II. TRAUMA-INFORMED INTEGRATED CARE

IN THIS CHAPTER:

- **Trauma Informed Care Defined**
- **Models for integrating services with families/communities**
- **Models for integrating services between mental and physical health providers**

What Do We Mean by "Trauma-Informed Integrated Care"?

The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines three criteria for *trauma informed* services, programs and organizations:

- **Awareness***:* Realizes the widespread impact of trauma and understands potential paths for recovery

- **Detection:** Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system

- **Integration:** Responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization

The Agency for Healthcare Research and Quality (AHRQ) defines integration as a process unifying care across different providers and sites. In our case, it specifically means breaking down barriers between primary care, mental health services, families, and communities (Figure 2). If viewed from a family perspective, integration also includes unifying services for children and other members of their families, especially caregivers

Figure 2: Integrated Care

For us, *trauma-informed integrated care* refers to services that unite primary care, mental health, families, and communities while also integrating knowledge of the impact of trauma on all aspects of care. Trauma-informed integrated care seeks to understand the origins of trauma faced by members of communities, to aid efforts to prevent trauma, and to help those who experience trauma flourish despite it. The first step to trauma-informed integrated care is bringing together all members of the team representing primary care, mental health, families, and community services. Only once these key players are "at the same table" can care be transformed using a trauma-informed lens. In the next sections we will explore models of pediatric integrated care. In the following chapters we will outline *how* services for children and families can be integrated and trauma-informed.

Trauma-Informed Integrated Care

Services that unite primary care, mental health, families, and communities to effectively understand, prevent detect, and address trauma in the community

Models of Integrating Services, Families, and Communities

Medical Home Model

In the 1960s, the American Academy of Pediatrics proposed the idea of the "medical home" for children as "a cultivated partnership between the patient, family, and primary care provider in cooperation with specialists and support from the community." Though the idea has proven more difficult to implement than initially thought, medical homes are now more widely established. Many states and agencies have sponsored medical home learning collaboratives, from which we have drawn valuable lessons. More information is available at www.medicalhomeinfo.org.

Chronic Care Model

The chronic care model (CCM) (Wagner 1996) has provided a way of thinking about how to integrate primary and specialty care for conditions that need treatment and monitoring over time. The CCM outlines roles for patients, primary care providers, staff, and specialists as well as principles of collaboration between generalists-specialists and providers-patient-community.

The CCM provides the following guidance for specialist-generalist collaboration:

- **Systematic monitoring:** Generalists should routinely look for common problems faced by their patients so that they can intervene early or try to prevent the problems altogether.

- **First-Line Intervention***:* Generalists should have the tools and assistance to provide first-line care for the problems right away.

- **Follow-up Systems:** Systems should be in place to follow-up the first-line treatment and decide if it has been successful.

- **Collaboration***:* When more treatment is needed, generalists should be able to work closely with specialists to assure that patients get the added care they need, and that the added care fits with the patient's other medical needs (this is often referred to as "stepped care").

In addition, the CCM emphasizes provider-patient-community collaboration. The CCM is a model of behavior change, and one of its goals is to help providers partner with patients to develop and nurture over time the skills required for "self-management." In our case, that means helping families feel more in control of their lives and develop the skills and knowledge to navigate the stressful circumstances that they face.

Table 2 looks at specific activities associated with the CCM to integrate services, families, and communities:

Table 2. Activities Associated with the Chronic Care Model (CCM)

Element of the CCM	Activities
Patient self-management support	Develops patient skills through coaching, education, and problem solving. *(e.g. Psychotherapy and psycho-education to promote self-management and engagement in care)*
Clinical information systems use	Facilitates information flow from relevant clinical sources to treating clinicians – most often this means assuring that information from specialists, community programs, and primary care providers can be shared and used to provide the best care with the least burden to the patient/family; *(e.g. "patient portal" with ability for families to access and track their own information; update system with progress reports or follow-up surveys)*
Delivery system redesign	Re-definition of physician and staff work roles to facilitate anticipatory or preventive rather than reactive care *(e.g. screening, discussing concerns, prevention counseling)*
Provider decision support	Facilitated provision of expert-level input to generalists to reduce need for consultation separated in time and space from clinical needs *(e.g. telephone consultation services for primary care doctors or easy ways to contact specialists)*
Community resource linkage	Support for family needs from resources outside the health care organization *(e.g. resource box in clinic for community support organizations)*
Health care organization support	Organization leadership and tangible resources to support goals and practices of the CCM

Adapted from Woltmann (2012)

Models of Integrated Clinical Services

Each primary care office has a unique structure in place to work with their mental health affiliate – and vice versa. At the level of health care organizations, different services might be provided by the same organization (possibly even the same location) or require coordination across sites. Scheduling and medical record systems might be unified or separate. Clinicians caring for a family might meet regularly as teams, have protocols for talking with each other one-to-one, or have little or no communication with each other. The following table sets out some of the possible combinations and assigns each a "degree of integration," with close and full integration theoretically being better.

Table 3. Levels and Degrees of Integration

Degree of Integration	Organization	Facility	Records and Scheduling	Communication
Minimal	Separate	Separate	Separate	Sporadic
Basic distance	Separate	Separate	Separate	Periodic
Basic on-site	Separate	Co-located	Separate	?
Close partly	Same	Co-located	Some shared	Regular
Close fully	Same	?	Shared	Team meetings

Adapted from Doherty (1995)

We will now take a moment to explore three specific models of integrated clinical services that can effectively facilitate collaboration between primary care providers and mental health providers: (1) co-location (2) screening, brief intervention, and referral to treatment and (3) task shifting. In practice, elements of all three of these models are often combined.

Co-location

Co-location refers to the placement of a specialist physically in a primary care office (or the opposite – placing a general medical provider at a site that mostly provides mental health services). There is some evidence that co-location increases the proportion of patients who are able to complete a mental health referral. However, there are a number of potential pitfalls, and not all co-location efforts have been successful. Benefits and pitfalls of co-location are summarized in Table 4.

Table 4: Benefits and Pitfalls of Co-located Services

Benefits	Pitfalls
"One stop shopping" Reduces the number of places clients have to visit, and sometimes allows more than one type of care to be delivered back-to-back in the same place **Reduce stigma:** May reduce some of the stigma or visibility associated with obtaining mental health or trauma services – the facility is not associated uniquely with mental health or trauma care **Personalized referrals:** Offers the opportunity for personalized referrals – specialist and generalist providers can meet together with a family to jointly plan how they will work together **Increase consultations:** May increase the chance that specialists and generalists can informally consult with each other or work as a team – they are in the same place and more readily find each other	**Does not ensure communication:** Being in the same building does not mean that generalists and specialists will meet each other or understand each other's jobs. This usually requires additional work **Diverts responsibility:** The presence of the specialist can lead the generalist to take even less responsibility for knowing about mental health or trauma care – the responsibility can just be shifted **Overload specialists' capacity:** The co-located specialist can be swamped with referrals, creating delays in treatment that discourage patients from returning (the same as when the specialist is located somewhere else) **Budget**: No one business model will work across all sites – in some places the specialist can bill separately for her services, in others there will have to be ways of factoring specialist costs into an overall budget

Below are a few suggested best practices for those interested in co-locating services:

- **Develop a work plan**

  Start off by developing a shared understanding between generalists and specialists about how they will work together. What will the specialist help the generalists learn? What criteria should be used to trigger informal consultations, team discussions, and referrals? The specialist may need to learn how the generalists work, too. Before starting, he or she may need to "shadow" the generalists and spend some time understanding how patients flow through the site.

- **Make a communication plan**
  Both generalists and specialists should set up rules for how they will communicate with each other and how their "native" work style will be modified to fit the shared environment. For example, mental health workers typically do not interrupt visits for telephone calls or knocks at their door, while primary care providers frequently break visits up into segments and, in some settings, may actually be seeing more than one patient simultaneously. How will these styles mesh, especially when there is a perceived need for a quick consultation or introduction of the patient and co-located therapist?

- **Set up mechanisms for sharing information**
  How will referrals be made, what information should they contain, and how will the specialist communicate their findings and suggestions back to the generalist? Can both specialist and generalist access the same medical record? How will families be able to control and consent for the exchange of information? Will mental health or substance treatment notes be kept separately from general medical records?

- **Develop a business plan**
  With different types of funding, reimbursements, and billing allowed, how do the generalists and specialists work in ways that are financially sustainable in the practice? How are their varying types of work and workload supported? How does the practice pay for some of the non-reimbursable activities, such as cross-education, consultation, and care management?

  [Note that all of the above points are discussed in greater detail later in the toolkit, including strategies, since they apply to nearly all forms of integration, not just to co-location.]

SBIRT (Screening, Brief Intervention, Referral to Treatment)

SBIRT is a model originally developed to identify individuals who could benefit from alcohol and substance abuse treatment and link them to care. The SBIRT model might be seen as a special application of the Chronic Care Model as the two models have very similar elements. The core components of SBIRT are discussed in Table 5.

Table 5: Core Components of SBIRT
Universal screening in primary care
Identification of a specific problem
Provider and patient agree that there is an issue
They work to develop a shared understanding of why the issue requires help and why now is a good time to act
Brief counseling specific to the problem
What might the patient do about the problem now – including seeking more specialized treatment
4) Long-term tracking of the issue since
a) Many patients may not immediately want to seek care
b) Even those who seek additional care may give it up
c) Many problems are recurring, even if successfully addressed in the short term

Task Shifting

Task shifting (or sharing) is a term for strategies that try to move tasks usually delivered by specialists (who are in short supply) to less-specialized health workers who are more easily accessible. For example, in some systems, mental health professionals deliver all depression care. A task-shifting plan would move some first-line depression treatments to primary care. Ideally, task shifting always involves sharing – the specialist and generalist are really sharing responsibilities. Specialists support generalists by providing training, advice to specific patients, and by collaborating in the care of patients with greater levels of need. The main motivations for task shifting are listed in Table 6 below.

Table 6: Promising and Challenging Aspects of Task-Shifting

	Motivation/promising aspects	Drawbacks/challenges
Lack of specialists	If there are long wait times for specialist care, task shifting can help address the lack of specialists.	May be most suited to care of mild/moderate severity problems or interventions that can be relatively standardized; risk that generalists will be overloaded with new tasks
Reduces barriers to access	Moving the services to the place where they are needed or where clients are more comfortable receiving them reduces the barriers to accessing care.	Some clients may still prefer to see specialist or separate specialty and general care
Possible reducing costs	Costs may be reduced by shifting some tasks to workers who are more numerous, can be trained more rapidly, or whose services are less expensive.	Lack of business models for specialists who provide initial training and ongoing coaching/supervision for generalists (time, methods of communication)
Knowledge of families	Less specialized workers may have more local knowledge, or, in the case of primary care providers, more in-depth knowledge of families and their communities. Task shifting can thus build upon the existing, established, trusting relationships that families and children often have with their primary care providers.	For sensitive issues, residents of some communities may prefer seeking care outside the community; concerns about ability to maintain confidentiality especially in small or closely-knit communities

Task shifting happens all the time in primary care as new campaigns attempt to include more preventive services (for example, asking pediatricians to apply fluoride varnish to protect teeth, shifting that task from specialty dental providers). There seem to be some key points to successful task shifting:

- **Redesign task**
  Often the tasks cannot simply be moved – they have to be redesigned to fit the context of the more general care setting. For example, pediatricians cannot deliver lengthy protocols for treatment of children's anxiety, but they can effectively deliver suggestions to caregivers for modeling and rewarding positive behavior.

- **Modify diagnostic process**

The kind of meticulous diagnoses made in specialty care may not be necessary to offer patients a first-line treatment. Specialists need to use their expert knowledge to design effective and safe but simple interventions for generalists to use, based on the specific problems for which families ask for help, while the diagnostic process unfolds.

- **Training on new ways to deliver care**

Generalist providers need training to deliver new forms of care, but they also need ongoing support to become confident and competent in delivering that care.

- **Integrate new process**

  The new care has to complement and fit well into the work the generalists are already doing. It cannot simply add another task to a list of responsibilities that already is too long for the time allocated for primary care visits.

Core Readings and Resources

- Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09- E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.

- Doherty, WJ. The why's and levels of collaborative family health care. Family Systems Medicine, 13(3-4), 1995, 275-281.

- Madras, B.K., Compton, W.M., Avula, D., Stegbauer, T., Stein, J.B., & Clark, H.W. (2010). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months. Drug and Alcohol Dependence, 99, (1-3):280-295.

- Pulido R, Monari, M, Rossi, N. Institutional therapeutic alliance and its relationship with outcomes in a psychiatric day hospital program. Arch Psych Nursing 2008;22:277-87.

- Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Q. 1996;74(4):511-44.

- Ware NC. (1999). An ethnographic study of the meaning of continuity of health care in mental health services. Psychiatr Serv. 1999;50:395-400.

- World Health Organization [Internet]. Task shifting to tackle health worker shortages. Geneva: World Health Organization; 2007.