Trauma Informed Care

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Objectives

- Understand about trauma treatment and trauma-informed care
- Understand the regulatory requirements related to trauma-informed care
- Understand the best practices and approaches to trauma-informed care
- Understand how person-centered care is important for trauma-informed care
- Understand assessment and care planning

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What is Trauma-Informed Care

- Trauma informed care is an approach that aims to engage people with histories of trauma, recognize the presence of trauma symptoms, and acknowledge the role that trauma has played in their lives (SAMHSA, National Center for Trauma Informed Care, 2014)
- Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing

Trauma Definitions

- **TRAUMA**: results from an **event**, series of events or set of circumstances that is **experienced** by an individual as physical, emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMSHA, 2014)
  - Or an intense event that threatens safety or security of an individual.
- **Chronic Trauma**: results from extended exposure to traumatizing situations, often occurring in childhood
  - Or experience of multiple traumatic events & impact of that experience.
- **Developmental Trauma**: multiple or chronic exposure to one, more forms of interpersonal trauma, (abandonment, betrayal, physical assault, sexual assault, threats to bodily integrity coercive practices, emotional abuse, witnessing violence or death)

Trauma Definitions

- **Acute Trauma**: results from exposure to a single overwhelming event
- **Post-Traumatic Stress Disorder** (PTSD): a recognized mental health condition that's triggered by a terrifying event
- **Vicarious/Secondary Trauma, Compassion Fatigue**: different but related secondary stress injuries

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Types of Trauma

- **Stress:** any experience that disrupts our sense of well-being.
- **Traumatic Stress:** long term reaction to trauma; refers to the combination of the event, the individual's experience/perception and the effects.
- **Complex Trauma: Trauma and Stressor-Related Disorders**

Trauma-Toxic Stress

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Why Trauma-Informed Care?

- Regulation

F699: §483.25(m) Trauma-informed care

- ***§483.25(m) Trauma-informed care***
- ***The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.***

Relevant F-tags

- F659 *§483.21(b)(3) Comprehensive Care Plans*
- *The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—*
- *(ii) Be provided by qualified persons in accordance with each resident's written plan of care.*
- *(iii) Be culturally-competent and trauma–informed.*
- F741 *§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder.*
- F740 *§483.40 Behavioral health services.*
- *Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.*
- F742 *receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;*

F-Tag 743

F743 no pattern of behavioral difficulties unless unavoidable

GUIDANCE §483.40(b)(2)

Nursing home admission can be a stressful experience for a resident, his/her family, and/or representative. Behavioral health is an integral part of a resident's assessment process and care plan development. The assessment and care plan should include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Facility staff must:

- *Monitor the resident closely for expressions or indications of distress;*
- *Assess and plan care for concerns identified in the resident's assessment;*
- *Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;*
- *Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;*
- *Ensure appropriate follow-up assessment, if needed; and*
- *Discuss potential modifications to the care plan.*

Care vs Action

Trauma Treatment

A framework that considers how trauma impacts people and organizations and uses trauma knowledge to make policy, procedure and practice decisions.

Trauma Treatment or Trauma Specific Services (TSS) are programs, interventions, and therapeutic services aimed at treating the symptoms or conditions resulting from a traumatizing event(s). (Oregon health department)

Trauma Informed Care

Trauma Informed Action

- Evidence-Based Practices, Interventions, Curriculum used with individuals and groups to create safety and improve outcomes.

- Trauma Informed Care (TIC) is an approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff. (Oregon health department)

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10 KEY INGREDIENTS FOR TRAUMA-INFORMED CARE

LEAD AND COMMUNICATE

ENGAGE PATIENTS IN PLANNING

TRAIN ALL STAFF

CREATE A SAFE ENVIRONMENT

PREVENT SECONDARY TRAUMA

BUILD AN INFORMED WORKFORCE

INVOLVE PATIENT IN TREATMENT

SCREEN FOR TRAUMA

USE TRAUMA-SPECIFIC TREATMENT

ENGAGE PARTNERS

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Event – Experience - Effects

Event – Actual or threat of physical or psychological harm, withholding resources essential to development. Can be single or repeated event.

Experience – How the person assigns meaning to the event depend on individual perception.

Effects – Result of the person's experience of the event may include neurological, physical, emotional or cognitive effects.

Examples of Trauma

- Domestic Violence (Witness, Perpetrator, Victim)
- Violent Crime
- School Violence
- Medical Trauma
- Accidents
- Military Combat
- Becoming a refugee
- Natural Disasters
- Experiencing or observing physical, sexual and/or emotional abuse
- Childhood neglect and abandonment
- Abandonment
- Having a family member with a mental health or substance use disorder.
- Terrorism
- Homelessness
- Death/Loss
- Severe Economic Hardship

Traumas Relating to the Aging Process

- Loss of loved ones;
- Loss of own capacities;
- Loss of roles and identity and of home;
- Increased dependence;
- Experiencing or observing physical, sexual, and emotional abuse;
- Childhood neglect;
- Having a family member with a mental health or substance use disorder;
- Experiencing or witnessing violence in the community or while serving in the military;
- Poverty and systemic discrimination

Examples of Workplace Trauma

- Death, grief, suicide, accident or injury
- Bullying, threats, harassment
- Betrayal, maliciousness
- Isolation, chronic pressure, unresolved conflict
- Uncertainty, downsizing or fear of unemployment
- Noise, Chaos, Harsh or Flashing Lights
- Extreme Temperatures
- Construction Projects
- No control over physical space
- Evacuation, Lockdown, Fire, Robbery

Symptoms of Trauma

***Physical* signs and symptoms** of trauma including shaking or trembling, inability to pay attention, sleep disturbances such as insomnia, and a racing heartbeat, pains, tense their muscles

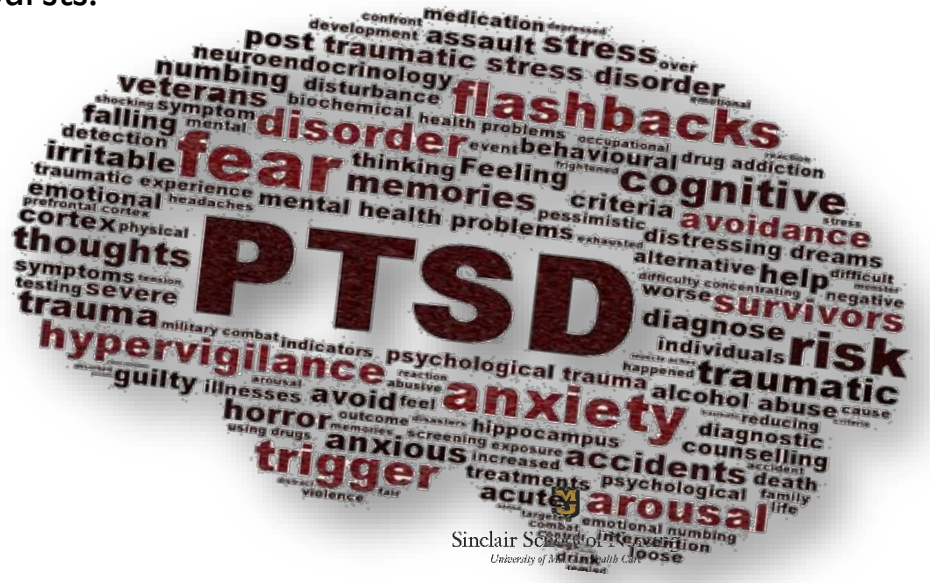
***Biological* symptoms** include brain function, headaches, stomach aches, sleep changes

***Social* symptoms** include apathy, isolation, difficulty trusting, detachment

***Spiritual* symptoms** include struggle to find meaning, anger with God

***Emotional* or psychological symptoms**

- Anger, irritability, mood swings, including emotional or violent outbursts.
- Anxiety and fear.
- Panic attacks.
- Guilt, shame, self-blame.
- Withdrawing from others.
- Feeling disconnected or numb.
- Obsessive and compulsive behaviors.



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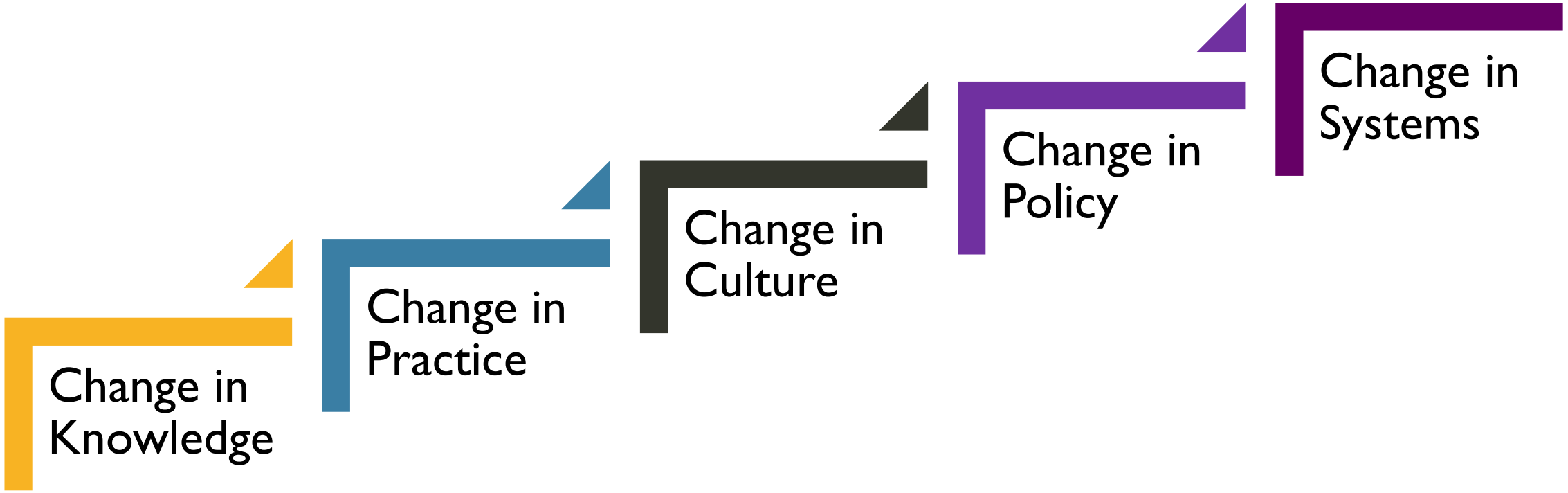
Retraumatization

WHAT HURTS?

SYSTEM (POLICIES, PROCEDURES, "THE WAY THINGS ARE DONE")	RELATIONSHIP (POWER, CONTROL, SUBVERSIVENESS)
HAVING TO CONTINUALLY RETELL THEIR STORY	NOT BEING SEEN / HEARD
BEING TREATED AS A NUMBER	VIOLATING TRUST
PROCEDURES THAT REQUIRE DISROBING	FAILURE TO ENSURE EMOTIONAL SAFETY
BEING SEEN AS THEIR LABEL (I.E ADDICT, SCHIZOPHRENIC)	NON COLLABORATIVE
NO CHOICE IN SERVICE OR TREATMENT	DOES THINGS FOR RATHER THAN WITH
NO OPPORTUNITY TO GIVE FEEDBACK ABOUT THEIR EXPERIENCE WITH THE SERVICE DELIVERY	USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE

Change Theory

Missouri Department of MENTAL HEALTH



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Trauma Informed Approach

SAMHSA issued guidelines for trauma informed care in 2014 that outlined four assumptions, six key principles and ten implementation domains for trauma informed care.

The Four Key Assumptions (the 4 R's) include:

1. **Realization** about trauma and its impact on individuals, families and communities
2. **Recognition** of the symptoms of trauma and traumatic stress
3. **Responses** that are trauma informed at all levels of the organization
4. **Resistance to re-traumatization** at all levels including at the staff level

Organizational Ingredients for Creating a Trauma Informed Approach

Leading and communicating	Leading and communicating about the transformation process with a goal of staff empowerment and buy-in
Engaging	Engaging residents in organizational planning with the development of a stakeholder committee
Training	Training clinical and non-clinical staff to create a trusting, non-threatening environment, identifying early champions or natural leaders
Creating	Creating a physically and emotionally safe environment
Preventing	Preventing secondary traumatic stress in staff which may lead to burnout and staff turnover
Hiring	Hiring a trauma informed workforce utilizing behavioral interviewing screening for empathy, non-judgement and collaboration

Clinical Ingredients for Creating a Trauma Informed Approach

- Involving residents in the treatment process with active engagement in care decisions allowing feedback to drive the plan of care
- Screening for trauma with upfront/universal screening or screening later after building trust between the resident and provider
- Training staff in trauma specific treatment approaches
- Engaging referral sources and partnering organizations within a given community or network system

Principles of Trauma Informed

SAFETY

Ensuring physical, emotional and cultural safety.

TRUST

Fostering genuine relationships that promote trust. Addressing bias and historical mistrust.

CHOICE

Maximize choice. Address how privilege and power impacts perception of choice and ability to act upon it.

COLLABORATION

Minimize impact of power differential. Maximize collaboration . Share responsibility for decision-making.

EMPOWERMENT

Identify strengths and skills that lead to recovery. Recognize and respond to historical trauma and oppression.

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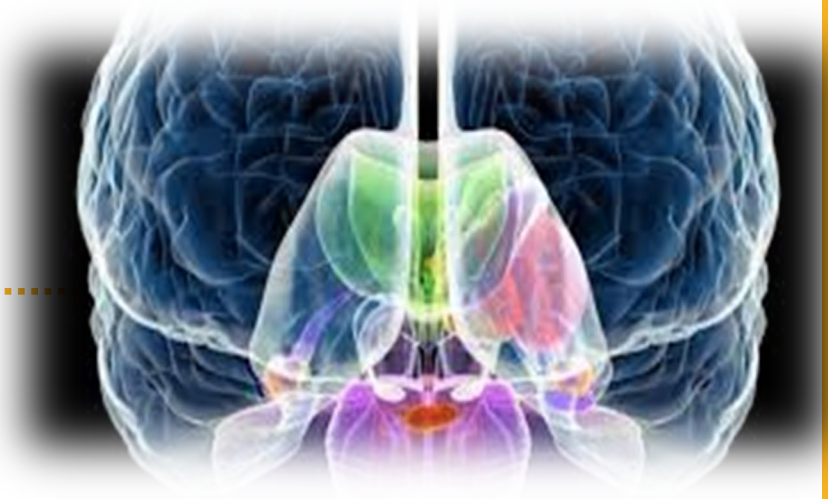
d Fallot, R (2001). Using Trauma Theory to Design Service Systems. New Directors for Mental Health Services. San Fransisco: Jossey-Bass., Missouri Trauma Roundtable

Screening For Trauma

- Screen every resident
- There is a lot of disagreement on when to screen.
  - Early as soon as possible
  - Or wait and build trust in the providers before being asked about trauma history.
- Regardless:
  - Treatment setting should guide screening practices. Upfront, universal screening may be more effective in primary care settings and later screening may be more appropriate in behavioral health settings.
  - Screening should benefit the patient. Providers who screen for trauma must ensure that, once any health risks are reported, they can offer appropriate care options and referral resources.
  - Re-screening should be avoided. Frequently re-screening patients may increase the potential for re-traumatization because it requires patients to revisit their traumatic experiences.
  - Ample training should precede screening. All health care professionals should be proficient in trauma screening and conducting appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).

Trauma-Assessment



- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the resident's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

Intent of F-tag 741

- ***§483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and***
- ***INTENT §483.40(a), (a)(1) & (a)(2)***
- *The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.70(e). This includes residents with mental disorders, psychosocial disorders, or substance use disorders. Facility staff members must implement person-centered, care approaches designed to meet the individual needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.*

TRAINING

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Staff Training Ideas

Incorporate trauma training during staff meetings:

- Basic trauma information
- Organizational philosophy and approach to trauma informed care
- How does past trauma impact the elderly?
- How does past trauma manifest itself in trauma survivors?
- How do you approach individuals with past trauma?
- Recognizing and responding to Covid fatigue in staff

What Can We Do... First!

- Continuous Training for staff
  - Know the individuals we care for, including information about their mental health, trauma history, coping, and resilience
  - Clinical – training on how to create a trusting, non-threating environment.
  - Non-Clinical - training on how to interact with residents and other staff
  - Hiring consultants
- Maybe even physical modifications to the home
- Provide opportunities for residents, family members, and all staff to learn
- Identify and build on strengths of residents, families, staff, and facility
- Build community partnerships and become familiar with mental health professionals and community resources

- Promote positive engagement among residents, families, and staff

Trainings:
Clinical as well as Non-Clinical Staff

- Training staff in trauma-specific treatment approaches
- Involving residents in the treatment process
- Staff know and understand to perform Screening for trauma
- Welcoming residents and staff so that they feel respected and supported;
- Ensuring staff maintain healthy interpersonal boundaries

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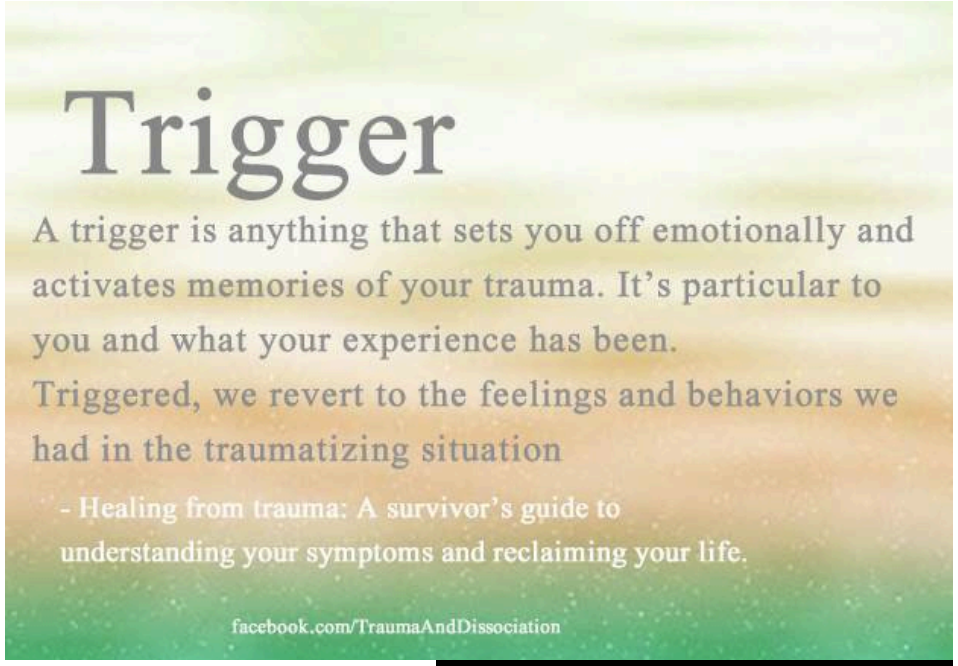
Creating a Safe and Social-Emotional Environment

- Ensuring staff maintain healthy interpersonal boundaries and can manage conflict appropriately;
- Keeping consistent schedules and procedures;
- Offering sufficient notice and preparation when changes are necessary;
- Maintaining communication that is consistent, open, respectful, and compassionate;
- The physical environment promote a sense of safety, calming, and de-escalation for clients and staff.
- Keeping noise levels
- Using **welcoming** language on all signage
- Monitoring who is coming in and out of the building
- Maintaining communication that is consistent, open, respectful, and compassionate
- Being empathetic and accommodated with needs

Developing a Program - Policies

- Trauma-informed screening and assessment
- Focus on trauma and issues of safety and confidentiality
- Trauma-specific treatment or refer to appropriate trauma-specific services
- Staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this, aware of how an individual's culture affects how they perceive trauma, safety, and privacy. (QAPI)
- Staff supports in working with sensitivity using effectiveness with trauma survivors.
- Staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training.



Regulatory: F Tags

- *F940*
- *§483.95 Training Requirements*
- *A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to—*
- *[§483.95 will be implemented beginning November 28, 2019 (Phase 3)]*
- *F949*
- *§483.95(i) Behavioral health.*
- *A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).*
- *[§483.95(i) will be implemented beginning November 28, 2019 (Phase 3)]*

Recovery

- People can recover from trauma. It is an individual journey for every person and often includes a combination of trauma education, increasing protective factors, building resilience and providing whole-person treatment.

Risk of Secondary Trauma

STRESS RECOGNITION IN STAFF

- chronic fatigue,
- disturbing thoughts,
- poor concentration
- emotional detachment and exhaustion
- avoidance, absenteeism, and physical illness

PHYSICAL SPACE

- Accessibility
- Lighting, Entrance & Exit
- Parking Lot and grounds surrounding the facility
- Posted information inside facility
- Adequate breakroom and restroom spaces

Facility Assessments

- https://www.law.cornell.edu/cfr/text/42/483.70
- **(e)** ***Facility assessment.*** The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:
  - **(1)** The facility's resident population, including, but not limited to,
    - **(i)** Both the number of residents and the facility's resident capacity;
    - **(ii)** The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
    - **(iii)** The staff competencies that are necessary to provide the level and types of care needed for the resident population;
    - **(iv)** The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
    - **(v)** Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

Facility Assessments

- **(2)** The facility's resources, including but not limited to,
  - **(i)** All buildings and/or other physical structures and vehicles;
  - **(ii)** Equipment (medical and non-medical);
  - **(iii)** Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
  - **(iv)** All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
  - **(v)** Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
  - **(vi)** Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
- **(3)** A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Trauma Informed Care Planning

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Applying the 4 R's to Care Planning

Realization: Understand what the trauma is and how it can impact the resident and their behavior

Recognize: Assess past trauma and remain alert for the efforts of past trauma to reemerge

Respond: Develop a care plan that addresses the trauma, including the effects of the trauma the resident experiences, i.e. how the effects of the event manifest themselves in the resident's behavior

Resist retraumatization: ensure care plan includes the triggers for retraumatizing and the interventions to avoid such an experience, i.e. the treatment and staff approaches used to support the resident

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Care Planning

Focus	• Focus on delivering person-centered care
Identify	• Identify the individual's definition of safety
Pay	• Pay attention to cultural, historical and gender issues, avoid stereotyping and gender or other biases
Identify	• Identify individual triggers and de-escalation techniques
Engage	• Engage families as appropriate, respect the resident's right to choose
Look	• Look for resident-resident peer support opportunities

Care Planning

Person-centered care plan is a key

- Address training needs of staff to improve knowledge and sensitivity
- Identify an individual's hopes, capacities, interests, preferences, needs, and abilities

  The individual is the expert on his/her life
- Practice is a collaborative process
- Individual choice is evident
- Resident's/client's voice is used in treatment plans – goals are in his/her own words, strength-based, with recovery-oriented principles
- Assess for traumatic histories and symptoms
- Recognize culture and practices that are re-traumatizing

Care Plan Framework

- **Problems**: Usually the subjective data that address the physical or psychosocial symptoms: anxiety, crying, isolation, nightmares, sleeplessness, fearful, withdrawal, refusal of treatments, activities, etc.
- **Support "problem" data**: Usually the objective data from trauma scales, screening test, diagnoses, past traumatic histories, events, affects, the escalated actions (crying, screaming)
- **Goal**: Learning coping techniques; sharing the traumatic issues; accept treatments; Less symptoms (timeframe)
- **Approaches**: Techniques to deescalated triggers (environment); support systems from family, peers, staff or additional professional therapies; How to increase safety? How to reduce stressors, triggers;? How to engage resident into the program? How to make staff aware of the monitoring system?
- **Evaluation**: Get input from family and resident. Does the care plan work?

Sample Trauma-Informed Care Plan

Problem	Goal	Intervention
Jim has a diagnosis of PTSD. He was a firefighter in New York City during 9/11. Loud popping or construction noises and crowded hallways makes him panic and become very anxious.	Jim will experience fewer episodes of anxiety related to PTSD in the next 92 days.	• Staff are educated to Jim's condition and triggers and will keep Jim from construction areas. • Jim will be informed ahead of time if loud maintenance projects need to be done near his room and given the opportunity to temporarily relocate. • Staff will take Jim to the dining room first and remove him from last at his request to avoid crowded hallways. • Jim prefers to sit near the doorway during activities. • Jim has prn anti-anxiety medication if nonpharmacological measures are not sufficient to calm him.

Care Plan
Psychosocial Well-Being: History of Trauma

Problem: (circle the related factors)

- ❒ ACTIVITY DEFICIT related to fatigue, tiredness from sleep apnea
- ❒ ACITIVITY DEFICIT: prefers changes in daily routine; awake most morning;
- ❒ DECREASING PSYCHOSOCIAL WELL-BEING: withdrawal; nightmares
- ❒ LACK OF SOCIAL INTERRACTIONS related to language barriers, sensory deficits
- ❒ EXPRESSION OF: fears, crying, sadness, negative beliefs
- ❒ MOOD DISTURBANCE: agitation, anger, panic attacks, self-blame, emotional numbness
- ❒ DISPLAY: sleep disturbance; avoid talking about what is bothering, being alert, scanning (hypervigilance); Started; flashback; Self-destructive behaviors; poor impulse control; hyper-arousal; guilty;

Contributing factors: ☐ New to facility ☐ Limited English Proficiency ☐ History of PTSD ☐ Loss of love one ☐ Limited mobility ☐ **Traumatic events:** _____

Goal: (will be reviewed and evaluated in 90 days or until the next assessment)

- ❒ Will participate in activity programs
- ❒ Will continue verbally expressing needs and share concerns, goals
- ❒ Will participate in having positive social interaction with peers
- ❒ Will express the triggered stresses, traumatic events and how to cope with it
- ❒ Will ac[illegible] relaxation techniques

Care Plan
Psychosocial Well-Being: History of Trauma

Approaches:

- ❒ Encourage resident to talk about the past, to make a goal and decision for care
- ❒ Maintain a calm, non-threatening manner while working with the resident
- ❒ Establish and maintain a trusting relationship by listening to the resident
- ❒ Displaying warmth, answering questions directly, offering unconditional acceptance; being available and respecting the resident's use of personal space
- ❒ Remain with the resident at all times when levels of anxiety are high (severe or panic); reassure resident of his or her safety and security

Care Plan
Psychosocial Well-Being: History of Trauma

- ❒ Move the resident to a quiet area with minimal stimuli and maintain calmness in your approach to the resident
- ❒ Provide reassurance and comfort measures if applicable
- ❒ Observe for increasing anxiety. Assume a calm manner, decrease environmental stimulation, and provide temporary isolation as indicated
- ❒ Encourage the resident's participation in relaxation exercises such as deep breathing, progressive muscle relaxation, guided imagery, meditation, etc.
- ❒ Teach relaxation techniques, deep-breathing exercises. Desensitize resident to his/her memories of traumatic event
- ❒ Assess client for suicidal or homicidal ideations

Care Plan
Psychosocial Well-Being: History of Trauma

- ❒ Assess /screen for post traumatic events, history of trauma, using appropriate screening tools
- ❒ Provide visit to the resident to inform activity schedule, encourage resident social interactions
- ❒ Provide instruction to encourage resident to be independent in ADL self-care.
- ❒ Provide assistance and supervision if needed during ADL care, assisting with set up as needed
- ❒ Inform staff of resident status and activity preference. Provide 1:1 visits to encourage resident to ventilate feelings about concerns and wishes.
- ❒ Provide activities and invite resident to participate. Praise for his/her engagement or participation in social interactions

Road Map to Success

Staff Education: understand the basic principles of trauma and trauma informed care

Trauma Screening: create a screening process specifically designed to identify residents with a trauma history

Care Planning; person-centered care planning with interventions specific to the trauma and trauma survivor

Behavioral Health Services: establish a diagnosis and assist in developing a person-centered care plan

Resources

- https://traumainformedoregon.org/resources/trauma-informed-care-principles/
- https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- www.cms.gov State Operations Manual Appendix PP, QSO 2003-NH, RAI User Manual Version 3.0
- https://qioprogram.org/facility-assessment-tool
- www.chcs.org
- www.leadingage.org RFA guidebook
- https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Resources

- Quality Improvement organization-QIM: **Resources to Support Trauma Informed Care for Persons in Post-Acute and Long Term Care Settings**
- A complete copy of the guidelines is available at: http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf
- https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Findex.html
- SHAMSHA-TIP 57-63
- SOM 2017
- https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
- https://www.hhs.gov/ash/oah/news/e-updates/march-2019-the-need-for-trauma-informed-care/index.html

Leadership Coaches and Admin Team

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QUESTIONS