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Shanti Varma-Lenz Date

Provider Perspectives on the Gaps in Knowledge, Skills, and Resources Necessary for Delivery of Trauma-Informed HIV Care: Implications for Future Curriculum Development

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2017

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An abstract of

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Hubert Department of Global Health

2021

Abstract

Provider Perspectives on the Gaps in Knowledge, Skills, and Resources Necessary for Delivery of Trauma-Informed HIV Care: Implications for Future Curriculum Development

By Shanti Varma-Lenz

Background: Trauma-informed care has been an increasingly developed area of research over the past several decades. There is a significant need for trauma-informed care training that is specific to HIV care providers due to the high levels of trauma experienced by people living with HIV and the impact on their HIV outcomes. Few studies have assessed provider gaps in skills and knowledge in provision of trauma-informed care.

Methods: This thesis focuses on the qualitative study of a larger mix-methods study among providers and staff of Ryan White HIV Clinics in the Southeastern United States. Twelve in-depth interviews were conducted with HIV care providers, examining their perceptions of gaps in knowledge and skills to effectively provide trauma-informed care, factors influencing prioritization of implementation of trauma-informed care training, and preferences for content and delivery of training. Interviews were conducted and recorded via Zoom. All twelve interviews were then coded and analyzed, using thematic analysis.

Results: The study found that HIV care providers would like to see trauma-informed care curriculum implemented into medical education curricula and clinical training, in addition to re-training for practicing providers. Providers would also like to see trainings delivered by subject-matter experts. Providers are particularly interested in population specific trauma-informed care training, as well as trauma-informed care training that focusses on not re-triggering or re-traumatizing a patient.

Conclusions: The study provides critical insight into the content and delivery of trauma-informed care training for HIV care providers. Future research should pilot and evaluate implementation of such trauma-informed care training and examine effects on providing trauma-informed HIV care to people living with HIV. Furthermore, trauma-informed care trainings should be piloted and subsequently added to medical training.

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Acknowledgments

I would like to extend the most heartfelt thanks to my chair, Dr. Ameeta Kalokhe, for her genuine belief in me and patience while working on this complex endeavor into trauma-informed care training for HIV providers. Her passion and dedication to trauma-informed care is truly inspiring. Dr. Kalokhe is one of the most kind-hearted people I have had the pleasure of working with. I consider myself lucky to be mentored by someone who is such a profound leader in the field. I look forward to our continued friendship throughout my public health career.

Thank you to the entire Trauma-Informed care study team—Dr. Jessica Sales, Chris Root, Olivia Manders, Caroline Kokubun, and all study team members. This thesis would not have been possible without your continued guidance and support. I sincerely appreciate and admire each of you. Thank you to Public Health Informationist Shenita Peterson for the continuous support and patience—especially during times of high stress.

Thank you to my family for always believing me, even when I did not believe in myself. I will never forget the words of encouragement you all have given me over the past two years. Thank you, Mom, I would not be where I am today without you. Thank you, Dad, for always being a phone call away. To my Nana, Dr. Badri Varma[1], thank you for showing me what it means to be a thoughtful, caring, passionate person in academia. You pushed boundaries that were set for you, doing it with grace and integrity—never losing who you were. If one day I am half the professor you were, I will consider that a success.

Finally, I would like to thank my fiancé Michael for taking a leap and moving to Georgia with me. I told you Emory Rollins School of Public Health was my dream and we made it happen. I will never be able to put words to how grateful I am to have you as my partner and to have experienced this program with you. Thank you for suffering through the cockroaches, heat, and humidity so I could follow my dreams.

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CHAPTER ONE: INTRODUCTION

Trauma-informed care has become an increasingly well-known subject matter in recent years. There have been numerous studies assessing and addressing trauma-informed care and trauma-informed care training. However, there has been a noticeable lack of research on trauma-informed care training for HIV providers.

SAMHSA defines trauma as that which "results from an *event,* series of events, or set of circumstances that is *experienced,* by an individual as physically or emotionally harmful or life threatening and that has lasting adverse *effects* on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [3]. People living with HIV have higher experiences of trauma than the general population [6, 7]. Current research indicated that some of the most frequently faced forms of trauma by people living with HIV include: interpersonal violence, childhood sexual violence, trauma from HIV diagnosis [8]. Experiencing one or more traumas has been linked to an increase in HIV-risk behaviors [7, 10]. Therefore, HIV care providers must have heightened awareness of the forms of trauma and how to screen for and address them in the context of providing care for their patients. They must consider how trauma treatment may impact a patients long-term health outcome, while simultaneously utilizing methods to avoid retraumatizing or retriggering a patient. Although the need for trauma-informed care trainings is gradually becoming more accepted in the clinical field, trauma-informed care has yet to be assimilated into medical training or curriculum [14, 27]. By establishing trauma-informed care in medical training and curriculum, best practices will be able to form and take root in practitioners.

More recently there has been an increase in recognition by providers regarding the importance of acknowledging a patient's trauma [14, 15, 24]. While there have been studies that have closely examined trauma-informed care and trauma-informed care trainings. There has not been a study that examines trauma-informed care trainings from the provider perspective. Nor has there been a study that focused specifically on trauma-informed care for providers working with people living with HIV.

Through my thesis, which employs a qualitative sub-analysis of a mixed-methods study, I aim to answer the following question: What knowledge and skills do Ryan White providers need to effectively provide trauma-informed care? This question will be addressed be evaluating HIV care providers responses to the following questions:

a. What are the strengths and gaps in knowledge and skills as they relate to trauma-informed care?
b. What factors may influence the prioritization and success of trauma-informed care training?
c. What is the perceived priority for trauma-informed care training/implementation?
d. What are the preferences among providers for the delivery of trauma-informed care training?

CHAPTER TWO: LITERATURE REVIEW

Trauma: Definitions

The word trauma has historically been a term that has an ambiguous definition[1],one that has been molded based on the scenario in which it is being used[2]. Although it is commonly used in research, public health and otherwise, in order to conduct a successful study a concise operational definition must be put forth. Therefore, for the purposes of this study the SAMHSA definition of trauma will be used as an operational definition. “Individual trauma results from an *event,* series of events, or set of circumstances that is *experienced,* by an individual as physically or emotionally harmful or life threatening and that has lasting adverse *effects* on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being”[3]. In order to accurately apply the SAMHSA definition of trauma the three ‘E’s” of trauma must be understood. *Events* and the circumstances surrounding the event may be a single occurrence or continually overtime[3]. The individual *Experience* is what determines if an event is a traumatic event[3]. Long-lasting *effects* of an event are final component of trauma as a whole[3]. While not all who experience trauma experience post-traumatic stress disorder (PTSD), PTSD is critical to understanding the definition of trauma[4]. It plays an important role in understanding the potential long-terms effects of trauma. PTSD can be divided into four main sectors. First, re-experiencing the original exposure[4]. Second, prevention of any types of reminders of the exposure[4]. Third, alterations of the memory or mood associated with the original exposure[4]. Finally, fluctuations surrounding reactions to the original exposure[4].

Acute trauma is the result of a single stressful event[5]. The event can be dangerous but is contained to a single incident[5]. A *chronic trauma* is the repeated and prolonged exposure to high intensity events/incidents[5]. *Complex trauma* is the outcome of multiple, compounded, events[5]. *Secondary trauma* is another form of trauma, where a person may develop trauma symptoms as a result of close proximity to another person that has experienced a level of trauma or is currently experiencing trauma[5]. These symptoms often present themselves in differing forms of post-traumatic stress disorder[1, 5].

Trauma Experience Among People Living with HIV

People living with HIV infection have historically been disproportionately burdened by trauma[6]. Between 30% and 40% of individuals living with HIV and have been diagnosed with PTSD have identify contracting HIV as the acute traumatic event[7]. Research indicates that individuals that are HIV positive are more likely than the general U.S. population to have significant trauma histories and comorbid medical conditions[7]. Studies have shown that trauma in people living with HIV infection ranges from 10%-90%, depending on the type of trauma exposure and level[6]. As many as 95% of those living with HIV report at least one severe traumatic stressor[6]. Furthermore, 54% meet of HIV positive people meet the criteria for posttraumatic stress disorder[6]. Based on available studies to date, some of the most commonly encountered forms of trauma by people living with HIV include: interpersonal violence, childhood sexual violence, trauma from HIV diagnosis[8].

Trauma: Effects on Health

Trauma is associated with increased HIV-risk behavior, poor overall health, poor adherence to treatment, poor HIV-related health outcomes[7]. Furthermore, trauma has been associated with intensification of depression, anxiety, and fatigue in people living with HIV populations[9]. One study found stressful events, PTSD, and recent trauma accounted for 12% to 27% of the variance in health-related functioning in HIV positive patients[7]. Patients that had experienced trauma were at greater risk for overnight hospital stays, emergency room visits, and four or more HIV outpatient clinic visits—within the last 9 months[10]. Patients that had experienced two or more traumas in their lifetime were at greater risk for falling out of care/not keeping up with medication cycles[10].

Trauma Among Providers and Staff

Compassion fatigue and burnout are common among providers who work with patients with histories of trauma[11]. Compassion fatigue is defined as the physical and mental exhaustion and emotional withdrawal experienced by those who care for sick or traumatized people over an extended period of time[12]. Burnout is defined as exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration[13]. That being said, much of the research on this subject fell off around 1997-1999. In more recent years self-care resources and policies have been enacted at several clinics across the United States[14, 15]. This was primarily a result of the trauma-informed care model becoming a more familiar discussion topic[5]. Yet, there is still a substantial lack of research on secondary and

vicarious trauma experienced by providers[16, 17]. Secondary trauma is defined as trauma that can be incurred when an individual is exposed to people who have been traumatized themselves, disturbing descriptions of traumatic events by a survivor, or others inflicting cruelty on one another[18]. Vicarious trauma is defined as a transformation of a helper's inner experience that is a result of empathic engagement with a client's traumatic experiences[19]. Vicarious trauma is similar to secondary traumatic stress, but individuals that have experienced vicarious trauma display only one subtype characteristic of PTSD, negative changes in beliefs and feelings. There is also an absence of current research on the prevalence of compassion fatigue among providers who treat HIV positive patients[11]. Some of the small-scale investigations that have explored this topic found that after implementation of trauma-informed practices burnout and secondary trauma among providers was identified[11, 16]. The studies specifically found a heightened awareness of one's own traumatic stress and need for self-care," as well as "greater sense of camaraderie and empathy for colleagues" [20].

Trauma: Safeguards

Safety, connections, and managing emotions are the three foundations of trauma-informed care[5]. Feeling unsafe has been identified as the crux of most trauma exposures[5]. Creating a safe environment for someone with trauma to exist in or receive treatment at is imperative. Engaging in human relationships, in a positive manor, is a necessary facet of human development and growth[1, 5]. For people who have had a trauma exposure establishing positive human connections is fundamental to

treatment and future healing[5]. The dysregulation of emotions, behaviors, or activities can have significant detrimental effects on trauma treatment[1, 5]. Thus, being able to practice self-regulation has been established as a key indicator for a trauma treatments success[5]. Trauma is a life-long, complex issue, one that will be a continuous work-in-progress. By establishing these three pillars during and throughout trauma treatment, the projected success of treatment/care only increases[5].

Trauma-Informed Care: A Framework for Addressing Trauma Among Patients, Providers, and Staff

Today SAMHSA defines trauma as, “Individual trauma results from an *event,* series of events, or set of circumstances that is *experienced,* by an individual as physically or emotionally harmful or life threatening and that has lasting adverse *effects* on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being”[3]. However, the history of trauma-informed care can be dated back to approximately 30 years ago[21]. A primary factor in the evolution of trauma-informed has been the understanding of post-traumatic stress disorder[21]. Which was driven predominantly by war and returning veterans[21]. While the term trauma-informed was not always the vocabulary used, providers have been providing care in an instinctively trauma-informed capacity[3]. The formal term trauma-informed was largely influenced by the feminist movement[21]. At the start of the 1990s into the 2000s, medical professionals began to “articulate the importance of the organizational context in the delivery of services to individuals who have experienced significant traumatic life events”[21]. The Substance Abuse and Mental Health Services Administration

(SAMHSA) was an influential entity in the formalization of trauma-informed care[3, 15, 21]. Thus, the foundation of modern trauma-informed care is the simple understanding of how trauma affects the life of an individual seeking services[2, 3, 21]. Subsequently SAMHSA has established ten trauma-informed principles that guide the establishment of trauma-informed care[3].

1. Safety: throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
2. Trustworthiness and transparency: organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.
3. Collaboration and mutuality: there is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
4. Empowerment: throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.

5. Voice and choice: the organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.
6. Peer support and mutual self-help: are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
7. Resilience and strengths based: a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.
8. Inclusiveness and shared purpose: the organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.
9. Cultural, historical, and gender issues: the organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural

connections, and recognizes and addresses historical trauma.

10. Change process: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments

Trauma-Informed Care: The Evolving Role of the Clinic and Providers

The role and responsibility of a provider is defined as diagnosing, treating, and preventing illness, disease, injury, and other physical and mental impairments[22]. Acknowledgement of a patient's traumatic life experience by a provider may frequently be overlooked[23]. This may be a result of lack of communication within a clinic, thinking it is someone else's responsibility to screen and assess for trauma[23]. Previously, it has been thought that 'trauma' does not fit well within traditional parameters of a physician's role[3]. However, in recent years there has been an increase in recognition by providers on the importance of acknowledging a patient's trauma[14, 24]. This is, in part, a result of the mounting evidence showing a direct relationship between trauma and a rise in medical and mental health services[4, 23]. A priority of a medical provider is to maintain the general health of patients through application of the principles and procedures of modern medicine[22]. With a provider responsible for the starting foundational point of a person's medical treatment, the implementation of trauma-informed care must start with there. Without a trauma-informed care practice in place a provider may inadvertently re-traumatize a patient[25]. Re-traumatization may not be inherently traumatic but may carry reminders of the

original traumatic event or relationship[26]. Re-traumatization may also indicate the reemergence of symptoms previously experienced as a result of the trauma[26]. Many providers may already be practicing some form of trauma-informed care. However, it is the clear identification of trauma-informed care and intent to implement that will create the necessary systematic change[6, 15, 16]. Moreover, providers have indicated they want clear training and guidelines for when the treat patients who have experienced trauma[17, 25]. While there are trainings for trauma-informed care, there are not HIV specific trauma-informed care trainings. Providing HIV care involves a different skill set, knowledge base, and understanding[8, 9]. A trauma-informed care training that is successful with one population may not be as applicable to populations with HIV, given differences in trauma experience and frequency among the patients served and integration of mental health and support services within HIV clinics [5, 14]. For this reason, HIV care providers need their own trauma-informed care training.

Trauma-Informed Care: Present Make-Up/Delivery

The need for trauma-informed care trainings has been increasingly recognized in established clinical practice[14]. Yet, trauma-informed care trainings have yet to become established in medical school settings[27]. It is imperative to implement trauma-informed care in current provider settings, but widespread best practices will only happen if trauma-informed care training is integrated into medical school curriculum[28]. A recent study focusing on medical students found that through trauma-informed care training students learned how to ask about and respond to adverse childhood experience disclosures and identify necessary resources to responsibly implement

trauma-informed care in medical settings[27]. Thus, it was ultimately concluded that trauma-informed care trainings are capable of filling a knowledge gap and provide associated benefits for medical students[27]. The Substance Abuse and Mental Health Services Administration have outlined ‘the key ingredients for successful trauma-informed care implementation.’ The recommendations at the clinical level are as follows: 1. Involving patients in the treatment process 2. Screening for trauma 3. Training staff in trauma-specific approaches 4. Engaging referral sources and partnering organizations[14]. It is crucial to the overall success of trauma-informed care that implementation occurs at the organizational level and clinical[14]. Current trauma-informed care trainings are built on the same five principles--patient empowerment, choice, collaboration, safety, and trustworthiness[14].

In a recent Emory Grand Rounds, Dr. Stan Sonu provided an up-to-date overview on the need for trauma-informed care trainings and a trauma-informed care mindset[28]. He highlighted the high frequency of adverse childhood experiences (ACEs) [28] and the impact they have on long-term care. Experiencing trauma during childhood, significantly increases the risk of serious health problems— including (but not limited to) chronic lung, heart, and liver disease as well as depression, sexually transmitted diseases, tobacco, alcohol, and illicit drug abuse[14, 28]. A study showed that 64% of study participants indicated they had experienced one or more ACEs[28]. Dr. Sonu presents an overall recommendation for the need for trauma-informed care trainings, as well as recommendations for when and how to implement. HIV population specific trauma-informed care was not discussed as this was not the focus of the lecture.

Trauma-Informed Care: Integration into HIV Clinics

The concurrent understanding and implementation of trauma-informed care has been linked to increased positive outcomes for HIV positive patients[25, 29]. By addressing trauma in the context of HIV, HIV related outcomes could be enhanced [8]. In regards to providers and trauma-informed care, although there are some variability (by provider and clinic) providers held favorable views toward incorporating trauma-informed care into their practice[17, 25, 29]. For providers who provide trauma-informed care, with adequate knowledge and understanding, they may be less likely to experience burnout and practice self-care [11]. Several studies have shown, while there may be some semblance of trauma-informed care at a clinic, without a comprehensive all-inclusive training and standard practices patients and providers are not reaching full potential[11, 16, 25].

Trauma-informed care training in the context of HIV should differ from trauma-informed care in a non-HIV context. Patients with a history of traumatic life events can become distressed or re-traumatized as the result of healthcare experiences[3]. Current empirical evidence demonstrates that trauma screening methods and provider characteristics can either facilitate or hinder patient disclosure[16]. As it has been established that between 10%-90% of HIV positive people have experienced some level of trauma it is imperative tailored trauma-informed care is established with providers and in clinics[6]. HIV patients are already at a higher risk for loss of care, lack of medication adherence, and long-term health adverse health outcomes[6]. It is reasonable to include providers in strategies, trauma-informed care implementation, to increase patient retention and medication adherence[7]. The development of a trusting

provider-patient relationship can help survivors feel comfortable and empowered to discuss traumatic experiences[30]. HIV care providers have an intense power dynamic with patients. Trauma-informed care requires that providers recognize and work against imbalances of power in provider-patient relationships that are often reminiscent of abuses of power in interpersonal violence[31]. Feelings of shame, guilt, and stigmatization associated with physical and sexual abuse can act as barriers to disclosure[30]. Both female and male sexual assault survivors emphasized the importance of providers' nonjudgmental and calm response to disclosures of trauma histories[30]. A person's HIV status already carries significant societal stigma[30, 31]. A provider must have specific training in navigating the stigmas HIV patients may face[30-32].

Often times the trauma that people living with HIV experience is a result of their identities/population they identify with (racial, ethnic, sexual, etc.)[30-32]. Furthermore, there is frequently stigmatization of the behavior that resulted in their HIV status (sex work, drug use, etc.) [31, 32]. The identities and stigmatization people living with HIV face places them in a highly vulnerable position to trauma [31, 32]. The high prevalence of trauma and its negative impact on health among people living with HIV underscore the need for adopting trauma-informed care[33]. Studies have shown a 33% lifetime prevalence of physical assault and 30% to 68% lifetime prevalence of sexual assault among HIV-positive individuals, versus 6.9% and 9.2% in the general population, respectively[34]. While there is significant evidence documenting the differences in trauma among HIV positive populations and non-HIV positive populations, there has not been much study of how trauma influences medication adherence or long-term health

outcomes[32, 34]. A literature concluded that to ensure the health of HIV-positive women clinics must address conditions that impact engagement in care and treatment[35].

Ryan White HIV Primary Clinics: Ideal Settings for Implementation of Trauma-Informed Care

The Ryan White HIV/AIDS Program is named after a young man, Ryan White, who was diagnosed with AIDS after receiving a blood transfusion[36]. The Ryan White HIV/AIDS Program was enacted in 1990[36]. It is the largest federal program designed specifically for people with HIV[37]. Ryan White HIV/AIDS Program provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV[38]. Through grants, states, cities, counties, and community-based organizations provide care and treatment services to people with HIV[37, 38]. This is done with the overarching goal of improving health outcomes and reduce HIV transmission among hard-to-reach populations[37]. At Ryan White Clinics there are a multitude of patient services available. Services range from peer navigators, to social workers, to social services, and clinical services[38]. Preliminary data suggests that providers may not have comprehensive understanding of trauma support services available at their clinic.[17, 25, 33]. Furthermore, preliminary data showed a difference in staff and provider understand of the level of trauma-informed care implementation at their clinic[25, 33]. Providers must also be trained on what services are available at the clinic. As of December 2020, more than half of people with diagnosed HIV in the United States received their services through the

Ryan White HIV/AIDS program[37, 38]. The Ryan White Program is the ideal organization to implement trauma-informed care trainings for providers for a multitude of reasons. First, the organization has a history of welcoming change/better practices[37]. The organization was founded on principles of progressive treatment and care[37]. The providers who work for Ryan White funded organizations want to learn more and ultimately implement trauma-informed care practices. Finally, the structure of the Ryan White Program would allow for the necessary changes at the organizational and clinical level, per SAMHSA recommendations[3, 38]. The Ryan White Program has many tools to support trauma survivors. The tools include but are not limited to: social support, peer support, legal support, mental health support, and extensive referral networks [3, 34].

Trauma-Informed Care: Need for Trauma-Informed Care training of HIV Care Providers

A cross-sectional study used an anonymous web-based survey to assess attitudes, knowledge, perceived competence, and practice of trauma-informed care among trauma providers from an urban academic medical center with a regional resource trauma center[39]. It concluded despite some variability, providers were generally knowledgeable and held favorable views toward incorporating trauma-informed care into their practice[39]. As seen in several other studies, many providers have some understanding of trauma-informed care[25, 33]. The responsibility of providing trauma-informed care is often noted as falling to social workers or peer navigators[40]. Providers need further detail and guidance to properly implement and execute[17, 41]. Trauma-informed care training for trauma providers is needed and

should aim to build providers' perceived competence in providing trauma-informed care[24, 39]. Provider burnout has become an increasingly noted phenomena[11]. Providers are at a high risk for secondary (vicarious) trauma while treating patients[3, 5, 11]. Organizations should encourage self-care practices for providers[11]. Education on burnout is a part of trauma-informed care training[3]. It has been established, through previous studies conducted, that trauma-informed care plays an important role[3, 24]. However, there is limited data and guidance on trauma-informed care for HIV providers. The traumas a patient may have experienced may be amplified in the context of HIV care[6, 8, 29]. In HIV care, providers may encounter a higher percent of patients who have experienced trauma[29, 42]. Therefore, there is a need for trauma-informed care training that is specific to HIV care providers.

A Need to Understand Gaps in Provider Knowledge and Skills to Inform Training of Providers

Critical to the development of a trauma-informed care training for providers is an understanding of their self-perceived strengths and gaps in knowledge and skills necessary to provide trauma-informed care. Specifically, do providers understand the definitions and types of trauma? Do they have a comprehensive understanding of the impact trauma can have on the health of a person living with HIV? Do they possess a well-rounded understanding of the justifications, pillars and methods for provision of trauma-informed care (e.g., screening for and addressing trauma)? Do they recognize, understand the effects of, and have the tools to address secondary (vicarious) traumatic stress? Little to no research has been done on understanding these knowledge gaps

necessary for a provider to provide trauma-informed care in an HIV context, HIV care providers must be aware that they are treating populations with a higher likelihood of a history of trauma, how trauma treatment may impact a patients long-term health outcome, and methods to avoid retraumatizing a patient in healthcare. Early studies suggest that providers have established they want to learn more and implement trauma-informed care but do not currently have the resources or capacity to do so[25].

In conclusion there is a significant need for trauma-informed care training that is specific to HIV care providers. Few studies, however, have assessed their gaps in skills and knowledge in provision of trauma-informed care. Through my thesis I aim to answer the following question: What knowledge and skills do Ryan White providers need to effectively provide trauma-informed care?

Sub Questions:

a. What are the strengths and gaps in knowledge and skills as they relate to trauma-informed care?
b. What factors may influence the prioritization and success of trauma-informed care training?
c. What is the perceived priority for trauma-informed care training/implementation?
d. What are the preferences among providers for the delivery of trauma-informed care training?

A thorough understanding of the responses to these research questions will inform the development of the content and delivery of trauma-informed care training for HIV care providers.

CHAPTER THREE: MANUSCRIPT

Abstract

Background: Trauma-informed care has been an increasingly developed area of research over the past several decades. There is a significant need for trauma-informed care training that is specific to HIV care providers due to the high levels of trauma experienced by people living with HIV and the impact on their HIV outcomes. Few studies have assessed provider gaps in skills and knowledge in provision of trauma-informed care.

Methods: This thesis focuses on the qualitative study of a larger mix-methods study among providers and staff of Ryan White HIV Clinics in the Southeastern United States. Twelve in-depth interviews were conducted with HIV care providers, examining their perceptions of gaps in knowledge and skills to effectively provide trauma-informed care, factors influencing prioritization of implementation of trauma-informed care training, and preferences for content and delivery of training. Interviews were conducted and recorded via Zoom. All twelve interviews were then coded and analyzed, using thematic analysis.

Results: The study found that HIV care providers would like to see trauma-informed care curriculum implemented into medical education curricula and clinical training, in addition to re-training for practicing providers. Providers would also like to see trainings delivered by subject-matter experts. Providers are particularly interested in population specific trauma-informed care training, as well as trauma-informed care training that focusses on not re-triggering or re-traumatizing a patient.

Conclusions: The study provides critical insight into the content and delivery of trauma-informed care training for HIV care providers. Future research should pilot and evaluate implementation of such trauma-informed care training and examine effects on providing trauma-informed HIV care to people living with HIV. Furthermore, trauma-informed care trainings should be piloted and subsequently added to medical training.

Introduction

Trauma-informed care has become an increasingly well-known subject matter in recent years. There have been numerous studies assessing and addressing trauma-informed care and trauma-informed care training. However, there has been a noticeable lack of research on trauma-informed care training for HIV providers.

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More recently there has been an increase in recognition by providers regarding the importance of acknowledging a patient's trauma [14, 15, 24]. While there have been studies that have closely examined trauma-informed care and trauma-informed care trainings. There has not been a study that examines trauma-informed care trainings from the provider perspective. Nor has there been a study that focused specifically on trauma-informed care for providers working with people living with HIV.

Through my thesis, which employs a qualitative sub-analysis of a mixed-methods study, I aim to answer the following question: What knowledge and skills do Ryan White providers need to effectively provide trauma-informed care? This question will be addressed be evaluating HIV care providers responses to the following questions:

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Methods

Study Overview:

This is a qualitative sub-study of a larger mixed-methods study assessing trauma-informed care (TIC) and readiness to change in Ryan White Primary Care

Clinics (RWPCCs) in the Southeastern United States. The larger mixed methods study first involved a survey conducted with 382 respondents who were administrative or clinical staff at 51 RWPCCs. Participants who completed the web-based surveys were asked if they would like to be contacted for an interview over Zoom. These key informant interviews were conducted to assess inner and outer context factors that may influence adoption of trauma-informed care. The proposed study is informed by the *Consolidated Framework for Implementation Research (CFIR).* CFIR serves as a common reference to many constructs identified as important for implementation success, including intervention characteristics, inner and outer setting. Utilizing CFIR allows us to comprehensively capture multiple factors, from many stakeholders' perspectives that will likely influence an organizations decision to adopt and implement trauma-informed care.

The part of these interviews which focused on provider strengths and gaps in knowledge and skills as they relate to provision of trauma-informed care was used for this qualitative sub-study.

Study Setting:

The study was conducted at Ryan-White funded Primary Care Clinics across the Southern United States. The United States Southern States accountant for an estimated 51% of new HIV cases annually[43]. The United States South is considered the epicenter of the HIV epidemic. Ryan White Primary Care Clinics across the Southeast United States, DHHS Region IV include: North Carolina, South Carolina, Georgia,

Florida, Alabama, Mississippi, Kentucky, Tennessee. This study began prior to the COVID-19 pandemic but continued throughout the pandemic.

Participants:

As part of the larger study, individuals working at Ryan White Primary Care Clinics (RWPCCs) as clinical, support staff, or administrative staff who completed the web-based survey were eligible for an interview. Between March 2019 and February 2021, there were a total of 38 interviews conducted. Participants worked at RWPCCs in rural, urban, and urban cluster locations. The analysis for this qualitative sub-study was restricted to interviews conducted with providers. Providers were defined as: physicians, physician assistants, nurse practitioners, and nurses. We limited this analysis to providers out of recognition that training for providers would likely differ from that of other clinic support staff. The intent is to build a foundation for future trauma-informed care curriculum—that could be implemented in medical education (e.g., of infectious diseases clinical fellows) or within HIV clinics. Interviewees were emailed in advance and sent a copy of ‘a brief overview of trauma-informed care’ to ensure all participants shared a standard definition of practices constituting trauma-informed care which to inform interview responses. Participants received $50 in compensation for their time.

Table 1

Gender	Clinic Role	Clinic Classification	State	Urbanicity
F	Clinical Peds ID Fellow	Hospital-based HIV Clinic	TN	Urban
F	Clinical Provider	Hospital-based HIV Clinic	GA	Urban
F	Nurse	Hospital-based HIV Clinic	NC	Urban
F	Clinical Provider	Hospital-based HIV Clinic	NC	Urban
F	Clinical Provider	Hospital-based HIV Clinic	GA	Urban
M	Physician Assistant	Stand-alone HIV/ID	GA	Urban Cluster
F	Nurse Practitioner	Hospital-based HIV Clinic	MS	Urban Cluster
F	Clinical Provider	Hospital-based HIV Clinic	TN	Urban
F	Physician Assistant	Federally Qualified Health Center (FQHC)	NC	Urban Cluster
F	Nurse	Hospital Based HIV/ID Clinic	AL	Urban
M	Clinical Provider	Hospital Based HIV/ID Clinic	TN	Urban
F	MSN, APRN, PMHNP-BC	Hospital-based HIV Clinic	TN	Urban

Data Collection:

The interview guide was developed by the Emory Trauma-Informed Care (TIC) team. The in-depth interview guide was informed by CFIR and SAMHSA guidelines/best practices. It was reviewed by a clinical and behavioral investigator team. The Trauma-Informed Care team also consulted with experts in research on trauma against gender/sexual minorities. The interviews were conducted by two research assistants, one note-take and one interviewer, with one participant. The interviews were conducted via Zoom and lasted approximately 1-2 hours and were audio recorded. Research assistants were trained in qualitative research methodology. The research assistants were at minimum master level students in public health. There were four sections of the interview: Clinical Environment, Screening/ Assessment, Staff/ Provider Care, and Planning for Action.

This qualitative substudy was on focused on provider strengths and gaps in knowledge and skills as they relate to trauma-informed care. Four questions from the interview guide, that assessed strengths and gaps in knowledge and skills, were selected and are listed below (question probes are not listed but can be found in the full IDI guide in the appendix):

1. Please tell me about your experience treating patients that have been exposed to trauma.
2. Would you describe enhancing trauma-related practices and services as a current/future priority? Why or why not?
3. Would you describe the provision of a clinic-wide trauma training for providers and staff as a current/future priority for your clinic? Why or why not?

4. How can administrators/providers/staff advocate for trauma-related practices?

Ethics:

The study team obtained IRB approval of the Emory University. Each study team member completed CITI socio-behavioral certifications prior to working on the study. A verbal informed consent from each participant was obtained at the start of the interview process. During the interview participants were never asked to disclose personal traumas. They were informed they could pause or leave the interview at any time. Participants were also reminded that any identifying information would be redacted from the interview transcript.

Data Management:

After completion of the interview, the interviewer downloaded the Zoom recording to a secure Emory University laptop. The recording was then sent to a transcription service, Verbalink or Happy Scribe. A copy of the recording was saved and password protected on the study team Box Drive. Once the interview was transcribed by the designated company it was returned to the interviewer. Transcriptions were saved and password protected on the study team Box Drive. All transcripts were then cleaned and de-identified by a study team member. They were then saved to a new password protected folder on Box Drive. Only when a transcript was fully cleaned and de-identified was it ready to be coded. For the purposes of this substudy all 12 transcripts were downloaded from Box Drive and saved to a separate password protected file. They were then coded.

Data Analysis

For this qualitative substudy a single coder was used. If questions came up during coding, they were discussed with the study team until consensus was reached. Coding was first completed by hand and then transferred to MAXQDA software for final analysis. Both CFIR and SAMHSA deductive codes were used to develop the study team codebook. The team codebook, developed by the larger study team, included definitions, use for statements, and examples to ensure a standardized approach to coding.

Results

Participant Characteristics

There were twelve interviews included in this qualitative substudy (see Table 1). Out of the twelve participants, ten identified as female and two identified as male. There were six physicians, two nurses, two physician assistants, and two nurse practitioners. Eight of the twelve participants worked at a hospital-based HIV clinic. Two participants worked at a hospital-based HIV/ID clinic. One participant worked at a stand-alone HIV/ID clinic and one participant worked at a Federally Qualified Health Center (FQHC). The twelve participants were drawn from 5 states within Region IV states: Tennessee, Georgia, North Carolina, Mississippi, and Alabama. Four participants came from Tennessee. Three participants came from Georgia. Three participants participated from North Carolina. Finally, one participant from Mississippi and one from Alabama. Four major themes emerged: 1) Existing Knowledge of Trauma-Informed Care & Trauma-

Informed Care Trainings, 2) Perceived Priority of Trauma-Informed Care Training, 3) Factors Influencing Implementation of Trauma-Informed Care Training, and 4) Preferences of Trauma-Informed Care Training.

Existing Knowledge of Trauma-Informed Care & Trauma-Informed Care Trainings

Participants had extremely varying knowledge on trauma-informed care. While some participants viewed trauma-informed care as, "someone else's area to handle," others explained that they understand basics of trauma-informed care but did not feel confident in the execution.

> *"…When I first started practicing in this clinic, I did not have an appreciation for how common of an experience trauma was for patients. I also think [I] lacked an understanding of how their experiences of trauma impacted their health. And I have – since working where I am, I have come to learn a lot more about how common trauma experiences are and the way in which those trauma experiences impact people's lives both from a personal and an emotional and an even physical health perspective."*

All participants indicated, in some form, that their primary focus was treating the patients' medical concerns.

"…And, so you know, for me as a clinician, it's challenging trying to treat both of those things in a 30-minute visit. I choose to focus on the medical concerns not the mental health."

Although some participants did not explicitly state they were utilizing a trauma-informed care approach, their descriptions of practices aligned with trauma-informed care principles. Several participants also noted that their organization tries to stay proactive in regards to new theories and best practices.

"Yes, yes, they are a very proactive and organized [with trauma-informed care information]."

Participants specified that trauma people living with HIC experience is, "very individualized," they did not always understand how to best engage with current trauma-informed care trainings. Finally, multiple participants discussed how the trauma-informed care they are aware of is heavily focused on adverse childhood experiences or cis-women.

"I think one area of difficulty of that training is that it often, trauma-informed care, at least that I've been exposed to, oftentimes, focuses on adolescence and early childhood experiences."

Several of the participants mentioned they received trauma-informed care training during their schooling. However, they specifically stated the training was brief and very limited.

> *"I feel like I could have used a lot more, and I feel like I haven't had enough time to really—it's been limited."*

> *"If I were a part of the deciding people for curriculum for nursing schools and for nurse practitioner schools, I would definitely incorporate more HIV education and incorporate the things that impacted the most successful treatment. So I don't think that there is enough on it, education wise, with school. And then, I think there is still a need once we become licensed and certified to have continuing education regarding HIV care and the trauma associated with that."*

Many of the participants had been in their current role for five plus years without any sort of formal trauma-informed care training. Furthermore, new hires were not aware of trauma-informed care training as it was not a part of onboarding.

> *" I hadn't had a lot of training in how to do that. A lot of it's come with when I started this job 14 years ago now in the clinic, I was told that – I wasn't really given any training at all when I started."*

Participants revealed they were aware of trauma training but not trauma-informed care training. This is important to note as there may be other providers confused on this distinction. Almost all participants made mention of the fact any trainings that had been delivered and related to trauma-informed care were not specific, did not have an implementation section, and did not go over well. A few participants indicated that the training did not meet expectations due to the fact it did not teach them how to actually work with people who have trauma.

Perceived Priority of Trauma-Informed Care Training

At the start of interviewing, March 2020, the COVID pandemic just began to reach peak—with many states entering a lockdown period. Therefore, many participants made it clear trauma-informed care training was a priority prior to the COVID pandemic.

> *"I think it [trauma-informed care training] does impact a lot of the relationship between the provider and the patient. I think, it definitely impacts their outcomes related to their HIV care. So it matters."*

However, they were unaware of the current standing on prioritization, as many factors of clinic functions are still unknown and in flux due to the pandemic. While many participants voiced desire for trauma-informed care training they raised the point that this need/desire was not always equated with priority status. Almost all participants indicated while they can identify they want and need some sort of trauma-informed care training.

"Hm. I believe just, you know, trying to get more of us trained, completely trained. I think that's pretty much going to be about the best way that they can advocate for it. Um, so that all of us are more."

A few participants discussed how trauma-informed care training will definitely impact their patient's health related HIV outcomes, in a positive way. Therefore, they are eager for the pandemic to be over—in order to seek out trauma-informed care training.

"There is a heartfelt commitment by some team members to make sure that everybody has some degree of trauma-informed care training".

Additionally, some participants noted that many administrators at their clinics did not understand their need or want for trauma-informed care training or did not hold the same level of prioritization.

"I think providers and staff want trauma-informed care training. I'm not so sure about administrators. We have different priorities."

While both providers and administrators may hold varying levels of prioritization for trauma-informed care trainings, participants made clear they believe this will be addressed further after the pandemic.

Factors Influencing Implementation of Trauma-Informed Care Training

A primary factor that a participant discussed was how many providers think implementing trauma-informed care trainings will add more to workload—when they want to focus on the patients' health. Similarly, another provider considered the importance of trauma-informed care with the time they had available. While stating it would be great to have a couple days of trauma-informed care training, not all providers or clinics will have the capability to support that.

> *"I think there are definitely people who, if they feel like it's gonna add to their workload, you know, and it's not something that's in the grant or we're getting paid for – yeah, and I think that's part of the challenge."*

One participant discussed how they did not think trauma-informed care training was a priority because administrators made clear priorities were elsewhere. Budget concerns, particularly during the COVID, the participant implied was the main priority of administrators.

> *"Of course, again, you know, things are a little bit changed right now 'cause of the COVID situation, budget, and furloughs and all that business."*

Overall, at present, one of the largest factors influencing trauma-informed care training implementation is the COVID pandemic. Participants elaborated on how their

clinics have had to move to telehealth, limit visits, and utilize new resources in order to make sure their patients got the support they needed. Therefore, while trauma-informed care training would be ideal, right now is not the time to explore how to go about implementation.

> *"So everything got messed up because of COVID. So I think the clinic is trying to adapt to this new normal that COVID has brought. But I do think that if we're going to build a new clinic structure or policies because of COVID, then trauma-informed training care should be one of the things that is put in place."*

> *"But it's a matter of, you know, time and resources, especially right now [inaudible] not the best time to be – I mean, I think it's fine to be thinking about it. But I don't' think that now's the best time to be, to try to do the incorporation."*

Stating, at present, there is not a modality available that would fit many provider's needs. Furthermore, as a result of the pandemic administrators' priorities may have shifted. Which would influence whether or not they sought out trauma-informed care trainings to be delivered to providers. It must be noted that a significant factor to consider in the implementation of trauma-informed care training is if the intended trauma-informed care trainings will be relevant to providers who treat people living with HIV.

Preferences of Trauma-Informed Care Training

Participants stated, while they are grateful for team members who lead trauma-informed care trainings within the clinic, it is generally just a staff member who did some research on what trauma-informed care was. Participants particularly want a formal training on trauma-informed care—with inclusions on how to implement.

> *"I think it'd be beneficial process for us to have some formal training on it to be completely honest."*

That being said, they are not sure what exactly they want or need. Participants believe trauma-informed care training should be introduced in early career settings (i.e., medical school, nursing school, physician assistant school, etc.)

> *"I think just even going back to my education as a nurse practitioner would – if I were a part of the deciding people for curriculum for nursing schools and for nurse practitioner schools, I would definitely incorporate more HIV education and incorporate the things that impacted the most successful treatment. So I don't think that there is enough on it, education wise, with school. And then, I think there is still a need once we become licensed and certified to have continuing education regarding HIV care and the trauma associated with that."*

While participants listed trauma-informed care training as a priority at their clinic. They also made clear that trauma-informed care training should first and foremost be a part of medical training and coursework.

> *"I think if we became more aware, if we were more educated on what trauma is and what it looks like or may not look like 'cause sometimes we have a picture in our head. So I think education is the first step that we need to take so that we can be informed and aware of how to identify and screen and address those traumas when they come up."*

Additionally, participants particularly noted that they would want someone who specialized in trauma-informed care to deliver their trainings a 'subject-matter expert'. For the participants that had some interaction with trauma-informed care trainings, they felt they did not receive the depth of the topic they were hoping for. They discussed how this could in part be a result of a co-worker leading the training, as opposed to a trauma-informed care specialist. The concern was voiced that it could also be a result of no formal HIV specific trauma-informed care trainings available.

> *"Ah I think, a specific trauma-related training…, the, you know, webinars or doing residency, when I was doing my training would have been helpful. How to include my HIV care into, you know, encompassing the traumatic experience that they've been living. I think, we, I mean, I think, I*

do it more intuitively because I've seen so many cases and I've learned, but I have never received any formal training about trauma."

For the training for practicing providers, there should be awareness of time restrictions/sensitivity.

"I think we my clinic have the time to actually organize this type of training, so I think in my situation, in my – in this background, I think it's possible, yes. I think that maybe in some other clinics, no, because they see maybe 50 patients per day. Maybe not possible there. A lot of larger clinics and providers don't have the same availability."

Overall, one of the principal goals of trauma-informed care training that providers would like to see is to ensure they learn how to avoid re-traumatizing and re-triggering their patients.

"I'd like to see…more than the actual – I mean, yes, like, how do you define trauma, how to identify patients who have had traumatic experiences in the past. So, basically, identifying it, and then the second part is what you do. So what can I do while I'm in the office with them. Um How trauma impacts their HIV care…how can I then make sure that someone who has experience in trauma can take care of this."

Discussion

The twelve provider interviews that were used for this qualitative substudy illuminated the importance and need for HIV specific trauma-informed care training. They each had varying levels of trauma-informed care training or exposure, but all recognized the importance of trauma-informed care training to provide more effective care to people living with HIV. Providers identified barriers, solutions, and preferences to implementing trauma-informed care training in the clinics. They openly discussed how trauma-informed care trainings must be more than the obvious, “your patients have trauma” statements they have previously heard. It was also explicitly mentioned that providers want trauma-informed care training on how to screen and discuss a patient’s trauma without re-triggering or re-traumatizing them, as one provider noted, “HIV patients are already at a higher risk for re-traumatization.” Furthermore, it became clear that providers believe trauma-informed care training should be included in medical training, as well as delivered to practicing providers.

The findings of this study align with similar findings that assessed providers knowledge, views, and practice of trauma-informed care. Although there may be fluctuating knowledge in regard to trauma-informed care training, providers largely agree more trauma-informed care training is needed and can significantly benefit the patient [39]. Trauma-informed care training for people living with HIV will require a certain amount of specificity. That being said, population-oriented training should also be developed and taught. This was a gap in the research that was discovered during data analysis. Our study suggested many of the current trauma-informed care trainings are focused on adverse childhood experiences or cis-women. There are many other

populations of people living with HIV. Participants made it clear they would want trauma-informed care training that was not just a ‘blanket’ fix, but oriented for towards the people they were treating. Thus, while there is current research and literature on the successes and implementation of trauma-informed care trainings. In order to develop population specific trauma-informed care trainings for providers providing care for people living HIV supplementary research is needed [24, 27].

This qualitative substudy had many strengths. The in-depth interview guide was created and reviewed by several team members as well as in consultation with experts in research on trauma against gender/sexual minorities. The codebook was developed and verified with all study team members. All in-depth interviews had two study team members involved, one conducting and one notetaking. During recruitment of participants the study was able to pull from a variety of states, clinic structure, and urbanicity, and we were liberal in our definition of “provider” so as to include physicians, advanced practice providers, and nurses.

There were also limitations to this qualitative substudy. Due to the Covid-19 pandemic few providers may have volunteered to participate in an interview; providers who were not willing/able to participate may have been those most taxed for time. The in-depth interview guide was altered during the study, to include questions about the Covid-19 pandemic, thus not all participants responded to these questions. There were multiple study team members who conducted the in-depth interviews. Therefore, the questions may have been asked in different ways. Lastly, for this thesis, coding was conducted by a single individual; however, when questions arose regarding appropriateness of codes, she consulted her thesis advisor.

Trauma-informed care trainings for HIV care providers has the potential to improve patient health outcomes, prevent re-traumatization and re-triggering, and validate the traumatic experiences people living HIV have lived. This research suggests that trauma-informed training for HIV care providers should be initiated during medical school and clinical training with retraining during clinical practice. Future research should pilot this training and examine impact on trauma-informed HIV care provision by clinical providers.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

In conclusion, this qualitative substudy is the first to assess what knowledge and skills Ryan White providers need to effectively provide trauma-informed care. The study has also established there is a need and want by providers for further trauma-informed care trainings, that are specific to their patients—people living with HIV. Continued research in trauma-informed care in an HIV care setting will help to inform trauma-informed care trainings. Furthermore, the assimilation of trauma-informed care training into medical curriculum will aid in the establishment of trauma-informed care importance. It will also begin to fill the gaps in trauma-informed care knowledge and skills at an earlier career point.

Key considerations that must be accounted for in development of trauma-informed care trainings are preventing re-traumatization and re-triggering, considering provider time/availability, implementation during medical training, and who is qualified to lead trainings. Implementation research should be conducted alongside the development and implementation of trauma-informed care training for providers who care for people living with HIV to evaluate provider responses to the trauma-informed care trainings and ensure the trainings are meeting the needs and gaps in knowledge and skills identified by providers. It will also be essential that subject-matter experts/trauma-informed care specialists are available to deliver the trainings to providers.

Ryan White clinics, at present, have trauma screening policies and extensive wrap-around services [36-38]. It will be critical that internal policies are adjusted to include any future HIV specific trauma-informed care trainings. Furthermore, it is

important current and future Ryan White providers have any trauma-informed care easily accessible throughout their career. A HIV specific trauma-informed care training for providers has the potential to considerably improve patient provider interactions. Therefore, it is of the utmost importance research on this subject and for this population continues. In order to adequately develop HIV specific trauma-informed care training for providers future research should replicate this qualitative substudy, in other Regions of the country. This will allow for full representation of providers gaps in HIV specific trauma-informed care skills and knowledge. Future research should also assess whether the findings from this study are applicable to other healthcare systems—for example, to clinics that provider PrEP for people at risk for HIV.

A final consideration moving forward with HIV specific trauma-informed care training for providers is to determine when curricula and trauma-informed clinical training would fit best. The timing of curricula delivery is of particular importance as students need to be prepared to understand the full significance of trauma-informed care. The delivery of trauma-informed care during medical training must also be appraised. Further research is needed to assess the modality that would provide the most impact on students.

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APPENDICES

In-depth Interview Guide

Qualitative Guide: TIC Staff / Provider Interview Guide (60 mins)
Study Title: Ryan White Trauma-Informed Care

Interviewee Information:

Age: _____ Gender: _____ Race: _____
State: _____ Urban/Rural: _____
Clinic Role: _____ Time in role:_____

Introduction

Thank you for agreeing to an interview with me today. My name is _____, and I am a Research Assistant with Emory University's Trauma-Informed Care (TIC) Study.

I am part of a research team that is conducting interviews with providers and staff at Ryan White Primary Care Clinics (RWPCCs) across the Southeast Region IV to understand the ways in which RWPCCs address patient trauma and are incorporating trauma-informed services in patient care at their clinics. We feel that it's important to speak directly with providers and staff to understand your experiences and perspectives.

During this interview, I will be asking questions aimed at identifying current protocols, policies, and practices related to implementation of TIC, as well as resources for providers and staff that interact with patients with complex needs. Additionally, we seek to gain your perspective on best practices for integrating services into care and how RWPCCs can create a safe environment for patients that have experienced trauma.

Because your perspective is important to us, please feel free to share your honest opinion. Information shared during this interview will be kept confidential within the research team, however, I would like to record our conversation in order to best capture your responses. For reporting purposes, we will redact any information that could identify you or your practice, and only report results in aggregate.

The interview will last about an hour. Before we get started, do you have any questions? **[Wait for a response and answer any questions.]**

Thank you for agreeing to participate in this interview. I will begin recording now. **[Turn on the recorder.]**

Warm Up

1. I'd like to begin by asking you to describe your clinic, as well as your role(s) and responsibilities.

2. Can you tell me about the patients that you see at your clinic? (probe if necessary, age, gender, race, ethnicity, and sexuality)

3. Thinking about what you see in your clinic, how do you define trauma as it relates to your patients?

4. Please tell me about your experience treating patients that have been exposed to trauma.

[Note for interviewer: Suggested response if participant brings up COVID-19 early in interview: *"Thank you for raising COVID-19 as a form of trauma. I'm going to ask you to hold that thought for now and think back to the pre-COVID-19 epidemic period first. Thinking about other common forms of trauma experienced by your patients living with HIV, let's work through the next set of questions. We'll come back COVID-19 at the end."]*

    a. How well prepared did you feel to manage that situation?

    b. What would have made you feel more prepared?

    c. Have you ever participated in a training in trauma-informed care?
    [If "yes"]:

        i. What worked well?

        ii. What didn't work well?

Section I: Clinic Environment

Feeling physically and emotionally safe while seeking health care is important, especially for patients with trauma histories. As many people served by RWCs have histories of violence and trauma, we would like to ask you some questions about TIC at your clinic.

Interviewer Note: *For Questions 4-6, we would like you to probe for nuances relating to age, gender, sexuality, race, and ethnicity.*

5. In your words, what might emotional/physical safety look like for a trauma survivor?

    a. Does that differ by age, gender, sexuality, race, or ethnicity? How so?

6. How does your clinic ensure that patients feel physically safe when they are seeking care? *[Probe, if necessary: well-lit spaces, comfortable examination rooms, gender neutral bathrooms, ability to accommodate patient's choice of gender-of provider, special considerations for gender, sexual, racial/ethnic minorities, etc.]*

    a. What barriers has your clinic encountered related to creating a safe environment for patients? *[Probe, if necessary: availability of gender concordant providers/staff members?]*

        i. What do you think would need to happen to overcome these barriers in your clinic?

7. **How does your clinic create an environment that makes patients feel emotionally safe? *[Probe, if necessary: establishing patient-provider relationships based on mutual trust and respect, creation of a safe space where patients can speak freely without judgment, setting ethical and professional boundaries, etc.]***

    a. What barriers has your clinic encountered related to creating an emotionally safe environment for patients?

        i. What do you think would need to happen to overcome these barriers in your clinic?

8. When an issue is identified or raised by patients, providers, or staff about the safety of the clinic environment, how is the issue handled by the clinic?

    a. Is this something that you as _____ would be involved in?

        i. If not, who would be involved?

    b. What roles can/do patients play as support systems for other patients?

        i. How is patient involvement organized? *[Probe, if necessary: is patient involvement formally or informally organized?]*

9. When changes have been made to create a safer physical or emotional environment for patients, what facilitated that change?

    a. How are new policies/procedures/protocols developed?

    b. Are patients ever involved in conversations about changing clinical protocol to respond to safety issues/concerns?

        i. In what ways can/do patients provide feedback about their experience with the clinic?

ii. Are special efforts made to ensure gender, sexual, racial, ethnic minorities are part of the process?

iii. What roles can/do patients play in ensuring the care provided by the clinic meets their needs and is not re-traumatizing/triggering?

Section II: Screening/Assessment

We would like to know more about how your clinic learns about patient experiences of trauma (i.e., violence, loss, HIV-related trauma). However, sometimes clinics and staff have limited resources and screening for trauma can be difficult to implement. These next questions are related to your clinic's current screening practices. We define "screening" as either formal (scale or tool) and/or informal (probing questions) about trauma.

10. Please describe what formal (scale or tool) and/or informal (probing questions) trauma screenings (e.g., IPV or other types of trauma) are conducted at your clinic. **[NOTE: If no screenings are conducted for trauma, skip to Question 10c, then go to 11.]**

    a. Are screenings done systematically (e.g., an established screening protocol for all patients or in specific circumstances)? Why or why not?

        i. How often are patients screened? *[Probe, if necessary: only at intake, routinely, at provider/staff discretion]*
        ii. Do screening practices differ by gender/sexuality and race/ethnicity *[Probe, if necessary: ask about hate crimes? Use screening tools validated for people of different gender?]*

    b. Are these screening practices consistent across all areas of your clinic services? Why or why not?
        i. Are these screening practices consistently conducted by providers/staff?

    c. What barriers has your clinic experienced related to screening for violence? *[Probe, if necessary: lack of knowledge/training, time, lack of resources, legal concerns (i.e. mandatory reporting), providers/staff discomfort with asking, competing clinical priorities, insufficient evidence base to support screening, etc.]*

        i. What do you think would need to happen to overcome these barriers in your clinic?

    d. When the screening goes well, what were the things that make it go well?

e. When someone screens positive for having experienced violence, what happens next?

    i. How are positive screens of violence communicated to other providers/staff in the clinic so that they are aware of this information when interacting with the patient?

    ii. How are they documented (i.e., form, patient note, etc.)?

    iii. Please describe the communication chain.

        1. To what extent is it adhered to?

f. What barriers has your clinic experienced related to following up on a positive screen for someone who needs mental health support? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]*

    i. What do you think would need to happen to overcome these barriers in your clinic?

g. What are barriers your clinic has experienced related to following up on a positive screen for someone who needs housing or social/legal services? *[Probe, if necessary: internal and external linkages, issues related gender, sexuality, race, or ethnicity]*

    i. What do you think would need to happen to overcome these barriers in your clinic?

h. When the linkage to services goes well, what are the things that make it go well? [*Probe, if necessary: facilitators related to internal and external linkages, gender, sexuality, race, or ethnicity]*

11. If systematic screening does not already exist at your clinic, how should it be implemented in your clinic? **[NOTE: If systematic screening exists, skip to Question 12.]**

    a. Who should conduct it and why? *[Probe, interviewer role, characteristics, should the individual conducting the screening be of the same gender/sexuality/race/ethnicity as the patient being screened?]*

    b. How should it be conducted (e.g., when or how often) and why?

    c. What infrastructure would need to be in place to make sure it is done right and why?

d. How should results be communicated to other providers/staff involved in patient care and why?

e. How should it impact their subsequent approach to the patient, and why?

12. What protocol is in place to address when patients disclose they are experiencing or have experienced trauma outside of the usual screening process (e.g. during the patient encounter)? [*Probe, if necessary: issues related gender, sexuality, race, or ethnicity]*

Section III: Staff/Provider Care

Another key component to trauma-informed care is recognizing that working with individuals with complex lives and trauma histories can take a toll on providers. Thus, trauma-informed settings sometimes put practices into place to address the impact this can have on staff/providers.

13. In what ways do you think working with patients with histories of trauma in your clinic has impacted you or other providers/staff positively or negatively?

14. Do you think staff/provider burnout is an issue at your clinic? Why or why not? *[Probe, if necessary: feeling overwhelmed by the experience of supporting patients with histories of trauma and complex needs.]*

15. What strategies (e.g., task shifting/sharing, reducing patient load, protecting time for addressing personal needs) does your clinic employ to support staff emotional well-being?

    a. Do you find these strategies effective? Why or why not?

        i. Do you think most providers/staff at your clinic share your opinion? Why or why not?
        ii. Do you think administrators at your clinic share your opinion? Why or why not?

16. What resources (e.g., services) are available for all staff/providers?

17. What suggestions would you have to improve how the clinic supports emotional well-being or burn-out? *[Probe, if necessary: self-care classes, changes to workload, social events, etc.]*

Section IV: Planning for Action

18. Would you describe enhancing trauma-related practices and services as a current/future priority? Why or why not?

    a. Do you think most administrators/providers/staff at your clinic share your opinion? *[Probe, if necessary: differences between admin vs providers/staff.]*

i. If not, why?

19. Would you describe the provision of a clinic-wide trauma training for providers and staff as a current/future priority for your clinic? Why or why not?

    a. Do you think most administrators/providers/staff at your clinic share your opinion? *[Probe, if necessary: differences between admin vs providers/staff.]*

        i. If not, why?

20. How can administrators/providers/staff advocate for trauma-related practices?

    a. Are there administrators/providers/staff in your clinic that currently serve as advocates?

    b. Are there administrators/providers/staff in your clinic that are not/would not be supportive of TIC? Why do you think that is?

COVID-19 Questions:

As many participants have raised community experience of COVID-19 as a form of collective trauma, we'd like to ask you some specific questions about your experience as an HIV care provider or clinical staff during the COVID-19 pandemic.

1. Can you please describe how COVID-19 has impacted your clinic (i.e. operations, culture)?
2. Can you please describe how COVID-19 has impacted providers at your clinic? Other staff at the clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: Are there things your clinic is doing to support the emotional well-being of providers and staff during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?
3. Can you please describe how COVID-19 has impacted the patients who receive care at your clinic?
    a. If they don't say anything about emotional well-being, probe: What impact has it had on their emotional well-being?
    b. Probe: are there things your clinic is doing to support the emotional well-being of patients during this time?
        i. Follow-up: Is this something that has always been in place, or something implemented in response to the impact of COVID-19?
4. Has COVID-19 epidemic shaped how your HIV clinic may prioritize trauma-informed care (i.e. once it returns to normal operations)? How so? (probe: perceived as more/less important, new TIC ideas or implementation strategies)

Closing

21. Overall, how does trauma-informed care fit with existing care infrastructure at your clinic?

    a. How easy or difficult will it be to integrate TIC in clinic practice?

22. Overall, what do you think your clinic is doing well in terms of providing trauma-informed care?

23. Overall, what are some things that your clinic could do to improve the provision of trauma-informed care?

CFIR Codebook

Code	Memo
CFIR	
CFIR\Intervention Characteristics	Use for intervention characteristics that don't fit under sub-codes. Do not use Intervention Characteristics for resources. Double Code with all Intervention Characteristics constructs.
CFIR\Intervention Characteristics\Relative Advantage	Use for comparing the full package of TIC against what clinics are currently doing. Use for statements such as, "If we did "X" or "something more" it would be great." Use for comparisons or statements about going beyond what currently doing. What does it contribute to what the clinic is currently doing? Also include any kind of perceived change or benefits in care quality that would come from implementing TIC services.

	Do not use for perceived difficulty in implementing TIC in existing services. What is the benefit to the end-users (patients and providers). Be careful with statements such as "This is too hard to do."
CFIR\Intervention Characteristics\Adaptability	Use for statements regarding the perceived ability to be able to adapt the TIC services into clinical care. Example: "We can't do everything, but we can do some things." Telemedicine could be an adaptation; delivering meds by mail, etc. What is the adaptation vs. what is TIC?
CFIR\Intervention Characteristics\Complexity	Use for statements regarding the complexity of offering TIC services themselves (e.g. incorporating longer or new screeners; too many elements of TIC; incorporating new services). Code discussions related to challenges or difficulty of having to navigate systems to be able to

	implement services (e.g. funding streams, bureaucracy) Do not use Complexity for lack of resources such as funding, staffing, or time. Use Available Resources. Intervention complexity / elements of intervention and how hard they are to do; not barriers such as funding, time, staffing.
CFIR\Inner Setting	Double Code with all Inner Setting constructs.
CFIR\Inner Setting\Culture	Use for statements related to staff, provider or clinic values, and mission and purpose. Also use for descriptions of the clinic environment or staff such as "warm", "inviting", "loving" that are created through the natural, subconscious ways of interacting with patients but that exemplify how patient care is viewed as a priority by clinic staff and administration as a whole. Use for description of a conscious effort by clinic leadership to create a

	supportive caring environment for patients as well as staff.
CFIR\Inner Setting\Implementation Climate	Shared receptivity of individuals involved in an intervention (e.g. it would be valued/supported if implemented). The extent to which use of intervention will be rewarded, supported, and expected within the organization. Double code with Relative Priority, Compatibility, and Tension for Change.
CFIR\Inner Setting\Implementation Climate\Tension (Need) for Change	Use for statements that recognize that more needs to be done for patients, or things need to be improved. There is a recognized NEED for change.
CFIR\Inner Setting\Implementation Climate\Compatibility	Do you see TIC fitting within Ryan White clinic settings? Use for statements that demonstrate the extent to which TIC is compatible with or "fits" clinic organizational values and work processes, and care infrastructure.

	Also use for how TIC aligns with individuals own norms, values, and perceived risks and needs, as well as how it fits within existing workflows and structures. E.g. Do you see TIC as an appropriate intervention in this setting/clinic?
CFIR\Inner Setting\Implementation Climate\Relative Priority	Include statements that reflect a perception that implementation of TIC is or should be a priority. Use for statements about enhancing TIC as a priority compared to other programs or services being offered. Also include mention of provision of clinic-wide TIC training as a priority. May double code with SAMHSA Training code if mention of need for TIC training.
CFIR\Inner Setting\Readiness for Implementation	Do they have the capacity to implement TIC? Are they prepared to implement TIC?

	Double code with Leadership Engagement, Available Resources, and Access to Knowledge. Also, double code with SAMHSA Training code if mention of need for TIC training.
CFIR\Inner Setting\Readiness for Implementation\Leadership Engagement	Does Leadership support TIC? Include statements regarding the level of engagement or support (advocacy) of organizational leadership for TIC, such as involvement in the process and investment of resources in TIC. Description of the expression of enthusiasm of leaders about incorporating TIC and extent to which they understand clinic needs. Extent to which leadership follows up with the implementation team and providers to ensure TIC is (or will be) implemented. This code refers to tangible evidence of leadership involvement in implementing TIC.

	Double Code with Champion if leadership is also an advocate for TIC.
CFIR\Inner Setting\Readiness for Implementation\Available Resources	The level of organizational resources available and\or dedicated to implementation and on-going operations to provide TIC services, including funding, training\education, physical space and time. Include mention of physical space, dedicated clinic personnel and staffing, money to pay for personnel, referral networks, training, etc. Use for statements relating to the cost of incorporating TIC into patient care, including modification of clinic space, training, additional staff time.
CFIR\Inner Setting\Readiness for Implementation\Access to Knowledge and Information	Include statements about access to expert knowledge (other staff; external expertise) training, documentation. Ability to search databases and online resources for information as needed.
CFIR\Inner Setting\Networks and Communications	Include statements about general networking, communications, and relationships in the organization, such as meetings, emails, and other

	methods of keeping people informed about TIC practices. Also include statements related to internal communications about patients that have positive screens for TIC (e.g. EMR notes, flags, etc). Include statements about the social networks that people have that facilitate their work and that can influence care (this may overlap with [Implementation/Context, and Culture codes.
CFIR\Outer Setting	Double code with Outer Setting Constructs: Patient Needs and Resources, Peer Pressure, External Policies and Incentives, Cosmopolitanism.
CFIR\Patient Needs and Resources	Use for statements that mention "Patient centered", or awareness of the needs and resources of patients. Also use for recognition of patient characteristics and consideration of patient needs and resources.

	Refers to the extent to which patient needs, as well as barriers and facilitators to meet those needs are accurately assessed, are known and prioritized by the organization. Analysts may be able to infer the level of awareness based on statements about: 1. Perceived need for the TIC in services based on the needs of those served by the organization and if the clinic has the external connections to meet those needs; 2. Barriers and facilitators of those served by the organization to accessing external services. Barriers for patients can include specific aspects of TIC services, such as connecting patients with external services (housing, mental health); or 3. Participant feedback on the innovation, i.e., satisfaction and success in a program. In addition, include statements that capture whether or not awareness of the

	needs and resources of those served by the organization influenced the implementation or adaptation of the innovation. This can also include perceptions of patients own resources (i.e. a lot of our patients are low income) and their ability to navigate services.
CFIR\Cosmopolitanism	Include descriptions of external collaborations and partnerships with other organizations. Include referral networks\partnerships for services such as housing, legal aid, mental health, etc.
CFIR\Characteristics of Individuals	Use for mention of individuals attitudes within the clinic who may be involved in TIC implementation, including knowledge, beliefs, self-efficacy, and prior experiences. Include description of habitual interaction with patients that follow TIC principles even if not specifically stated that they are providing TIC.

	Also use for value placed on offering TIC services, as well as familiarity with facts, truths, and principles related to TIC.
CFIR\Process	Refers to discussion and activities about how TIC might be or is being implemented or carried out at each specific clinic or site. Specifically, what would happen for each step of implementing TIC in the clinic. Process components: planning (training, tools), engaging (champions, implementation teams), executing, and reflecting and evaluating (monitoring and deciding about continuation\refinements). Double code with Planning, Engaging, Implementation, Sustainment as appropriate.
CFIR\Process\Planning/Needs Planning	Thinking about or in the process of planning implementing TIC or planning SHOULD take place. This is Use for discussion of the activities, tasks, or methods related to the process of planning the TIC implementation.

	Include any discussion of training or protocols.
CFIR\Process\Engaging\Needs Engaging	Refers to the involvement of individuals or teams (change agent, champions, opinion leaders) within the organization in the implementation of TIC.
CFIR\Champions (Advocates)	Include statements related to who might be a good champion for TIC and why, as well as how they can be engaged. Use for mention of administrators\providers\staff support of or advocating for TIC at the clinic. Also, what makes the individual a good champion, i.e their capabilities, qualities, motivation, and skills.
CFIR\Process\Executing	Refers to carrying out or accomplishing the implementation according to plan (fidelity).
CFIR\Process\Evaluating and Reflecting	Use for discussion of formal and informal quantitative and qualitative staff forms of feedback about the progress and quality of implementation. Use to describe group and personal reflection on TIC implementation and sharing lessons

	learned. How are clinics measuring or ensuring protocols are being followed? This may be accompanied with regular personal and team debriefing about process and experience (Reflecting). This includes discussion about how and why clinics gain feedback from staff about new interventions or on-going processes. This could be referral to team discussions about what is working\not working; debriefing about progress and experience, or not debriefing, and what kind of debriefing takes place.
General\Good Quote	Use for quotes that exemplify a code or that are relevant or interesting.

SAMHSA Codebook

SAMHSA Code System

SAMHSA
Staff Development
Training
Staff Support Outlets
Self-care
Burnout
Positive and Negative Impact
Safe and Supportive Environment
Emotional Environment
Physical Environment
Assessing for Trauma and Referral for Services
Screening Procedures
Referral Procedures Improvement
Offering Referral to Services
Formal Screening
Informal Screening

- Patient Involvement
  - Patient Feedback
  - Peer-Advocates
  - Peer Support
- Provider Feedback
- Clinic Policies
  - Policy Process
  - Existing Policies
  - Safety Issues and Crisis Response
- Safety and Crisis Prevention

General

- Clinic Description
- Participant Description
- Ryan White Policies and Procedures
- Good Quote
- Innovations
- Patient Demographics
- Barriers

Facilitators
Stigma
Definitions of Trauma
Wrap-around Services
Service Utilization
Suggestions for Facilitating TIC Implementation

SAMHSA >> Staff Development

Double code with Training, Staff Support Outlets, Self-Care, Burnout Prevention Strategies.

SAMHSA >> Staff Development >> Training

Use for any mention of TIC training including opportunities or plans for TIC training; having participated in TIC training on or off-site; conducting training; or need for training.

SAMHSA >> Staff Development >> Staff Support Outlets

Use for institution-sponsored or hosted (during working hours) services and\or promoted resources and outlets for staff support such as EAP, counselling, gym memberships, group sessions, and wellness programs.

If unsure, double code with Self-care and memo.

SAMHSA >> Staff Development >> Self-care

Use for mention of self-care, including taking advantage of resources provided by institution on own time such as gym memberships and Headspace, as well as non-sponsored (informal) social events with colleagues, or yoga.

Double code with Staff Support Outlets and Burnout Prevention Strategies and memo.

SAMHSA >> Staff Development >> Burnout

Describes the strategies clinics use to reduce burnout among on staff and providers. These may include the strategies used to reduce burnout such as task shifting or job sharing, reducing patient load, providing protected time for work and taking care of personal needs, and opportunities to debrief.

Use for institution-provided and\or promoted resources and outlets for staff support such as EAP and onsite counselling.

May double code with: Staff Development

SAMHSA >> Positive and Negative Impact

Use for descriptions of the positive and negative impacts on provider well-being of working with people with complex lives on the clinic staff, providers and administrators.

Also use for positive and negative impacts of provider interactions on patients.

SAMHSA >> Safe and Supportive Environment

Refers to descriptions of what comprises an environment that is safe and supportive of patients and staff, including considerations of physical and emotional safety, gender identify, cultural competence, privacy, mutual trust and confidentiality.

Also use for discussion of trainings attended, steps in place to ensure patient privacy and confidentiality in waiting areas, not discussing patients in front of others, using people's preferred pronouns and names.

SAMHSA >> Safe and Supportive Environment >> Emotional Environment

Use for mention of the way in which clinic staff and providers interact with patients that creates or establishes rapport and intimacy, creates an environment where patients feel comfortable speaking freely and without judgement, ethical boundaries, use of appropriate pronouns\pronouns of choice and name of choice, privacy and confidentiality, cultural competence, sensitivity. Some of these may overlap with Physical Environment.

Also use for descriptions that indicate a lack of these element and for considerations of safe emotional environment for staff and providers.

SAMHSA >> Safe and Supportive Environment >> Physical Environment

User for descriptions of clinic infrastructure and measures taken and\or changes to the physical\built environment that are put in place to help patients, providers and staff feel physically safe.

These include but are not limited to: well-lit spaces, gender neutral bathrooms, comfortable exam rooms, comfortable waiting area, security, locked doors, access for differently abled people, accommodations for privacy concerns and availability of a gender-appropriate provider. Some of these, such as availability of gender-appropriate provider may overlap with Emotional Environment.

Use for mention of physical safety, lack of physical safety, what clinics do to create an environment in which their patients and staff feel physically safe.

Use for descriptions of the clinic space, patient flow, and considerations made to accommodate concerns of individuals that do not feel comfortable in a fixed physical environment that cannot be changed. Use for discussion of changes made to the physical clinic environment to make it feel safer for patients and staff and what prompted those changes. Also use for plans to improve the physical space and what prompted those changes.

SAMHSA >> Assessing for Trauma and Referral for Services

Use for mention of formal or informal regular and routine conduct of screening and assessment for trauma and trauma symptoms (PTSD). Use if there is a plan to modify or change existing screening and assessment practices or to introduce systematic screening and assessment. Also use for mention of any screenings currently in place. Use for mention of frequency of screening (e.g. at intake, yearly, every visit) and\or recognition of need for regular screening.

Use for mention of offering to refer patients for internal and\or external services and\or trauma-specific interventions. This may be individual or team practice or a clinic policy. Also use for lack of procedures and policies around referral for services and interventions.

Use for mention of need for or plans to strengthen (improve) or systematize referrals to internal and external services for trauma.

SAMHSA >> Assessing for Trauma and Referral for Services >> Screening Procedures

Use for discussions around screening that is formal or informal but that encompasses existing screening practices.

Also use for discussion about potential barriers, the broader context of screening, how it should be improved and integrated.

SAMHSA >> Assessing for Trauma and Referral for Services >> Referral Procedures Improvement

Use for discussion about the strength and weakness of internal and external referral for trauma services. Use for mention of the process of improving procedures, plans, or the need to improve patient referrals.

Use for references to improving the process of referral to internal or external partner services for trauma. This could be incorporating processes such as walking with a patient to their mental health or other service to ensure they get there; meeting with partner providers to determine if patients are getting to services, or working to identify

and\or resolve barriers to the patient following up on a referral for services outside of the clinic.

SAMHSA >> Assessing for Trauma and Referral for Services >> Offering Referral to Services

Use for mention of providers and\or staff offering to refer to internal or external services following a positive informal or formal screen for trauma\violence. Services offered include mental health, substance abuse, trauma and abuse, adult protective services, food security, legal services and housing. Services may be internal to the clinic (e.g. mental health services provided in-house), external, or both.

NOTE: This code focuses on the provider-patient interaction and provider offer of referral for service.

SAMHSA >> Assessing for Trauma and Referral for Services >> Formal Screening

Use for the conduct of routine or systematic use of questionnaires, scales or validated tools to assess or screen for violence or trauma at patient intake, or during first patient encounter. Also use for mention of regular periodic screening (e.g. every six months, yearly etc).

SAMHSA >> Assessing for Trauma and Referral for Services >> Informal Screening

Use for mention of informal conversations had with patients outside of the formal screening process (e.g. not part of formal screening or assessment). This includes asking probing questions about events disclosed or comments made by patients during patient encounters and informal conversations.

This encompasses casual conversations about life or mention of trauma during informal moments and may be patient (e.g. patient mentions experiencing abuse) or provider initiated (e.g. provider\staff mentions asking questions about signs of abuse or based on past comments\discussion about abuse).

SAMHSA >> Patient Involvement

Use for description of how patients are involved in the clinic. This may involve providing peer support, serving as advocates for other positive people, participating on committees and advisory boards.

Also use for discussion about how patients are involved in the selection of trauma-recovery services to be offered, experiences involving patients as peer-advocates; involving patients in policy decisions; providing multiple outlets for patients to provide feedback.

Double code with Peer Support, Peer-Advocates and\or Patient Feedback.

SAMHSA >> Patient Involvement >> Patient Feedback

Opportunities for patients to provide feedback on satisfaction with services, suggestions and quality. (e.g. surveys, suggestion boxes, exit interviews, direct patient-provider feedback).

Also use for patient involvement in decision making about their own clinical care.

SAMHSA >> Patient Involvement >> Peer-Advocates

Use for patient participation on Community Advisory Boards and \ or vocal individuals who speak on behalf of the patient population\group.

Includes participation in selection of services, developing policy or protocols and changes in clinic procedures.

SAMHSA >> Patient Involvement >> Peer Support

Use for mention of the role of existing support groups, individual direct peer-to-peer relationships (e.g. Peer Navigators), or lack of peer support options.

SAMHSA >> Provider Feedback

Use for mention of how staff and providers can provide feedback on satisfaction with services, suggestions and quality. (e.g. team meetings, debriefs, concerns about personal safety or patient's safety).

SAMHSA >> Clinic Policies

Use for mention of clinic protocols, policies and procedures in place related to addressing safety issues raised by patients, staff or providers. Also use for regular review and modification of existing policies and the recognition of the need for new ones. Include discussion about how processes are developed and how policies and procedures are communicated to administrators, staff, providers and patients.

Double code with Existing Policies, Policy Process, and Safety Issues\Crisis Repones codes.

SAMHSA >> Clinic Policies >> Policy Process

Use for discussion about how and why policies are created, modified or reviewed, who is involved, and what prompts or triggers the process. Include description of the steps to develop a new policy, procedure or protocol.

Describes the process of developing new policies, and the review and modification of existing policies (frequency). Describes who is involved at the clinic level, if and how patients are involved, what are the steps taken to develop a policy.

SAMHSA >> Clinic Policies >> Existing Policies

Use for description of clinic or department policies in place that relate to addressing patient trauma. This may include discussion about existing policies or absence of clinic policies, and what triggers the development of a new policy.

Use for discussion about formal\informal clinic policies and procedures in place to address safety issues that are raised by patients, staff or administrators.

SAMHSA >> Clinic Policies >> Safety Issues and Crisis Response

Measures taken to address safety issues related to the clinic environment raised by patients\providers\staff (e.g. established protocols developed, regular review and modification of policies as needed, clinic enhancements to address physical\ emotional safety, training).

Use for mention of policies and procedures to respond to patient crisis or safety concerns, and the existence of written safety and crisis prevention plans.

Do not use for policies outlining patient crisis prevention. For this use Safety Issues and Crisis Prevention code instead.

May be double coded with: safe and supportive environment, physical safety, emotional safety, training, clinic policies and existing policies.

SAMHSA >> Safety and Crisis Prevention

Use for measures taken to address safety issues raised by patients\providers\staff, and the changes, policies and procedures developed and put in place to address them.

Also use for the process of developing and establishing protocols and formal or informal policies and practices, and the steps taken to prevent crisis.

SAMHSA >> Safety Issues and Crisis Response

Measures taken to address safety issues related to the clinic environment raised by patients\providers\staff (e.g. established protocols developed, regular review and modification of policies as needed, clinic enhancements to address physical\ emotional safety, training).

Use for mention of policies and procedures to respond to patient crisis or safety concerns, and the existence of written safety and crisis prevention plans.

Do not use for policies outlining patient crisis prevention. For this use Safety Issues and Crisis Prevention code instead.

May be double coded with: safe and supportive environment, physical safety, emotional safety, training, clinic policies and existing policies.

General >> Clinic Description

Use for description of the clinic itself, the services provided, size, etc.

General >> Participant Description

Bucket code for background on participant; their role, training, experience, demographics who they take care of.

General >> Ryan White Policies and Procedures

Use for any mention of RW mandated policies or procedures.

General >> Good Quote

Use for quotes that exemplify a code or that are relevant or interesting.

General >> Innovations

Use for innovative or creative tools, resources and\or policies.

General >> Patient Demographics

Use for description of patient population (age, race, ethnicity, etc.).

General >> Barriers

Use for references to barriers to implementation, including lack of staff, time, funding, institutional support, culture, climate, etc.

Double code with Existing Resources (staffing, space, funding), internal rules and regulations that require TIC, and externally imposed rules and regulations (e.g.: RW, FQHC, HHS).

General >> Facilitators

Use for things that facilitate the implementation of TIC, such as references to or facilitators of implementation, including's staff, resources, funding, institutional support, culture, climate, etc.

Double code with Existing Resources (staffing, space, funding), internal rules and regulations that require TIC, and externally imposed rules and regulations (e.g.: RW, FQHC, HHS).

General >> Stigma

Use for mention of stigma as it relates to patients. This may include patient fear of stigma or history of experiencing stigma, either in the broader community or within the clinic. Also use for providing trauma informed care and avoiding re-stigmatizing patients, including practices or efforts to reduce stigma in the clinic.

General >> Definitions of Trauma

Use for provider\staff member definitions of trauma as they see and understand it in their patient populations.

Use also for types of trauma providers\staff discuss in relation to their patients, e.g. violence, partner violence, mental health, stigma, HIV diagnosis, sexual abuse, child abuse, absent parents, etc.

Use for levels of trauma described as "severe", "little", "least", etc.

General >> Wrap-around Services

Use for type of services provided onsite such as mental health, housing, food\food security, legal aid, substance abuse, etc.

Use for both services provided onsite or in partnership with outside organizations (referral).

NOTE: Use Clinic Services to describe services available to patients in-house or through a partner or outside organization. Use SAMHSA\Offering Referral to Services code for provider referral to Clinic Services.

General >> Service Utilization

Use this code for mention of patients accessing trauma-related services (completing referral) either in-house or through an external partner\organization. E.g. completed a warm-handoff; did the patients engage in care? How does the clinic know that the patient completed the referral?

General >> Suggestions for Facilitating TIC Implementation

Practical considerations, adaptations, or ways to implement TIC. This could be processes or practices that facilitate implementation of services as well as recommendations for best practices.

Note: This is not the same as the CFIR code for Adaptability. Do not use for general comments about the need for trauma informed care changes (Tension for Change) within the organization, or the presence or absence of trauma informed care implementation.