacy is the best option to promote a more soothing environment. In the absence of natural light, warmer hued LED lighting can serve as an alternative that resembles daylight. Fluorescent green or yellow-tinged lighting will make the space feel more institutional. Finally, make sure parking lots, common areas, bathrooms, entrances, and exits are well lit.<sup>10</sup>

“They brought in elements of nature: raindrops, curves, shelves that look like trees. I think my favorite thing is the main reception desk that is split into two levels, so that little kids can see with their heads over the desk. This detail and so many others will give kids a sense of control and safety.”

– Naomi Barasch, Senior Director of the Queens Child Advocacy Center (CAC) from “Trauma-Informed Design Creates a Safe Space for Children”

<sup>10</sup> Center for Health Care Strategies. Key ingredients for successful trauma-informed care implementation. Issue Brief. 2016.

## Reduce Stimuli and Environmental

**Stressors:** Keep spaces clean, organized and clutter free. Aim for simple and easy to navigate spaces and consider using arrows on the ground to help patients navigate their way throughout the center. In fact, if your physical space is especially confusing, consider having someone escort patients from one place to another, so they don't feel trapped or lost. Make sure patients have clear access to the door in exam rooms. Finally, have a separate space for patients who are in distress, even if it's an empty exam room.<sup>11</sup> Patients who are having a hard time will appreciate the effort to keep their emotions private and will be appreciated by others who might feel uncomfortable witnessing others in distress.

## Considerations for Pediatric Practices:

- Furniture: Make sure it is kid friendly, sturdy, and that children of different sizes can use it.
- Seating: Provide small, clustered seating options so that families can sit together and are not separated throughout the waiting room.
- Bathrooms: Provide bathrooms that are big enough to fit more than one person at a time (parents with children who need bathroom help, disabled children, etc.), and have lower toilets and sinks for younger children.
- Activities: Provide books and toys for children of all ages (ensure they are offered from behind the desk and then cleaned after each use).

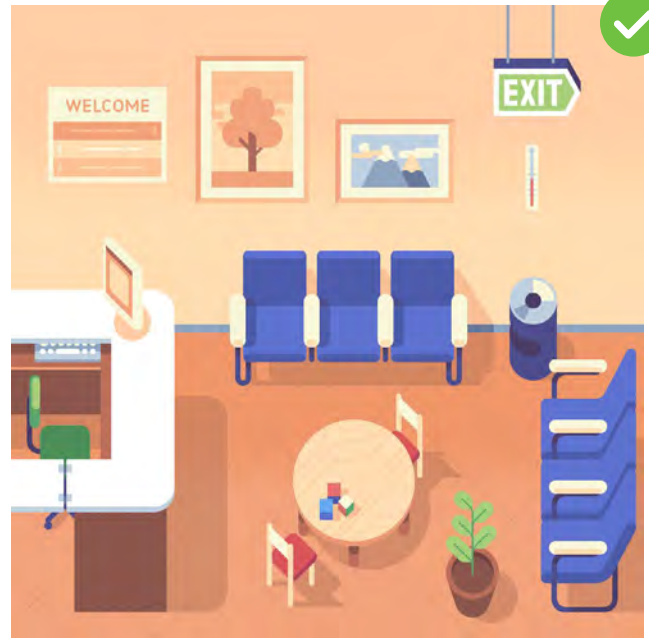
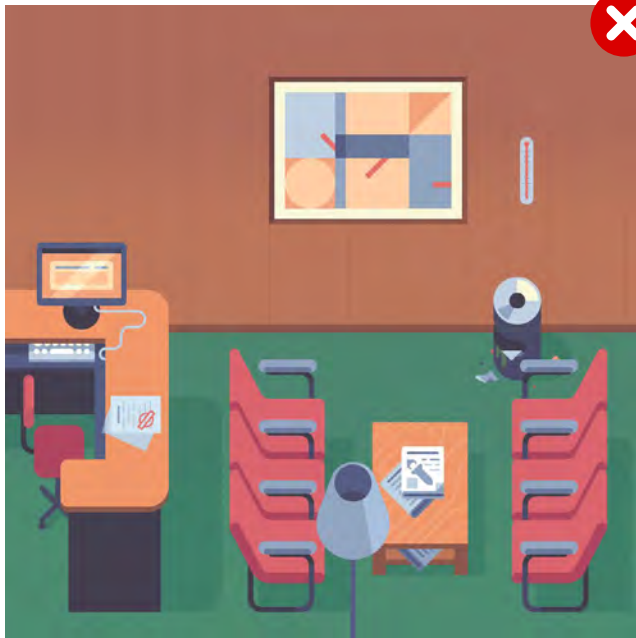
<sup>11</sup> Menschner, C and Maul, A. Key ingredients for successful trauma-informed care implementation. [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/childrens\\_mental\\_health/atc-whitepaper-040616.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf) Published April 2016. Accessed August 12, 2021.

## The Physical Space in the New Normal

COVID-19 has forced healthcare to implement new safety protocols that may not be inherently trauma-informed. Here are some suggestions for trauma-informed spaces:

- **USING** thermometers that read temperature at the wrist instead of the forehead (this reduces the feeling of having something weapon-like aimed at patient foreheads)
- **ASKING** permission to take temperatures and not assuming that people will know that temperatures must be taken due to COVID-19 safety protocols
- **PROVIDING** hand sanitizers and masks for those who need them
- **EXPLAINING** the purpose of newer safety protocols to everyone using plain language that most people understand

## Trauma-Informed Design – Do's and Dont's



Farrell J, and Weeks, R. *Trauma-Informed Spaces & Places*. VT Office of Economic Opportunity Conference. April 3, 2019.

### What did they get wrong?

- ❌ Dark colors that make the space feel ominous
- ❌ Seats that face each other
- ❌ Clutter and trash
- ❌ Reception desk computer in full view for all to see
- ❌ Abstract art on wall
- ❌ Temperature of room is too hot
- ❌ No signs

### What did they get right?

- ✅ Lighter colors that make the space feel light and airy
- ✅ Age and size appropriate seating arrangements that allow patients to sit away from each other and in small groups
- ✅ Space is clean and tidy
- ✅ Reception desk computer can only be seen by staff
- ✅ Art that shows nature and natural objects like plants
- ✅ Room is a comfortable temperature
- ✅ Clear signs



### **The Front Desk & Reception Experience:**

Taking a trauma-informed design approach not only includes the look and feel of your space, but also how staff operate within that space. Patients should be greeted by warm and friendly staff, who welcome them and direct them on what to do and where to go. Consider whether well-intentioned security protocols may be triggering to your patients with trauma histories. For example, if patients have to go through a security entrance and meet a security guard, you may want to tell them this ahead of time, so they are prepared.

Patients should not feel rushed when they are checking in. For example, if there are lots of forms to fill out, ask patients to arrive a few

minutes early and offer help in filling out forms to everyone. This allows patients who may have health literacy and literacy challenges get the help they need without feeling stigmatized. You can also give patients clear expectations of what their visit will entail and how long they might be waiting. Patients will feel much more at ease if they understand the expected wait time and why there may be a delay.

All staff should be trained in-and use plain language (see page 18 for more information on the use of plain language) and speak slowly. Similarly, when patients call the practice, the navigation of phone prompts should be easy to understand.

## **The Front Desk – General Guidelines**

- Friendly and warm staff who greet patients and slowly guide them through the registration process
- Organized and clean spaces
- Explanation of forms in plain language & assistance in filling out forms
- State expected wait time and why
- Check out should also be warm and friendly as survivors may have been triggered during the visit
- Training for all front desk/appointment line/administrative staff in trauma
- Follow up communication: How will it happen? Do patients feel safe that way?

Other trauma-informed approaches for the front desk include limiting the amount of personal

information asked for by the reception staff. A flexible cancellation policy may also increase a practice's level of TIC. For survivors of trauma who sometimes feel ambivalent about going to the doctor in the first place, it may feel shaming to be penalized for cancelling the same-day or arriving 10 mins late to an appointment. Being clear about cancellation policies prior to a patient's visit and ensuring that staff take an empathetic tone will reduce the likelihood of future and/or present anxiety.

Finally, check-out should also be warm and friendly. Trauma survivors may have been triggered during their visit and others may have received bad news. It is always a good idea to leave a positive impression no matter the outcome of a patient's visit. Remember, the front desk sets the tone.

## A Word on Communication

Communication is everything and it starts at reception. Below are several steps front desk and reception staff can take to guarantee positive communication:

- Greet everyone - use names and greet individually, if possible
- Explain who you are and what your role is
- Be self-aware of your mood and responses, and give patients your full attention
- Use an empathetic tone
- Use plain language and the teach-back method
- Recognize stress and respond appropriately
- Use motivational interviewing skills (open-ended questions, affirmations, reflections, summaries) when appropriate

**Training for Front Desk Teams:** In addition to general training on trauma, front desk staff can benefit from training on:

- Customer service
- How to manage a challenging or hostile patient
- How to build trusting relationships

**How to Get Started:** The first step in bringing trauma-informed design into your center or practice is to first assess your spaces and reception areas. Below are some resources that can be used to assess your space:

- PACEs Connection, Trauma-Informed Physical Environments: [Agency-Environmental Components for Trauma Informed Care](#)
- National Council for Behavioral Health, Trauma-Informed Primary Care: [Trauma-Informed Care Safe and Secure Environment Patient Survey \(S&SE Patient Survey\)](#)
- National Council for Behavioral Health, Mental Health First Aid: [Organizational Self-Assessment, Adoption of Trauma-Informed Care Practice](#)

Small and large practices alike can implement trauma-informed design and improve their reception and front desk experience by conducting trauma-informed assessments of the physical spaces and teams, and then engaging staff on what they want to change or improve. Practices might also consider partnering with a larger social work or public health program at a local university to obtain capacity building, volunteers, or technical assistance via special projects. Getting support from local volunteers to help greet patients and fill out forms or displaying artwork from a local artist/patient is also an easy and cost-effective way to bring trauma-informed design and approaches to your center. When in need of furniture, community donations or estate sales can provide quality products at a free-or reduced price. And consider using staff meetings for continued training and discussions around TIC.



## Small Practice Considerations

- Lots of no-cost training available on-line and in person
- Volunteers can help greet patients & fill out forms
- Use staff meetings time for continued training & TIC discussion and planning
- Consider partnering with a social work or public health program at a local university for volunteers or special projects
- If you need a total makeover, consider getting community donations of furniture or visiting estate sales
- Display artwork from a local artist/patient

## More Resources for Implementing Trauma-Informed Design:

- [The National Center on Domestic Violence, Trauma & Mental Health: Tools for Transformation Toolkit](#)
- [The Agency Environmental Components for Trauma Informed Care Assessment](#)

# Trauma-Informed Clinical Encounter: Exams, Tests & Procedures

The re-traumatization of people with trauma histories by-and within the health sector is pervasive, deeply entrenched, and has been a major impetus for the development of trauma-informed care.<sup>12 13</sup>

Clinical encounters can be especially triggering because of their invasive nature, fear of results, and loss of control. This may be exacerbated by low-health literacy which puts people at risk of not fully understanding what is being done, the reason for it and next steps. As a result, people may delay or avoid procedures that are considered “routine” like pap smears, colonoscopies, vaccines, and dental care. People with trauma histories may seem anxious, disconnected, or distracted during and after a clinical visit and may display a variety of “odd behaviors”.

At the core of TIC is trust. Trust between providers and patients counters feelings of secrecy and betrayal by promoting transparency, consistency, and clarity around the expectations,

commitments and parameters of healthcare services and creates a safe atmosphere for patients.<sup>14</sup> In addition, taking a trauma-informed approach to healthcare means exploring and possibly challenging your assumptions about why people do what they do when they are struggling.<sup>15</sup> It asks providers to examine their personal attitudes and beliefs about their patients and shift these to a strengths-based framework that recognizes mal-adaptive behaviors as coping skills – a person’s best efforts to deal with a situation – and a form of resilience in the face of hardship. Implementing trauma-informed approaches can mitigate triggering experiences and build trust between providers and patients.

<sup>12</sup> Jennings, A. Models for developing trauma-informed behavioral health systems and trauma-specific services. <http://www.theannainstitute.org/MDT.pdf> . Published 2004. Accessed on August 12, 2021.

<sup>13</sup> Kezelman C ad Stravropoulos, P. “The last frontier”: Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. [https://www.childabuseroyalcommission.gov.au/sites/default/files/IND\\_0521\\_001\\_0001.pdf](https://www.childabuseroyalcommission.gov.au/sites/default/files/IND_0521_001_0001.pdf) . Published 2012. Accessed on August 12, 2021.

<sup>14</sup> Warshaw, C. Trauma-informed services: Implications for healthcare providers and systems. <https://www.bu.edu/familymed/files/2014/06/BMCLynneStevensMemorialLecture51314Handout.pdf>, Published on May 13, 2014. Accessed on May 13, 2014.

<sup>15</sup> Bruun, A. & Mitchell, P. YouthAOD Toolbox. [www.youthaodtoolbox.org.au](http://www.youthaodtoolbox.org.au). Melbourne: YSAS. <https://www.youthaodtoolbox.org.au/principle-4-strengths-based-approach>. Accessed on May 20, 2021

“I’m just a little jumpy when people come close to me.”

“The doctor was lingering way too long when touching me.”

“I blanked out during the exam. I don’t know what happened. I’m not sure what the doctor did or didn’t do.”

Quotes reported to military sexual trauma (MST) counselor at Providence VA Medical Center after appointments with their primary care doctors, 2017. From Elisseou, S. Trauma-informed physical examination: Practicing sensitivity. 2017.

“The medical model highlights pathology and inadvertently gives the impression that there is something wrong with a person rather than that something wrong was done to that person. Trauma-informed practice recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past adaptations and ways of coping are now causing problems. Understanding a symptom as an adaptation reduces the client’s guilt and shame, increases [their] self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation”

Elliott, D. E., Bjelajac, P., Falot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4) 461-477. doi:10.1002/jcop.20063

## The foundations of trauma-informed care are strong communication and establishing trust.<sup>16</sup>

### Trauma-Informed Communication includes:

- Speaking clearly, slowly, and at an appropriate volume
- Using the preferred language of the patient or a trained medical interpreter
- Using OARS (open-ended questions, affirmations, reflections, summaries) via a motivational interviewing approach
- Using plain language and the teach-back method (read-on for further explanation of these)
- Being engaged and calm
- Maintaining appropriate eye contact
- Sitting/standing at eye level with the patient
- Avoiding sudden movements
- Keeping hands outside of pockets
- Being genuine and empathetic
- Paying attention to patient cues (i.e., tensing muscles, fidgeting, breathing quickly, flushing, crying, trembling, appearing distracted or spaced out)

<sup>16</sup> Elisseou, S., Puranam, S. & Nandi, M. A novel, trauma-informed physical examination curriculum for first-year medical students. *Journal of Teaching and Learning Resources*. [https://doi.org/10.15766/mep\\_2374-8265.10799](https://doi.org/10.15766/mep_2374-8265.10799)

## Health Education Techniques to Promote

**Health Literacy:** Education is an integral component of TIC. Health literacy enables patients to use health information to make informed decisions to promote or sustain good health. Many people, regardless of how educated or literate they are, struggle with understanding health, medical and scientific information. In fact, up to 80% of medical information given by healthcare providers is forgotten immediately by patients and almost half of the information that is remembered is remembered incorrectly.<sup>17</sup>

At a minimum, we suggest using a few techniques to help you in your work. The first one is called the “need to know vs. nice to know” technique and refers to thinking about what information patients need to know to act on to improve their health. Healthcare providers often give out a lot of information, and while some of it may be nice to know or interesting to some patients, it is often not needed and confuses patients.

The Teach-Back Method allows you to check your patient’s understanding of medical or other instructions by asking patients to explain what they heard in their own words. For patients to not feel as though they are being tested, you can tell them that the request to re-explain or “teach-back” is because YOU do not always do a great job explaining. For more information on using the teach-back method, check out [teachback.org](http://teachback.org)’s website.

Plain language means translating hard to understand medical and scientific language into words and explanations that more people will understand. See the [Center for Disease Control and Prevention’s Plain Language Materials & Resources](#) for more information.

**Remember, language can harm!** Examples of “plain” and “inclusive” language...

Instead of saying...	Try ...
I am going to check your vitals now.	I will be checking your blood pressure, temperature and pulse next.
It’s conclusive that your diagnosis is diabetes. We will need to set you up with a CDE and a nutritionist.	The tests that we did show that you have diabetes. I am going to take some time right now to explain what diabetes is and answer all your questions. I know this may be surprising and you may feel scared or nervous. That’s completely normal. We are going to take this step by step and create a plan together to take care of you.
We will have to monitor your weight and blood pressure.	We will need to keep track of your weight and blood pressure for the next few months. Let’s review what a healthy weight and blood pressure would be for you. How does that sound to you?
If you feel nauseous or short of breath, discontinue the medication.	If you feel sick to your stomach or have trouble breathing, stop taking the medication and call me.
That looks good.	That looks healthy.

<sup>17</sup> Kessels RP. Patients’ memory for medical information. *JRSM*. 2003;96(5):219-222. doi:10.1258/jrsm.96.5.219

Other techniques include using educational tools like short videos, health literate reading material, 3-D models, and drawings.

**Shared Decision Making:** Another component of trauma-informed clinical encounters is the use of shared decision making. According to the Agency for Healthcare Research and Quality, “Shared decision-making is a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health.”<sup>18</sup> The goal of shared decision-making is to ensure that patients understand their options and the pros and cons of each option and that patient’s goals and treatment preferences are used to guide healthcare and treatment decisions. Providers should communicate about healthcare and treatment risks and benefits clearly, ask about patient’s goals and treatment preferences, and respect patient’s values, preferences and desired outcomes when making recommendations for care.<sup>19</sup>

## **Trauma-Informed Physical Exams, Tests & Procedures:**

Exams, tests, and procedures can be broken down into three stages: 1) Before the exam and during triage; 2) During the exam; and, 3) after the exam.

Elisseou, S., Puranam, S. & Nandi, M. A novel, trauma-informed physical examination curriculum for first-year medical students. Journal of Teaching and Learning Resources. [https://doi.org/10.15766/mep\\_2374-8265.10799](https://doi.org/10.15766/mep_2374-8265.10799) medical students. Journal of Teaching and Learning Resources. [https://doi.org/10.15766/mep\\_2374-8265.10799](https://doi.org/10.15766/mep_2374-8265.10799)

**Pre-Visit & Triage:** setting the stage, establishing rapport, explaining what will happen.

**During:** explanation of what is happening, going slowly.

**After:** wrap up, follow up instructions, teach back, check in.

**Before the Exam and Triage:** Pre-visit trauma-informed approaches are meant to set the stage for the visit, help build rapport with the patient and educate about what to expect throughout the visit. Pre-visit planning is something many practices already engage in. Its purpose is to prepare for the day by reviewing who is coming in and why. Pre-visit planning can be done the day before or in huddles in the morning before the day starts. In smaller practices doing these things in huddles is often less demanding on staff and fosters a team approach. By reviewing who is coming to the practice that day, you prepare for the patients and what they may need. For instance, perhaps you know there is a patient coming to give blood and that person always struggles with it due to a phobia of needles. In pre-visit planning you can prepare how to manage the situation. Perhaps this patient has a good rapport with the front desk associate, so the team strategy could be that the front desk associate will be in the room with the patient while he/she gets blood drawn and that someone else will cover the front desk during that time.

<sup>18</sup>Agency for Healthcare Research and Quality. Strategy 6I: Shared decision making. <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/6-strategies-for-improving-communication/cahps-strategy-section-6-i.pdf> . Published July 2017. Accessed on August 12, 2021.

<sup>19</sup>Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. BMJ. 1999;319(7212):766-71.

## Steps for Pre-Visit Planning

- Review chart as part of pre-visit planning or daily huddles to ensure all of the referral notes, labs, exams, tests, etc. are available to discuss with patients and learn what preventive tests, etc. may need to be done
- Review the care plans and determine who on team will need to see the patients and when
- Anticipate any challenges based upon internal processes and history of patient interactions
- Review patients charts for trauma-related documentation to avoid asking the patient to repeat their history
- Prepare patient for what to expect with regard to history, examination, and any type of procedure if possible (via phone, text reminder, etc.)
- Ask patients to bring in all medications for review (patients could also snap a pic of all medications)

### **Triage is as important as any other aspect of the visit and should be treated as such. Easy to implement trauma-informed approaches include:**

- Asking patients where they are most comfortable sitting: Many patients may not feel comfortable on the exam table or may be uncomfortable getting up on the exam table. Asking the patient where they are most comfortable helps them feel more in control because they have choices.
- Clearly explaining the role of whomever is doing the triage: Clearly explain each staff person's role throughout the visit. In some smaller practices staff may have multiple roles (i.e., a medical assistant who also works the front desk). Be sure to let patients know who you are (whether a RN, MA, CPN, etc.) and what you are there to do.
- Explaining what is going to happen using plain language: Explain how the procedure, exam, or test may feel using plain language while remembering that people have different pain and discomfort tolerances.
- Considering the temperature of the room.
- Asking permission to touch and allowing for questions: Ask permission to touch the patient and to move on to other parts of the exam.
- Meeting with patients when they are clothed: If possible, meet patients in an office (vs. the exam room) and while they are fully clothed. In smaller practices, this may not be possible due to space challenges. However, meeting patients while they are fully clothed is preferable and reduces feelings of vulnerability.
- Setting the Agenda: Set the visit's agenda with the patient and try to remain present. Be sure to speak to the patient without a computer blocking your view.
- Allowing for patient support: Offer a chaperone or ask the patient if they have someone they want in the room, when appropriate (regardless of gender), so that they have the support they want and need.
- Keeping hands outside of pockets.
- Being genuine and empathetic.
- Pay attention to cues: Paying attention to patient cues (i.e., tensing muscles, fidgeting, breathing quickly, flushing, crying, trembling, appearing distracted or spaced out).

### Example of Explaining What is Going to Occur:

Today, I will be doing a full physical exam. In order to complete it, I will need to examine you in several places using my hands and also my stethoscope. As I go along, I will explain each step before I do it. How does that sound to you? Is it ok to start? Feel free to stop me anytime if you are uncomfortable or have a question. You can also raise your arm if you are uncomfortable and that will tell me I should stop.

### Example of Asking Permission:

I would like to examine your breasts to make sure there are no lumps that could be a sign of cancer. I will be pressing on them with my fingers and it may feel awkward. Is it ok to move your gown now to begin? What questions do you have about this?

### During the Exam:

- Make sure patients have privacy when undressing and provide a secure, clean space for patients to put their personal belongings (e.g., their clothing, bags, paperwork, etc.).
- Use a paper draping or gown to cover as much of the patient's body as possible and provide tissues and paper towels anytime lubrication is used.
- Allow patients to re-dress privately once the exam is finished. You can come back into the exam room once the patient is dressed to discuss results or next steps.

### More on Draping and Modesty...

**Being undressed is a vulnerable position for all people. For trauma survivors, it can be even more uncomfortable. Try to alleviate some of that vulnerability by doing the following: :**

- Refer to the “gown” (what the patient wears) and the “drape” (the sheet over their lap) in clear ways so that instructions are not confusing.
- Get gowns in a variety of different sizes and preferably in fabric, as this helps patients preserve their dignity and privacy more so than paper gowns.
- Ask patients if they would like to move their own gown and/or drape or if it is ok for you to do.
- Only ask patients to undress fully if it is absolutely necessary - for a limited exam, ask the patient to move their own clothing.
- Knock before entering the room and listen for the response that it is ok to enter.

When possible, stay in eyesight of the patient so that the patient is always able to see you and what you are doing. Try to leave reasonable space between you and the patient, so they do not feel their personal

space is being violated. Use a professional touch<sup>20</sup> which is deliberate, firm but not hard. Avoid any unnecessary interruptions throughout the exam process, such as calls or questions from other staff.

### If The Patient feels uncomfortable...

If you notice that the patient seems uncomfortable, follow these steps to help them feel safer and in control:

1. Pause the exam and step away from the patient slowly.
2. Avoid sudden movements.
3. Ask the patient how they are feeling and/or what can be done to make them feel more comfortable.
4. Reassure them that they are safe and remind them where they are.
5. Include a chaperone for required clinical exams and offer based on patient preference.

### Example of what to say if patients appear tense...

I am noticing that you're tensing up when I touch your back. Is there something I can do to make this more comfortable? Is there something you want me to know about being touched there?

The following pictures show a provider performing common exams. The A pictures show a less trauma-informed approach while the B pictures show a more trauma-informed approach.

01

Provider in A is behind the patient and can't be seen. In B, she stays within eyesight which is better.



A



B

02

In A, her hand is resting on the patient's thigh. In B, only her fingers are touching the patient which is better.



A



B

03

In A, provider's hip or thigh is touching the patient's knee. In B, her body is no longer leaning against the patient.



A



B

04

In A, the patient cannot see the provider. In B, the exam table is tilted up so the patient can see the provider.



A



B

Source: The National Council for Behavioral Health

<sup>20</sup>Singh, C., & Leder, D. (2012). Touch in the consultation. The British journal of general practice: the journal of the Royal College of General Practitioners, 62(596), 147-148. <https://doi.org/10.3399/bjgp12X630133>



## After The Exam:

- Thank the patient for collaborating with you.
- Discuss results of the exam and any next steps using plain language and the teach-back method.
- Finish the visit by asking open-ended questions like “what questions do you have?” as opposed to “do you have any questions?”.

### Recognizing and Identifying Social Determinants of Health:

As noted by the Institute for Health Policy and Practice, “successfully mitigating the impact of ACEs and SDOH requires an entire community response, not just a clinic response.”<sup>21</sup> Social determinants of health such as poverty, discrimination, and food insecurity are associated with health risks and may also be risk factors for toxic stress.<sup>22</sup> Therefore, when screening, social needs should also be addressed through connections to appropriate services. However, social needs scores should not be added to the ACE score for the purpose of the toxic risk assessment, treatment planning and billing.

### Example of the Teach-Back Method

I want to be sure I did a good job explaining the new medication you will be taking because I know it can be confusing and sometimes I don't explain it well. So, can you tell me exactly how and when you will take it?

### Trauma-Informed Approaches for Working with Children and Young People:

- Ask parents and caregivers to prepare the child ahead of time for the visit by talking to them about the visit and what they should expect.
- When working with children, engage in conversation around non-medical topics first before performing any exam or procedure. This helps build trust and lets you learn a little about the child and family.
- Do not make empty promises about how the exam will feel, particularly by saying that something will not hurt.
- Offer distractions like toys, books, or other objects that the child can hold during the exam or ask the parent to help choose a comfort toy or object from home to bring in.
- Pay attention to non-verbal cues and adapt accordingly.
- Speak directly to the child during the visit rather than the adult.
- Ask the child permission to touch.

It is not uncommon for youth to fear going to the doctor. In fact, half of all parents of toddlers and preschoolers say their child is afraid of going to doctor – mostly due to getting shots – and one in 25 parents has even postponed a vaccine due to their child’s anxiety.<sup>23</sup> While most of the same trauma-informed principles apply to children, adolescents and teens, here are a few additional tips:

<sup>21</sup>Covini, M, Cox, K, O’Neil, M, Ryer, J and Tutko, H. Addressing childhood adversity and social determinants in pediatric primary care: Recommendations for New Hampshire. <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1000&context=ihpp> Published July 2018. Accessed on August 12, 2021.

<sup>22</sup>ACESAware.org. Provider Toolkit; Screening and responding to the impact of ACEs and Toxic Stress. <https://www.acesaware.org/wp-content/uploads/2020/05/ACEs-Aware-Provider-Toolkit-5.21.20.pdf>. Published May 2020. Accessed on August 12, 2021.

<sup>23</sup>Mott Poll Report. Education or placate when young child is afraid of doctor’s visits? National Poll on Children’s Health. October 15, 2018; Volume 32. Issue 5.

1 in 5 parents struggles to concentrate on what the doctor or nurse is saying due to child's reaction in the exam room.

– *Mott Poll Report*

### **Working with teenagers:**

The teenage years are when risk taking behavior begins. Teens are also taking greater responsibility for their lives. Therefore, as much as possible, try to have some one-on-one time with the teen. Current guidelines from the American Academy of Pediatrics (AAP) recommend that providers begin having one-on-one time, commonly referred to as “time alone”, with young people as early as age 11.<sup>24</sup> Time alone between providers and young people offers teenagers the opportunity to discuss sensitive issues,<sup>25</sup> such as romantic relationships and sex, sexually transmitted infection (STI) and birth control, mental health, and drug and alcohol use.

38% of teens 15 – 17 years old had one-on-one time with a provider during a clinic visit in the prior year

– *NCHS Data Brief 2016*

A provider who asks open-ended questions about these topics, is comfortable discussing them, listens, and does not judge is likely to build a trusting relationship with the teen and increase the likelihood that the teens will come to them when a need arises -- increasing their future access to-and satisfaction with healthcare.<sup>26</sup> As part of this, remind the young person that most things are confidential between the provider and the patient. Minors' rights, including provider confidentiality and healthcare, will vary by state. So be sure to check your state's confidentiality policies!

<sup>24</sup>Breuner CC, Mattson G. Sexuality education for children and adolescents. *Pediatrics*. 2016;138(2). doi:10.1542/peds.2016-1348

<sup>25</sup>O'Sullivan LF, McKee MD, Rubin SE, Campos G. Primary care providers' reports of time alone and the provision of sexual health services to urban adolescent patients: results of a prospective card study. *J Adolesc Health*. 2010; 47(1): 110-2

<sup>26</sup>Brown JD, Wissow LS. Discussion of sensitive health topics with youth during primary care visits: relationship to youth perceptions of care. *J Adolesc Health*. 2009; 44(1): 48-54

# Screening for ACEs and Responding to Trauma

## Success Story...

– *Dr. Miriam M. Rhew, MD, Pediatrician at UBCP Bancroft Pediatrics – California*

Miriam and her team at the UBCP Bancroft Pediatrics, a smaller practice, began incorporating TIC at their center in 2019. At Miriam’s practice, screenings are started with patients at 4 months old with a 15-month follow-up, and then are conducted annually after the age of 2. Caregivers of children 11 and under and teenagers aged 12 and up fill-out a de-identified ACE screener with an SDOH component (the PEARLS screener). The screener scores are entered into the practices EMR system by a Medical Assistant and a paper copy of the screener is left outside the exam room for the physician to review with the family. Families are asked to come 15 minutes ahead of their appointment to fill out the screener when meeting in-person or, when meeting via tele-health, are called 15 minutes ahead of their appointment by a staff member.

Once the physician reviews the screener, and depending on the result, the physician will then address the patient’s and/or families social and emotional needs by first inviting them to talk more about the issues affecting their lives. The physician will also discuss the impact that stress has on health and how stress could be related to the patient’s health. Following this, they will then refer the patient to any necessary therapeutic interventions (which for this practice are both in-house and external).

For families who do not screen positive for any needs, physicians will use that as an opportunity to provide education on how stress affects health and ensure the patient/family knows that the UBCP Bancroft Pediatrics is there for them should they ever need any support. The results of the screener are also reviewed by a Patient Navigator who then conducts a follow-up screening and refers and connects the family to additional resources related to SDOH and other social services.

According to Miriam, one of the biggest and surprising successes of their trauma-informed approach is that through routine screenings patients and caregivers who were not ready to disclose any traumas in previous visits usually feel comfortable disclosing trauma in subsequent visits. This showed Miriam the importance of annual screenings and that by creating a safe and trusted space, individuals with trauma, especially young people, can feel like they have a place where someone not only cares about them but can also help them. Miriam’s advice is for providers is to remember, “...you don’t need to fix their problems. You just need to be supportive of the family – to help them care for themselves and find and use resources right now that will help them.” In this way, TIC is about finding resources, educating patients about trauma and toxic stress, and encouraging them along the way.

The purpose of screening is to identify patients at risk for toxic stress<sup>27</sup> and then implement strategies to reduce the impacts of toxic stress and the risk of negative health and social outcomes (a.k.a ACE-Associated Health Conditions).<sup>28</sup>

Common ACE-Associated Health Conditions include cardiovascular, pulmonary, immune and metabolic disorders, as well as mental illness and substance use disorder.<sup>29</sup> The benefits to conducting ACE and trauma screening is that by identifying individuals at risk for chronic stress, you can then treat them by implementing a variety of interventions detailed below. ACE and trauma screening also help you understand why patients have developed various chronic conditions. Anecdotally, many patients and providers say that the screening itself was therapeutic for the patient and helped to improve the provider/patient relationship.

## Steps for incorporating ACE and Trauma Screening:

**Step 1: Set the Stage:** Before implementing any new protocol or program, it's important to prepare the practice for the change. First and foremost, all staff need to understand what changes are taking place, why the changes are being implemented, and what their role in the process is going to be. Try having staff lead the effort since they know the patients and practice best. Including staff conveys respect and appreciation for them. Staff may need training and discussion about ACEs, trauma, and screening. This should not be a one-time discussion but should be incorporated into all clinical communications and feedback mechanisms.

Next, decide which ACE screening tool(s) you are going to use, the format of the tool (digital or paper), and how the screening will take place and be incorporated into the overall clinical workflow.

### Here are some questions to ask yourself and the team:

- Will the screenings be administered on paper or via tech devices?
- Will the screening be incorporated into your Electronic Health Record (EHR) and how (i.e., will a template in your EHR be created or will the paper screener be scanned into the record?)?
- Will staff screen patients directly or will patients fill out the screening themselves?
- Will staff receive a digital version of the screening responses that goes into a patient's chart, or is someone going to transcribe patient responses into the EHR?
- Where will patients complete the screening – and can you provide multiple options for patients to choose from? For example, if the practice only has a small, crowded waiting room, patients may not feel comfortable filling out the screening next to others. Do you have a place where patients can go for privacy? If not, how can you work around this?

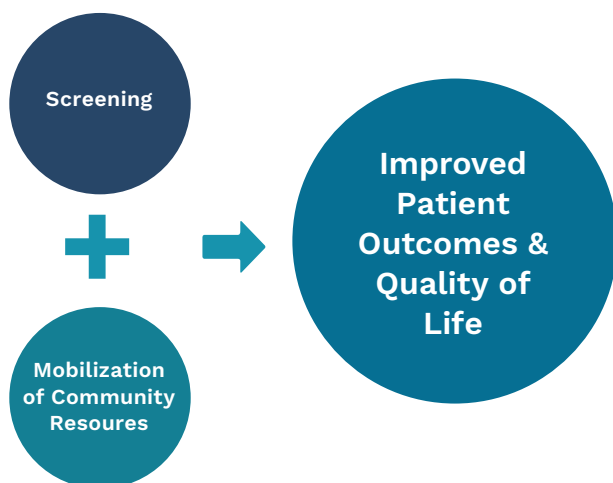
<sup>27</sup> Learn about screening: Using early detection and intervention to improve health outcomes. ACES Aware. <https://www.acesaware.org/learn-about-screening> Accessed on June 3, 2021.

<sup>28</sup> ACEsAware.org. Clinical response to ACEs and Toxic Stress. <https://www.acesaware.org/wp-content/uploads/2020/05/Provider-Toolkit-Clinical-Response-to-ACEs-and-Toxic-Stress.pdf>. Accessed on July 2, 2021.

<sup>29</sup> ACEsAware.org. Clinical response to ACEs and Toxic Stress. <https://www.acesaware.org/wp-content/uploads/2020/05/Provider-Toolkit-Clinical-Response-to-ACEs-and-Toxic-Stress.pdf>. Accessed on July 2, 2021.

### Other promising practices include:

- Offer assistance and avoid assumptions about who may need help in filling out the screener. Consider offering assistance to all patients.
- Learn about what resources are in your community and establish strong linkages with organizations that provide any trauma-related treatment your clinic does not, as well as those who offer services around housing, food, legal services, benefits, etc. Challenges related to social needs have the potential to exacerbate toxic stress so helping patients address them is part of TIC and treatment.
- Consider having health literate material about the connection between trauma and health in the waiting area for patients to read if they want.
- Be prepared to change! You may need to change your implementation process as you learn more about what works and what does not. Continue to involve all staff so that the process is efficient and meets the needs of all those involved.



**Step 2: Prepare Patients and Families:** Prepare patients for screening by explaining the rationale/benefits of screening ahead of the appointment via appointment reminder calls, texts, and/or emails. Front desk staff should explain it again if they are giving out the screener. For more information, please visit ACES AWARE’s How-to Guide Stage 2 for scripts for conversations with patients (see [acesaware.org/implementation/screenings/stage-2-select-approach/](https://acesaware.org/implementation/screenings/stage-2-select-approach/))

If a patient has concerns about filling out the screener, assure them that they do not have to participate but you can ask them about their concerns and if it is ok to follow-up with them about it at the next visit. Make sure the provider knows the patient declined to participate as well.

**Step 3: Integrate Screening Tools into the EHR:** If you use an EHR, you will want to decide how to integrate the screening tool and/or the results into the EHR. For example, if the tool is not in the EHR, you will need to consider who will scan or enter the results into medical records and how the providers will get the results before they see the patient.

**Step 4: Billing for ACE screenings:** In California, as of 2021, ACE screenings are eligible for payment under Proposition 56,<sup>30</sup> which allows Medi-Cal accepting practices to receive a \$29.00 payment for each screening (once in a lifetime for adults age 21 – 64 and as needed, but not more than once a year for children under the age of 21). For more information on this, visit [ACESAware.org](https://acesaware.org).

Currently, there is work being done to incorporate screening tools into common EHRs. Check out [ACESAware.org](https://acesaware.org)’s Screening Toolkit to learn more!

<sup>30</sup>California Proposition 56. Department of Health Care Services. <https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/default.aspx>. Accessed on June 3, 2021.

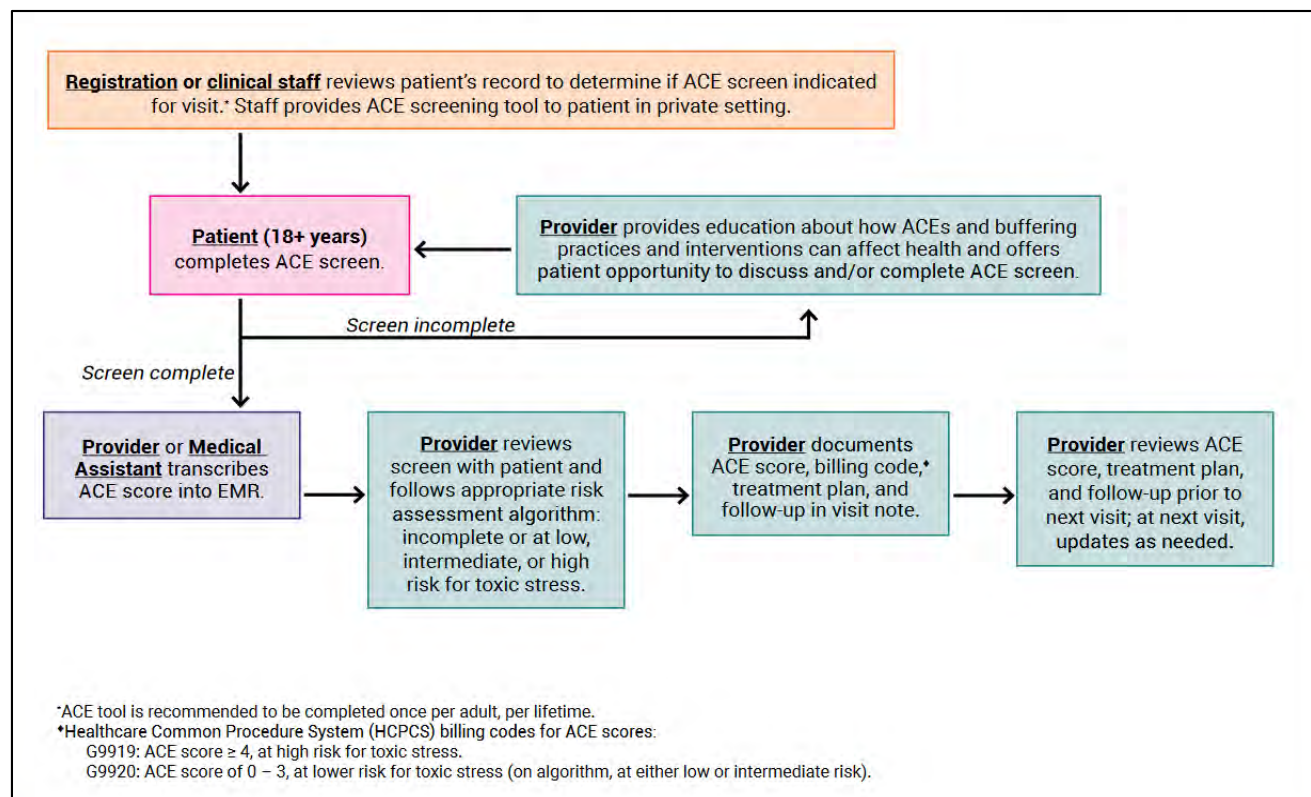
## Putting it all together

**Developing Screening Workflows:** Deciding who will administer the screener and how the results will get to the provider before the provider sees their patient is critical to successful screening and response and an aspect that some practices have found challenging. Anecdotally, it has been shared by practices that providers do not always get the results of a patient's screener in time to discuss the results. Careful planning around screening workflows, along with continuous quality improvement practices can help mitigate these challenges.

The following screening workflows provided by ACES Aware,<sup>31,32</sup> demonstrate a suggested clinical workflow for both adult and pediatric settings.

If a patient does not fill out the screener completely, the provider needs to know this. In this case, the Medical Assistant, nurse, or even a front desk associate who the screener was returned to can inquire as to why it was not filled out (utilizing trauma-informed approaches, of course). They can then offer assistance as needed or go over the screener's purpose again and how it will be used by the provider. Assuming the screener is filled out, the provider will review the ACE score with the patient and offer the appropriate intervention. Note that the provider must enter the ACE score, correct billing code and treatment plan in order to get reimbursed for the screening.<sup>33</sup>

### Adult ACE Screening Clinical Workflow



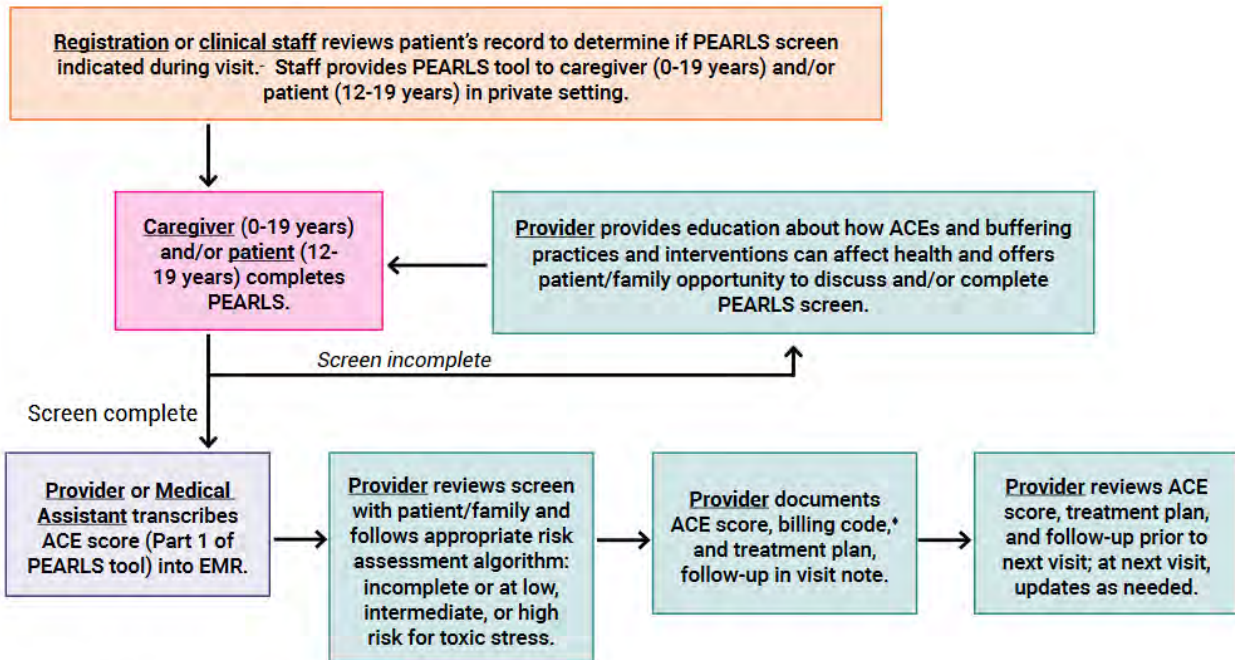
<sup>31</sup> Screen. Treat. Heal. ACES Aware. <https://www.acesaware.org/wp-content/uploads/2019/12/ACES-Aware-Initiative-Unveiling-PPT.pdf>. Accessed on June 5, 2021.

<sup>32</sup> Fundamentals of ACE Screening and Response in Practice. ACES Aware. <https://www.acesaware.org/wp-content/uploads/2020/04/ACES-Aware-June-Webinar-Slide-Deck.pdf>. Accessed on June 5, 2021.

<sup>33</sup> Billing and Payment: Qualified Medi-Cal providers can receive payment for screening children and adults for ACEs. ACES Aware. <https://www.acesaware.org/learn-about-screening/billing-payment/>. Accessed on June 5, 2021.



## Pediatric ACE Screening Clinical Workflow



\*PEARLS is recommended to be completed once per year.

\*Healthcare Common Procedure System (HCPCS) billing codes for ACE scores:

**G9919:** ACE score  $\geq 4$ , high risk for toxic stress

**G9920:** ACE score of 0 – 3, lower risk for toxic stress. For purposes of coding, scores of 1-3 with ACE-Associated Health Conditions should be coded as G9920, even though patient falls into the high-risk category of the clinical algorithm.

\*\*\*PEARLS to be completed once per year, and no less often than every 3 years

2

For pediatrics, if the child is 12 or older, they can fill out the form themselves if they are able. If not, a parent or guardian can fill it out on their behalf. This latter point offers some challenges which we discuss later in the chapter.

### Evaluating Screening Workflows...

Any time you are implementing a new screening or program, it is important to periodically assess how it is going to ensure it is going as hoped and is efficient and effective. This can easily be done utilizing any of the many continuous quality improvement (CQI) activities common in public health settings and can include formal and informal processes.

### Evaluation best-practices:

- Get feedback from staff during daily huddles and weekly meetings

- Use both quantitative and qualitative data from staff and patients
- Use PDSAs (Plan, Do, Study, Act) (for more information about this important QI approach, visit [acesaware.org/network-of-care](http://acesaware.org/network-of-care))
- Set realistic timeframes to implement processes and assess their effectiveness
- Use 90-day cycles
- General things to measure/keep track of:
  - # of people screened vs. how many qualify for screening
  - Who is doing the screening
  - How many screenings are being conducted with results that make it to the provider vs. number of results that do not make it to the provider

Check-Out PCDC's Online [Small Practice Management Essentials Course](#) to learn more about small practice evaluation and quality improvement!

**Selecting ACE Screening Tools:** To-date there are several commonly used ACE screening tools available for use. What differentiates one tool from another is:

- If it should be used for adults or children and teenagers. Questions for children and teenagers will be different than those for adults.
- Whether they are de-identified or identified. De-identified means that the person responding does not have to disclose which traumas they have experienced, only the number of traumas.
- Does the screener include a social needs section?

#### Common Validated ACE Screening Tools

[PEARLS Identified for Children with Related Life Events](#)

The Identified Pediatric ACEs and Related Life Events Screener for children combines an ACE screening with some screening for SDOH. The term identified means that the person responding to the screener will check off the actual ACEs the child has experienced -- the specific ACEs are documented which tells you which events have impacted the patient.

[PEARLS De-Identified for Children with Related Life Events Identified](#)

The De-Identified Pediatric ACEs and Related Life Events Screener for children also combines an ACE screening with some screening for additional related life events. However, this screener is de-identified which means that the person responding does not have to disclose the specific traumas the child has experienced. They just have to indicate how many traumatic experiences the child has been exposed to. The Related Life Events portion of the screener is still identified, which is always the case because providers need to know the specific social needs people are struggling with in the moment in order to connect them to the appropriate support services.



<a href="#">PEARLS for Teens Identified by Caregiver</a>	<p>The Identified Pediatric ACEs and Related Life Events Screener is for teenagers and is meant for the caregiver to fill out. There is also a similar screener that is a <a href="#">teenager self-report</a> tool, and <a href="#">another that is de-identified</a> with SDOH as well. Questions included on the teen screening also ask about incarceration and teen dating violence which are not included in the adult versions of the tools.</p>
<a href="#">ACE Screening Tool for Adults Identified And De-identified</a>	<p>The Identified Adverse Childhood Experience Questionnaire for Adults is a short screener that does not ask about related life events. It is also available as a De-Identified screener as well.</p>

## Identified vs De-Identified: Which to Use?

**Choosing between De-Identified vs. Identified Screeners:** Choosing whether to use the identified or de-identified screener really depends on your practice’s and patient’s preference. Below you will see some practice-based considerations for each. If your practice is brand new to screening, you may want to begin with the de-identified screener which may be less overwhelming for staff and patients and then move onto the identified screener once everyone gets more comfortable. Whichever one you choose, remember to communicate a clear rationale to patients and staff.

Benefits of Identified Screener	Benefits of De-Identified Screener
Can provide more accurate resources & referrals	More Privacy for patient
More fully understand your patient	With reluctant patients, more likely to get accurate score and participation
Could be validating/therapeutic for patient	Could be less overwhelming for staff who are new to addressing trauma in a healthcare setting
If there is an immediate threat to safety, the right safety intervention can be applied.	Less likely to be triggering for patients to disclose
	Patient may have more control of the discussion (can decide how much or how little to disclose)

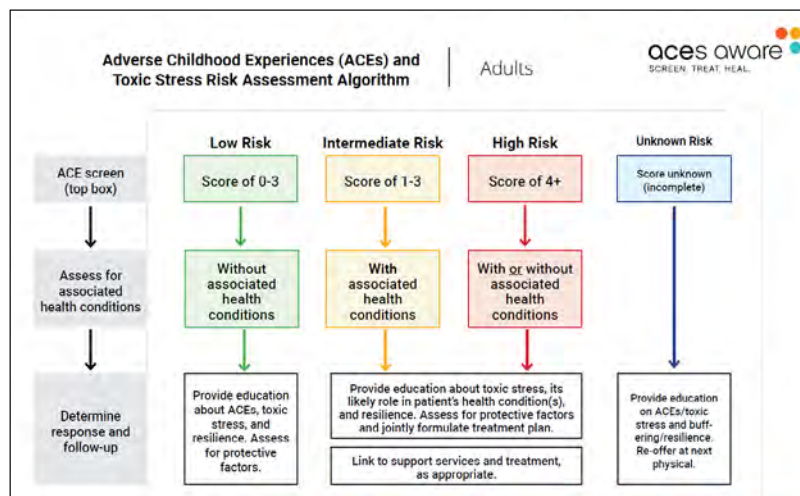
**Screening Scores and Risk Assessments - What the Scores Tell us:** The ACEs and Toxic Stress Risk Assessment Algorithm<sup>34 35</sup> for adults and pediatrics provides a roadmap for interpreting a patient’s level

of risk based off their ACE score and assessing for underlying health conditions associated with the risk level. For more information visit the Aces AWARE How-To Guide (<https://www.acesaware.org/implement-screening/about-the-guide/>).

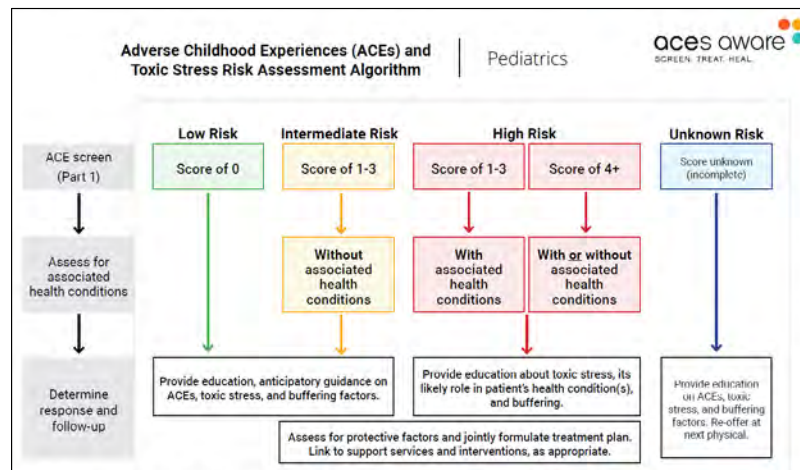
If the ACE score is 0, the patient is at “low risk” for toxic stress. You may still offer education on the impact of ACEs and other adversities on health and development, however, as well as on buffering factors and interventions.

If the ACE score is 1-3 without ACE-Associated Health Conditions, the patient is at “intermediate risk” for toxic stress. If the ACE score is 1-3 and the patient has at least one ACE-Associated Health Condition, or if the ACE score is 4 or higher, the patient is at “high risk” for toxic stress. In both cases, you can offer education on how ACEs may lead to toxic stress and ACE-Associated. You should also assess for protective factors, and with the patient, jointly formulate a treatment plan and link to supportive services and interventions, as appropriate.

### Adult ACE & Toxic Stress Risk Assessment



### Pediatrics ACE & Toxic Stress Risk Assessment



<sup>34</sup> Screen. Treat. Heal. ACES Aware. Accessed on June 5, 2021 from <https://www.acesaware.org/wp-content/uploads/2019/12/ACES-Aware-Initiative-Unveiling-PPT.pdf>

<sup>35</sup> Fundamentals of ACE Screening and Response in Practice. ACES Aware. Accessed on June 5, 2021 <https://www.acesaware.org/wp-content/uploads/2020/04/ACES-Aware-June-Webinar-Slide-Deck.pdf>

For the PEARLS, answers from Part 2 should not be added to the ACE score. If someone does not fill out the whole screening, ask if they need help and remember that partial completion may indicate discomfort or lack of understanding. However, if through the partial responses a patient indicates they are at intermediate or high risk, you should follow the guidelines for that category.

**Screening via Telehealth:** Telehealth visits gained popularity throughout the COVID-19 pandemic and many practices want to continue using them. When screening via telehealth consider the following practice-based suggestions:

1. Verify the patient's location/contact information at beginning of the encounter in case emergency response is necessary.
2. Establish a safety word or phrase at in-person visits, when possible, to be used during telehealth visits for the patient to signal to you that they are not alone.
3. Use headphones to ensure patient confidentiality unless you are in a private space.
4. Sit far enough from the screen so the patient can see your body language.
5. Allow time to establish comfort level and privacy level and state: "Before we begin can you share with me- Are you alone and free to speak openly or do you have family members close by that can hear our conversation? Are you able to move to a more private space?"
6. Follow the patient's lead about the conversation -- they may be hesitant, speak softly, or seem anxious and may not be able to openly express why.
7. If there are indications for safety concerns, proceed with caution around the dialogue; be prepared to switch the conversation.

### Confirming Results and Responding to Trauma

**Disclosures:** For many healthcare staff, confirming and responding to screening results is the most challenging part of being trauma-informed. You may find the following steps helpful:

1. Confirm results with the patient.
2. Explain the rationale for screening again and

thank the patient for trusting you and sharing the information and experiences with you. Ask them if there is anything else they would like to add.

3. Provide the appropriate intervention. For more information please visit Aces AWARE's How to Guide for clinical responses and scripts for talking to patients (<https://www.acesaware.org/implement-screening/>).

### Interventions to Address Trauma & Toxic Stress for Adults & Children

When responding to trauma disclosures, the three main things providers should do are:



Acknowledge, validate, and educate



Provide referrals to support services and social needs resource



Create/modify care plan incorporating risk level and screening results

1. Acknowledge, validate, and educate: Say things like "Thank you...", "I care about you," and "I am concerned about you/your condition; health; well-being; safety, etc.", and validate the patients existing strengths and protective factors.
2. Provide referrals to support services and social needs resources: Be prepared to discuss referral options to specific trauma therapy (if needed and wanted), other support services, and appropriate community-based resources that address social needs as they are integral in helping patients reduce toxic stress.
3. Create a care plan: Every patient is unique, so each solution should be customized and based on a collaborative approach. For more

information visit Aces AWARE's The Science of ACEs and Toxic Stress (Part 3) (<https://www.acesaware.org/events/the-science-of-aces-and-toxic-stress-part-3/>).

Educate patients about ways to reduce toxic stress. The following are evidenced-based strategies for adults:

- Supportive Relationships: Help patients identify supportive people in their lives and discuss ways they can foster those relationships.
- Sleep: Most adults need eight hours of quality sleep. Strategies for achieving this include decreasing caffeine intake, creating a regular bed-time routine, not taking your phone to bed, and making the room as dark or quiet as possible. Sound machines are sometimes helpful as well as room darkening shades or curtains.
- Balanced Nutrition: Patients should try to eat fresh whole foods, avoid processed and sugary

foods, and try to drink eight glasses of water a day. If patients have trouble finding and affording healthy foods, they can be referred to food pantries and other organizations that help with resources for food.

- Exercise: 30 minutes of exercise every day is ideal. Walking, biking, and housework count.
- Mindfulness: Patients should try and take a few minutes every day to check in with themselves. They can sit quietly with their feet on the floor and breathe deeply. When they are upset or angry, they can be coached to count to 10 or take three deep breaths before they do anything else.
- Mental Health Treatment: Some patients may benefit from therapy. If you don't provide mental health care, be sure to create and maintain strong collaborative partnerships with outside providers so that warm handoffs are doable.

For most patients with trauma histories, education about toxic stress, its role in health conditions and buffering factors, and referrals to community-based resources for social needs will be the sufficient intervention. Other stress reducing strategies are listed below.

#### **For adults:**

- Pets
- Hobbies/Activities that produce happiness
- Take time away from social media/TV/etc.
- Join and participate in solidarity groups (political, social, etc.)
- Spend time outside in nature
- Pray
- Journal/Read
- Say no to things that are too much
- Learn how to self-reflect
- Use affirmations
- Allow crying and emotions
- Find things that create laughter
- Sing

#### **For Kids:**

- Mental healthcare
- Family therapy
- Conscious breathing
- Cool-down Corner
- Journaling: Open or closed
- Color journaling
- Sticking to routines
- Balanced nutrition
- Physical activity
- Quality sleep
- Supportive relationships
- Attachment practices (for babies)

**A Word on Therapeutic Approaches to Addressing Trauma:** Some patients may want or require trauma-specific therapy. You do not have to offer these services in your practice, but you should be able to refer to them and know a little about each one. Common trauma therapies are listed below.

- Eye Movement Desensitization and Reprocessing (EMDR)
- Trauma- focused Cognitive Behavioral Therapy (TFCBT)
- Accelerated Experiential Dynamic Psychotherapy (AEDP)
- Child-parent Psychotherapy (CPP)
- Animal, play, art therapies
- Body work such as yoga, reiki, acupuncture and breathing techniques
- Sharing, reflection, and advocacy such as support talk-groups and story-telling groups
- Medications such as SSRIs and SNRIs, antidepressants, anti-psychotics, benzodiazepines

For more on the different trauma therapies you can employ and/or refer patients to, visit the [American Psychological Association's](#) website.

# Staff Wellness – Avoiding Burnout and Vicarious Trauma

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.”

– Dr. Rachel Remen, *Kitchen Table Wisdom*

Caring for people with trauma histories and social needs has the potential to profoundly impact you and your teams. For empathic people, it is normal to become adversely affected from hearing trauma stories day-in and day-out. However, there are many ways you and your organization can address this so that staff have the support they need to stay motivated, positive, and productive at work. Three common outcomes are prevalent in the helping professions – burnout, compassion fatigue, and vicarious trauma.

Burnout, Compassion Fatigue & Vicarious Trauma: According to the National Institutes of Health, “... burnout is a combination of exhaustion, cynicism, and perceived inefficacy resulting from long-term job stress” and results from excessive demands on energy, strength or resources in the workplace.<sup>36</sup> Burnout can happen to anyone in any kind of work because it is about being exhausted and overwhelmed by the amount and type of work that leads to feelings of reduced accomplishments and loss of personal identity.<sup>37</sup>

Many things can cause burnout. For physicians, burnout can be caused by working long hours, taking night and weekend calls, the demands of technology and documentation, student debt, dealing with bureaucracy, receiving incentive pay, being mid-career, gender-based discrimination, having young children, and are more common in certain specialties such as emergency medicine, general internal medicine, and neurology.

<sup>36</sup> Reith TP. Burnout in United States Healthcare professionals: A Narrative Review. *Cureus*. 2018. doi:10.7759/cureus.3681

<sup>37</sup> Know the signs of job burnout. Mayo Clinic. <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642>. Published June 5, 2021. Accessed August 15, 2021.

## Burnout During COVID-19

The COVID-19 pandemic has greatly affected the mental and emotional well-being of healthcare workers around the world, exacerbating feelings of burnout for many.<sup>37</sup> A survey of 1,119 healthcare workers surveyed indicated that:<sup>39</sup>

**93%**

were  
experiencing  
stress

**86%**

reported  
experiencing  
anxiety

**77%**

reported  
frustration

**76%**

reported  
exhaustion  
and burnout

**75%**

said they were  
overwhelmed

**More than 75%** of healthcare workers with children said they were worried about exposing their child to COVID-19, nearly half were worried about exposing their spouse or partner, and **47%** were worried that they would expose their older adult family members.

**About 39%** said they didn't feel like they had adequate emotional support. Nurses were even less likely to have emotional support (**45%**).

We have not been directly exposed to the trauma scene, but we hear the story told with such intensity, or we hear similar stories so often, or we have the gift and curse of extreme empathy and we suffer. We feel the feelings of our clients. We experience their fears. We dream their dreams. Eventually, we lose a certain spark of optimism, humor and hope. We tire. We aren't sick, but we aren't ourselves.”

– Charles Figley, Professor of Traumatology Institute (1995)

*Compassion fatigue* refers to the profound emotional and physical exhaustion that healthcare workers can develop over the course of their career when they are unable to refuel and regenerate, and is a normal consequence of working in high-stress settings with heavy workloads, including busy hospitals, where staff are exposed to a large volume of cases, with little

time to debrief and regroup and from being exposed to too many patients with similar problems.<sup>40</sup> Compassion fatigue is characterized by the inability to tolerate strong emotions in patients, colleagues and loved ones or to listen to difficult stories. Over time, healthcare workers may develop a detached affect and lose their ability to connect with patients.

<sup>38</sup> Lagasse, J. Healthcare workers experiencing burnout, stress due to COVID-19 pandemic. Healthcare Finance. <https://www.healthcarefinance-news.com/news/healthcare-workers-experiencing-burnout-stress-due-covid-19-pandemic>. Accessed on June 11, 2021.

<sup>39</sup> Lagasse, J. Healthcare workers experiencing burnout, stress due to COVID-19 pandemic. Healthcare Finance. <https://www.healthcarefinance-news.com/news/healthcare-workers-experiencing-burnout-stress-due-covid-19-pandemic>. Accessed on June 11, 2021.

<sup>40</sup> Francoise, M. Occupational hazards: Compassion fatigue, vicarious trauma and burnout. Canadian Nurse. <https://www.canadian-nurse.com/en/articles/issues/2014/june-2014/occupational-hazards-compassion-fatigue-vicarious-trauma-and-burnout>. Published 2014. Accessed on June 13, 2021.



People who are naturally empathetic may be at higher risk for developing compassion fatigue because they tend to align with traumatic situations and stories more deeply.

**Vicarious (or Secondary) Trauma**, on the other hand, refers to the personal impacts of working specifically in work-related settings where there is exposure to trauma and/or with trauma survivors.<sup>41</sup> It is a response that results from hearing and/or witnessing patients' trauma, such that the trauma experienced by the patient begins to be felt by the staff. As a result, healthcare staff begin to experience negative changes (a transformation of self) that may lead to psychological, physical, and spiritual changes. In the short-term, individuals experiencing vicarious trauma may report experiencing intrusive images, nightmares, and intense preoccupation with patients' stories long after the encounters end. In the long-term, as vicarious trauma sets in, people experience changes in their sense of safety and become more anxious or fearful about specific situations.<sup>42</sup>

**Impacts on Practices and Patients:** Burnout, compassion fatigue and vicarious trauma affect healthcare providers and caregivers in deep and personal ways. In practices where burnout, compassion fatigue and vicarious trauma are experienced, there are higher rates of staff turnover, more sick days taken, and generally a reduction in productivity and poorer communication between staff which can lead to reduced quality of care and worse health outcomes.

**Risk Factors:** There are risk factors that can alert leadership to the possibility of these things becoming prevalent. Organizational factors that put people at risk are lack of quality supervision, high incidence of trauma amongst patients/case

load, lack of experience (due to age or in the role), inadequate training/preparation for the role, cultural clashes between patients and staff, lack of a professional support system, and a work environment that rewards going "above and beyond". Personal factors may include staff with a history of trauma themselves, pre-existing mental health conditions, lack of boundaries between personal and professional lives, cumulative effects of trauma and stressors, isolation, inadequate social supports, and having a "superhuman" complex.

**Addressing Staff Wellness:** Trauma-informed practices must address burnout, compassion fatigue and vicarious trauma. The best way to do this is to prevent it from happening.

**Organizational Solutions:** While self-care is often touted as the best way to prevent vicarious trauma and compassion fatigue, it places the responsibility on staff themselves and does not get at the root causes, which often originates from organizational cultures and practices. Organizations must reflect on how their processes, protocols, and cultures are contributing to burnout and vicarious trauma in their staff.

The following strategies for addressing burnout are suggested by the Institute for Healthcare Improvement's Framework for Improving Joy in Work:<sup>43</sup>

1. Ask staff "what matters to you?" and "what gets in the way of what matters?" and really listen to their responses.
2. Commit to addressing the things that get in the way by involving staff in those solutions.
3. Use improvement science to help measure the impact of the changes.

<sup>41</sup> What is vicarious trauma? A look at an important yet overlook concept. Regis College. <https://online.regiscollege.edu/blog/what-is-vicarious-trauma/#:~:text=Specifically%2C%20vicarious%20trauma%20refers%20to,developing%20symptoms%20of%20vicarious%20trauma>. Accessed on June 13, 2021.

<sup>42</sup> Francoise, M. Occupational hazards: Compassion fatigue, vicarious trauma and burnout. Canadian Nurse. <https://www.canadian-nurse.com/en/articles/issues/2014/june-2014/occupational-hazards-compassion-fatigue-vicarious-trauma-and-burnout>. Published 2014. Accessed on June 13, 2021.

<sup>43</sup> Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.



In addition to the above, the following are critical components of a healthcare organization that promotes safety, well-being, and joy in work. These include:

- **Meaning & Purpose** – Daily work is connected to staff’s reasons for working in healthcare, the organizations mission, and values.
- **Choice and Autonomy** – Organization promotes choice and flexibility in work, hours, use of EHRs, and problem solving.
- **Recognition and Rewards** – Leaders understand daily work and recognize and celebrate accomplishments of staff.
- **Camaraderie and Teamwork** – There is shared understanding and responsibility for work generated by trusting and helpful relationships.
- **Co-Creation and Participative Management** – Management creates space to listen to staff without judgement and involve staff in decision making.

- **Promoting Resilience** – Staff feel they have control of their work, they can pursue personally meaningful tasks, leadership promotes health through employee assistance programs, healthy work/life balance, peer support, generous paid time off, excellent health insurance, including mental health, and complementary medicine.
- **Daily Improvement** – Improvement sciences are used to help measure and track changes.

As part of this, practices can also implement vicarious trauma-informed supervision. This is done by creating a safe space for addressing vicarious trauma, which allows staff to feel comfortable coming forward and speaking about their experience. Consider peer supervision opportunities in addition to hierarchical structures as a way to build staff comfort in speaking about their experiences. Supervisors should also work with staff to manage workloads and expectations and identify and address warning signs in any staff as they arise.

## Success Story

- *Dr. Omoniyi Omotoso, MD, UCSF Benioff Children’s Hospital - California*

As result of Dr. Omotoso implementing trauma-informed practices in his clinic, the team’s daily meetings now include a time for all staff to check-in on how they are feeling personally and about the work. In addition, every meeting now has a trauma-informed activity which a different staff member leads each week. These include games, quizzes, yoga, and meditation. The team also engages in team building exercises to improve teamwork and personal relationships.

Personal Solutions: Self-care is important in the helping professionals as well. Self-care is defined as any activity that people do deliberately to take care of their mental, emotional, and physical health. Good self-care is key to improved mood and reduced anxiety. It is also the key to a good relationship with oneself and others. Self-care tends to the whole person including physical, psychological, emotional, spiritual, intellectual, and interpersonal well-being in our personal and professional lives, which is what makes it such a valuable tool for combatting burnout, compassion fatigue and vicarious trauma. Self-care is “something that refuels us, rather than takes from us.”

Below are some self-care strategies that can be employed at work or at home:

- **Build a support network if you do not already have one.** Make time to meet with the people in your network regularly.
- **After a critical event, ask for debriefing at work when you need it.** If it isn't available, reach out to a therapist or to your employee assistance program.
- **Find better ways to decompress.** At the end of a long day, many of us are tempted to reach for a glass of wine, a bowl of chips or the remote control. In moderation, none of these are a problem, but when we start using them regularly to cope with stress, they can become unhealthy. Instead, go for a run or a walk, play with your pets, journal, do yoga, meditate, spend time with children — yours or someone else's.
- **Practice mindfulness-based stress reduction.** Try it for three minutes a day, and gradually build up to 10-20 minutes.
- **Reduce your trauma inputs.** Limit the amount of stressful or violent material you are exposed to while watching the news or your favorite TV shows and when reading for pleasure.
- **Advocate for a change in workload.** If the amount or kind of work is driving your stress and burnout, ask for a change in workload and/or more control over your schedule.

## Check-Out these Self-Care Assessment Tools...

And consider using them with your staff to better understand how you can support each other's wellness!

- [Self-care Professional Quality of Life \(PROQOL\) Scale: Compassion Satisfaction and Fatigue Self-Test for Helpers \(B. Stamm, 2009-2011\)](#)
- [Self-Care Assessment \(Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996\)](#)
- [Stamm, B.H. \(2016\). The Secondary Effects of Helping Others: A Comprehensive Bibliography of 2,017 Scholarly Publications Using the Terms Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, Vicarious Traumatization, Vicarious Transformation and ProQOL. <http://ProQOL.org>](#)
- [Guidelines for a Vicarious Trauma-Informed Organization](#)
- [Trauma-Informed Organizational Assessment \(TIOA\) Information Packet](#)
- [Aces AWARE Self-Care Tool](#)

# Conclusion

Adverse childhood experiences can impact the whole person — body, mind and spirit — and have been shown to have a ripple-effect that compounds overtime, manifesting in toxic stress when not buffered. Healthcare providers, particularly small practices that serve as trusted members of their local communities, are critical in healing communities and individuals managing the impacts of trauma. Individuals with histories of trauma, including trauma related to medical care, are often reluctant to initiate and continue care, especially when medical offices themselves produce fear or anxiety. Practices and clinics can play a role in helping trauma survivors feel safe and comfortable in healthcare settings, and ultimately increase their likelihood of reaching their health goals.

The steps and considerations in integrating trauma-informed approaches outlined in this paper are meant to show practices the actions they can take – both big and small – to work with patients and communities to address trauma and toxic stress within the healthcare visit. Increasing staff’s awareness of trauma-informed approaches and incorporating trauma-informed design into the clinic’s physical environment and via the front desk experience can go a long way to helping individuals with trauma histories regain a sense of control and comfort in healthcare settings. Implementing and practicing trauma-informed approaches within the clinical encounter, such as when conducting exams, tests, and procedures, will not only help staff build trust and better communicate with patients, but help patients feel comfortable continuing in care. Screening for ACEs and measures to identify and address unmet needs as part of routine healthcare visits furthers these strategies to mitigate the impact of trauma and toxic stress on health. Finally, ensuring that healthcare staff themselves are safeguarding their own physical, mental, and emotional wellbeing will enable staff to perform at their best without sacrificing their own needs while doing their important and valuable work.

Practices of all sizes can dramatically improve the health trajectories of their communities by acknowledging the experiences of their patients. By incorporating these tools and resources to implement trauma-informed approaches, staff and practitioners are honoring their patients, improving access to care, and maintaining an open door to health promotion.

This paper was produced with grant funding support from the California ACEs Aware Initiative, a first in the nation effort to screen children and adults for adverse childhood experiences (ACEs) in primary care, and to treat the impacts of toxic stress with trauma-informed care. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation. Please visit [AcesAware.org](https://AcesAware.org) for more information and [PCDC.org/ACES](https://PCDC.org/ACES) to view the year-long virtual learning series on screening for and addressing ACEs in small practices.