National Council for Behavioral Health

Trauma-informed Primary Care: Fostering Resilience and Recovery Learning Community

Request for Applications

INTRODUCTION
The National Council for Behavioral Health (National Council) is pleased to announce the Trauma-informed Primary Care: Fostering Resilience and Recovery Learning Community with support from Kaiser Permanente Community Benefit (Kaiser Permanente). This 16-month learning community will support efforts to expand the use of trauma-informed approaches within the primary care setting.

The primary goal of the project is to pilot a newly-created change package developed by a national panel of multidisciplinary experts using a learning community approach. This change package offers a comprehensive set of tools and guidance on integrating trauma-informed approaches into the primary care setting. Multiple studies have demonstrated that infusing trauma-informed approaches helps improve overall health outcomes and reduce staff turnover (Dolezal, McCollum & Callahan, 2009; Stroul et al., 2015). The learning community will support primary care settings with targeted, responsive training and technical assistance and peer-to-peer learning to successfully incorporate trauma-informed approaches into their environment. The change package will be refined based on feedback from the learning community before it is shared with the wider health care community.

A change package is a practical toolkit that is specific enough for clinicians and practices to implement, test and measure progress on an evidence-based set of changes and generalized enough to be scaled in multiple settings. They have proven to be an effective tool to actuate practice transformation in primary care, most notably through the 2002 depression change package which led to the widespread use of the PHQ9.

Through a competitive application process, the National Council will select seven primary care organizations to participate in this learning community. With technical assistance and guidance, participating sites will identify and implement changes to effectively integrate trauma-informed approaches. Throughout this process, these sites will test the change package, provide input and participate in an external evaluation to assess impact and outcomes. We are seeking a range of organizations with diversity in geography, setting, patients served and levels of integration and readiness that serve safety-net populations.
In medical settings, the term “trauma” has historically referred to severe physical injuries that occur suddenly and require immediate emergency medical response. When applied to trauma-informed approaches, this concept is expanded to include past experiences and a range of other physical, emotional and psychological events. Trauma is more prevalent than previously assumed; the Centers for Disease Control and Prevention (CDC) estimates rates of approximately 60 percent in the general population (CDC, 2010). The impact of trauma is especially profound for communities affected by poverty, crime, discrimination, unemployment and poor health. Some individuals who have experienced significant trauma may be sensitive to stressors that are common within the primary care environment, which can result in avoidance of primary care services and poor management of health conditions. For others, this may result in overuse of health services, including emergency department (ED) visits. Trauma also impacts the primary care workforce as workers strive to meet the increasing needs of patients – many impacted by trauma – in a high-demand, high-volume environment.

Trauma-informed practices emphasize the importance of creating a safe and comfortable primary care environment, as well as facilitating access to trauma-focused services (Schachter, C.L., 2008). A trauma-informed environment and workforce can improve patient engagement and treatment outcomes. Ultimately, this can impact health issues upstream, reduce dependence on EDs and decrease missed appointments, all of which can reduce costs and improve patient experience. In short, trauma-informed approaches can address health care’s quadruple aim of patient satisfaction, improved health outcomes, decreased costs and staff satisfaction.

Are you ready to build internal capacity, impact your quadruple aim and integrate trauma-informed care to enhance overall health? Apply today!

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**2015 Trauma-informed Primary Care Initiative**

The initial 2015 National Council and Kaiser Permanente collaboration, designed to educate 14 Federally Qualified Health Centers (FQHCs) to advance trauma-informed approaches and practices, demonstrated promising results.

- **Eight of 10** agencies reported that their clients maintained a high adherence to treatment (defined as attending at least 70 percent of appointments) during the study period.
- **Five** of the participating agencies reported improvements in health outcomes among their clients (primarily reducing A1C levels).
- **One** clinic reported that 75 percent of an initial patient cohort was no longer identified as high-risk due to improved outcomes related to diabetes.

McSilver Institute for Poverty Policy and Research, 2016

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McSilver Institute for Poverty Policy and Research, 2016
We encourage applications from interested organizations regardless of their level of familiarity with trauma-informed approaches and change implementation. It is expected that selected sites will represent varying degrees of readiness for implementation. Successful applicants will show evidence of effective leadership that strategically works through barriers and champions organizational change.

Important Dates:
- Application Deadline: May 25, 2018
- Notification of Acceptance: June 15, 2018
- Orientation Webinar: July 6, 2018

BENEFITS OF PARTICIPATION
- Comprehensive support for integrating trauma-informed approaches into organizational culture.
- Ongoing technical assistance (TA) for adopting and implementing trauma-informed approaches that are practical, accessible and responsive to need.
- Access to national experts in trauma-informed approaches and organizational change, as well as experiences of other participating organizations.
- Early access to the newly created change package with established standards for trauma-informed practice.
- Ability to leverage participation in support of accreditation and/or existing quality and/or practice improvement initiatives.
- Assistance developing useful metrics to enhance integration of trauma-informed approaches.
- Ability to enhance infrastructure and develop internal “change experts” who can support sustainability and replication.
- Positive impact on clinical workflows, pathways and outcomes.
- Improved overall community wellness by enhancing health outcomes across chronic health conditions.
The National Council, in coordination with other national experts and organizations, will provide TA to all participants in the learning community through a variety of methods, which will consist of in-person meetings, webinars, individual consultation with experts and group TA and training. TA activities will cover a host of topics, including:

- Domains of trauma-informed primary care
- Workforce and staff development
- Policy and procedure development
- Effective organizational change
- Clinical workflow for education, inquiry and response
- Financing trauma-informed activities
- Data collection and utilization
- Leadership in quality improvement initiatives

**ORGANIZATIONAL COMMITMENTS**

- **Actively participate throughout the duration of the learning community**: At least one site/clinic, serving a sufficient number of patients per year within the identified target population must make a 16-month commitment to participate in the learning community.
- **Demonstrate executive leadership sponsorship and support**: Both administrative and clinical leadership must endorse participation in the learning community, promote organizational buy-in and support internal champions to make on-the-ground changes.
- **Partner with a behavioral health provider**: The site must have an established relationship with an internal or external behavioral health provider to support referral to treatment for patients needing complex care, as evidenced by a Memorandum of Understanding (MOU) or other written documentation.
- **Develop a Core Implementation Team**: Applicants are required to propose a team that, at minimum, includes:
  - **Project Lead**: Acts as communication liaison across team, partners and National Council; internal champion of change (e.g., clinical executive, primary care clinicians with leadership authority or executive backing).
  - **Data Lead**: Ensures accurate collection and timely submission, works to develop workflow for collection and communicating data and liaises with external evaluator (e.g., staff from information technology or quality improvement department).
Behavioral Health Lead (if available): Supports care integration and coordination in operations and for patients in need of specialized behavioral health care; may be internal staff or external referral partner (e.g., director or clinician of behavioral health, social services).

Trauma-informed champions from the executive, clinical and behavioral health staff: Support functional implementation and integration of trauma-informed approaches into organizational culture.

Note: Additional individuals are often considered part of the Core Implementation Team, including direct care providers, peer specialists and people with lived experience of trauma, mental illness or substance use.

Engage in technical assistance activities: These activities include the three in-person meetings, webinars, coaching and affinity calls, and trainings.

Provide monthly progress reports and data: Generate and share an electronic data file (CSV file) that contains individual level patient descriptors/demographics (e.g., age, gender, race/ethnicity, veteran status) for the target population as described in the Data Framework document.

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Identify at least one designated staff member to accurately enter the data using tools provided by the National Council.

Participate in external evaluation: Complete evaluation-related surveys and permit staff to participate in interviews with National Council and the project’s evaluator. Collect data for six months after conclusion of the learning community.

Participate in webinar(s) following the learning community: Participation in at least one regional and/or national webinar/training up to a year after project completion may be requested.

APPLICATION

Eligibility information

Primary care organizations, such as hospitals, FQHCs, FQHC Look-alikes and other systems of primary care.

Located in one of the following Kaiser Permanente service areas: Northern California, Southern California, Colorado, Georgia, Hawaii, Mid-Atlantic (Maryland; Virginia; Washington, D.C.), Oregon or Washington.

Partnership with an internal or external behavioral health provider.

Adherence to Organizational Commitments.

Required application and submission components

A completed online application form including the signature and full support of either the CEO or CMO.
Written agreement from a behavioral health provider-partner or stand-alone behavioral health program within the FQHC. Please see Organizational Commitments above for more information.

- **Application deadline: May 25, 2018**
  - The National Council must receive all applications by 11:59 p.m. ET on Friday, May 25, 2018.
  - Applications must be submitted electronically through the secure OpenWater platform. You will receive electronic acknowledgement that your application was received.

- **Technical questions regarding application**
  - Technical questions regarding the application should be submitted to: Sharday Lewis
    Project Manager, Practice Improvement
    National Council for Behavioral Health
    Email: ShardayL@TheNationalCouncil.org
    Phone: 202-684-3734

- **Notification of selected applicants**
  - The National Council will provide notice of selection by **June 15, 2018**, to the contact person identified in the application.

- **Financial information**
  - There is no financial award for selected organizations. However, an honorarium of $5,000 will be provided to support continuous data collection efforts.
  - Training and technical assistance activities are provided free-of-charge.
  - Travel and lodging scholarships will be provided to up to two members of the Core Implementation Team to attend three in-person meetings (at least one in Washington, D.C.).
  - Further organizational costs (e.g., electronic health record [her] modification, staff time) will be the responsibility of the participating site.
SAMPLE APPLICATION

ALL APPLICATIONS MUST BE COMPLETED AND SUBMITTED THROUGH THE APPLICATION PORTAL. The content of the application form is shown here for your convenience. DO NOT COMPLETE THIS FORM FOR SUBMISSION.

<table>
<thead>
<tr>
<th>Part I. Federally Qualified Health Center Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of primary care setting is your organization?</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Organization Name</td>
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<tr>
<td>Website</td>
</tr>
<tr>
<td>Mailing Address</td>
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<tr>
<td>City, State and Zip Code</td>
</tr>
<tr>
<td>Contact Person/Title</td>
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<tr>
<td>Contact Information</td>
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</table>

<table>
<thead>
<tr>
<th>Part II. Core Implementation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please identify 3-5 members of your organization’s Core Team who have the time, energy and enthusiasm to participate in this process, in addition to the support of your organization to engage in the learning community. Please refer to the guidance below, to create a team that best reflects your needs and capacity.</td>
</tr>
</tbody>
</table>

- **Project Lead (Required):** Acts as communication liaison across team, partners and National Council; internal champion of change (e.g., *clinical executive, primary care clinicians with leadership authority or executive backing*).

- **Data Lead (Required):** Ensures accurate collection and timely submission; works to develop workflow for collection and communicating data (e.g., *staff from information technology or quality improvement*).

- **Behavioral Health Lead (if available):** Supports care integration and coordination, in operations and for patients in need of specialized behavioral health care; may be internal staff or external referral partner (e.g. *director or empowered clinician of behavioral health, social services*).

- **Trauma-informed Champions from the Executive, Clinical and Behavioral Health Staff:** Supports functional implementation and integration of trauma-informed care into organizational culture.

- Additional individuals are often considered part of the Core Implementation Team, such as direct care providers, peer specialists and people with lived experience of trauma, mental illness or substance use.
Executive leadership sponsorship and support: Administrative and clinical leadership must endorse participation in the learning community, promote organizational buy-in and liaise with and support internal champions to make on-the-ground changes.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Email</th>
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<tbody>
<tr>
<td></td>
<td>Project Lead</td>
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<td></td>
<td>Data Lead (may be one of the clinical staff members)</td>
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<tr>
<td></td>
<td>Behavioral Health Lead</td>
<td></td>
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<td></td>
<td>Team Member</td>
<td></td>
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<tr>
<td></td>
<td>Team Member</td>
<td></td>
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</table>

Part. III Organizational Summary

- Are you currently a National Council member?
  - Yes
  - No

- Which most closely describes your organization’s geographic location?
  - Rural
  - Frontier
  - Urban
  - Suburban
  - Other (Specify):

Patient Volume
- How many visits/encounters did your organization provide in FY 2017? (Report numbers for your target delivery site).
- How many unduplicated clients did your organization serve in FY 2017? (Report numbers for your target delivery site).

Annually, what percent of your clients are children/youth, adults or older adults?
- Children/Youth (0-17):
- Adults (18-64):
- Older Adults (65+)
### FY 2017 Budget

<table>
<thead>
<tr>
<th>FY 2017 Revenue Budget: $</th>
<th>FY 2017 Expenditures Budget: $</th>
<th>Total FTEs: Behavioral Health FTEs:</th>
</tr>
</thead>
</table>

### Sources of Revenue as a Percentage (%)

<table>
<thead>
<tr>
<th>Medicaid: %</th>
<th>Medicare: %</th>
<th>Private Third-Party Insurance: %</th>
<th>Self-Pay/State Grant: %</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Block Grant: %</th>
<th>Substance Abuse Prevention and Treatment Block Grant: %</th>
<th>Other Funding: %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specify Source(s):</td>
</tr>
</tbody>
</table>

### Are you enrolled or impaneled with your state Medicaid organization or designee?

- [ ] Yes
- [ ] No

### How many sites/clinics are run by your organization?

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### Part. IV Data Collection/Submission Infrastructure

Data collection and submission is an essential component of this learning community. It is very important to accurately reflect your organization’s capacity to complete the items listed below. Please see the learning community data framework for a more comprehensive depiction of planned data processes.

Please select the response that best describes your organization’s ability to complete the following:

<table>
<thead>
<tr>
<th>YES... Easy for us</th>
<th>MAYBE... But it would be difficult</th>
<th>NO... Impossible</th>
</tr>
</thead>
</table>

- [ ] Make a subset of core implementation staff available for interviews/data gathering (approximately 2-hour time commitment per staff as requested).
- [ ] Help coordinate logistics for staff-sourced data collection (e.g., scheduling, providing contact information, helping prompt staff to complete electronic surveys).
- [ ] Sign a Business Associate Agreement (BAA) with National Council that allows for sharing of patient level protected health information (PHI).
- [ ] FIND ADULTS on MEDICAID
Generate and share an electronic data file (e.g., CSV file) on a subset of people served in our clinic that are adults (age 18-64) and Medicaid insured.

**FIND ADULTS ON MEDICAID WITH TRAUMA SCREEN (i.e., THE TARGET POPULATION)**

“Drill down” further and identify patients who have had a trauma screen during a specific enrollment timeframe, with the date of the screening encounter available in the data file.

**DESCRIBE THE TARGET POPULATION**

Generate and share an electronic data file (e.g., CSV file) that contains individual level patient descriptors/demographics (age, gender, race/ethnicity, veteran status) for the Target Population described above.

**HEALTH METRICS FOR THE TARGET POPULATION:**

Generate and share an electronic data file that contains the following health metrics for the target population:

1. Patient level hemoglobin A1C values, tied to encounter dates and time parameters of evaluation.
2. Diastolic/systolic values, tied to encounter dates and time parameters of evaluation.
3. Results of tobacco use screen, tied to date of screen and time parameters of evaluation.
4. Presence/absence of receipt of tobacco counseling on those who screened positive for tobacco, tied to encounter dates and time parameters of evaluation.
5. Depression screening scores tied to encounter dates and time parameters of evaluation.
6. Depression follow-up plan documented, tied to encounter date and time parameters of evaluation.
7. BMI (or weight) values, tied to encounter dates and time parameters of evaluation.
8. Frequency of primary care visits tied to encounter dates and time parameters of evaluation.
9. Frequency of hospitalizations tied to encounter dates and time parameters of evaluation.

What data are you currently collecting?

- Uniform Data System (UDS)
- National Committee for Quality Assurance (NCQA)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Other:

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Communications@TheNationalCouncil.org | 202.684.7457 | 1400 K St., NW, Suite 400, Washington, DC 20005  www.TheNationalCouncil.org
### Part V. Short Answer Questions
(300-word limit per response)

Please tell us why your organization would like to participate in this initiative and/or provide any other supportive comments.

What other practice improvement initiatives, if any, has your organization been involved in (with the National Council, other organizations or internally)?

Describe how the selected leadership on the Core Implementation Team will function to support the organization throughout the learning community. Please explain the role of each Core Implementation Team member and why they were selected.

Describe any previous efforts to address trauma among your patients, including any previous use of screening and/or assessment tools.

Describe your past and/or anticipated challenges or barriers in implementing trauma-informed care in your organization. Explain how you plan to address each of them.

### Part VI. Readiness Assessment

Using the parameters below, describe your organization’s level of primary-behavioral health integration:

1. Do you have behavioral health and medical providers physically or virtually located at your facility?
   - [ ] “No” - Go to question 4
   - [X] “Yes” - Go to question 2
2. Are medical and behavioral health providers equally involved in the approach to individual patient care and practice design?

☐ “No” - Go to question 7

☐ “Yes” - Go to question 3

3. Are behavioral health and medical providers involved in care in a standard way across ALL providers and ALL patients?

☐ “No” - Go to question 7

☐ “Yes” - Go to question 8

4. Do you routinely exchange patient information with other provider types (primary care, behavioral health, other)?

☐ “Yes” - Go to question 5

5. Do providers engage in discussions with other treatment providers about individual patient information?

☐ “Yes” - Go to question 6

6. Do providers personally communicate on a regular basis to address specific patient treatment issues?

☐ “Yes” - Your organization is Level 1 coordinated - STOP

☐ “Yes” - Your organization is Level 2 coordinated - STOP

7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care?

☐ “Yes” - Your organization is Level 3 co-located - STOP

☐ “Yes” - Your organization is Level 4 co-located - STOP

8. Has integration been sufficiently adopted at the provider and practice level as a principal/fundamental model of care so that the following are in place?

a. Are resources balanced, truly shared and allocated across the whole practice?

b. Is all patient information equally accessible and used by all providers to inform care?

c. Have all providers changed their practice to a new model of care?

d. Has leadership adopted and committed to integration as the model of care for the whole system?

e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?

f. Are all patients treated by a team?

g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?

h. Does the practice systematically track and analyze outcomes related for accountability and quality improvement?

☐ “No” to any - Your organization is Level 5 integrated - STOP

☐ “Yes” to all - Your organization is Level 6 integrated - STOP

Based on the results above, designate your current level of integration:
Please Note: If results denote pre-coordination, please record below. Though pre-coordination does not fall into the 6 levels of integration, that result alone does not disqualify an organization from applying.

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**Implementation:** Organizations representing *varying degrees* of being “ready and able” for implementation will be selected for participation. Successful applicants will show evidence of effective leadership that strategically works through barriers and champions organizational change. Please select the degree to which you agree or disagree with each statement below.
<table>
<thead>
<tr>
<th>My Organization is “ready and able” to…</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>... implement new trauma-informed workflows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... develop in-house ongoing trainings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... collect, track and analyze data monthly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... establish community partnerships that enable referrals to other services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... engage one or more primary care providers to facilitate a warm hand-off or referral to the behavioral health practitioner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... modify existing workflows to introduce a trauma screening and assessment process for a target patient population.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... engage behavioral health practitioners to participate in training focused on expanding their role in assessing and providing short-term trauma focused counseling in both individual and group modalities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... track screening and assessment rates for the target population using an evidence-based tool.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... engage behavioral health practitioner(s) to track utilization and outcomes for the patients they offer trauma-related services to in individual and/or group services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>... engage medical staff to attend webinars focused on meeting the aims of the initiative.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Part VII. Attachments

Please attach the following documents:

1. **Written documentation from a behavioral health provider-partner or standalone behavioral health program within the organization.** Please see Commitment Criteria above for more information. You may access a sample [Memorandum of Understanding (MOU) template](#).
Applicant CEO/CMO Signature

I, __________________________________________, ________________________________

Name

Title

attest that the information in this Application is true and accurate and reflects the intention
of my organization to implement trauma-informed approaches to create safer spaces for staff
and improve clinical decision-making by equipping providers to identify and respond to
trauma and build collaborative care networks to increase providers’ capacity to address
holistic needs. I commit to promoting organizational buy-in and empowering champions and
staff to create meaningful organizational change toward trauma-informed care integration.

_____________________________________

Signature

____________________

Date