ISSUE BRIEF
Key Ingredients for Successful Trauma-Informed Care Implementation

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IN BRIEF

Because of the potentially long-lasting negative impact of trauma on physical and mental health, ways to address patients' history of trauma are drawing the attention of health care policymakers and providers across the country. Patients who have experienced trauma can benefit from emerging best practices in trauma-informed care. These practices involve both organizational and clinical changes that have the potential to improve patient engagement, health outcomes, and provider and staff wellness, and decrease unnecessary utilization. This brief draws on interviews with national experts on trauma-informed care to create a framework for organizational and clinical changes that can be practically implemented across the health care sector to address trauma. It also highlights payment, policy, and educational opportunities to acknowledge trauma's impact. The brief is a product of *Advancing Trauma-Informed Care*, a multi-site demonstration project supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies.

Exposure to abuse, neglect, discrimination, violence, and other adverse experiences increase a person's lifelong potential for serious health problems and engaging in health-risk behaviors, as documented by the landmark Adverse Childhood Experiences (ACE) study.[1,2,3] Because of the ACE study, and other subsequent research, health care policymakers and providers increasingly recognize that exposure to traumatic events, especially as children, heighten patients' health risks long afterward.

As health care providers grow aware of trauma's impact, they are realizing the value of trauma-informed approaches to care. Trauma-informed care acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness. A set of organizational competencies and core clinical guidelines is emerging to inform effective treatment for patients[*] with trauma histories (Exhibit 1), but more needs to be done to develop an integrated, comprehensive approach that ranges from screening patients for trauma to measuring quality outcomes. Questions remain for the field regarding how to conceptualize trauma and how to develop payment strategies to support this approach.

This issue brief draws insights from experts across the country to outline the key ingredients necessary for establishing a trauma-informed approach to care at the organizational and clinical levels (*see Exhibit 1*). It explores opportunities for improving care, reducing health care costs for individuals with histories of trauma, and incorporating trauma-informed principles throughout the health care setting.

[*] *For simplicity, the term "patient" is used throughout this brief to refer to individuals receiving services in clinical settings. The authors recognize that the terms "client" and "consumer" are often used in behavioral health and social services settings.*

Exhibit 1. Key Ingredients for Creating a Trauma-Informed Approach to Care

Organizational	Clinical
- Leading and communicating about the transformation process - Engaging patients in organizational planning - Training clinical as well as non-clinical staff members - Creating a safe environment - Preventing secondary traumatic stress in staff - Hiring a trauma-informed workforce	- Involving patients in the treatment process - Screening for trauma - Training staff in trauma-specific treatment approaches - Engaging referral sources and partnering organizations

Background

Experiencing trauma, especially during childhood, significantly increases the risk of serious health problems — including chronic lung, heart, and liver disease as well as depression, sexually transmitted diseases, tobacco, alcohol, and illicit drug abuse[1, 2, 3]— throughout life. Childhood trauma is also linked to increases in social service costs.[5] Implementing trauma-informed approaches to care may help health care providers engage their patients more effectively, thereby offering the potential to improve outcomes and reduce avoidable costs for both health care and social services. Trauma-informed approaches to care shift the focus from "What's wrong with you?" to "What happened to you?" by:

- Realizing the widespread impact of trauma and understanding potential paths for recovery;

- Recognizing the signs and symptoms of trauma in individual clients, families, and staff;

- Integrating knowledge about trauma into policies, procedures, and practices; and

- Seeking to actively resist re-traumatization (i.e., avoid creating an environment that inadvertently reminds patients of their traumatic experiences and causes them to experience emotional and biological stress).[6, 7]

No Universal Definition of Trauma

Experts tend to create their own definition of trauma based on their clinical experiences. However, the most commonly referenced definition is from the Substance Abuse and Mental Health Services Administration (SAMHSA):[4]

"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."

Examples of trauma include, but are not limited to:

- Experiencing or observing physical, sexual, and emotional abuse;

- Childhood neglect;

- Having a family member with a mental health or substance use disorder;

- Experiencing or witnessing violence in the community or while serving in the military; and

- Poverty and systemic discrimination.

To develop this report, CHCS conducted interviews with nationally recognized experts in the field, including primary care physicians, behavioral health clinicians, academic researchers, program administrators, and trauma-informed care trainers, as well as with state and federal policymakers. Information from the interviews is organized within a framework outlining key steps and skill sets essential to trauma-informed care. The paper also summarizes opportunities for further exploration to advance the field of trauma-informed care.

Implementing a Comprehensive Trauma-Informed Approach

Trauma-informed care must involve both organizational *and* clinical practices that recognize the complex impact trauma has on both patients and providers. Well-intentioned health care providers often train their clinical staff in trauma-specific treatment approaches, but neglect to implement broad changes across their organizations to address trauma. Widespread changes to organizational policy and culture need to be implemented for a health care setting to become truly trauma-informed. Organizational practices that recognize the impact of trauma reorient the culture of a health care setting to address the potential for trauma in patients and staff, while trauma-informed clinical practices address the impact of trauma on individual patients. Changing both organizational *and* clinical practices to reflect the following core principles of a trauma-informed approach to care is necessary to transform a health care setting:

> **❝** *Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land.* **❞**
>
> Sandra Bloom, MD,
> Creator of the Sanctuary Model

- *Patient empowerment*: Using individuals' strengths to empower them in the development of their treatment;

- *Choice*: Informing patients regarding treatment options so they can choose the options they prefer;

- *Collaboration*: Maximizing collaboration among health care staff, patients, and their families in organizational and treatment planning;

- *Safety*: Developing health care settings and activities that ensure patients' physical and emotional safety; and

- *Trustworthiness*: Creating clear expectations with patients about what proposed treatments entail, who will provide services, and how care will be provided.[8]

These attributes form the core principles of a trauma-informed organization and may require modifying mission statements, changing human resource policies, amending bylaws, allocating resources, and updating clinical manuals. The following sections describe key strategies for adopting these principles at the organization-wide and clinical levels.

Organizational Practices

Changing organizational practices to fit trauma-informed principles will transform the culture of a health care setting. Experts recommend that organizational reform precede the adoption of trauma-informed clinical practices. Key ingredients of an organizational trauma-informed approach include:

Leading and Communicating about the Transformation Process

> **Key Ingredients of Trauma-Informed Organizational Practices**
>
> 1. Leading and communicating about the transformation process
> 2. Engaging patients in organizational planning
> 3. Training clinical as well as non-clinical staff members
> 4. Creating a safe environment
> 5. Preventing secondary traumatic stress in staff

Becoming a trauma-informed organization requires the steady support of senior leaders. Crafting a plan that empowers the workforce to be part of the transformation process can help generate buy-in throughout the organization. Leadership will need to establish strategies for rolling out the changes, particularly with regard to clearly communicating the rationale and benefits to both staff and patients. It is important for both groups to understand why there will be changes in how the organization functions. Because trauma-informed approaches to care are evolving,

communication strategies are just beginning to emerge, and each organization will need to take its size and structure into account when developing ways to discuss trauma-informed care.

A successful transformation will likely require significant investments — to continuously train staff, hire consultants, and make physical modifications to the facility — and senior leaders are typically responsible for identifying the resources needed to do so, often through outside funding. At the same time, leadership must also consider how designating time for staff training, rather than billable clinical activities, could influence the financial health of the organization.

Engaging Patients in Organizational Planning

When a health care organization commits to becoming trauma-informed, a stakeholder committee, including individuals who have experienced trauma, should be organized to oversee the process. These individuals can provide valuable first-hand perspectives to inform organizational changes by serving alongside staff, patient advisory boards, and boards of trustees. Health care organizations should consider compensating patients and community members for their time as they would with other highly valued consultants.

Training Clinical as well as Non-Clinical Staff

Providing trauma training is critical for not only clinical, but also for non-clinical employees. Providers should be well-versed in how to create a trusting, non-threatening environment while interacting with patients and staff. Likewise, non-clinical staff, who often interact with patients before and more frequently than clinical staff, play an important role in trauma-informed settings. Personnel such as front-desk workers, security guards, and drivers have often overlooked roles in patient engagement and in setting the tone of the environment. For example, greeting people in a welcoming manner when they first walk into the building may help foster feelings of safety and acceptance, initiate positive relationships, and increase the likelihood that they will engage in treatment and return for future appointments.

> #### The San Francisco Department of Public Health's Training Model for a Trauma-Informed Workforce
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> The San Francisco Department of Public Health (SFDPH) is using an innovative approach to respond to the impact of trauma. Its *Trauma-Informed Systems Initiative* aims to develop and sustain organizational and workforce change by training its entire workforce. Using the principles of implementation science,[9] SFDPH is seeking to create an organizational structure that supports its commitment to becoming trauma-informed. It will designate specific staff to lead trauma-informed training, spark collaboration across systems, and engage in continual evaluation.

Creating a Safe Environment

Feeling physically, socially, or emotionally unsafe may cause extreme anxiety in a person who has experienced trauma, potentially causing re-traumatization. Therefore, creating a safe environment is fundamental to successfully engaging patients in their care. Examples of creating a safe environment include:

Physical Environment

- Keeping parking lots, common areas, bathrooms, entrances, and exits well lit;
- Ensuring that people are not allowed to smoke, loiter, or congregate outside entrances and exits;
- Monitoring who is coming in and out of the building;
- Positioning security personnel inside and outside of the building;
- Keeping noise levels in waiting rooms low;
- Using welcoming language on all signage; and
- Making sure patients have clear access to the door in exam rooms and can easily exit if desired.

Social-Emotional Environment

- Welcoming patients and ensuring that they feel respected and supported;
- Ensuring staff maintain healthy interpersonal boundaries and can manage conflict appropriately;
- Keeping consistent schedules and procedures;
- Offering sufficient notice and preparation when changes are necessary;
- Maintaining communication that is consistent, open, respectful, and compassionate; and
- Being aware of how an individual's culture affects how they perceive trauma, safety, and privacy.

> *A non-trauma-informed system punishes and blames your adult actions and asks, 'what's wrong with you?' A trauma-informed provider will hold you accountable for your adult actions, but give you space and time to process 'what happened to you?' without adding guilt and more trauma.*
>
> Patient at Stephen and Sandra Sheller
> 11th Street Family Health Services
> of Drexel University, Philadelphia, PA

Preventing Secondary Traumatic Stress in Staff

Working with patients who have experienced trauma puts both clinical and non-clinical staff at risk of secondary traumatic stress. Defined as the "emotional duress that results when an individual hears about the firsthand trauma experiences of another,"[10] secondary traumatic stress can lead to chronic fatigue, disturbing thoughts, poor concentration, emotional detachment and exhaustion, avoidance, absenteeism, and physical illness. Clinicians and other front-line staff experiencing these symptoms may struggle to provide high-quality care to patients and may experience burnout, leading to staff turnover — which can create a negative feedback loop that intensifies similar feelings in remaining employees.

Many in the "helping professions" may have their own personal trauma histories, which may be exacerbated by working with others who have experienced trauma. Non-clinical staff may also have trauma histories, which can especially be true when the care facility is located in a community that experiences high rates of adversity and trauma (e.g., poverty, violence, discrimination) because non-clinical staff often live in the neighborhood.

Preventing secondary traumatic stress can increase staff morale, allow staff to function optimally, and reduce the expense of frequently hiring and training new employees. Strategies to prevent secondary traumatic stress in staff include:

- Providing trainings that raise awareness of secondary traumatic stress;
- Offering opportunities for staff to explore their own trauma histories;
- Supporting reflective supervision, in which a service provider and supervisor meet regularly to address feelings regarding patient interactions;
- Encouraging and incentivizing physical activity, yoga, and meditation; and
- Allowing "mental health days" for staff.

Hiring a Trauma-Informed Workforce

Hiring staff suited for trauma-informed work — based on factors including previous experience with relevant patient populations, training, and personality — is essential for employing a trauma-informed approach. Although medical, nursing, social work, and public health school curricula generally do not incorporate training in trauma-informed principles, organizations can begin by hiring staff with personality characteristics well suited for trauma-informed work. Hiring managers can use behavioral interviewing,[11] a technique that relies on candidates' past behavior as a predictor

Clinical Practices

While the concept of a comprehensive trauma-informed approach is still taking shape, there are a number of evidence-based clinical practices for working with individuals who have experienced trauma. Key ingredients of a trauma-informed clinical approach include:

Key Ingredients of Trauma-Informed Clinical Practices

1. Involving patients in the treatment process
2. Screening for trauma
3. Training staff in trauma-specific treatment approaches
4. Engaging referral sources and partnering organizations

Involving Patients in the Treatment Process

Patients need a voice in their own treatment planning and an active role in the decision-making process. In traditional care, clinicians often dictate the course of action without much opportunity for patient feedback or dialogue. In a trauma-informed approach, patients are actively engaged in their care and their feedback drives the direction of the care plan.

One promising engagement strategy uses peer support workers — individuals with lived trauma experiences who receive special training — to be part of the care team.[12] Based on their similar experiences and shared understanding, patients may develop trust with their peer support worker and be more willing to engage in treatment. Peer engagement is a powerful tool to help overcome the isolation common among individuals who have experienced trauma.

Screening for Trauma

Although trauma screening is recognized as the most fundamental aspect of a clinical trauma-informed approach, experts often differ on *when* and *how* to screen patients for trauma. Upfront and universal screening involves screening every patient for trauma history as early as possible. Proponents of this approach assert that it allows providers a better understanding of a patient's potential trauma history, helps target interventions, provides aggregate data, and quantifies the risk of chronic disease later in life. Universal screening can also reduce the risk of racial/ethnic bias by screening all patients. Furthermore, a patient can be asked to share a cumulative ACE or other trauma screening score after completing a questionnaire rather than identifying specific traumatic experiences, which allows patients to decide how much detail to provide.

The Center for Youth Wellness Begins with Patient Screening

The Center for Youth Wellness in San Francisco, CA, begins its integrated pediatric and behavioral health services by screening children for ACEs and assessing their overall health status. For children with high ACE scores and other health conditions, the organization provides care management and prevention strategies. Prevention activities are focused on these patients' elevated risk for physical and behavioral health problems.

Opponents of upfront screening feel that patients should have the opportunity to build trust in providers before being asked about their trauma history. Those who favor later screening for trauma contend that upfront screening removes the patient's choice of sharing sensitive information, can re-traumatize a patient, and may hinder progress made if there are not appropriate interventions or referrals in place.

Despite differing viewpoints, consensus is building in the field around several aspects of screening:

- **Treatment setting should guide screening practices.** Upfront, universal screening may be more effective in primary care settings and later screening may be more appropriate in behavioral health settings.

- **Screening should benefit the patient.** Providers who screen for trauma must ensure that, once any health risks are reported, they can offer appropriate care options and referral resources.

- **Re-screening should be avoided.** Frequently re-screening patients may increase the potential for re-traumatization because it requires patients to revisit their traumatic experiences. Minimizing screening frequency and sharing results across treatment settings with appropriate privacy protections may help reduce re-screening.

- **Ample training should precede screening.** All health care professionals should be proficient in trauma screening and conducting appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).

Training Staff in Trauma-Specific Treatment Approaches

While the concept of a comprehensive trauma-informed approach is relatively new, a number of evidence-based trauma-specific treatment approaches are available. Exhibit 2 (*see next page*), while not exhaustive, offers select examples of treatment options for both adults and children and describes major characteristics, target populations, and outcomes to date. Additional treatment options include, but are not limited to, motivational interviewing, mindfulness training, and formal peer support programs.

Engaging Referral Sources and Partnering Organizations

Individuals who have experienced trauma often have complex medical, behavioral health, and social service needs and, therefore, receive care from an array of providers. If providers screen for or inquire about trauma, they need to be able to offer appropriate care responses, often including referrals, ideally to other "practitioners" of trauma-informed care. It is essential that providers within a given community or system of care work together to develop a trauma-informed referral network. Opportunities for providers to engage with potential referral sources might include: inviting them to participate in internal training; hosting community-wide trauma-informed care training efforts; or encouraging patients serving on advisory boards to lobby organizations in a given provider network or community to become trauma-informed.

> " *It is very difficult for most providers and clinics to help patients heal from lifelong trauma and prevent re-victimization on their own. Forming partnerships with community-based organizations is essential.* "
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> Edward Machtinger, MD, Director of the Women's HIV Program at the University of California, San Francisco

Exhibit 2: Examples of Trauma Treatment Approaches: Characteristics and Evidence

Treatment Model	Description	Target Population(s)	Outcomes
Adult-Focused Models[13]			
Prolonged Exposure Therapy (PE Therapy)	▪ Focuses on: (1) posttraumatic stress disorder (PTSD) education; (2) breathing techniques to reduce the physiological experience of stress; (3) exposure practice with real-world situations; and (4) talking through the trauma. ▪ Eight to 15 60-90-minute sessions that occur 1-2 times a week.	Adults who have experienced trauma or who have been diagnosed with PTSD.	▪ Has been shown to be one of the most effective PTSD treatments for veterans. ▪ Meta-analysis showed that the average PE patient had better outcomes than 86 percent of counterparts in the control group.
Eye Movement Desensitization and Reprocessing (EMDR)	▪ Focuses on: (1) spontaneous associations of traumatic images, thoughts, emotions, and sensations; and (2) dual stimulation using bilateral eye movements, tones, or taps. ▪ Information processing therapy to reduce trauma-related stress and strengthen adaptive beliefs.	Adults who have experienced trauma or who have been diagnosed with PTSD.	▪ Meta-analyses show similar outcomes to other exposure therapy techniques. ▪ Endorsed by World Health Organization and Department of Veterans' Affairs.
Seeking Safety	▪ Focuses on: (1) prioritizing safety; (2) integrating trauma and substance use; (3) rebuilding a sense of hope for the future; (4) building cognitive, behavioral, interpersonal, and case management skill sets; and (5) refining clinicians' attention to processes. ▪ Present-focused treatment to help individuals attain a sense of safety.	Adults who have experienced trauma, or who have been diagnosed with PTSD or substance use issues; groups and individuals in a variety of settings, including residential and outpatient.	▪ Listed as "supported by research evidence" for adults by the California Evidence-Based Clearinghouse and "strong research support for adults" by the Society of Addiction Psychology of the American Psychological Association.
Child-Focused Models			
Child-Parent Psychotherapy	▪ Focuses on: (1) the way trauma has affected the caregiver-child relationship; and (2) the child's development.[14,15] ▪ A primary goal is to bolster the caregiver-child relationship to restore and support the child's mental health.[16]	Youth, ages 0-6, who have experienced a wide range of trauma, and parents with chronic trauma.[17]	▪ Listed as "supported by research evidence" by the California Evidence-Based Clearinghouse.[18]
Attachment, Self-Regulation, and Competency (ARC)	▪ Focuses on: (1) attachment; (2) self-regulation; (3) competency; and (4) trauma experience integration; developed around an overarching goal of supporting the child, family, and system's ability to engage in the present moment.[19,20] ▪ Grounded in attachment theory and early childhood development; addresses how a child's entire system of care can become trauma-informed.[21]	Youth, ages 2-21, and families who have experienced chronic traumatic stress, multiple traumas, and/or ongoing exposure to adverse life experiences.[22]	▪ Research suggests that ARC leads to a reduction in a child's posttraumatic stress symptoms and general mental health symptoms, as well as increased adaptive and social skills.[23]
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	▪ Focuses on: (1) addressing distorted beliefs and attributions related to abuse or trauma; (2) providing a supportive environment for children to talk about traumatic experiences; and (3) helping parents who are not abusive to cope with their own distress and develop skills to support their children.[24] ▪ Designed to reduce negative emotions and behaviors related to child sexual abuse, domestic violence, and trauma.[25]	Youth, ages 3-21, and parents or caregivers who have experienced abuse or trauma.[26]	▪ Highlighted by several groups of experts and federal agencies as a model program or promising treatment practice, including the National Child Traumatic Stress Network, the California Evidence-based Clearinghouse, and SAMHSA.[27]

Key Opportunities for Advancement

As discussed above, implementing a trauma-informed approach requires organizational policy change at the provider level. Furthermore, program and payment reforms at the payer and health system levels, as well as at the state and federal level, can also help support the adoption of trauma-informed care approaches. Examples are touched on below.

Standardizing Language Used for Trauma-Informed Approaches

There is no universally accepted definition of trauma, and there is disagreement about the need for one. Some experts encourage open-ended definitions, positing that the idea of trauma is too broad to be defined and fearing the potential exclusion of patients who need trauma-informed services, but whose experiences do not fit within the definition. Others view the lack of standardized terminology as a barrier to developing trauma-informed cross-sector collaboration and advancing the field. Key policymakers and stakeholders, such as SAMHSA and the National Child Traumatic Stress Network, have created their own definitions.[28,29]

Nonetheless, the language used in the field — in medical and behavioral health settings — influences both providers' practices and patients' experiences. When explaining trauma-informed approaches to patients, it is important to describe trauma in terms that reduce stigma and accommodate low health literacy. Patients may also be more likely to trust providers and follow the treatment plan if providers explain how patients' traumatic experiences contribute to their overall health instead of focusing solely on the experience of trauma itself.

Payment Considerations

Traditional payment systems present major barriers to implementing a trauma-informed approach. Presently, providers lack billing codes to charge for trauma-informed services and face limitations on billing for multiple types of treatment and prevention. Some payers prohibit reimbursement for same-day and two-generation services, strategies that could allow children and parents to be served together. Fee-for-service reimbursement practices also often limit primary care visits to 10-15 minutes, which makes it difficult to administer screening tools, discuss the patient's history of trauma, and offer appropriate follow-up care or referrals.

Moreover, the fragmented care caused by separate physical and behavioral health service systems creates additional barriers. Integrated behavioral health and primary care services, which provide coordinated care and a whole-person approach, increase the opportunity for successful trauma-informed treatment. Rethinking reimbursement strategies, lengthening the amount of time providers spend with patients, and reducing siloed funding streams are critical for more coordinated care.

Fortunately, some delivery system and payment reforms are beginning to address these barriers. Payers are increasingly integrating physical and behavioral health services financing, which should streamline integration at the practice level. Likewise, current efforts to promote accountable care entities hope to address misaligned incentives in the fee-for-service payment model. By moving toward incentives that reward value over volume, accountable care organizations and other similar models should improve providers' financial incentives for investing in trauma-informed care.

Building the Evidence Base

Identifying appropriate metrics, best practices, and scalable solutions for trauma-informed approaches will require more evaluation of patient outcomes and implementation costs. However, in the absence of dedicated funding, collecting patient, cost, and system-related outcomes may present an ongoing challenge. The field also needs to create

tools to measure the adoption of trauma-informed approaches and progress over time within organizations and across the health care system.

Because the field of trauma-informed care is new, there is a lack of consensus about what can be achieved or how to measure it. Health care providers and policymakers need more guidance on how to collect data and track outcomes specific to trauma-informed care. The potential for broader adoption of trauma-informed approaches will increase as there is more evidence of the positive impact of trauma-informed care on patient outcomes, staff wellness, and overall costs.

Building Awareness and Competency

Trauma is a public health issue and calls for public education campaigns akin to those used in anti-smoking efforts, vaccination promotion, and seat belt use. Changing the health care culture hinges on increasing the recognition of the lifelong impact of trauma on people's physical health, behavioral health, and social outcomes. Health care organizations may benefit from clear education and marketing materials for patients and providers, social media campaigns, and public service announcements to build awareness and reduce stigma about receiving trauma-informed services.

This transformation requires a paradigm shift for health care workers that recognizes the significance of trauma and the importance of trauma-informed care. Cross-disciplinary training in trauma-informed approaches should ideally start early in a provider's education. Trauma training in medical, public health, nursing, social work, and residency/fellowship programs should be considered as a standard practice. Continuing education credits around trauma-informed training and services would also build awareness among current health care workers.

Upstream efforts are also critically important for advancing the field, especially in light of the multigenerational nature of trauma. Prevention initiatives — such as improving care for new mothers and young children; supporting families through home visit programs; promoting universal strategies to nurture safe, stable, and caring parental relationships; and creating violence prevention programs — should be further supported and implemented broadly.

A Recipe for Trauma-Informed Care

The health care community increasingly recognizes trauma and its associated avalanche of long-term negative consequences as a serious public health crisis. Research shows that early adversity has lasting effects on a child's brain. It increases the risk of developing adaptive yet ultimately unhealthy coping behaviors that can lead to serious health problems throughout life.[30,31,32] By adopting trauma-informed approaches to care, health care systems and providers can help mitigate those risks, improve health outcomes for children and adults who have experienced trauma, and reduce costs inside and outside the health care system.

Through the early work of leaders in trauma-informed care, organizational and clinical processes are emerging to guide better care for patients and further the field. Organizations wishing to implement a trauma-informed approach must provide steady leadership and clear communications strategies to support the transition to trauma-informed care; engage patients in planning; train and support *all* staff; create safe physical environments; prevent secondary traumatic stress in staff; and hire trauma-informed workforces. There are a number of clinical practices that are critical to advancing a trauma-informed approach, including screening for trauma; training staff in trauma-specific treatment approaches; and engaging both patients and appropriate partner organizations within the treatment process.

While there is a surge of interest in using trauma-informed care to address the physical health, behavioral health, and social impacts of trauma, there is a lack of understanding about the most effective way to standardize the approach to meet patients' needs. There is also disagreement about the need for a standard definition of trauma and trauma-

informed care terminology. On a payment and policy level, reimbursement structures must support provider incentives to implement a trauma-informed approach. Furthermore, investments in research and evaluation are necessary to achieve consensus around standardized measures related to trauma and to support the establishment of effective approaches.

Building foundational awareness of trauma-informed approaches should begin early in a provider's education and be reinforced through continuing education. Reinforcing upstream prevention efforts, such as providing high quality care for new mothers and young children and strengthening parenting capacity, is also critical to advancing the field. Collectively, policymakers, providers, and payers have a compelling opportunity to confront the short- and long-term impacts of trauma, and pursue the opportunity that trauma-informed care presents to improve health outcomes and decrease costs.

Advancing Trauma-Informed Care is a multi-site demonstration project to better understand how to implement trauma-informed approaches to health care delivery. Supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies, this national initiative is developing and enhancing trauma-informed approaches to care and sharing emerging best practices. For more information, visit **www.chcs.org**.

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