

Lessons from the Front Lines: Insights into Trauma-Informed Care for Medicaid's Complex Populations

Webinar Transcript
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Hello everyone and welcome to the Center for Health Care Strategy's Webinar: Lessons from the Frontlines: Insights into Trauma-Informed Care for Medicaid's Complex population. This webinar is supported by Kaiser Permanente Community Benefits. My name is Alex Maul with the Center for Health Care Strategies, and I am delighted to be with you all and lead today's webinar.

During today's call, we will provide an overview of trauma and trauma-informed care, its relevance to the field of complex care and the work that CHCS is doing within this field. We'll then hear from Laurie Lockert who will share the work that CareOregon has done to build a trauma-informed workforce, including outlining successful practices for hiring, training, and supporting staff. We'll also hear from Victoria DeFiglio who will highlight the work that Camden Coalition of Healthcare Providers is doing within this space as well as some of their cross-sector efforts to create a trauma-informed community in Camden, New Jersey.

Questions will be addressed following each speaker's presentation and we encourage you to type questions in the question box throughout the webinar. My name is Alex Maul and I am a program associate here at the Center for Health Care Strategies. I work with our complex populations team on both children's health quality issues such as childhood obesity and children's oral health, as well as our adult health initiative including our complex care innovation lab(?) and a new initiative around advancing the adoption of trauma-informed approaches to care.

Prior to joining CHCS, I worked in maternal and child health education and policy in Los Angeles and Washington, DC. I have a master's in public health from the UCLA Fielding School of Public Health and an undergraduate degree in human and organizational development from Vanderbilt University. I'm also pleased to introduce today's speakers, Laurie and Victoria. Laurie Lockert is the manager of the health resilience program at CareOregon and has collaborated with over 24 primary care and specialty clinics a health resilience specialist and develops new work flows to incorporate this unique workforce. She has over 30 years of experience as a clinician, manager, and consultant in a variety of care settings. And Laurie has also provided trainings on group therapy and trauma-informed care for the Institute for Health Improvement, Oregon Health Authority, health plans, primary care clinics to name a few. Laurie has a master's in psychology from Portland State University and has her license as a licensed professional counselor.

Victoria DeFiglio is the clinical director of Cross Site Learning and Workforce Development at Camden Coalition of Healthcare Providers. She guides their population health and super utilizer work through bi-directional learning with technical assistance sites across the country, as well as engineering curriculum to prepare the future workforce for us to engage the vulnerable, complex populations. Prior to joining the coalition, Victoria served as a Teach for America member where she taught high school science in St. Louis. She is a graduate of Simmons College and Goldfarb School of Nursing and is currently pursuing her master's in healthcare administration at the University of Pennsylvania.

Just to give you a bit of background about CHCS and who we are before we get into the meat of the presentation, CHCS is a nonprofit health policy resource center dedicated to improving the health of low income Americans. CHCS was established in 1995 through a major grant from the Robert Wood Johnson Foundation and our work is centered around advancing the access, quality, and cost-effectiveness in publicly financed healthcare. To achieve our mission, CHCS works with states, health plans, and federal policy makers focusing on enhancing access to coverage and services, advancing quality, and delivery system reform and integrating care for people with complex needs, and building Medicaid leadership capacity.

So CHCS has recently begun some new work and several initiatives to advance trauma-informed approaches to care. Through support from Kaiser Permanente Community Benefit, CHCS developed the Complex Care Innovation Lab to bring together leading innovative thinkers from 13 organizations across the country who are really making strides and improving quality and cost-effectiveness of care for complex populations. And within the Innovation Lab, a small subset of organizations who are really interested in exploring trauma and pursuing training around trauma-informed care. These organizations are currently undergoing formal training and seeking safety which is a trauma treatment, and a small subset are also training in eye movement, desensitization and reprocessing, also known as EMDR which is another evidence-based trauma treatment. And CHCS is facilitating the collection of feedback around these trainings to share learnings with a larger innovation lab group as well as informed next steps in this field.

So we also want to let you know about a few resources that are available also as part of the innovation Lab and with support from the Kaiser Permanente Community Benefits. CHCS has also released an issue brief this past March entitled, ‘Trauma-Informed Care: Opportunities for High Need, High Cost Medicaid Populations,’ as well as a resource document with relevant tools and articles and a blog post written by one of today’s speakers, Laurie Lockert, outlining CareOregon’s trauma-informed approach. These resources can be found on the CHCS website, www.chcs.org. And lastly, with support from the Robert Wood Johnson Foundation, CHCS has launched a new three year initiative to increase the understanding of how trauma-informed approaches can be implemented in a healthcare sector to improve patient outcomes and increase costs. Through this initiative, CHCS will work to build awareness and understanding of the impact of trauma and the importance of trauma-informed approaches to care among providers, and this work includes an environmental scan to identify best practices and key ingredients of successful implementation, as well as a multi-site demonstration across diverse delivery settings, extensive technical assistance to participating pilot sites, a learning collaborative, and a robust dissemination strategy to share findings. We’re very excited about this work and look forward to sharing more in the future.

I will now talk a little bit about trauma, trauma-informed care and its relevance to the field of complex populations. So what is trauma and why does it matter? So, while there are a variety of terms and definitions used for trauma, we find it helpful to use the framework defined by the Substance Abuse and Mental Health Services Administration, SAMHA saying individual trauma results from an event, or a series of events, or a set of circumstances that's experienced by an individual that's physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Some of you may have heard of the Adverse Childhood Experiences Study. So this landmark Adverse Childhood Experiences Study, also known as the ACES study, as well as many studies that builds(?) on the original ACES research demonstrate that the more an individual is exposed to adverse experiences, such as physical, emotional, or sexual abuse, neglect, discrimination, and violence, the greater the risk for serious health problems and health risk behaviors including depression, heart disease, liver disease, sexually transmitted diseases, smoking, alcohol abuse, and illicit drug use. In addition to the elevated risk of negative health outcomes, childhood trauma is also linked to detrimental social outcomes and increased cost to social service systems. As more and more research becomes available, experts are finding out more about the neurobiology behind toxic stress and how it really influences the development of the brain, as well as how changes in a child's development will affect the trajectory of his or her health and social behavioral and emotional health throughout the child's life.

So what is trauma-informed care? A helpful framework for thinking about trauma-informed care is SAMHA's definition that states that trauma-informed care or also known as a trauma-informed approach realizes the widespread impact of trauma and understands potential paths for recovery, recognizes the signs and symptoms of trauma in(?) clients, family, and staff, responds by fully integrating knowledge about trauma into policies, procedures, and practices and seeks to actively resist the traumatization. The trauma-informed care acknowledges that in order to provide effective care services, the care team needs to have a complete picture of a patient's life situation, so both past and present. And this approach shifts the focus of healthcare professionals away from a framework that asks what is wrong

with you to one that asks one has happened to you. Trauma-informed care recognizes that much of the behavior demonstrated by individuals with a history of trauma developed as coping mechanisms to help people deal with trauma and suggests that appropriate treatment can actually re-train the brain to respond to situations in a healthier way. It also acknowledges that the care delivery setting itself can unintentionally re-traumatize individuals and strive to create an environment that is sensitive to this for both patients and staff.

Establishing a trauma-informed care framework or lens(?) or is a really important step for organizations to reorient their culture and create an environment that supports trauma survivors. And it's important to note that trauma-informed care is both organizational and clinical. So, while culture change and organizational change is necessary to become trauma-informed, evidence-based clinical interventions are also part of the clinical framework to address trauma related symptoms. Trauma treatments or interventions like Speaking Safety and EMDR that I mentioned a few slides back, they can be used by themselves but may not constitute trauma-informed care. They are an integral part of an overall framework for trauma-informed care. So, by recognizing trauma is of a possible determining factor of serious health problems and health-risk behaviors throughout the life span and by practicing within a trauma-informed care lens, particularly in conjunction with access to trauma treatments or interventions, providers can more effectively engage and treatment their patients and potentially help reduce utilization and access cost in both the healthcare sector and social service system

While the experience of trauma crosses gender, socioeconomic, ethnic, and racial lines, many “complex” Medicaid beneficiaries display symptoms associated with trauma and are challenging to engage due to a range of physical health, behavioral health, and environment circumstances. These individuals are typically frequent users of emergency departments, have higher disease rates, higher rates of substance abuse and behavioral health disorders, and poor social outcomes that all show as symptoms of trauma. Healthcare organizations and delivery systems serving this high need, high cost population are increasingly recognizing the prevalence of trauma among these individuals. Using trauma-informed care to better engage with this difficult-to-reach population may help providers and case managers build a

trusting relationship with these individuals and has the potential to enhance quality and cost outcomes to the Medicaid program overall. And lastly we want to acknowledge that this is an emerging field in many respects, and we found that most experts agree that more data is needed for how trauma and some care can be provided for complex populations.

So we will now hear from Laurie Lockert with CareOregon who will share the work that CareOregon has done to build a trauma-informed workforce. So, Laurie, I will hand it over to you.

Laurie Lockert, CareOregon

Thank you very much, Alex. You laid great foundational groundwork for me. Next slide, please. I appreciate the introduction and let me start. Since you already gave the definition, this is just to highlight, again, that we're all on the same page about understanding what trauma-informed care is. Today I wanted to focus on the three central principles of trauma-informed care and how we are applying that to our workforce. I might interchange client and patient at times because of the mental health background and world we tend to call our individuals clients. However, since my staff is embedded in primary care clinics, we use patient, too. They're one in the same.

We developed our workforce in according with the three principles of trauma-informed care: Creating safety, meaning physical safety as well as emotional safety which obviously is built by establishing trust, a trusting relationship which you do through offering choices, having transparency with leadership, and predictability. It's really important to know when meetings are going to happen, when you can turn on people. Is someone going to show up when they say they're going to show up? Restoring power. Certainly, that's involved with so many of the underprivileged and people living in poverty that we work with, but I've also found that it applies to the workforce. We've hired many people from community mental health and other social service agencies where they didn't have much power. And, again, that's about providing choices and teaching skills. Finally, valuing the individual which is done through collaboration, acceptance, being non-judgmental. We know that being judgmental changes the way we treat people. As the ACES study, which was mentioned by Alex by Felitti and Anda in 1998 demonstrated experiences of adversity occur across all socioeconomic culture ethnic boundaries, so that we are just as likely to be working with a colleague with an ACE score of 5 than serving a patient.

Next slide please. I want to show the story of what we've learned by intentionally building a program from the ground up. I was delighted to start working at CareOregon four years ago to develop this program and had the opportunity to start hiring people with a trauma-informed care lens. I put this slide up because I have often run into people who have a misperception about what trauma-informed care means. One of my first experiences where I learned a lot was presenting to a local police department. It

was very clear they had interpreted trauma-informed care as letting people off the hook, not holding them accountable. And I've since run into that. Many people still hold that perception, even if it's unspoken. Being trauma-informed means applying these principles to everyone, I believe, our staff, our patients, even our community partners, so that by adopting what I might call universal precautions, we assume that staff come with histories of adverse experiences. The bottom line is people are not trying to be difficult. They're doing the best they can with what they've got, and believe me, I've used that phrase in my head over and over again when I have felt frustrated with both staff and clients. So the intention was to treat our staff with the same principles we treat patients.

Next slide. A little bit about an overview of what an organizational structure would look like that is trauma-informed. And this is for you to take away and review later. It lays everything out that I've talked about in terms of the safety, the power, and the individual. So this is more of a schema for you to take away and look at and take back to your organizations and show them.

Next slide. A little bit about CareOregon. We're the largest Medicaid insurer in Oregon, and the health resilience program serves the most complex high-risk population. The criteria for the program has been the Medicaid people we serve and some dual eligibles 18 years and older, and their data that we use for our cut-off is to take a look at somebody as one inpatient admission and/or six or more avoidable ED visits, non-OB. For the CareOregon population, that brought in the top 5% of the people utilizing, having avoidable use of acute care services. And the other piece of our criteria is that it's voluntary which is trauma-informed. We asked people if they want help from us with their healthcare issues. In addition, we are not working on a billable hour. We have time to build a relationship and build trust which we believe is critical with this population with such trauma histories.

Next slide please. What we're all observing out there in primary care safety net clinics is that people aren't coming on. They're no-shows. People do not seem engaged with their care provider. Providers are upset with patients. Patients are feeling shamed or punished by their providers, not understanding how the healthcare system works, a lot of emotional reactivity from both providers and clients, provider burnout, cynicism and a lot of reactivity. And we also hear a lot in the labeling of clients

as drug abusers or drug seeking. Going back to what Alex said is sort of what happened to this person isn't being asked. It's more about what's wrong with you, you're a drug seeker. So our whole healthcare system has gotten caught in a very reactive mode which is not unusual. This population we serve are not only costing a lot because of utilization and the expense of that utilizing acute care services, but they're being re-traumatized. Our very system is re-traumatizing these people, and much of what the health resilience program does is step in and try to act like say a couples therapist, trying to get a balance back between the two players - the clients and the doctors and the healthcare providers, whether it's community, mental health, or the primary care clinic and have a conversation. We didn't think it was going to make a difference by simply adding outreach workforce to primary care but a specifically trained workforce who could reach a population of people who have had repeated failures of care, a population filled with trauma experiences. We wanted a workforce understanding the impact of trauma and being able to recognize trauma behaviors, and therefore be able to address and mitigate those. We also wanted to role model trauma-informed care behaviors to the primary care clinics to demonstrate how slowing things down and listening to people can actually help increase not only the morale and happiness with your job but people will tend to feel heard and therefore, feel engaged in wanting to talk with us.

Next slide please. We've started. Let's start with creating safety. Keep going. You were on the right track there, thank you. Creating safety which is about, again, transparency, predictability, trust. If we expect staff to provide trauma-informed care, the workplace environment should be trauma-informed. We looked to hire, at first, four years ago, bachelor's level people who had experience in healthcare. We started out with a couple of people with bachelor's degrees and at the same time, we found some master's level people wanting to work for us from community mental health. So we had an interesting pilot, unintentionally, that we started up from the very beginning with two different kinds of backgrounds. We used behavioral interviewing which was really helpful in terms of identifying staff who understood the principles of trauma-informed care. Often times, we'll see people who don't use the language per se of trauma-informed care but have the principles down. What we looked for with behavioral interviewing was that they weren't being judgmental. They weren't using labels, calling people, for instance,

noncompliant, or drug abusers, or showing more depth in understanding the problems with this workforce this population has. We didn't also want people who took sides, people who could remain neutral, not a rescuer, not directive but to listen to people and be able to be, as I said, kind of Switzerland-like, neutral.

Next slide. The ways we demonstrated valuing staff was to use the values as collaboration, mutuality, and again applying non-judgmentalness to our own workforce in each other. We established a learning environment from the beginning. Our huddles included medical director, my director, myself, the health resilience specialist and an opportunity to talk about clients and get ideas on approaches from each other. It was wonderful having this blended lens of the medical and the psychosocial brought together in one room, so that we didn't spend too much time on one or the other but could look and understand our clients from both perspectives. In the weekly huddle we also would work on our own trauma-informed cells, listen for our judgmental language which inevitably tops out. And in an environment that no one is going to jump on you but to be able to help us see when we are actually becoming judgmental and using judgmental language. So very challenging to do in a culture that has judgmentalness in every layer of it, but it was really helpful for us in terms of growing our program and being in a safe place to inform each other that we were sounding judgmental. We also started to include peer wellness(?) specialists which helped us, again, look at ourselves in a language we were using about clients. Valuing our staff also means providing training, recognizing the difficulty of the work and I do mean the difficulty. Certainly, when I have worked in community mental health, it is so fast-paced and there is so much responsibility placed on the shoulders of one individual, and I see the same in primary care. We can all relate to this, I know, but everyone is doing the best they can and running as hard as they can. Taking time to sit and talk can connect to your fellow workforce, there isn't much time for that, yet that is what we draw on and the strength we draw to do this work we do. We also started doing some off-site lunches with the group, going to have lunch and doing Kigami in the park, taking an hour-and-a-half in the work week, providing time in the work week for the staff to build a relationship with each other and talk and share their struggles.

Next slide please. Over the first two years, we learned that the master's prepared staff, those with a psychology and social work background were better prepared than the bachelor's level in some key areas. The master's prepared skill sets included training on trauma-informed care, mental health diagnoses, addictions, outreach, knowing how to be safe going into someone's home, also setting goals with clients which is really critical for us. As we work with people from six to nine months, we want to be very intentional about helping them set health goals that they can achieve and working with them, so having training in that is actually very, very beneficial. Also, the master's level people came prepared with more systems thinking and constructs because we expected them to not only work within a primary care setting but go out in the community and work independently and connect people to services that were needed across the community. This skill set was really valued that they came with. When I think of the third principle, restoring power, I think of the working experiences with staff again in the social services system and what I've seen in the safety net systems. There isn't much time to slow down and breathe, to learn more around how to stop and be able to listen to clients, and what a difference that will make.

Next slide please. What you see here is some of the trainings that we've done for the health resilience specialists. The highlighted ones in bold are ones we do consistently and repeat. The others are just a smattering of what we provide. Valuing the individual. We are always asking our staff what they need to do their job better. It's not that we can always give it to them, but, again, asking people what they need, trying to get it and/or saying this is something we can do or this is something we can't has been very powerful. Providing the tools for them to do the work makes them feel valued. It also helps all of us in terms of the work and what we're trying to achieve. We have brought some of the clinic doctors that we're partners with in to help us and do specific trainings around diabetes, CHF, and that has been very valuable in terms of sort of mini trainings. Again, our staff have the psychosocial ins(?) for the clinics. They get to go out and bring back what is happening with those clients who are not being successful to the medical system who can't leave the four walls and only have training through seeing people for the most part through the medical lens. We also have the self resilience specialists teach each other. We have a respiratory therapist on our team. We have an addictions health resilience specialist and we recently

added a housing specialist. I believe empowerment is about asking the staff what they need to do to get their job done to the best of their ability.

Next slide. Another way that we check ourselves if we're doing what we think we're doing is there's a staff evaluation that's been done at CareOregon, an Annual Staff Engagement survey. Up here on the screen is the 2014 result, and this goes back to creating safety. No matter how safe we as leadership try to make a program, many people come with trauma histories into this workforce and to this work and even when given an open and transparent environment can get triggered and(?) fear authority and not speak up. So, by doing this, we're able to kind of match this is what we're seeing and here's an opportunity for people who don't feel safe to speak up. CareOregon utilized a professional survey which guaranteed anonymity. It asked questions about the work, the work environment, manager actions, as well as what people felt about the organization. In 2013, our fully engaged results were 19%. Our engaged results were 71%, and our somewhat engaged were 10%. You can see the jump we made in 2014 there on the slide in that we moved out of somewhat engaged and those who were engaged even moved into fully engaged. What we found out is that we have set our salaries at more community mental health worker levels, master's level which is about half of what medical master's level people make, social workers. And we went back to CareOregon and said we feel that there is a discrepancy. We're under paying our staff and they agreed and raised the staff salaries significantly which, as you could see, made people very happy. However, that is just one other aspect in terms of touching base with our staff as to how we're doing.

Next slide please. In the past six months, we have added almost 13 new staff. Because our program has been getting a fair amount of notoriety, other primary care clinics have asked for health resilience specialists and in other CCOs in the state, as well as needing to hire more people to support the team. This ramp-up was really fast, and we started out with CareOregon funding this. Then we've been on a three year grant which is sun setting June 30th. So CareOregon is going to take us in-house as one of their departments now fully. There's been a lot of stress that's been going on here in the past six months. Leadership has been tested by this as have the health resilience staff. We've noticed the increased level of

stress. Our old ways of communicating were not being effective. The model for seeking staff input as a group became unwieldy. Having a conversation and getting feedback with 30 people to 35 people was not being effective. With the communication breakdown, some staff became mistrusting of leadership. Despite our transparency, there's been an issue happening here of a little bit of mistrust bubbling up around the leadership. So for complete transparency with you all, I've been really having a hard time with that because of my intention to build a trauma-informed program. I've tried to be both curious and reflective this past month and not reactive as to what is off track and how to get back. Certainly, the rapid growth was the likely initiating event starting in December. I also saw that I was the primary driver of having a trauma-informed program and I should have shifted over the responsibility as I hired supervisors on. Having trauma-informed care policies and procedures from the beginning for the program would have been a perfect foundation to help staff understand this process. We only recently developed trauma integration supervision policy and procedure, so making sure that my supervisors are having conversations that are trauma-informed and talking about vicarious traumatization with our staff will now be put in place on a standardized way. In addition, having completed an organizational self assessment for trauma-informed care would have helped provide a concrete road map. So stay tuned. There's more to learn and I am confident we'll get back on track, but it has been a bump in the road that I have had to practice being trauma-informed and be curious and not reactive.

And finally, last slide. I do believe we can't ask our staff to behave in a trauma-informed towards our clients if we aren't practicing the same principles within our workforce. So I will stop here. Thank you.

AM: Great. Thank you, Laurie. Laurie, we will now ask that you field a few questions from participants. So the first question is for organizations that are just beginning to explore this field and want to become more trauma-informed and are really interested in implementing a trauma-informed care framework within their care setting, what's your biggest piece of advice or what would you really recommend they get started doing now?

LL: I would go back to what I wish I had done in the beginning was doing an organizational self assessment. In other words, from the top down looking at what, and you can find these at, I believe, the National Board for Counselors and Therapists, but I know SAMHSA probably has them, too, of starting with a self assessment, starting with what's the training that needs to be rolled out, and starting to identify policies and procedures around that and have that structure, and then identifying rolling out the information in the kinds of conversations that need to happen.

AM: Great. I guess a step before that, how did you create buy-in? How did you kind of get this started where you were at CareOregon?

LL: Well, the director who hired me and the medical director both had not heard as much about trauma-informed care but again we're(?) one of those people we all know out there and some of us are it who operated pretty much that way in our work for a long time, being nonjudgmental, being open, listening. And so they got it immediately when I started talking about it and continued to encourage and support training staff in this way, encouraging staff to be this way, and basically role modeling how to be respectful and trustworthy. So it comes down to doing a lot of role modeling for people.

AM: Great. And I know this program started four years ago. How were you able to get CareOregon to take on the program permanently or sustain?

LL: excellent(?). So data again. We sent out, last fall, we were evaluated by an independent, as part of the grant, data analyst organization and who looked at what we were doing in terms of utilization and we did show that there was a trend downward we were creating in both ED visits and inpatient readmissions. And also what was most powerful to CareOregon was we did a qualitative study, too. We sent out questionnaires to 10 clinics, asked the staff to fill them out about their experience with the health resilience specialist, and we had a resounding chorus of support from the providers saying that it made their job easier. They were better able to work with some of the clients that prior they had not been able to, and our program gave them hope. They had lost hope in some patients which I know we all have had that experience. When you're in it alone and see the work that the client is not doing for themselves, you do begin to get hopeless and that nothing will work or change their behavior. So I believe

CareOregon was most impressed with those factors that they were seeing from the self reports of the physicians, and the nursing staff, and the MAs.

AM: Great, Laurie. That's really helpful. Thank you. So we have a question about how would you apply these lessons to a setting other than primary care, for example, to dementia care or other long-term care settings?

LL: Oh, that's a great question. I would apply it to the same way I apply it anywhere else. It is about training staff, and I have to add, the training of the staff, one of the key pieces that I think is really critical is the neurobiology of trauma, so that we help people understand that it's a wiring issue and we tend to be more forgiving of people when we understand that they have some sort of a physical handicap allowing them to not be able to do what we want them to do, and we don't always see that with trauma, right? So training staff in the neurobiology of trauma which then starts staff thinking, ah, they can't really help it so they're behaving in a way that they need to manage and can learn to manage, but they don't get it right now. So applying those principles to a dementia setting, to any other setting is where I would start and the judgmental language. Erasing(?), describing someone as what, I remember working inpatient site, a goober I think was a name someone used or a frequent flyer. Immediately you get the impression that we've distanced ourselves from who that person is. I see that person in a different way. I don't see them as a human being when we start using labels. So labeling, I've found in changing the labeling process has been a big stride for how we see people and how we interact.

AM: Great. And kind of along the same lines, are you having much luck getting primary care physicians trained and engaged and how are you doing that? Does your training provide CMEs?

LL: Interesting. It's starting to take off around the state. I have gone to clinics where have health resilience staff and done an intro to trauma-informed care like in an hour which is way too short. But they have asked me to come and they're inevitably the people who are interested and get it right away, and so that sparks some discussion as well as they have a health resilience specialist there that they can watch how they operate. So that helps and as well, more and more organizations, Oregon Health Authority, other organizations across the state are providing access to trauma-informed care trainings for

primary care physicians and more physicians are starting to be involved in some of those trainings. So there's a groundswell happening which is very, very exciting.

AM: Yes, absolutely. So we have a question about what is a trauma stewardship training.

LL: Actually, there's a book called Trauma Stewardship by a woman in Seattle, van Dernoot Lipsky, it's a mouthful, and she's the one who goes out and does some trainings on the west coast here and across the nation on trauma stewardship, meaning we have to take care of ourselves when we're in a workforce that deals with people who have high rates of trauma, whether you're police, mental health, primary care, social services that we have to recognize our own triggers. We have to recognize that if we're getting burned out. It's accountability on the workforce and learning to recognize that. And her book is great. We bought one for all of our team members and have sent our team to her training. She does it very well with some humor and some understanding, having been there herself, and that's what the trauma stewardship is. And if you Google the book, you'll find it on Amazon.

AM: Great. When you were talking about the health resilience program, you might have mentioned this, but would love to get more detail about the types of trauma specific treatment interventions used and what the format for sessions are with clients and groups and the number of sessions over time.

LL: Sorry, what was the first part of the question?

AM: What types of trauma treatment and interventions are used?

LL: Our whole model is, I call it pre-trauma work in that our first job is developing a trusting relationship with somebody which is very powerful, one where they feel supported, they know what it's like to work with someone who's not telling them what to do but can offer support. We can then open the door to them asking us questions about what might be more helpful – building trust with someone, creating a safe space to talk, giving them choices; do you want me to go with you to the doctor's appointment or do you want me to sit outside? Treating the person with respect. All of those are trauma interventions on a very one-on-one basic way and all have value. In essence, we're doing some pre-work, so that people have a chance to, as I say, calm their amygdalas down and be better able to make choices

and listen. So we do some meditation. We teach some meditation which we do. In our weekly huddle, we all do a two minute meditation. So we teach that to our clients, how to calm themselves because that is one of the hallmark signals of trauma is the reactivity. So that is some of the trauma work we do. In addition, for longer term trauma work, we help them get into either community mental health or some of the primary care settings have a Seeking Safety group. We've just started training a couple of our staff on that to hold those in the clinics, so experimenting with that also. So we don't do specific trauma interventions per se other than trying to start the Seeking Safety groups in clinics, but what we are doing is the trauma work of helping people learn how to manage their reactivity and teaching skill building, very basic.

AM: Wonderful, Laurie. So we just have a few more minutes for questions. A question on funding. Outside of grant funding, are there other sources of funding for trauma-informed training programs?

LL: What I'd say is so we have Trauma-Informed Oregon, an organization that was just started up here and they are going around the state providing trauma-informed trainings. I do training for my staff. There are people starting to offer those services, but for free is a challenge. I think that's going to have to come from counties and state organizations who see the value of training the people in the workforce to do this because it is going to make for reduced utilization, and we're going to be able to help people actually change their healthcare behaviors by doing this. Does that answer your question?

AM: Yes, thank you.

LL: Okay.

AM: One last question. So, when you started four years ago, just a little bit more history, what were the biggest barriers that you encountered and do they have to do with financing, or staff buy-in, or resources, just to shed more light on really getting it started?

LL: Yes. The biggest barriers I saw were organizations that were in chaos, were traumatized. So the parallel process is that organizations mimic an individual's trauma behavior. So you look at an organization, if I see a couple of clinics that we started at that didn't work because you couldn't count on

when a meeting was going to be, there was always a crisis happening, everybody was running really fast so that there was no intentional slowing down process to be thoughtful. So there was so much pressure to hit billable targets that staff were just overwhelmed and basically really reactive. And I think that the hardest part is getting buy-in from the administration that it's okay to slow down. In the long run, you're going to be much more effective if you can slow the reactivity down, just like with our clients. If systems can stop and think and be intentional about where changes need to make, which certainly is with the staff and staff morale. When staff stop feeling listened to or appreciated, valued, or they don't feel it's safe to speak up and say, "I am so burned out and cynical, I need a day off, but I have to call in sick to have a day off. I can't say to my supervisor, I am about to hit the wall and I need a day off." So there are a lot of things that the system, we can do that will open a space to have the staff start to feel safer, to try different things and to speak up which then will impact how they treat the patients. I have known organizations where the CEO is not trauma-informed at all but everyone below them was, and they were able to push through an initiative to be a trauma-informed care work place. So it can happen, but it certainly helps to have those in authority have buy-in with it because it does mean taking time to attend to your staff.

AM: Great. I know here at CHCS the work that we've done in trauma-informed care has really shown that staff is just as important as patients, and I think we tend to concentrate on outcomes for patients and we have to realize that staff are important as well. So thank you. One last question that we've gotten several questions about. Do you have a dog as part of your team and, if so, what role does the dog play?

LL: That is so great. I started bringing my Goldendoodle to work about a year-and-a-half ago one day a week and I just saw people's faces light up. And what we know is that what happens is endorphins get released when people get happy seeing a pet. And so I now bring her two days a week and I bring her to the huddle and the team meeting. I have about 60 people on this floor who now know Stella intimately and she makes the rounds and it makes people really happy. So, yeah, Stella is part of the team.

AM: That's great. Thank you. All right, thank you so much, Laurie. And I will now turn it over to our next speaker, Victoria DeFiglio with Camden Coalition of Healthcare Providers to discuss some of

the work that they are doing within their patient population, as well as highlight some really innovative community transformation efforts taking place in the city of Camden, New Jersey. So, Victoria, I will hand it over to you.

Victoria DeFiglio, Camden Coalition of Healthcare Providers

Great. Thank you so much for the introduction. Laurie, I just want to thank you for your presentation. Our team had a chance to go visit CareOregon a while ago, and we left so inspired because the feeling of trauma-informed care is truly present everywhere you go and people breathe it. So you've really made a model out of it and an operation out of it, and we came home inspired and many of the things that you're going to hear me talk about are really reflective and echo many of the themes that Laurie just said.

So my intention today is to provide you with a context of what we do internally at the coalition in regards to trauma-informed care but also to share the Camden citywide movement around trauma and the energy that trauma-informed care has incited in our community.

Before I do a deep dive into the coalition's philosophy around trauma-informed care, I'll just start by providing a quick overview of who we are and what we do for those of you that might be new or unfamiliar with our work. We're located in Camden, New Jersey which is an interesting geography in that it's a 9 square mile city with about 80,000 people and it's the poorest city in the nation. I joined the coalition three years ago when our staff was less than 20 people and in just three years, we've grown to 79 full-time staff. And our mission and vision is to improve quality, capacity, coordination, and accessibility of the healthcare system for all of the residents in Camden, and our vision is to be the first city in the country to bend the cost curve. I'd like to draw your attention to the third bullet on the slide which is that we're a membership organization with a 22-member board. And really what that means is we have board members from the three competing hospitals in Camden, in addition to residents of Camden, local home health facilities. So it's a large stakeholder group and it really allows us to get a broad perspective around both our internal operations and also about our presence in the community.

For those of you who might be unfamiliar and just as a reminder as our organizational background, we work with the top 1% of patients who are the most vulnerable and the most complex. And this really came out of basically a data collation that our executive director, Dr. Jeff Brenner, completed in which he discovered that 1% of the patients were responsible for 30% of the receipts here in

Camden. And we've done that same analysis in city after city across the country and found that that same ratio holds true. And so the question he really wanted to know was what happens if we go out and meet this top 1%. What if we go and we deep dive and we find out who these people are? And in the spirit of this webinar, I'd like to add that we're moving away from calling the folks in the top 1% super utilizers but rather people with complex needs or people with the phenomenon of super utilization.

Our intervention really started with Jeff going out to home visits. As a primary care doctor, he started taking an interest in that top 1% of folks who he saw over and over again kind of cycle in and out of the hospital and he often wondered what's their story. And so he started going out visiting patients with his office manager which she still works with us as a community health worker. And slowly what they started realizing is that segmenting people by disease and(?) an intervention doesn't always make sense because what they realized is someone who has, let's say, blood sugars that are consistently uncontrolled may look more similar to someone who has consistently uncontrolled COPD but might look less similar to someone who has very well controlled blood sugars. What made people more similar and what made it easier to develop a similar intervention was actually their pattern of utilization, that the pattern of utilization was a signal that something was going on and that there was a crisis. And so when we triage folks with complex needs, we're not doing so by disease state, we're really doing it by complexity and targeting complexity means that we're taking into account traditional medical, mental health as well as psychosocial and environmental factors. And early on in our work we started recognizing these folks with high complexity were telling stories over and over again of significant early childhood trauma. And so it started to be an area of interest for us very early in the work.

In my day to day role in cross-site(?) learning, I essentially have the privilege of talking to people all over the country who call us and want to know how we do what we do. And many people get on the phone and think that we've figured out some magic formula or that we've figured out some magic bean, some sort of magic bullet to work with folks who are complex, very vulnerable and complex. And what I always have to tell them is there is no magic bullet, that this is actually really hard work and that it's grounded. Certainly, trauma-informed care is a pillar in that work and a pillar is part of our philosophy

but that also it's a broader care. It has roots in harm reduction, unconditional positive regard, and motivational interviewing. And at the heart of it is really this basic concept of acceptance and support of a person regardless of what the person says or done, especially focusing on the person as a holistic patient-centered approach. And this is really at the core of how we do what we do.

I echo Laurie's ideas so much and what Laurie said really resonated with me in the idea that parallel processing is at play. So we can't expect to treat our staff members one way and be super outcomes focused and concerned and driven with outcomes and then expect them to go out and slow down with patients and be kind-centered(?) and focus on the holistic picture. What we have to do as an organization is set up systems and set up management structures and signal through informal representations of values that trauma-informed care is present not only with our patients but also in the broader organizational structure and philosophy. So I just want to highlight. I couldn't help but put up our core values and our people principles. Our core values, and I'll take a minute to talk about them, were really organizational processed. So, from the ground up, people were involved in developing our core values. From the ground up, people were involved in developing our people principles. And I want to highlight some policies that we put in place as an organization that really reflect trauma-informed care to our everyday lives. So one of the key pieces is that we have a \$1500 mental health benefit that's accessible to everyone on our staff. It's used in the form of a debit card. It's not like EAP which we often found that there was a lot of bias around going to EAP, that people felt like somehow their employer was going to find out, some sort of employee assistance programming, that they would find out that they had visited a counselor. So this is a \$1500 debit card, so even if your provider of choice does not take insurance, it swipes like a debit card and it functions like cash so it's completely anonymous. It can also be used for marriage counseling and for your dependents. So one of the things we found is that often times on our staff is people who are struggling in their marriage, or in their relationships, or if their child was struggling, they're not able to function and really provide therapeutic relationships with patients. So what we found is that traditional insurance benefits for mental health don't often cover those things in a plan, and we found that in order to reinforce how important it was that people are present, and

therapeutic, and trauma-informed, we had to make sure that they were okay at home. And so that was a structure that we chose to put in place. As Laurie mentioned, it's incredibly crucial that our folks have significant PTO available, so we have a generous PTO policy here. It's totally within our culture for a frontline staff member to go to their supervisor and say I'm feeling really burned out and I really think I need the day off. And that's a conversation that we're used to having within the organization. We have tuition reimbursement, and additionally tuition reimbursement, which many of our staff have used for things like mindfulness meditation training, so it can be kind of unconventional uses of tuition reimbursement. And policies and procedures around what happens when a patient passes away, what is the policy around the organization, how do we memorialize that, what is the policy when someone expresses suicidal ideation. But not only for the patient but also what happens to the staff member and how do we wrap our arms around them and care for them and make sure that they're doing okay. So I think that every day within an organization, we represent informal values and it's really crucial that these are part of what we live in trauma-informed care.

I want to highlight a patient story to tell you what this really looks like on the ground. Before I do, I know Elizabeth is not on the line today but I do just want to acknowledge that she's been gracious enough to share her story. And if you log on to that link, it will log you on to the NPR(?) story in which you can actually hear her voice and it's a very powerful story that really makes me emotional almost every time I hear it. She was part of our P3 which is a pregnancy program that our frontline nursing staff used to engage in essentially where women who were pregnant would be in a cohort and basically participate in a group visit model. So, as they went through their pregnancy, our frontline nurse would engage with them during visits leading up to their pregnancy. This nurse had access to the electronic medical records at the hospital and would get flags every time one of our patient had something happen. And so one day she logged on and noticed Elizabeth's name and noticed that when Elizabeth was three months pregnant and enrolled in the program, she had visited the emergency room. And all the note in the emergency room said was that she was high on 'wet' which is PCP dipped in formaldehyde and that she had smoked it and she was brought in to the emergency room in an incoherent state. Her children were

found wandering and picked up by DYFS, and there was a note in the EMR that was incredibly hostile towards, basically about her, about the situation, using a lot of labels. And Rene read the note who is one of our frontline nurses and basically went to Elizabeth and said, “I’m curious as to what happened to you to get you to the point where you decided to smoke.” And Elizabeth was so taken aback by the question that she told Rene a story that she only told two other people in her entire life which was that she had a dream about past sexual abuse and in order to cope with the dream, that was what she decided to smoke. It was an incredibly powerful moment for her because she described that no one had ever stopped and said to her, what happened to you? Instead, the frame was always, what’s wrong with you? Why did you do that? What would have made you do that? Don’t you know you’re pregnant? Don’t you know you have other children? And so what’s fascinating about this story is that if you were to ask Rene if she’s trained in trauma-informed care, she’d likely say no in addition to the rest of our frontline staff which was an interesting development as I started to prepare for this webinar. She would likely say no and many of the frontline staff, as I was walking around doing an informal poll, said, no, I don’t think I’m trained in trauma-informed care. And I believe that it goes back to an earlier slide that as an organization, our stance really is that trauma-informed practice and care is part of a broader philosophy, and it’s really not a standalone practice, and it’s not a one and done piece of information that you walk away with. It’s really this idea of putting someone at the center of the relationship.

And when I talk about relationship-centered care, I can’t help but think about Michael. He was somebody who we originally engaged with very early on as a patient and he had. When we walked in his room, basically the folks at the hospital said, don’t bother. He’s really difficult. He’s never going to participate in your program. And it really just took Jason engaging with him at the frontline and saying, tell me more about what’s going on with you. It seems like you’ve been in the hospital a lot. And it was really remarkable to see Michael turn around and what you’re looking at is Michael actually doing his own care plan. And Jason, who is one of our nurses, spent two hours with him in his room really learning everything about him and who he was and where he was in his life. And so this has really spiraled into a deeper practice of what we do at the coalition, and part of our broader philosophy that trauma-informed

care isn't standalone, that it's really about; it starts with the idea of building relationships. And when you ask our staff, they echo many of the principles in trauma-informed care, if not all of them, and I just thought it was interesting that so many of us in healthcare know the core frameworks and components of trauma-informed care but might not use the language and say trauma-informed care. So I just wanted to highlight that just perhaps because you don't do an ACE survey or you're not involved in Seeking Safety training doesn't mean that you're not already practicing trauma-informed care. I couldn't help but laugh walking around and preparing for this webinar and noticing that it's not yet part of our staff's vernacular.

I wanted to highlight the idea about ACE surveys. ACE surveys, as many of you have heard of, the Adverse Childhood Experiences Study and Alex referenced it in the beginning of the webinar, nationally we're on this platform where we constantly are talking about trauma-informed care and the importance of it. I started here at the coalition seeing patients on the ground. Everyone who is clinical here at the coalition has, at some point, touched patients on the ground and we all breathe this. We get it. We know how important it is, and internally we were still very much struggling with the conversation of whether or not to implement ACE surveys at the frontline. Because what we assume is that all of our patients have experienced early childhood trauma. So, as of now, we don't universally administer the ACE survey, but what we did do this past spring is start a lean startup pilot where we assessed nine patients with the Philadelphia Urban ACE survey which any of you that are currently working in urban communities, I recommend you logging on. I've hyperlinked it here in this slide, but I recommend you logging on because it's an expanded version of the original questions of ACE. So it's an expanded version that is particularly attuned to folks who live in urban areas. It was really remarkable. It actually elevated and expanded the list of questions but also found that a large percentage of Philadelphians, over 40% actually who were coming into emergency rooms reported four or more adverse childhood experiences. And the average ACE score was 5.6 which is quite elevated from the original survey. So that's something that we're working on and we're an active dialogue. I wanted to be transparent about that and say that that we're in active dialogue as a staff about whether or not to make that a universal part

of our programming. Additionally, we're also deepening our trauma-informed care learning here at the collation in that we're engaging in Seeking Safety training as well.

One of the last pieces, the last piece I'll share about our internal approach to trauma-informed care is that these are our domains of care planning. And so when you look across our domains of care planning, what you see is that very few of them are traditionally medical or what I like to call below the neck. Instead, many of them are really psychosocial factors, environmental factors, or above the neck or mental health support as we would know it. These domains of care planning came from incorporating MBAs with operational background into our frontline care team. They led(?) our care team through a human-centered design process to understand all of the domains of what we do in our work with patients, and we really had to define what we do in order to make an operation of how we do it. When we're looking towards understanding how you make an operation out of a genuine healing relationship, it becomes very difficult to do that without understanding what you do and making a replicatable model.

And now comes the fun part. So not only internally have we adopted a trauma-informed care approach at CCHP but we've also seen a huge interest city wise among Camden. But we've hosted two trauma summits which drew hundreds of people, and I want to acknowledge really the organization that's at the forefront of this work in our community with is Hopeworks 'N Camden. Father Jeff, who is a priest, recently left the organization as executive director to pursue a degree in organizational dynamics at Penn. We're incredibly excited and anxious for him to finish that degree, so he can spread more learning. But he really drove the conversation around trauma-informed care locally and these trauma summits put national experts of trauma to discuss the neurobiology. He invited people from all different sectors, so the police department, healthcare, the Camden School District, hosts of other nonprofits, and leaders in these organizations. We had the chief of police at the trauma summit. Hundreds of people attended, and everyone is getting on the same page and getting engaged in dialogue and conversation around what does it mean to move a city towards trauma-informed care. From the first trauma summit, the energy and excitement was just overwhelming that this ideal of Healing 10 came out of it. And so Healing 10 is the idea of getting 10 organizations in a community involved in sanctuary certification which is really

leadership, so top down. Similar to what Laurie was describing, it's an organizational assessment of how are we doing in trauma-informed care from the top down and also how can we then move our organization towards policies, procedures, systems that allow us to be trauma-informed. And so the idea would be to get 10 organizations, so healthcare, schools, the police department, any other nonprofits. How do we get at least 10 organizations and sectors in Camden to become trauma-informed. And through this, so we have at least 10 organizations now at the table. I've listed the website there if any of you are interested in seeing how it's progressing or replicating it in your community. We expect to impact over a third of Camden's children and families in a given year if 10 organizations can become sanctuary certified and trauma-informed. That is profound, and so the Healing 10, it will effect change by utilizing the sanctuary model of trauma. And the impact is expected on three levels. It's not only the city level but the organizational level and also the individual level that Laurie very much spoke to in her presentation.

And lastly where we're headed. We've signed a data sharing agreement with the local police department to cross match healthcare utilizers with arrest and jail records. We found 200 overlapping individuals which was very exciting, so we're now engaging in a pilot where we can essentially work with a few of those, so just a handful, five or less folks who overlap both systems and target them in a really intensive pilot where we start to understand who they are and start to understand what does their everyday life look like. Additionally, we're in discussions with the Camden City School District to obtain data and to start even further cross matching what that would look like. And so the idea of that is exciting to me and, as a city, I think that there's a lot of interest and huge amounts of buy-in and excitement around trauma-informed care because people see the effects it has on the frontline.

AM: Great. Thank you, Victoria. Victoria, we'll now ask you a few questions that are coming in from the participants. The first question is what was the impetus for you all as an organization, Camden Coalition, for getting involved with the Healing 10 and how did that linkage occur?

VD: Sure. So Father Jeff has been talking about Healing 10 and Hopeworks 'N Camden, like I said, really has helped to forward the dialogue in our community. So Father Jeff really already had a close connection and relationship with our CEO, Jeff Brenner, the primary care doctor that started our

organization. So the two of them spoke regularly and basically they started hosting community meetings. We decided and knew how important trauma-informed care was and really made it a priority to be not only a passive participant in those meetings but really an active participant and really mold and shape the dialogue.

AM: Great. Thank you. Another question is have you received any data around the benefits that you talked about at the beginning of the presentation around the mental health benefit and the paid time off for your staff. Just wondering about staff support.

VD: That's a great question. We've only been our own nonprofit since July of last year, and so we haven't actually been able to collect any data as of yet. It's very recent, so it's something we'll keep you informed on.

AM: Great. What are the next steps? You mentioned you're doing Seeking Safety training. What are the next steps with you all regarding trauma-informed care within your organization? With this lean start-up pilot, are you moving forward there? Are there other areas you might pilot or are there other specific focus areas within trauma-informed care that you're looking to explore?

VD: One of the big pieces that I want to emphasize is our foundation, and our core, and our policies, and really our work flow is all relationship-based. Everything is really about looking at the broader philosophy and the broader perspective of the patient. When you highlight those care domains, so many of them are about not only just what's going on with you medically but also what's going on in your life. And so by the nature of the way the intervention is set up, I believe that it's already trauma-informed. I think in terms of deepening, even greater expanding our trauma-informed care approach, the ACE survey pilot is certainly moving forward. I think that the broader conversation that our staff is really having and weighing out ethically. And I think it's important to have those conversations at the frontline level and really engage in conversations around what are the pros and cons of asking every patient their ACE score because if the frontline staff is not engaged in it and doesn't believe in it, it's likely to not take off and have meaning. So it's really about creating buy-in at the frontline level and having them really give their feedback and inform what are their concerns, what do they see as positive. One thing I will say

is that the early results of the pilot really did inform that they believe, folks really do believe that it improves the provider/patient relationship when the provider is more informed of the patient's ACE score. So I will say that that's been a huge positive, and then the Seeking Safety training, and we're constantly engaging with Hopeworks and learning about the trauma triangles, how trauma affects not only patients but organizational dynamics as well.

AM: Great. I think that's something that we've found here at CHCS in our work as well is it differs by organization. So an organization, the way that they approach trauma-informed care may look a little bit different from another one. So we've heard from experts that it's up to an organization how it's implemented and broad out and viewed. So I think we echo that as well. So this is a question for our first speaker, Laurie, as well as you, Victoria. What are your thoughts about administering ACE studies to staff? And Laurie, I know you talked about hiring and staff support as well, so would love for either of you to jump in.

LL: Should I go, Victoria?

VD: Sure, go ahead.

LL: Okay. My first thought is that I don't see that for our staff that's necessary. I think what I've done in some of my trainings is there's an application you can use where I ask people in the audience to read the ACE survey and then text to a certain number what their ACES score is. And so that the audience can see up on the screen and this was not professionals. The number of people with ACE scores, usually 4, 5, 6 in the audience and that's a powerful tool for staff to begin to understand that we work with colleagues who have ACES scores. I don't know that it's necessarily to do that with staff as long as we're all having the conversation around being triggered, that the supervisor is intentionally having conversations with their supervisee around how do you take care of yourself when Jane comes in. What happens when you start getting reactive with her. You were talking about that the other day. How do you know and how do you calm yourself down? So I think what's most important is that people feel safe to talk about it and it comes up in a conversation easily, but supervisors have to intentionally be alert to that and listen for it. Besides which, doing this as long as I've done, I can tell if someone has an ACE

score by some of the behaviors and comments they even make and their reactivity. Victoria, what are your thoughts?

VD: So we do something similar in all of our trauma-informed trainings as well. We've done it both ways where we've had people read the survey on the spot and actually at all of the trauma summits, that's been part of the agenda is that people actually read the ACE survey to themselves and give themselves their own score. We've been in situations also where it's been up on the screen. I also don't believe it's necessary to do with folks. I go back to the same thing that you're saying is the management structures that exist and that are in place have to allow space for our managers and employees and even employee to employee to have those dialogues and conversations and have to allow time, and room, and space and give weight to that, that when you're seeing behavior that's coming up that's clearly maybe emotionally triggers or that someone is really struggling with that is a transparent dialogue that people are seeing and that it's out in the open and that it's not being shoved down. Because I think as soon as you start to lock it down and emotions are seen as something as bad, outbursts are seen in a really negative light, I think that that starts to breed a toxic culture. So I think that it really goes back to the way you implement your management structure and making sure that your managers do have time and space to be with their folks and really address that stuff head on.

LL: One other thing I'll tag on, which I bet you would agree with also, Victoria, is that we see trauma as basically a public health issue. And much like when AIDS was being talked about, the longer something is a secret, the more power it has. So being able to talk about it and normalize it is so powerful and it is a public health issue, so why not be able to talk about it. And yet we're also doing something new and people have to feel a certain sense of safety to talk about personal and private things.

VD: I totally agree.

AM: That's a great point, Laurie, and actually you answered the next question we had for you. So I'll ask this to you, Victoria. How do you see the concept of trauma-informed care spreading? So Laurie mentioned it's a public health issue and there's more awareness and so forth. What are your thoughts around that?

LL: I started doing this training probably in 2005 and what I've seen is barely anyone had heard of the ACES study then. And since then, and I'd say in the past four years, I have just seen the level of awareness and understanding take off. So I think people are recognizing in the medical world as well as social service agencies that here is something that can help us do our work. We are seeing results. People are actually more willing to be helped. We can now reach people that we weren't able to reach before, so it seems to be spreading by word of mouth because people are having really good results with it and experiences. So I think opportunities to bring it up with colleagues, have you heard about the ACES study? Do you know about the neurobiology of trauma? That people who are screaming at our receptionist, they don't know any better. No one taught them the about how to get what they need, so let's train our reception to be better prepared to work with those people.

AM: Great. Thank you, Laurie. Victoria, we'd love to hear from you.

VD: Sure. I think I echo what you're saying. I walk into rooms now and people have heard about the ACE survey which is a huge difference. I completely agree that that's really marker that trauma-informed care is taking off. I think the other piece is really this idea of more movements like Healing 10. So I think within our own community, it's been incredibly powerful that something like Healing 10 has brought together the chief of police who is sitting next to the superintendent of schools who is sitting next to the CEO of a hospital here in our community who all are really bought in and engaged in figuring out how we implement trauma-informed care through organizations, and particularly organizations that really address and come in contact with children and families who are often in vulnerable situations. I have to say I think at the organizational level and top down, that can't be replaced in terms of what it does for a community and what it does for people in that community not only who are residents there but also people who work there to start to live and breathe the philosophy.

AM: Great. Thank you. All right, thank you both, Victoria and Laurie. A few closing remarks before we adjourn. The slides and a recording from this webinar will be available on our website shortly, and an email announcing the posting of these materials will be sent to all of the participants on today's webinar. We ask that all participants complete a very brief online evaluation and this will pop up on your

screen after the webinar is done. Your feedback is very important to us and will really help guide future CHCS events, so we thank you in advance. And lastly we want to thank Kaiser Permanente Community Benefits for funding to support this webinar, as well as a big thank you to our speakers, Laurie and Victoria, for their wonderful presentations. And thank you all for participating today and we hope you'll join us again soon.

VD: Thank you.

LL: Thanks so much.

END OF WEBINAR