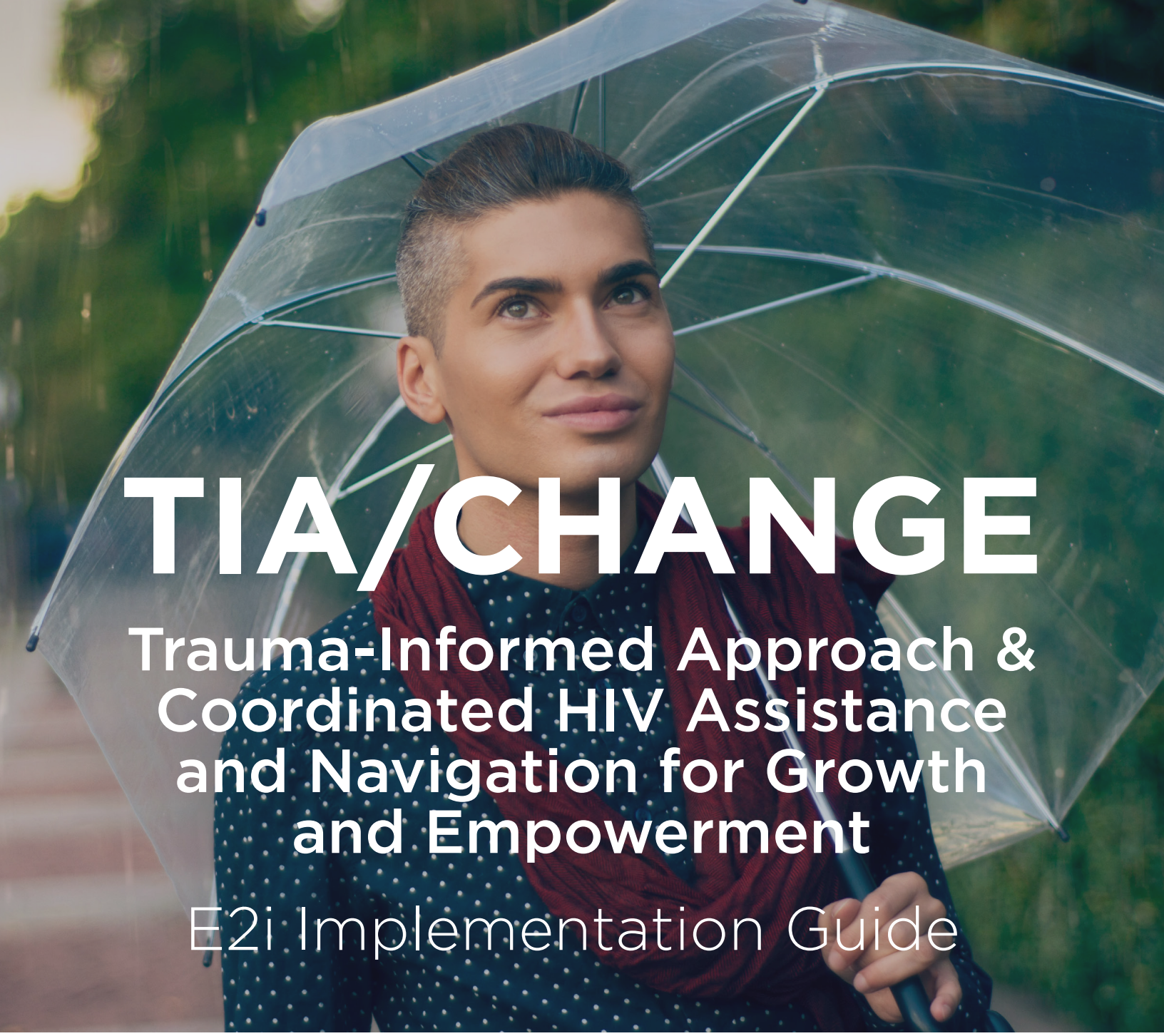

TIA/CHANGE

Trauma-Informed Approach & Coordinated HIV Assistance and Navigation for Growth and Empowerment

E2i Implementation Guide

An evidence-informed and resilience-focused intervention, adapted for the Health Resources and Services Administration's Ryan White HIV/AIDS Program, that provides guidance and structure for becoming a trauma-informed HIV service organization.

FALL 2021

RYAN WHITE E2i HIV/AIDS PROGRAM

A SPECIAL PROJECT OF NATIONAL SIGNIFICANCE

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Table of Contents

EXECUTIVE SUMMARY

Trauma-Informed Approach & Coordinated HIV Assistance and Navigation for Growth and Empowerment (TIA/CHANGE) is an evidence-informed intervention developed by HIV experts in collaboration with community members to improve health outcomes among people with HIV. Using a strength-based approach to HIV service provision, TIA/CHANGE offers guidance and structure for an organization to become trauma-informed. A trauma-informed organization is one that understands, recognizes, and responds to the effects of trauma.

This Implementation Guide was developed for *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, which tested TIA/CHANGE within Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) settings and evaluated its impact. Additional easy-to-use implementation tools, tips, and resources to support replication of TIA/CHANGE in the RWHAP and other HIV service organizations can be found in the ***TIA/CHANGE E2i Toolkit***.

INTRODUCTION TO THE IMPLEMENTATION GUIDE

INTRODUCTION TO THE IMPLEMENTATION GUIDE

What is TIA/CHANGE?

TIA/CHANGE is a mission-driven, resilience-focused, and strength-based approach to HIV service provision that provides guidance and structure for an organization to become trauma-informed. A trauma-informed organization is one that understands, recognizes, and responds to the effects of trauma.

Purpose of the Implementation Guide

The purpose of this Implementation Guide is to provide essential information and tools for understanding, planning, and delivering TIA/CHANGE in the Ryan White HIV/AIDS Program (RWHAP) and other HIV service organizations. This Guide is part of the ***TIA/CHANGE E2i Toolkit***, a comprehensive collection of helpful resources for implementing TIA/CHANGE.

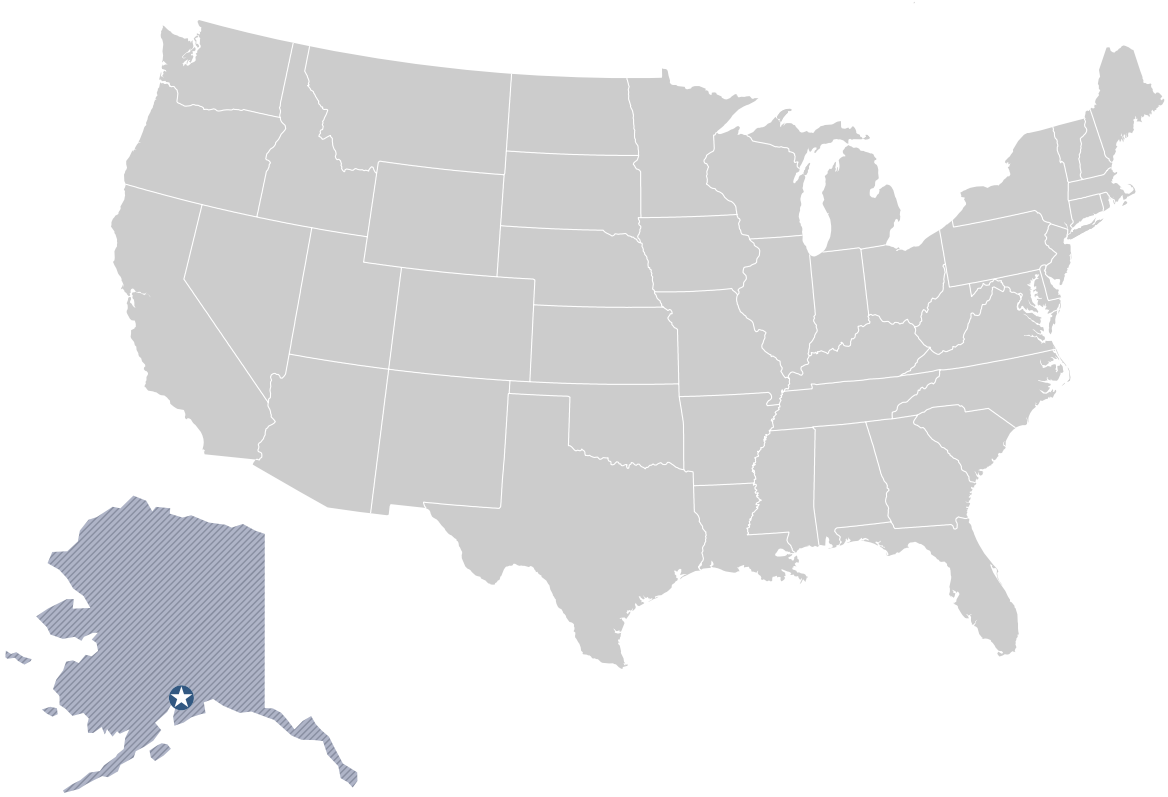
Implementation Guide Background

This Guide was developed as part of the RWHAP Part F Special Projects of National Significance (SPNS) Program *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, a four-year initiative (2017-2021) funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) of the U.S. Department of Health and Human Services. E2i was designed to improve HIV health outcomes for people with HIV who experience persistent gaps along the HIV care continuum, such as engagement in care, retention in care, adherence to antiretroviral therapy (ART), and viral suppression. Many people with HIV have a history of trauma, and trauma is associated with adverse effects on HIV health outcomes.

E2i chose to pilot the implementation of TIA/CHANGE within HIV service organizations because of its demonstrated efficacy in improving outcomes for people with HIV. Through a competitive request for proposals, one HIV service organization in the RWHAP was selected to implement TIA/CHANGE between 2018 and 2020. This site reported program and client outcome data to a team of evaluators who then analyzed these data. The stories, experiences, and evaluation outcomes of the site are integrated and highlighted throughout this Guide.

The E2i Implementation Sites

FIGURE 1. Location of the site that implemented TIA/CHANGE through the E2i initiative.



Alaska Native Tribal Health Consortium (Anchorage, Alaska)

- Tribal health organization with an HIV Early Intervention Services program
- RWHAP Part C recipient
- 230 clients with HIV a year
- 8 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: linguistic/translation services (98%), other professional services, such as housing and transportation assistance (95%), referral and navigation to healthcare (93%)

Implementation Science Evaluation

E2i used an implementation science approach to evaluate TIA/CHANGE in the E2i site. The evaluation aimed to answer the following questions:

- "What does it take to implement TIA/CHANGE in an HIV service organization?"
- "To what extent is successful implementation related to better HIV outcomes for the clients?"

E2i evaluators collected TIA/CHANGE client data from the E2i site throughout the initiative to measure engagement in care, prescription of ART, retention in care, and viral suppression. They also collected and reviewed site staff surveys, client encounter forms, site visit reports, and meeting notes in order to learn more about: key factors for successful implementation; challenges encountered by the implementers; and adaptations to the intervention to achieve more successful implementation. The major findings from the evaluation are reported throughout this Guide. For more detail on E2i's theoretical approach and evaluation methods, see ***Appendix A***. See also the ***TIA/CHANGE E2i Toolkit*** for additional evaluation findings reported in manuscripts.

TIA/CHANGE OVERVIEW

TIA/CHANGE OVERVIEW

Goal

» The primary goal of TIA/CHANGE is to improve client engagement in HIV care by guiding an organization to implement a trauma-informed approach to the delivery of care.

Intervention Description

TIA/CHANGE is a mission-driven, resilience-focused, and strength-based approach to HIV service provision that provides guidance and structure for an organization to become trauma-informed. A trauma-informed organization is one that understands, recognizes, and responds to the effects of trauma.[1] There is no one-size-fits-all approach to trauma-informed care. As such, an organization must tailor trauma-informed care to fit their own mission as well the needs of their clients.

For TIA/CHANGE to succeed, staff at all levels of the organization, particularly those in leadership positions, must demonstrate their commitment to a trauma-informed approach. Just as importantly, every aspect of the process meaningfully involves people with and affected by HIV who have experienced trauma.

On the clinical level, the TIA/CHANGE core philosophy is to create a collaborative relationship between the service provider and the client. This collaborative approach is accomplished when:

» The client and the provider acknowledge that they both bring knowledge and experience to the table.

» Health and treatment goals are established mutually and arrived at collaboratively between the provider and client.

» The client is given choices, and has a sense of control, over decisions regarding the treatment process and other aspects of care.[2]

» Staff attend to issues of power and hierarchy in ways that minimize potential for re-traumatization.

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[1] Trauma and Justice Strategic Initiative. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (HHS Publication No. SMA 14-4884). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. Available at: https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

[2] Elliot DE, Bjelajac P, Fallot RD, Markoff LS, Glover Reed B. Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. J Community Psychol. 2005; 33(4):461-477.

Priority Population

» People with HIV who have a history of trauma; for example, people affected by childhood sexual abuse, physical abuse, HIV diagnosis, intimate partner violence, and bias and discrimination

Rationale

» People with HIV experience a disproportionate burden of trauma. Past and recent traumatic experiences can lead to symptoms of posttraumatic stress disorder (PTSD) and poorer quality of life.

» Among people with HIV, trauma is associated with lower adherence to HIV medications and higher mortality.[3]

» A trauma-informed approach has the potential to improve medication adherence and retention in care for people with HIV.

Intervention Background

TIA/CHANGE was originally developed by ***Christie's Place***, an organization in California that implemented a trauma-informed approach with training and technical assistance from HRSA's Office of Women's Health.[4] While TIA/CHANGE at Christie's Place was developed for women, children, and families affected by HIV, the E2i Implementation Guide is for organizations that serve people with HIV of all genders and ages.

TIA/CHANGE Enrollment at the E2i Site

32 clients

40-59 years old

56% women

94% American Indian/ Alaska Native

[3] Cuca YP, Shumway M, Machtinger EL, et al. The association of trauma with the physical, behavioral, and social health of women living with HIV: Pathways to guide trauma-informed health care interventions. Womens Health Issues. 2019;29(5):376-384.

[4] AIDS United and Christie's Place. Trauma Informed Care—Improving Services, Saving Lives. Washington, D.C.; 2017. Available at: https://www.aidsunited.org/resources/trauma-informed-care?docid=83.

Duration

» TIA/CHANGE is an ongoing and dynamic endeavor based on three implementation phases (early, mid, and late implementation). The length of the intervention depends on the needs, goals, and priority population(s) of the implementing organization.

The E2i site that implemented TIA/CHANGE is an HIV Early Intervention Services program that provides clinical care and case management services to American Indian/Alaska Native people with HIV in all urban and rural areas of Alaska.

Settings

» TIA/CHANGE can be implemented in any organization that offers services to people with HIV

Staffing

TIA/CHANGE is an organization-wide intervention; therefore, all staff and stakeholders are involved in the intervention. This includes, but is not limited to:

» Administration and management staff

» Clinical staff

» Support staff

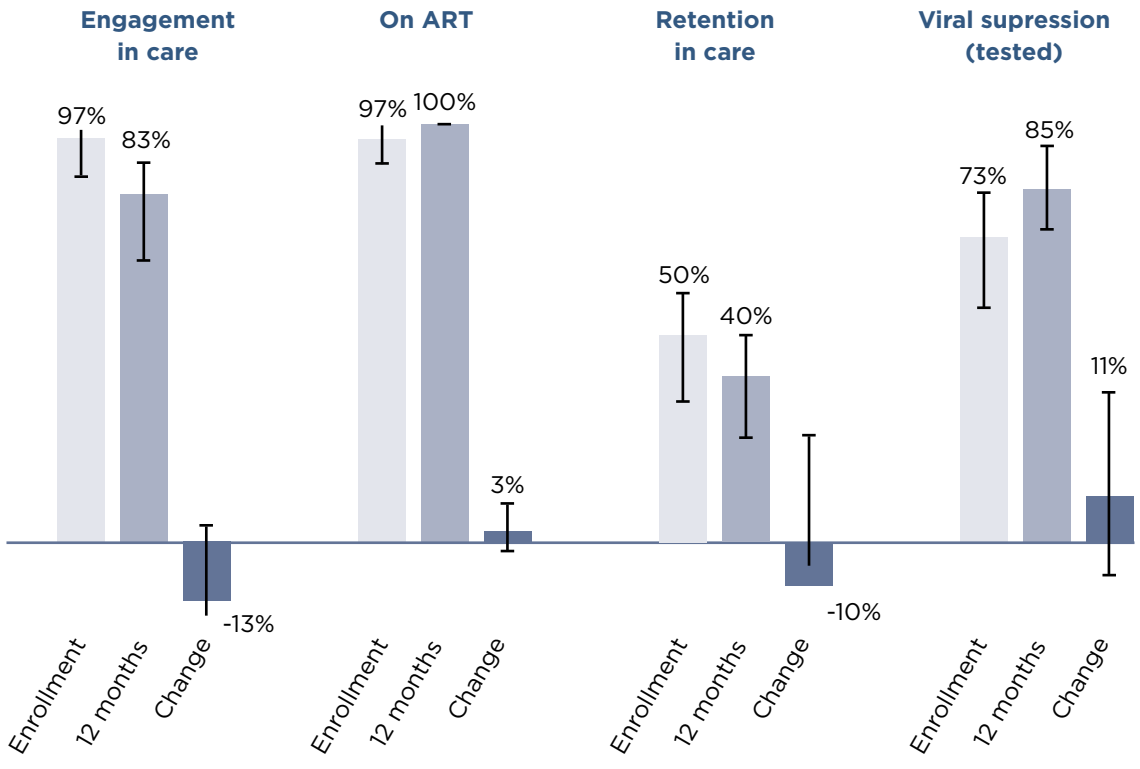
» Governing boards

All eight HIV service employees at the E2i site were considered part of the TIA/CHANGE intervention. The staff members most actively involved in the intervention were the Intensive Case Coordinator, who conducted trauma-informed case management with clients, and the Senior Program Manager, who supervised the intervention.

E2i EVALUATION:
TIA/CHANGE HIV CARE CONTINUUM OUTCOMES

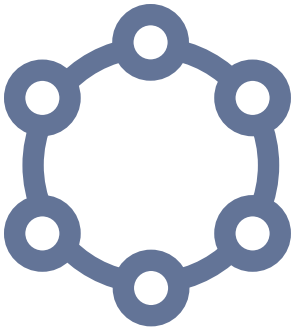
- **Enrollment:** Over 9 months, the E2i site enrolled 32 people in trauma-informed intensive case management services. Clients were middle aged (40-59 years); 56% were women, 44% were men, and nearly all (94%) identified as American Indian/ Alaska Native.
- **Outcomes:** The E2i initiative measured HIV care continuum outcomes at the time of enrollment and 12 months later. Among the clients enrolled in TIA/CHANGE, there were no statistically significant changes in outcomes. A possible reason why no significant changes were detected was because there were relatively few clients enrolled in TIA/CHANGE. In addition, engagement in care and ART prescription were already high at time of enrollment.

FIGURE 2. HIV care continuum outcomes among the 32 people enrolled in TIA/CHANGE as part of the E2i initiative.



Note: E2i used the following HRSA definitions for HIV care continuum outcomes:

- *Engagement in care* = At least one primary HIV care visit in the previous 12 months
- *On ART (adherence)* = Having been prescribed ART in the past 12 months
- *Retention in care* = At least two HIV care visits in the past 12 months
- *Viral suppression* = Having an HIV viral load test in the past 12 months AND having a result of less than 200 copies/mL at the last viral load test



CORE ELEMENTS

CORE ELEMENTS

Core elements are the "active ingredients" essential to achieving an intervention strategy's desired outcomes. It is critical to follow the core elements when implementing an intervention in an HIV service organization; otherwise, the intervention may not work as intended.[5] All other activities, such as staffing arrangements and clinical workflows, can be adapted to fit the unique circumstances of an organization. However, adaptations should not compete with or contradict the core elements of TIA/CHANGE. **TIA/CHANGE has three core elements:**

1. Organization-level Implementation

- The intervention affects all aspects of the organization.
- All key stakeholders are involved, including community members, partner organizations, and all staff and leadership of the organization.
- All staff develop competencies in trauma-informed care (not just clinical providers).
- The service environment provides a safe place for healing and wellness.
- People with HIV who have experienced trauma, as well as their family members, are meaningfully involved in all aspects of the process of change and implementation of TIA/CHANGE. See ***AIDS United's resources on meaningful involvement of people with HIV***.

2. Trauma-informed Approach

A trauma-informed organization is one that:

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the organization
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization[6]

3. Guiding Principles

To become trauma-informed, organizations should adopt guiding principles that establish a solid foundation for all planning, implementation, and evaluation activities. Guiding principles should align with your organization's mission, while supporting a trauma-informed approach.

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[5] Psihopaidas D, Cohen SM, West T, et al. Implementation science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's work towards ending the HIV epidemic in the United States. PLoS Med. 2020;17(11):e1003128.

[6] Substance Abuse and Mental Health Services Administration. Trauma-informed care in behavioral health services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. Available at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

IMPLEMENTATION ACTIVITIES

IMPLEMENTATION ACTIVITIES

TIA/CHANGE has three implementation phases: early, mid, and late implementation. Typically, activities in the early implementation phase are conducted before activities in the mid-implementation phase, and so on. However, there is no "one-size-fits-all" approach. An organization may work on any phase, at any point in time, if it makes sense for their local community needs.

For additional helpful planning and implementation tools, see:

Appendix B: TIA/CHANGE "Go Live" Worksheet

Appendix C: TIA/CHANGE Organizational-level Implementation Checklist

EARLY IMPLEMENTATION PHASE

Activity 1: Community Needs Assessment

A needs assessment allows an organization to better understand the effects of trauma on the local community and staff, ultimately leading to programs that are more effective and meaningful to the community. The assessment should engage stakeholders within and outside of your organization. Understanding the internal and external resources available allows staff to develop referral resources to address needs that fall outside of the scope of the organization. Suggested needs assessment strategies include:

» **Conduct interviews with key informants,** such as:

- Community leaders
- Advisory board members
- Behavioral health professionals
- Community residents
- Others who have firsthand knowledge about the impact of HIV and trauma on people in the community

» Key informant interviews collect in-depth information from people who know the community well.[7] Interview questions may include:

- What are barriers and facilitators to engaging people with HIV into care?
- What types of trauma most affect the local population, and what are the best ways to identify and address this?

» **Hold focus groups** with:

- Clients
- Community providers
- Clinicians
- Other community members to learn more about their needs and thoughts related to trauma-informed care

[7] See UCLA Center for Health Policy Research. Section 4: Key Informant Interviews. http://healthpolicy.ucla.edu/programs/health-data/trainings/documents/tw_cba23.pdf

» Focus groups are structured interviews, typically with five to eight participants. Groups may have participants of similar or different back ground and experiences (e.g., only clients vs. both client and providers).[8]

Questions may include:

- How can the organization respond best to trauma?
- What kinds of programs would be helpful?
- What are your thoughts about the TIA/CHANGE program we are proposing?

When conducting focus groups and interviews, be sure to:

- ***Inform*** *all participants in advance about the topics you will be exploring*
- ***Emphasize*** *that participants can take a break or stop participating at any point*
- ***Identify*** *beforehand any behavioral health resources to provide to participants who experience distress*
- ***Avoid*** *holding interviews or focus groups if referrals and resources are not available - these can take place at a later stage of implementation*

» **Review existing local and state data** on rates and types of crime, violent incidents, substance use, and mental health. These data may come from:

- The ***Behavioral Risk Factor Surveillance System (BRFSS)***
- County and state public health departments
- Client data from your organization or other community organizations

Activity 2: Onsite Resource Identification

The purpose of onsite resource identification is to:

» **Evaluate** your organization's current policies, practices, and preparedness.

» **Determine** additional resources needed to provide trauma-informed care.

See **Onsite Resource Identification** (***Appendix D***) for sample questions.

[8] Marczak M, Sewell M. Using focus groups for evaluation. CYFERnet-Evaluation. University of Arizona Tucson. Available at: https://cals.arizona.edu/sfcs/cyfernet/cyfar/focus.html

Activity 3: Guiding Principles of Trauma-informed Care

To help plan and implement TIA/CHANGE, it is vital to adopt clear and meaningful guiding principles that align with your organization's mission. The principles should be short and easy to understand. You can adjust the principles as you implement TIA/CHANGE and learn from the process. For now, these initial principles will guide your planning, practice, and evaluation activities.

Consider adopting the trauma-informed principles developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA):[1]

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

Read more about these principles ***here***.

Another example of guiding principles that can be adapted are those developed by Christie's Place:[3]

- Agency and empowerment
- Meaningful inclusion of women living with HIV
- Education and support
- Stakeholder involvement
- Trauma-informed environment
- Intentional practice

The Office on Women's Health also provides an example of guiding principles for a trauma-informed system of care:[3]

- **Intentionality**
  - Purposeful efforts towards creating and sustaining healing and growth.
- **Mutuality**
  - "Healing happens in relationship."
  - Reciprocal connections which foster increased understanding and shared learning.

» **Commonality**

  • "We all have a story."
  • Life experiences shape our perceptions of ourselves and others.

» **Potentiality**

  • Positive change is possible for all (individuals, organizations, & communities).

Activity 4: Champions of Trauma-informed Care

Establish a group of "champions" that includes leadership, staff, and clients of your organization. Champions:

» **Encourage** all stakeholders to become and stay invested in trauma-informed care; this includes ensuring that your organization's leadership understands the program's goals and commits to supporting those goals.

» **Identify** resources for staff support, such as clinical supervision and wellness activities that promote self-care.

» **Lead the work** necessary to ensure the organization is progressing towards its goals.

MID-IMPLEMENTATION PHASE

Activity 1: TIA/CHANGE Committee

TIA/CHANGE champions and other staff members should establish a committee that works to create and sustain trauma-informed care. The committee meets regularly to achieve the following:

- Position TIA/CHANGE within a culturally responsive and intersectional framework.
- Increase knowledge and awareness of the impact and prevalence of trauma on clients and staff members.
- Incorporate policies, practices, and procedures that are trauma-informed and resilience-oriented.
- Regularly check to ensure policies and procedures are understood and are being followed by all levels of staff.
- Meet frequently with leadership and staff to ensure a shared understanding of program goals, deliverables, progress, and deadlines.
- Train staff on trauma-informed care and resilience-oriented practices.

To improve internal communication, the E2i site held 'clinical huddles' twice a week to discuss issues faced by clients in clinic.

Activity 2: Organizational Assessments and SMART Goals

It is important to conduct a baseline organizational assessment to identify areas of strength and areas of needed development and growth within two competency areas: **1) the service environment**, and **2) staff competencies**. Organizations will want to repeat these assessments at regular intervals, such as every six to 12 months, to monitor progress and to identify what more needs to be achieved. ***Appendix E*** and ***Appendix F*** provide sample assessments that can be adapted by any HIV service organization.

» **Service Environment Assessment** (***Appendix E***): Ask all staff and other identified stakeholders (e.g., clients), to complete the Service Environment Assessment, which asks about:

- *Physical space*: confidentiality and privacy, accessibility, appearance, and climate
- *Atmosphere*: transparency, consistency, predictability, resource availability, and cultural responsiveness
- *Relational qualities*: boundary maintenance, rapport, and authenticity

» **Staff Core Competencies Assessment** (***Appendix F***): Ask all staff to assess their competencies and beliefs in the following areas:

- *Knowledge*: understanding of trauma-informed concepts
- *Skills*: ability to create a trauma-informed environment and to engage with others in trauma-informed ways
- *Values*: beliefs about trauma-informed care (e.g., possibility of recovery from trauma)

» Based on organizational assessment findings, the committee can develop **SMART Goals** to achieve specific changes within a defined amount of time. SMART goals are:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-bound

Be sure to develop SMART goals in the spirit of your guiding principles. It is recommended to establish two to five SMART goals, especially at the beginning stages of implementation, in order to build momentum but not overburden staff. At a later date, you will evaluate your progress and can update your goals as needed. Present assessment findings and SMART goals to leadership and other identified stakeholders for additional input.

An example of an effective SMART goal is one that the E2i site developed based on their service environment assessment. The assessment showed that 75% of staff disagreed or strongly disagreed with the statement: "Space is available for private conversations for clients and staff." Based on this finding, the site's SMART goal became: "By the end of the calendar year, designate two additional private spaces where staff can meet privately with each other and with clients." This goal is relevant because it is in direct response to the needs assessment. The goal is also specific, measurable (two spaces), and timebound (end of year). Finally, it is likely achievable to identify two spaces.

Activity 3: Staff Training

All staff should participate in ongoing training in trauma-informed care. Organization staff can develop and facilitate their own trainings based on needs, or can hire outside experts. When creating trainings, be sure to account for diverse educational and experience levels.

» Sample training topics include:

» Introduction to trauma-informed care for new staff members and volunteers

» Trauma-informed and resilience-oriented service provision

» Trauma-informed orientation and client assessment

» Understanding and practicing trauma-informed language

» The physiology of trauma

» Historical and cultural trauma

» Adverse childhood experiences and complex trauma

» Impact of vicarious experiences on helping professionals

» Healing from trauma: forming relationships

A recommended approach for delivering staff training is to:

1. Introduce trauma-informed care to new staff members and volunteers as part of the organization's onboarding process.
2. Present trainings at monthly staff meetings.
3. Review and update curriculum annually based on identified training needs and new developments in the field. Repeat topics annually to refresh the knowledge of existing staff, and to ensure new staff members receive trainings.

For more training resources, visit the ***SAMHSA-HRSA Center for Integrated Health Solutions***

The E2i site believed that having the trauma-informed care trainings conducted by onsite staff, rather than offsite consultants, would help sustain the intervention. Staff trainers may also be more effective at linking the trainings to the organization's overall mission.

Activity 4: Community Partnerships

It is essential to develop referral partnerships with a network of trusted providers in the community to fill in service gaps for clients. These partnerships can include:

- Behavioral health care organizations
- Legal services
- Housing agencies
- Intimate partner violence shelters and services

Coordination with partners should be formalized, documented, and routinized through a detailed plan that is established early on and revisited annually. Clear messaging that describes the program, includes benefits to community partners and clients, explains the partnership and the collaboration that occur on behalf of the client, and distinguishes the program from other services in the community, is critical to successful relationship building. Also critical is ensuring that the clients understand each referral, referral process, steps to accessing external resources, and any support that may be provided to them to be able to access these resources.

Activity 5: Client-level Interventions to Identify and Address Trauma

The following interventions can help to identify and address trauma, as well as treat trauma-related mental health and relational issues. You may use your SMART goals to help select interventions best suited to your organizational strengths and client needs. Always pilot the interventions prior to full implementation.

When considering a client-level intervention, be sure that it addresses gaps in your trauma-informed service provision, according to your guiding principles, SMART goals, and organizational assessment results.

» For other intervention ideas, see the E2i Toolkits for ***Seeking Safety*** and ***Cognitive Processing Therapy***.

» For the **Client-level Interaction Self-rating Scale**, see ***Appendix G***.

Trauma-Informed Client Orientation: New clients receive an orientation from staff, prior to service delivery, that introduces the client to the collaborative, strength-based trauma-informed treatment philosophy. The client also engages in an informed consent process that reinforces the client's role as an active collaborator and decision-maker in the treatment plan.

Trauma Assessment, Treatment Plan, and Referral:

» *Trauma Assessment*: At intake and annually, clients complete a mental health, substance use, and support system assessment administered by a peer counselor, case manager, or other appropriate provider. Examples of validated assessments are available from the U.S. Department for Veterans Affairs. Assessments may ask about the client's:

- Current level of functioning
- Availability of social support
- Past or current trauma event(s)
- Current safety
- Use of substances
- Mental health status
- Other barriers to optimal engagement in care

- *Treatment Plan*: Based on the assessment, an interdisciplinary treatment team develops an initial treatment plan. The client then meets with a member of the team to discuss the assessment results and treatment recommendations. The client provides feedback, and the treatment plan is revised.
- *Referral*: In accordance with the treatment plan, the client is linked to onsite medical and support services or with trusted partners.

Facilitative Supportive Services: A necessary part of trauma-informed care is the provision of wraparound services. These services can be offered onsite or with trusted partners. Services include:

- Assistance for basic needs
- Transportation
- Childcare
- Legal services
- Education and treatment adherence
- Health care system navigation

If your organization already offers these services, staff should ensure that provision of services are focused on trauma-informed care that is responsive to the whole person, including their gender,[9] family systems,[10] socioeconomic status, sexual orientation, gender identity, and race/ethnicity.

Peer-based Patient Navigation: Peer navigators are people with HIV who have experience with navigating health care and support systems. They may also have a history of trauma. For more resources on peers, see ***Best Practices: Integrating Peers into HIV Models of Care***. The peer navigator's role is to:

- Identify potential clients through in-reach and outreach to community-based organizations, community health centers, substance use disorder treatment programs, and housing assistance programs.
- Act as a trusted guide and role model to help clients navigate service delivery systems that are often fragmented.
- Support treatment teams by helping to administer assessments, give information

[9] Covington SS, Bloom BE. Gender-responsive treatment and services in correctional settings. Women & Therapy. 2007;29:3-4,9-33.

[10] Kuo DZ, Houtrow AJ, Arango P, et al. Family-centered care: Current applications and future directions in pediatric health care. Matern Child Health J. 2012; 16(2):297–305.

on HIV, motivate clients to adopt healthy behaviors, provide adherence education and counseling, bring clients to medical appointments, and attend appointments.

» Help clients to build autonomy, confidence, and determination to stay in care and on treatment, through guidance and sharing lived experiences.

Strength-based Medical Case Management: This intervention is recommended for clients who are out of care or at risk of falling out of care and have high-acuity needs. In conjunction with the treatment team, the medical case manager's role is to:

» Provide skills-building, education, and continuous assessment of a client's barriers to treatment engagement.

» Provide care coordination with HIV medical care providers.

» Help clients access needed resources, such as food assistance, safe shelter, childcare, and legal services to pursue child support or escape violent partners.

Trauma-specific Behavioral Health Services: With this intervention, clients with PTSD or other behavioral health challenges receive referrals to individual, couple, family, or group mental health services.

» The behavioral health provider and client formulate a tailored treatment plan in collaboration with the treatment team. Components may include:

  • Counseling services (individual, couple, family, and/or group)
  • Referral to a psychiatric prescriber
  • Release of information to existing treatment providers

» The client maintains a central role in their treatment.

» Progress towards behavioral health goals is assessed regularly.

» Counseling services expand upon current support systems, and may regularly include family members, friends, or other sources of support to enhance the client's ability to remain in care.

The E2i site found that simultaneously implementing client-level and systems-level interventions can be challenging. Sufficient numbers of staff need to be available to support work in both areas. In addition, service gaps within the organizational system may slow or negatively impact any intervention attempting to change it. Assessment of gaps and strategies to address those gaps are necessary for success.

Activity 6: Support for Staff

All staff require ongoing support to prevent vicarious trauma and burnout. Staff support may include:

- **Regular supervision** (individual and group) for staff who may be indirectly exposed to trauma through clients' accounts of traumatic events.
- **Ongoing training** on coping with secondary traumatization[11] and vicarious trauma,[12] building resilience,[13] and positive development through learning about overcoming adversity from trauma survivors.
- **Diversity of roles and balance of workload** to lessen the likelihood of burnout.
- **Wellness committee** to plan activities that promote health and wellness among coworkers.
- **Time to access therapy** to give staff the space and time needed to remain emotionally healthy and resilient.
- **Positive organizational culture and management style** to support the needs of staff through sufficient resources and time.

[11] Secondary traumatization is defined as indirect exposure to trauma through a firsthand account or narrative of a traumatic event.

[12] Vicarious trauma is occupational exposure that counselors can have from hearing their clients' trauma stories and becoming witnesses to the pain, fear, and terror that trauma survivors have endured. It is important not to confuse vicarious trauma with "burnout".

[13] Vicarious resilience refers to the positive effects on the counselor or service provider witnessing how clients cope constructively with adversity.

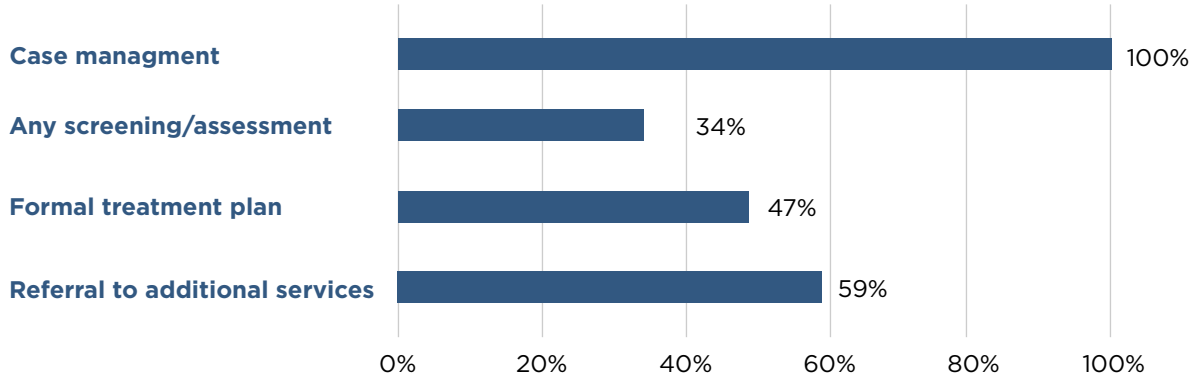
E2i EVALUATION: TIA/CHANGE IMPLEMENTATION OUTCOMES

To learn more about how TIA/CHANGE was viewed by the E2i site's leadership and staff members, E2i collected data from the people implementing the intervention. The data included: (1) an organizational survey completed by site leadership once during the planning period, and every six months during implementation; and (2) a review of site documents created by staff during implementation, including site visit reports, meeting notes, and cost workbooks (see *Appendix A*).

Measure (definition)	Results at the E2i sites
Acceptability: how well staff and leadership regard the intervention	The E2i site initially found the intervention acceptable and a good fit for their organization's mission and goals. Over time, acceptability decreased and then gradually increased back to its initial level. The TIA/CHANGE committee faced some push-back by other staff and leadership during implementation.
Adoption: the intention, initial decision, or action to implement the intervention	The site reported slow but steady progress in adoption of the intervention during the initiative.
Appropriateness: the compatibility of the intervention to address a particular issue or problem	Initially, the site reported low appropriateness; however, their rating for appropriateness steeply increased over time. By the end of the initiative, they rated TIA/CHANGE as highly appropriate.
Feasibility: the extent to which the intervention can be successfully carried out	Feasibility was reported in the moderate range throughout implementation. Staff turnover, particularly in the role of the intensive case coordinator, may have affected staff perceptions of feasibility. In addition, staff found it overwhelming to implement system-level changes and a client-level case management intervention over just two years.
Fidelity: the degree to which a site felt able to (a) implement the intervention as it was intended by the program developers, and (b) monitor progress	The site reported low fidelity at first; fidelity slowly increased over time. The site initially encountered challenges with implementing the intervention according to the core elements. Their intervention goals did not always match with what they were able to implement due to several barriers, including difficulty with engaging the whole organization in the intervention; difficulty with clarifying staff roles; staff turnover; and difficulty understanding how to apply guiding principles to their work.
Penetration: the integration of the intervention within the organization	The site reported consistently moderate integration of the intervention over time. The challenges to penetration related to the TIA/CHANGE committee's slow start to getting staff to "buy into" the intervention.
Cost: the costs associated with planning and implementation, such as personnel, training, supplies, incentives, and outreach activities	Costs included both direct and in-kind expenses. The average expenditures for each site were: • *Planning period:* $312,428 • *Recruitment:* $1,007 per client enrolled • *Implementation activities:* $12,006 per client enrolled • *Supervision and management of intervention:* $3,095 per client enrolled These numbers do not necessarily reflect what it would cost to implement TIA/CHANGE in other HIV service organizations. Costs per client would be lower in settings with larger client populations.

E2i EVALUATION: TIA/CHANGE PARTICIPATION OUTCOMES

FIGURE 3. Participation outcomes among the 32 clients enrolled in TIA/CHANGE as part of the E2i initiative.



- **Strength-based case management services:** All 32 enrolled clients received strength-based case management services.
  - The median number of case management sessions per client was 4.5.
- One-third of clients received a formal intake and assessment, which included questions on trauma exposure.
- **Treatment plans:** While all clients were given the opportunity to create a formal treatment plan, less than half developed and completed one.
- **Referral to services:** Over half of the clients were referred to additional medical, behavioral, or supportive services.
- **Completion of intervention:** Completion of the intervention was not assessed because the site planned to provide ongoing support to all enrolled clients.

LATE IMPLEMENTATION PHASE

The late implementation phase consists of evaluation and refinement of strategies that were piloted during the mid-implementation phase. This phase sets the stage for successful long-term sustainability of trauma-informed care.

Activity 1: Evaluation

A formal and structured evaluation process can identify the strengths, areas for growth, and challenges and barriers to implementation. Evaluation strategies may include:

- Collecting and reviewing health outcome data and satisfaction surveys from clients in piloted interventions
- Reviewing progress towards SMART goals
- Reflecting on previous needs assessments and organizational assessments
- Conducting new interviews and focus groups to assess current community needs as well as gather feedback on current programs
- Performing another round of organizational assessments, comparing the results from previous assessments

The evaluation process can help to:

- Determine how to meet unmet SMART goals
- Identify new SMART goals
- Choose to continue or discontinue specific strategies and interventions
- Determine resources needed, including new partnerships, additional staff time, areas of further training, and funding
- Revise guiding principles
- Develop a schedule of evaluation activities for the coming year

Activity 2: Core Components

Evaluation activities allow TIA/CHANGE committees to reflect on their guiding principles:

- Do the principles still align with the organizational mission?
- Do they continue to guide you in the direction you need to go?
- Are they meeting the needs of your clients?

Eventually, the committee can solidify the guiding principles into "core components" of the organization's trauma-informed approach. An example of core components comes from ***Christie's Place***, the original developer of TIA/CHANGE.

- Agency and empowerment (building a client's confidence and determination to stay in care and on treatment)
- Meaningful inclusion of women with HIV
- Education and support
- Stakeholder involvement
- Trauma-informed environment
- Intentional practice to purposefully sustain healing and growth

Activity 3: Innovation and New Partnerships

Based on evaluation findings, an organization may decide to seek new partnerships with providers of behavioral health care, legal services, shelters, and other services. In addition, organizations may wish to apply for funding and partner with academic or research institutions to develop new and innovative programs. Academic and other partnerships also provide opportunities to grow your referral base and bring training and technical assistance to others.

Activity 4: Sustainability and Maintenance

Sustainability refers to the ability to maintain programming and its benefits over time. A helpful resource for building capacity for sustainability is the ***Program Sustainability and Assessment Tool*** developed by the Center for Public Health Systems Science at the Brown School, Washington University in St. Louis.

This tool helps program planners achieve the following:

1. **Understand** the factors that influence a program's capacity for sustainability
2. **Assess** the program's capacity for sustainability
3. **Review** results from the Assessment
4. **Plan** to increase the likelihood of sustainability by developing an Action Plan

Achieving sustainability typically involves applying for grants and accessing available reimbursement options to support activities and staffing. Client-level psychotherapy is a core service under RWHAP funding and would likely be covered through Outpatient Mental Health Current Procedural Terminology (CPT) Codes. Peer services is covered by some state Medicaid programs, although certifications and restrictions vary by state. RWHAP-funded organizations can also receive technical assistance on health coverage options from the ***Access, Care, and Engagement Technical Assistance (ACE TA) Center***.

Maintaining a trauma-informed approach over time is challenging. It is therefore vital to:

- Designate at least one administrative leader to oversee the maintenance of TIA/CHANGE
- Continue to have an active TIA/CHANGE committee to review policies, procedures, and training
- Continue to identify new champions
- Provide ongoing training to staff
- Share success stories and small wins with all staff
- Continue to nurture relationships with partners in the community
- Continue to build new relationships both locally and nationally

Additionally, once you have achieved a level of sustainability, consider helping to spread the adoption of trauma-informed care in the community and beyond by presenting your efforts and outcomes at conference and meetings.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

The E2i site shared barriers and facilitators to successfully implementing TIA/CHANGE. They also made changes to the original intervention to meet the specific needs of their clients and staff members. Here is a summary of adaptations and lessons learned. Additional information about the site's experience can be found in the Program Spotlight below.

- **Challenges with organization-wide implementation:** The E2i site was an HIV Early Intervention Services (EIS) program within a non-profit tribal health organization providing comprehensive medical services, wellness programs, and other services with American Indian/Alaska Native people across the state of Alaska. The EIS-based TIA/CHANGE committee originally aimed to implement trauma-informed guiding principles across the entire organization. As a small clinic within a large organization, however, the EIS-based committee struggled to gain enough buy-in from organizational leadership and staff. Thus, the committee eventually decided to focus the bulk of their efforts on integrating TIA/CHANGE into the EIS clinic by implementing a client-level, strength-based case management program that addresses social determinants of health causing trauma among their clients. To accomplish this, they hired a full-time intensive case coordinator (ICC) to provide trauma-informed case management for clients with HIV and trauma experience or exposure. The committee eventually improved organizational buy-in after crafting and facilitating a "Principles of Trauma-Informed Care" training, which attracted about 60 staff from the overall organization. After this training, several board members expressed interest in becoming TIA/CHANGE champions.
- **Moving from concept to action:** The site also struggled with developing guiding principles that they believed would translate into actual practice. Making system-level changes while also implementing client-level interventions also began to overwhelm the small committee 's resources. As a result, the committee changed their goals several times, and eventually shifted to focusing primarily on integrating and implementing the intensive case management program.

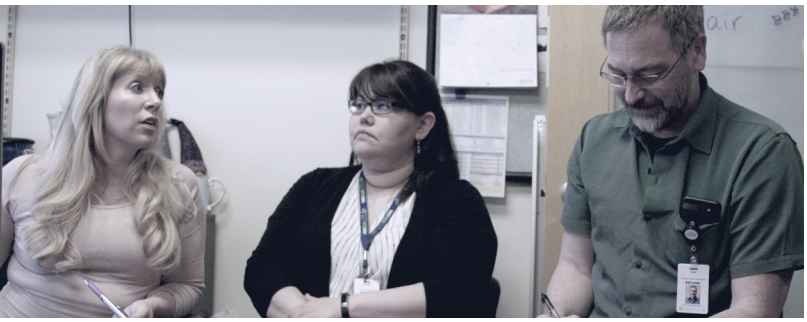
E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

- **Challenges with intensive case management:** Getting clients enrolled and retained in trauma-informed, strengths-based case management was difficult for several reasons. First, many American Indian/Alaska Native people with HIV lack trust in the broader medical system due to historical and systemic trauma. Second, some clients lived several hours away in rural areas, making it difficult for the clients to attend referrals and appointments. At the same time, there were other organizations in the same area that served the same population, making referrals and services difficult to monitor. Additionally, because of limited connectivity in their homes, many clients could not use telehealth.
- **Internal organizational issues:** The TIA/CHANGE committee learned that the regular case management team did not understand how the role of the TIA/CHANGE ICC differed from their own roles, which led to lack of buy-in. Due to challenges with organizational buy-in, the committee was not able to consistently implement trauma screening and case coordination referrals. Moreover, halfway through implementation, the person originally hired as the ICC left the organization. The site was able to hire another ICC, but this took time and thus left a gap in services for clients.
- **Facilitators for intensive case management:** Integration of the intensive case management improved by having the ICC work within the HIV clinic, allowing him to actively participate in medical care team meetings, receive informal referrals from medical providers, and develop care plans. It was also helpful to have identified ICCs who were very familiar with the population and services available in the Anchorage area.

E2i PROGRAM SPOTLIGHT

PROGRAM SPOTLIGHT

Alaska Native Tribal Health Consortium



Organizational Background

Located in Anchorage, Alaska, the Alaska Native Tribal Health Consortium (ANTHC) is a non-profit tribal health organization providing comprehensive medical services, wellness programs, disease research and prevention, rural provider training, and rural water and sanitation systems construction with American Indian/Alaska Native people across the state. ANTHC is one of 20 co-signers of the Alaska Tribal Health Compact, a self-governance agreement with the Indian Health Service. ANTHC's HIV Early Intervention Services (EIS) program, a RWHAP Part C recipient, provides comprehensive clinical outpatient care and case management services to people with HIV through in-person visits, field clinic visits to tribal health care organizations in rural areas, and virtual visit options. The EIS program collaborates with multiple private and public health care systems and providers to address the unique challenges of providing optimal HIV care across vast geographical areas with limited access to care.

Implementation Goals and Context

TIA/CHANGE at ANTHC is a resiliency-focused and strength-based approach to HIV service that involves understanding, recognizing, and responding to the effects of trauma. Many American Indian/Alaska Native people with HIV have experienced trauma in their lives and have not had opportunities to process and address that trauma. They also lack trust in the broader medical system due to broken promises and a history of mistreatment. ANTHC therefore tailored its TIA/CHANGE efforts to be effective for the American Indian/Alaska Native community of people with HIV. An ANTHC staff member who is an Alaska Native also helps train other staff members on cultural issues.

For the E2i initiative, ANTHC's EIS staff acted as the TIA/CHANGE committee. Because the EIS-based committee struggled to gain enough buy-in from ANTHC leadership and staff, the committee moved back and forth between the early- and mid-implementation phases of TIA/CHANGE, eventually deciding to focus mostly on integrating TIA/CHANGE into the EIS clinic. As part of this process, the committee chose to implement a client-level, strength-based case management program that addresses social determinants of health causing trauma among their clients and thus preventing them from engaging in care. To accomplish this, they hired a full-time intensive case coordinator (ICC) with experience in trauma-informed care to provide trauma-informed case management for clients with HIV. An important aspect of this work includes improving referral relationships with community programs.

Recruitment and Delivery

The TIA/CHANGE committee implemented a process to assess clients based on needs for intensive case management or other services. Client referrals to the ICC have come primarily from internal providers at ANTHC, and also from partnerships with community agencies. The ICC assesses clients using structured questions, but with an open-ended approach. Based on the assessment, the ICC develops a care plan with meaningful goals and in coordination with a team consisting of the HIV provider, RN case manager, and the client.

> *"These clients are finally being heard as human, as a whole human. They know they have value."*—ANTHC staff member

To facilitate referrals, the ICC developed partnerships with multiple organizations and stakeholders. One such partner organization, Alaska AIDS Assistance Association, provides support services such as behavioral health treatment, health insurance assitance, medications through the AIDS Drug Assistance Program, oral health, and other services that complement the needs of ANTHC clients. As part of ongoing support for their clients, the staff provide cell phones for clients that experience instability with communication methods; they also locate and support clients that may be experiencing homelessness. Although buy-in from existing staff of TIA/CHANGE had its challenges, the committee believes they were eventually able to create a program that provides whole-person continuity of care that meets clients "where they are."

Adaptations and Innovations

» **COVID-19 pandemic:** During the COVID-19 pandemic, the TIA/CHANGE committee was able to focus on predicting daily client needs and challenges, including mental health concerns. They switched to conducting phone assessments with each client monthly, providing mail-out options for medications, phone/video visits with providers, safe transportation options, and care packages of personal protective gear for all clients. The ICC was able to keep contact with the community partners that also support clients in housing and food options. During this time, the team also took steps to address the pandemic-related mental and emotional toll on the team.

Program Integration

As described above, the TIA/CHANGE committee experienced challenges with integrating the intervention across the entire ANTHC organization, and thus focused mostly on implementation within the EIS clinic. Even within the EIS clinic, the committee experienced barriers to integration, mainly related to difficulty in distinguishing between the ICC's role and the roles of the other case managers. After presenting trauma-informed care training to the whole organization, and clarifying the different roles, the TIA/CHANGE committee was better able to move forward with the case management intervention, and to incorporate trauma-informed principles into staff culture.

ANTHC has secured funding for the ICC and behavioral health consultation positions to sustain TIA/CHANGE beyond the E2i funding period. To further foster institutional buy-in for program integration, ANTHC intends to develop a program guide for tactics and strategies based on the ***TIA/CHANGE E2i Toolkit***. This guide will be useful for internal program assessment, external stakeholder education, and overall marketing of the service for programs in need of trauma-informed interventions.

Lessons Learned

» **Organizational change:** ANTHC has learned that clarifying staff roles, providing education and training on trauma to all staff, and developing a clear organizational process are vital to bringing about effective change.

Contact Information

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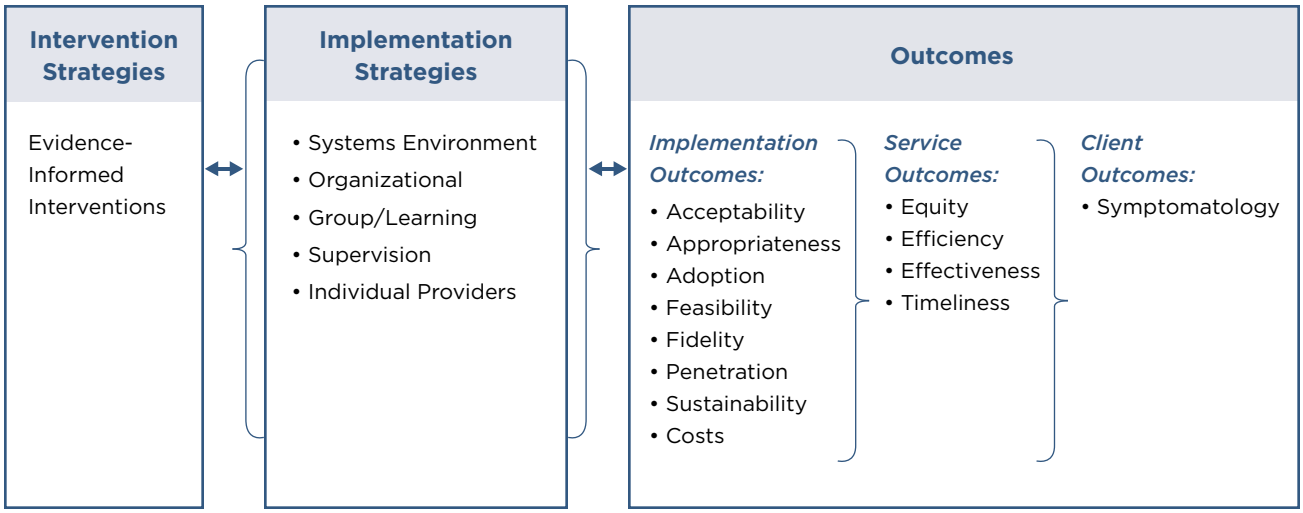
APPENDICES

APPENDIX A. IMPLEMENTATION SCIENCE AND EVALUATION: FRAMEWORK AND METHODS

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco conducted the evaluation of the E2i program implementation. The evaluation used the Proctor Model Framework for Implementation Research.[14] This approach suggests that program assessment should include an understanding of the process of implementation and its impact on all people and systems that are involved in the implementation:

1. The core elements of the program (intervention strategies).
2. The efforts to put the program into place (implementation strategies).
3. How the program is viewed by the people involved (implementation outcomes).
4. How the program is delivered (service outcomes).
5. The impact on the participants (client outcomes).

The E2i Proctor Model



[14] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76.

Six types of information were gathered over the three years of E2i program implementation. These include:

Organizational Assessment: Every six months, the site program director completed a survey. This survey had questions about the organization (e.g., number of patients, types of services provided, and staffing). It also included questions about program delivery and how the staff views the program.

Proctor Concepts

- Implementation strategies (systems environment, organizational, group/learning, supervision)
- Implementation outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability, costs)

Document Review: Evaluators reviewed documents that were created during implementation and technical assistance activities. Documents were created by either the sites themselves or by The Fenway Institute/AIDS United and included: E2i funding applications, site visit reports, quarterly reports, monitoring call notes, cohort call notes, and presentations in meetings.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual clents)
- Implementation Outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability)

Observations: Sites participated in two Learning Session Meetings each year. Evaluators took notes on discussions and presentations. These notes focused on barriers and facilitators to implementation.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual clients)

Costing Data: Program managers and financial administrative staff completed two cost workbooks. One was for the three-month preparation/planning period and the first year of program implementation. The other was for the second year of program implementation. Costs included personnel and expenses paid for by E2i as well as in-kind donations.

Proctor Concepts

» Implementation Outcomes (costs)

Intervention Exposure: Information was collected on clients who participated in the intervention between September 2018 and December 2020. Demographic information was collected on enrollment forms. Intervention exposure forms were collected whenever staff had program-related interactions with participants. These forms included information such as: date of the interaction, the staff person who had contact, type of interaction, activities completed, and outcomes of the activities.

Proctor Concepts

» Service Outcomes (fidelity, penetration, equity, efficiency, effectiveness, timeliness)

Medical Records: Medical records were collected on participants for the 12 months before enrollment in the program and for the 12 months after enrollment in the program. The information was specific to HIV-related medical care, such as: appointment dates; prescription of ART; viral load test dates; and viral load test results.

Proctor Concepts

» Client Outcomes (symptomatology)

Quantitative Analysis: Organizational assessment data was used to describe organization characteristics and readiness for implementation based on Proctor Concepts. Client level enrollment and intervention exposure data was analyzed using descriptive statistics to understand client demographics, proportions of clients receiving intervention services, and frequencies of exposures. When appropriate, proportion of clients completing the intervention was included. Repeated measures modeling methods were used to assess changes in HIV care continuum outcomes for clients enrolled in the intervention. This compared data from 12 months prior to enrollment to 12 months following enrollment. Costing data was analyzed to provide information on cost of intervention implementation per client enrolled.

Qualitative Analysis: Documents and observations were thematically analyzed using the Proctor Concepts. The intervention was the primary unit of analysis.

APPENDIX B. TIA/CHANGE "GO LIVE" WORKSHEET

Purpose

The purpose of the "Go Live" Worksheet is to:

1. Guide organizations in planning the intervention's implementation activities
2. Monitor progress in meeting implementation goals

Instructions

The team that is leading the intervention should identify a team member to complete this worksheet over time. Use the worksheet to:

- Develop and drive team meeting agendas
- Document decisions made by the team
- Track progress towards goals

Appendix B. *TIA/CHANGE "Go Live" Worksheet*

Name of organization	
Name (Who is completing this worksheet?)	
Intervention goals	To improve client engagement in HIV care by guiding an organization to implement a trauma-informed approach to the delivery of care
Core elements	**1.** Organization-level Implementation **2.** Trauma-informed Approach **3.** Guiding Principles
Planning Steps	
TIA/CHANGE committee (Who is on the committee?)	**1.**
	2.
	3.
	4.
	5.
Engaging stakeholders (What strategies will you use to gain "buy-in" and feedback?)	**1.** Organizational leadership:
	2. Relevant staff:
	3. Local community members:
	4. Clients:

Appendix B. *TIA/CHANGE "Go Live" Worksheet*

Intervention staff (Who will do what?)	**Role/Task**	**Staff Responsible**
	Oversee community needs assessment	
	Oversee organizational needs assessment	
	Lead the development of the guiding principles	
	Lead community partnerships	
	Lead the TIA/ CHANGE committee	
	Develop and run staff training	
	Lead the selection of trauma interventions	
	Lead evaluation activities	
	Lead sustainability planning	
Guiding principles (How will you develop your guiding principles?)		
Staff training plan (When, where, and how will staff be trained?)		

Appendix B. *TIA/CHANGE "Go Live" Worksheet*

Assessment tools (What trauma screening instruments and assessments will you use?)	**1.**
	2.
	3.
Additional tools (e.g., enrollment forms, referral forms, client satisfaction)	**1.**
	2.
	3.
Referrals (Who will you partner with for services not offered by your organization?)	**1.**
	2.
	3.
	4.
Incentives (What incentives, if any, are you giving participants for client-level interventions?)	
Building trust (How will you build rapport and trust with clients?)	
Sustainability (What are you doing to make your program sustainable?)	

Pilot the intervention (When and how will you test a pilot of the client-level interventions?)	
After pilot: (What worked, what did not work? What changes will you make?)	
What are your SMART goals for the year? (Specific, Measurable, Achievable, Relevant, Time-Bound goals)	**1.**
	2.
	3.
	4.
	5.

APPENDIX C. TIA/CHANGE ORGANIZATIONAL-LEVEL IMPLEMENTATION CHECKLIST

Purpose

The purpose of this checklist is to:

- Provide guidance on important components of the organization-level changes required in TIA/CHANGE
- Monitor progress in implementing the organization-level changes

Instructions

It is recommended for the TIA/CHANGE Committee to convene regularly to complete this checklist as a team. This would allow the team to monitor the organization's progress toward full implementation. The checklist can be completed less frequently once most of the activities have been implemented. The checklists may be adapted to meet the needs of your organization.

Staff will go through each activity and leave a checkmark (✓) in one of the four options:

- Complete: Activity has been implemented
- Current: Activity is being planned and will be implemented soon
- Future: Activity will be implemented sometime in the future
- N/A: Activity is not applicable/relevant to the organization

Staff can also use the space provided under "Additional comments" to document any of the following:

- Examples and details of how the organization has done (or plans to do) the listed activities
- Variations of the listed activities that the organization has done (or plans to do)
- Additional activities that the organization has done (or plans to do)
- Reasons why an activity has not been done (or will not be done)

Early Implementation Phase

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
Community Needs Assessment				
Conduct community needs assessment with key stakeholders within and outside your organization, using strategies such as • Existing data • Key informant interviews • Focus groups				
Additional comments:				
Resource Identification and Procurement				
Evaluate current policies, practices, and knowledge within your organization relevant to trauma-informed care using the questions in Onsite Resource Identification (*Appendix D*)				
Additional comments:				
Guiding Principles of Trauma-Informed Care				
Develop guiding principles of trauma-informed care that align with your organization's mission and that can be easily articulated to stakeholders within and outside of your organization				
Additional comments:				

Mid-Implementation Phase

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
TIA/CHANGE Committee				
Establish a TIA/CHANGE Committee that will: • Advance the knowledge of the impact of trauma • Incorporate policies, procedures, and practices informed by this knowledge • Provide staff training on trauma-informed care				
Additional comments:				
Baseline Organizational Assessments				
Assess your organization's service environment using an assessment tool such as the one provided in ***Appendix E***				
Identify environmental change needs based on the organizational assessment findings				
Assess staff competencies in trauma-informed care using an assessment tool such as the one in ***Appendix F***				
Identify staff training needs based on staff competency assessment findings				
Develop SMART goals for your organization based on assessment findings				
Additional comments:				

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
Staff Training				
Develop a staff training curriculum that covers: • Guiding principles of trauma-informed care at your organization • Basics of trauma-informed principles and approach • Topics specific to the effects of violence and abuse • Culturally affirming care for people with HIV and other priority population(s) within your client base				
Update and review curriculum annually based on identified training needs and new developments in the field				
Develop a plan for ongoing staff training in trauma-informed care				
Additional comments:				
Community Partnerships				
Develop partnerships with providers in the community (e.g., behavioral health care, legal services, housing, and intimate partner violence shelters and services)				
Additional comments:				

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
Interventions to Address Trauma				
Select trauma-informed or trauma-specific interventions based on your organization's SMART goals				
Identify evidence-based tools for assessing trauma				
Pilot the interventions				
Additional comments:				
Support of Staff				
Develop a plan for ongoing support for staff to ensure their own self-care and reduce the possibility of vicarious trauma and burnout (e.g., regular clinical supervision, training on vicarious resilience, diversity of roles and balance of workload, etc.)				
Additional comments:				

Late Implementation Phase

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
Evaluation				
Conduct evaluation of progress towards SMART goals, using strategies such as • New key informant interviews or focus groups • Follow-up organizational assessment				
Develop a plan based on evaluation results • Determine how to meet unmet SMART goals • Identify new SMART goals • Identify which strategies and interventions to continue • Determine resources needed (new partnerships, additional staff time, areas of further training, funding)				
Determine and schedule evaluation activities for the coming year				
Additional comments:				
Identifying Core Components				
Identify core components of trauma-informed care tailored to your organization based on evaluation results (solidify the guiding principles into core components)				
Additional comments:				

Complete: Activity has been implemented **Current**: Activity is being planned and will be implemented soon **Future**: Activity will be implemented sometime in the future **N/A**: Activity is not applicable/relevant to the organization	Complete	Current	Future	N/A
Sustainability and Maintenance				
Identify reimbursement opportunities to cover clinical care and support services				
Identify outside grant funding opportunities to pay for costs not covered by insurance and in-kind support				
Use the Program Sustainability Assessment Tool				
Designate at least one staff member in a leadership position to oversee the maintenance of trauma-informed care				
Continue holding TIA/CHANGE committee meetings to manage the implementation of trauma-informed service provision and to update policies and procedures				
Continue to identify champions				
Continue to train existing and new staff and volunteers on trauma-informed care				
Continue to nurture relationships with partners in the community				
Develop relationships with new partners locally and nationally, as needed				
Additional comments:				

APPENDIX D. ONSITE RESOURCE IDENTIFICATION: GUIDING QUESTIONS

By answering the following guiding questions, you will better understand your organization's baseline preparedness for implementing trauma-informed care and will be able to determine resources needed to start implementation.

1. To what extent (and how) does your organizational mission and vision foster individual agency? Agency is "[the] ability to take action, be effective, influence your own life, and assume responsibility for your behavior [as] important elements in what you bring to a relationship… Having a sense of agency influences your stability as a separate person; it is your capacity to be psychologically stable, yet resilient or flexible, in the face of conflict or change."[10]

2. To what extent (and how) does your organizational mission and vision foster empowerment? Empowerment is "[the] process in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action toward that goal, and observes and reflects on the impact of this action, drawing on [their] evolving self-efficacy, knowledge, and competence related to the goal."[16]

[16] Cattaneo LB, Chapman AR. The process of empowerment: A model for use in research and practice. American Psychologist.2010;65:646-659.

3. To what extent does your organization meaningfully engage people with HIV in programmatic design, implementation, and evaluation? For example, do you place importance on recruiting people with HIV for staff, board, and volunteer positions?

4. Who in your organization is currently knowledgeable about trauma?

5. What processes are in place for ongoing staff development inclusive of staff at all levels of the organization?

6. Does your organization's staff recognize the prevalence and impact of trauma on the lives of the people you serve? Does your organization's staff see the value of moving toward a trauma-informed care environment?

7. How does leadership support resource allocation needed to implement trauma-informed care?

8. What aspects of your physical space and organizational atmosphere promote safety, healing, and wellness for clients and staff?

9. To what extent has your organization institutionalized practices that promote informed consent,[17] and ensure confidentiality?[18]

10. What, if any, processes do you have in place to assess for trauma and current safety?

11. What trauma-specific behavioral health services and support groups do you already offer?

[17] Wagner, R. What is informed consent? eMedicineHealth. 2020. Available at: https://www.emedicinehealth.com/informed_consent/article_em.html

[18] DeBord J, Burke W, Dudzinski DM. Ethics in medicine: Confidentiality. University of Washington School of Medicine, Department of Bioethics and Humanities. Available at: https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/58

12. Do you have support from stakeholders in your community to implement trauma-informed care? If so, list these stakeholders.

13. Do you have existing relationships with, or at least know of resources and providers of trauma-related services in your community? If so, list these providers.

APPENDIX E. TRAUMA-INFORMED SERVICE ENVIRONMENT ASSESSMENT FOR ALL STAFF

Purpose

The purpose of the Trauma-informed Service Environment Assessment is to identify areas of strength and areas for growth within the organization with relation to trauma-informed care. The findings are used to inform SMART goals and a list of resources needed to create a trauma-informed care environment for staff and clients.

Instructions

It is important to gain feedback from as many staff members and other identified stakeholders (e.g., clients, partners) as possible. To increase participation, consider the following:

- Introduce the survey during an all staff meeting as part of a larger explanation of the benefits and purpose of trauma-informed care.
- Create an online version of the survey and send out a link to the survey via email.

Trauma-informed Service Environment Assessment: Creating Conditions for Safety

This is an assessment of our current service environment. The information gathered from this assessment will be used to inform action plans for trauma-informed care at the organization This assessment is anonymous and will be analyzed together with the responses of all staff.

Thank you for your time, participation, and honesty.

Physical Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Confidentiality and Privacy						
Space is available for private conversations for clients and staff						
Staff do not talk about clients in common areas						
The agency informs clients about what information is gathered, where it is kept, and who has access to it, and when and what the agency has to report and to whom						
Staff supervision is made available in a private confidential space						
Accessibility						
All doors have automatic openers and all furnishings set up for ease of movement of wheelchairs and walkers						
All materials are available in audio versions as well as big print						
Interpreters are available for the deaf and hard of hearing when requested						

Physical Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Appearance						
Space is kept clean and neat						
Space is well lit						
Parking area is well lit at all times						
Furnishings are comfortable						
Climate						
Layout of space promotes interactions between clients and staff						
Posted signs have "person-centered language"						
Someone is always available to welcome anyone walking into space						
Space reviewed and assessed by clients						
Space is reviewed and assessed by former and/or current clients						

Supportive Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Transparency						
Policies and procedures are reviewed with client						
Clients are informed why they are asked to fill out certain forms and who has access to them						
Clients are informed of program protocols on how staff respond to people experiencing a crisis						
Policies and procedures are reviewed with staff						
Consistency and Predictability						
Hours of operation are posted and adhered to						
Change in hours is provided to clients with advance notice						
Change in staff is provided to clients with advance notice						
Staff are responsive to clients' inquiries for services/support within 48 hours						
Staff meetings and supervision are on a consistent and predictable schedule						

Supportive Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Resource Availability						
Staff are culturally responsive to people of all gender identities						
Resources are compiled, updated and made available to clients and staff						
Staff serve as a resource to clients and are responsive to needs of clients						
Clear Expectations						
Code of ethics is developed with clients						
Code of ethics is developed with staff						
Codes of ethics are posted in common areas						
Codes of ethics are reviewed regularly with clients and staff						
Common group agreements are developed and followed for all meetings						
Agency mission, vision, and/or guiding principles are posted in common areas						
Staff and clients' actions are guided by the agency mission, vision, and/or guiding principles						

Supportive Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Cultural Sensitivity						
Signs are posted in different languages to meet needs of community						
Images and language on posters and artwork represent the demographics of the community						
Staff represent the demographics of the community						
Inclusive Environment						
Voice						
Former and/or current clients are involved in program development						
Former and/or current clients are involved in program implementation						
Former and/or current clients are involved in program evaluation						
Clients self-identify their own goals						
Different perspectives are included						

Inclusive Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Choice						
Information and resources are shared with clients so they can make an informed choice						
All program functions and regulations are clearly described so clients make informed choices						
Language						
All written and verbal communication uses person-centered language						
Language does not limit what a person can do (people are not viewed or talked about as a diagnosis or "label")						
Materials are available in the primary languages of community members						
Relational Environment						
Boundaries						
All staff and volunteers have clear job descriptions						
The role of staff is made clear to clients						
Staff do not do for one person what they would not do for all						
When ready and appropriate, staff share their own life experiences						

Relational Environment						
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Not Relevant**
Balanced						
Mutuality is demonstrated between staff and clients						
Whenever and wherever appropriate, decisions are made collaboratively between clients and staff						
Staff seek ways to share power with clients						
Supervisors seek ways to share power with staff						
Authentic						
Staff are able to relate and empathize with clients in response to the very human experience of woundedness and recovery						
Staff are able to engage with clients and notice what each brings to the interaction						
Staff meet people (clients, other staff, etc.) where they are at in their healing and recover journey and offer support and guidance without judgment						
Agency recognizes that the staff person's lived experience affects their response to clients' narratives/stories						

APPENDIX F. TRAUMA-INFORMED STAFF CORE COMPETENCIES ASSESSMENT

Purpose

The purpose of the Trauma-informed Staff Core Competencies Assessment is to identify areas of strength and areas for growth among staff. The survey asks about current levels of knowledge, skills, and values relevant to trauma-informed care. The findings are used to inform staff training and mentorship needs.

Instructions

Staff may self-report or a supervisor may complete the assessment. To increase participation, consider the following:

- Discuss the assessment during a supervision meeting
- Explain that the assessment is anonymous and not tied to salary or promotion
- Create an online version of the survey and send out a link to the survey via email

Trauma-informed Staff Core Competencies Assessment

The purpose of this assessment is to better understand what staff trainings and resources are needed to become a more trauma-informed organization. Please answer these questions to the best of your knowledge. This assessment is anonymous and will be analyzed together with the responses of all staff.

Thank you for your time, participation, and honesty.

Demonstrates KNOWLEDGE in the Following Areas			
	Demonstrates Competency	**Needs Further Development**	**Uninformed**
Describes interconnection of violence, trauma, and social issues			
Describes impact of trauma on the body, spirit, mind			
Understands impact of trauma over the life- span			
Understands "symptoms" are considered adaptive strategies/coping mechanisms from trauma			
Understands the complex needs of trauma survivors			
Understands the prevalence and impact of gender disparities			
Describes the impact of cultural trauma			
Understands re-traumatization			
Understands cultural differences in how people understand, respond to, and treat trauma			
Understands universal precautions			

Demonstrates KNOWLEDGE in the Following Areas			
	Demonstrates Competency	**Needs Further Development**	**Uninformed**
Understands the impact of natural disasters and war and its link to earlier traumatic experiences for trauma survivors			
Understands impact of trauma on LGBTQIA+ individuals and community			
Understands healthy boundaries within trauma-informed contexts			
Understands the intergenerational cycle of violence			
Understands the importance of self-care			
Understands the building blocks of establishing a trusting relationship			
Understands collaborative decision-making processes and the need to seek common ground			
Understands the role of staff self-disclosure in trauma-informed settings			
Understands the need to know peers/clients beyond their label, disability and/or affect			
Understands why gender specific options are available			

Demonstrates SKILLS in the Following Areas			
	Demonstrates Competency	**Needs Further Development**	**Uninformed**
Articulates a working definition of trauma			
Articulates difference between trauma-informed and trauma-specific			
Able to establish and maintain healthy boundaries			
Able to create a safe and welcoming physical environment			
Able to create a supportive environment			
Able to create an inclusive environment			
Able to provide gender-specific supports and services			
Supports peer skill development by sharing power			
Supports peer/client involvement by providing opportunities for clients to facilitate, organize, and/or coordinate activities			
Able to establish and maintain transparency in actions and interactions			
Establishes means for sharing information in an ongoing, consistent manner			
Able to establish trusting relationships with colleagues			
Able to establish trusting relationships with peers/clients			

Demonstrates SKILLS in the Following Areas			
	Demonstrates Competency	**Needs Further Development**	**Uninformed**
Able to make appropriate referrals with timely follow-up			
Able to communicate and collaborate with peers/ clients in a respectful, inclusive manner			
Able to make decisions in collaboration with peers/clients			
Able to engage peers/clients with empathy, warmth, and sincerity			
Able to practice self-care in an intentional, consistent manner			
Able to maintain confidentiality			
Able to identify and use relevant existing community programs and resources and alternative peer/clients operated supports/programs			
Willing to ask for help from supervisor, peers/ clients, colleagues			
Willing to learn from peers/clients			
Able to offer true choice to peers/clients and to honor their choice			
Able to coach peers/clients to know their strengths and talents			
Demonstrates culturally appropriate respect			
Able to tailor staff person approach to individual peer's/clients unique goals and needs			

Demonstrates the Following VALUES			
	Demonstrates Competency	**Needs Further Development**	**Uninformed**
Values the lived experience of peers/clients			
Peers and clients are the experts in their own recovery			
Healing from trauma is transformative			
Connections between staff and clients are reciprocal and offer opportunities for shared learning			
Clients heal in relationship with self, others, and/or a source outside of themselves			
Pathways to recovery are diverse and vary from individual to individual			
Recovery is a spiral path, not direct, not linear			
Healing builds strength in the “broken places”			
Recovery from trauma is possible for all			
Informed choice is central to trauma recovery			
Healing happens in relationships			

Note: These values for trauma-informed care organizations were identified by the Office of Women’s Health.

APPENDIX G. TRAUMA-INFORMED CARE CLIENT-INTERACTION SELF-RATING SCALE

Instructions

Use this worksheet to rate yourself on a scale of 1 to 5, with 1 being "Can improve" to 5 being "Did well". If an aspect is not relevant for the session, leave a checkmark under "N/A" (not applicable). Provide a short reflection on ways to improve delivering trauma-informed care for future client interactions.

Date: _____ Start Time: _____ End Time : _____

Session No. : _____ Staff: _____ Client: _____

Trauma-Informed Care

Below are important aspects of trauma-informed care. Rate how well you did the following:

	Can do better		Did okay		Did well	
	1	2	3	4	5	N/A
Built trust with client	☐	☐	☐	☐	☐	☐
Engaged client with empathy, warmth, and sincerity	☐	☐	☐	☐	☐	☐
Created a positive relational environment (clear boundaries, balanced power, authenticity)	☐	☐	☐	☐	☐	☐
Helped client feel empowered to make their own choices about health care	☐	☐	☐	☐	☐	☐
Honored client's feedback and choice	☐	☐	☐	☐	☐	☐
Fostered client's agency (confidence and determination) to stay in care and on treatment	☐	☐	☐	☐	☐	☐
Focused on client's strengths	☐	☐	☐	☐	☐	☐
Provided easily understandable information	☐	☐	☐	☐	☐	☐

In reviewing your interaction with the client, what are some of the challenges you faced in using any of the above aspects of trauma-informed care? Reflect on how you can overcome those challenges and improve on the delivery of trauma-informed care in future sessions: