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"*They are human*": Creating Safe and Supportive Environments in Trauma Informed Settings for People Living With HIV

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2020

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Abstract

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Background

Human Immunodeficiency Virus (HIV) has impacted people living with HIV (PLWH) ability to retain care in the Southern United States for multiple decades. The Traum-Informed Care framework's domain of Safe and Supportive Environments emphasizes the impact that positive clinical environments can have on a patient's experience. The goal of this study was to explore the strategies employed by Ryan White clinics in the Southeastern US in creating safe and supportive environments for their patients. The purpose of this qualitative analysis was to identify existing strategies and areas for improvement in Ryan-White clinical environments.

Methods

This qualitative sub-study was nested within a larger mixed-methods study. The parent study used an explanatory sequential design, which utilized web-based surveys among 400 Ryan white Clinics within the Southeast. For this sub-study, a qualitative methodological approach was utilized to analyze the original 36 key informant interviews conducted with clinic staff and providers.

Results

Thematic analysis resulted in four primary themes: 1) Definitions of Safety, 2) Barriers to Creating a Safe Environment, 3) Methods Currently Employed to Create a Safe Environment, and 4) Methods for Enhancing a Safe Environment. Within this analysis, themes were developed by consistent descriptions and patterns relating to the safety and security of a Ryan White Clinic's environment. Key areas for improvement included: strengthening comprehensive understanding of providers and increasing the presence of providers and staff that have diverse cultural, ethnic, and racial backgrounds. Improving infrastructure is an additional action that can be taken create a to create a safe and comfortable environment within Ryan White clinics.

Discussion

Thematic analysis of in-depth interviews demonstrated that values of safe and secure clinic environments often encompassed trust in providers and clinic staff, comprehensive understanding of providers, general maintenance of privacy, and physical manifestations of security. These findings provide an opportunity to open and shape conversations with Ryan White clinic staff and HIV patients, surrounding the creation of safe spaces in TIC environments.

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CHAPTER 1: LITERATURE REVIEW

Prevalence of HIV in the USA

Over decades, the human immunodeficiency virus (HIV) slowly spread across Africa, and then on to other parts of the world. Zooming in on the United States, HIV trends have changed decade by decade. The virus has been in the United States since the late 1970s, although the first known cases of AIDS were reported at the start of the 1980s (KFF, 2021). Although there is currently no cure for HIV, it can be controlled with effective medical care. Today, 1.2 million individuals are living with HIV, while 13% are unaware they have HIV (HIV & AIDS Trends and U.S. Statistics Overview, n.d.). Throughout the decades, HIV has had a disproportionate effect on specific populations, including African American and Latino communities, gay and bisexual men of all races, transgender women, and injection drug users (Populations at Greatest Risk | HIV/AIDS | CDC, 2020). Risk factors that put people at the highest risk for contracting HIV include: "having condomless sex, having sexually transmitted infections (STIs), sharing contaminated needles or syringes when injecting drugs, receiving unsafe injections or blood transfusions, and experiencing unexpected needle stick injuries," (HIV, n.d.).

Prevalence of HIV in the Southern USA

According to the Centers for Disease Control's "HIV Surveillance Report, 2015-2019,", the prevalence rate of those living with HIV in the South was 524.4 per 100,000 population (Estimated HIV Incidence and Prevalence in the United States, 2015–2019, n.d.). In 2020, the South has the highest percentage of new HIV diagnoses by region, with a total of 51% (Estimated HIV Incidence and Prevalence in the United States, 2015–2019, n.d.). Factors contributing to the heavy burden of HIV in the South include socioeconomic issues, such as poverty and high rates of unemployment. Both factors can create an increased concentration of HIV and other chronic diseases in this region. There are additional barriers to access that PLWH in the South may experience. Almost half of all uninsured or underinsured US citizens live in the South. In rural and remote areas of the South, PLWH faces problems accessing

consistent HIV treatment due to a lack of transportation, longer travel times to treatment, and reduced accessibility of resources and services that might be available in urban or suburban areas (HIV in the Southern United States, n.d.). These factors contribute to the lower retention rates of HIV care in the South.

In "HIV/AIDs in the Southern USA: a Disproportionate Epidemic," states within the South include Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas (Reif et al., 2014). The prevalence of HIV in the South is higher in comparison to other regions of the US due to certain characteristics. These characteristics include "overall poor health, high poverty rates, and poor health outcomes for those infected with HIV," (Reif et al., 2014).

HIV Care Continuum

The HIV Care Continuum is a public health model that demonstrates steps to reach viral suppression. Viral suppression means that the amount of HIV in an infected person's body is very low or even undetectable (HIV Care Continuum, n.d.). Viral suppression is reached when there are less than 200 copies of HIV per milliliter of blood. The stages of the HIV Care Continuum include HIV diagnosis, linkage to HIV care, receipt of HIV medical care, retention of HIV care, and achievement and maintenance of viral suppression (HIV Care Continuum, n.d.). The overall goal of the care continuum is to decrease the morbidity and mortality of people living with HIV (PLWH). The care continuum is significant because when PLWH sustains their viral suppression, it decreases the risk of passing HIV to other individuals and reduces their own HIV-associated morbidity and mortality (Understanding the HIV Care Continuum, 2019).

The HIV Care Continuum is represented as a linear framework, however, PLWH "often experience the care continuum in a less streamlined fashion, skip steps altogether, or even exit" the HIV care cascade (Kay et al., 2016). Research has continued to suggest that individuals' experience is often nonlinear, i.e., people cycle back and forth between steps of the care continuum. Additionally, half of

them are not retained in HIV care, a step critical for viral suppression. According to Kay and Batey, in HIV research, there is a lack of agreement on how to efficiently measure a person's retention, and continuity, within HIV care (Kay et al., 2016). Retention in care can be defined by the IOM, NHAS, and CDC as "two or more visits for routine HIV medical care in the is set definition for HIV retention in care in the preceding 12 months at least three months apart (Kay et al., 2016)." However, there are gaps in this definition as it only accounts for adherence to scheduled appointments and does not include missed or canceled appointments (Mugavero et al., 2013). Another challenge of the HIV Care Continuum is that there are very limited evidence-based interventions known to improve retention in HIV care (Gardner et al., 2012). For this reason, there is a distinct need to take a closer look at PWLH living in the Southern United States, which face challenges with being retained in care.

Ryan White Clinics

The Ryan White HIV/AIDS Program (RWC) was enacted in 1990 and has been providing underinsured and uninsured individuals access to HIV outpatient care, supportive services, and medications for over 30 years (Ryan White HIV/AIDS Program - 2018 State Profiles, n.d.). The program, overseen by the US Department of Health and Human Services, is the largest federally funded HIV/AIDs program in the United States (Resilience and Innovation to End the HIV Epidemic in the U.S., 2021 Ryan White HIV/AIDS Program Highlights, n.d.) In 2019, close to 568,000 people participated in care via Ryan White clinics. This number equates to over half of the US population of PLWH (KFF, 2022).

In a study conducted in 2016 by the Infectious Disease Society of America, results demonstrated that 40.7% of PLWH seeking medical care received RWC assistance; this includes the 15.3% of PLWH who only relied on RWCs for HIV care and 25.4% who relied on a combination of RWC and other healthcare coverage (Bradley, n.d.). In terms of Ryan White funding, many PLWH residing in the South are dependent on Ryan White funding for basic HIV medical care. According to Reif and Saffey, "these

states often lack sufficient Ryan White funding for critical HIV services such as HIV case management and transportation to medical care and support services," (Reif et al., 2017).

Barriers to HIV Care

Many barriers have been identified as barriers to HIV care. Some barriers that can disturb a patient's involvement in HIV care include the lack of financial resources, healthcare resources available in the area, lack of access to transportation, and lack of emotional or physical support (Dombrowski et al., 2015). Barriers to HIV care in the South can be particularly challenging, as the region has higher HIV diagnoses rates, poverty, lack of insurance, stigma, rural geography, and the limited existence of public health programs in comparison to the rest of the United States (Kimmel et al., 2018).

One barrier to HIV care and retention more recently identified by the scientific community is a patient's traumatic experiences. SAMSHA defines trauma as 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" (Trauma-Informed Care in Behavioral Health Services, n.d.). Traumatic events can affect an individual's well-being, mentally, physically, socially, and emotionally. Results from the Coping with HIV/Aids in the Southeast (CHASE) study, highlight the prevalence of trauma on PLWH in the Deep South: over 50% of participants were abused during their lives, and 30% experienced abuse before the age of 13 (Whetten et al., 2006). Childhood sexual abuse and physical trauma were the most common forms of trauma. Patients were less likely to engage in HIV treatment, as trauma is associated with increased risk-taking behavior (Springs & Friedrich, 1992).

Impacts of Trauma on the HIV Care Continuum

Among the steps of the HIV Care Continuum, retention in care is the most challenging. As many as 50% of PLWH patients are not retained in HIV care (Understanding the HIV Care Continuum, 2019).

This can lead to a progression of the virus and eventual death. Patients' traumatic experiences contribute to poor retention rates within HIV care. According to "The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS" by Wells Pence, depression and stress are highly prevalent in PLWH (Pence, 2009). PLWH experiencing psychological adversity are more likely to have lower ART adherence, lower retention in care, and increased mortality (Pence, 2009). Additionally, research highlights that PLWHs have "significant trauma histories when compared to the general population," (Trauma-Informed Approaches, 2018). Furthermore, 70% of PLWH have had traumatic experiences. In comparison to the general population, PLWHs are twenty times more likely to have had traumatic experiences (Trauma-Informed Approaches, 2018). Furthermore, several traumatic factors may describe elevated levels of stress among PLWH. These factors include a higher likelihood of exposure to trauma at a young age, repeated traumatization, and exposure to trauma that can such as physical sexual abuse, assault, and crime-related violence.

Additionally, intimate partner violence (IPV) has been strongly linked with HIV infection and engagement in HIV care. IPV not only increases the risk of HIV infection but also interferes with a patient's engagement and retention in care (Sullivan, 2019). Data from a previous study indicates that women living with HIV who experienced IPV had lower adherence to HIV care (Sullivan, 2019). Research reveals that patterns of IPV survivor's adherence to care can been affected by "abusive partners actively, or passively interfering with care," (i.e., victims hiding signs of abuse from their health care providers) (McCloskey et al., 2006). Due to the various types of traumas PLWH may face, there is a distinct need for trauma-informed care in HIV settings, to create safe and supportive environments for this population. PLWH's traumatic experiences contribute to a patient falling out of care, or lack of retention in care.

Trauma Informed Care Framework

The trauma-informed care approach, otherwise known as the TIC approach, was developed by the United States Substance Abuse and Mental Health Services Administration (SAMHSA). This framework

"takes an informed approach to the delivery of behavioral health services, which includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations," (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.). The guidance for implementing a trauma-informed approach is presented in the ten domains. The domains include governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening/assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation. These implementation domains build off of each other for developing a trauma-informed care approach across an organization. For this review, we will be analyzing the domain of the Physical Environment (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.). According to SAMHSA, the physical environment in an organization "promotes a sense of safety and collaboration" among staff (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.). Per SAMHSA, personnel that work in the organization and patients need to experience a setting that is safe, inviting, and does not pose a threat to their physical or psychological well-being or safety. The physical environment of the clinic should also support the collaborative aspect of a trauma-informed approach through openness, transparency, and shared spaces. SAMSHA highlights that a clinic can ensure a safe and supportive environment by ensuring that staff and patients experience a safe, inviting, and collaborative space. A supportive physical setting can be created through "openness, transparency, and shared spaces," (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.).

In a simplified way, the TIC approach is guided by the four R's. The four Rs of TIC include: "realization about trauma and how it can affect people and groups, recognizing the signs of trauma, having a system which can respond to trauma, and resisting re-traumatization," (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.). The infrastructure of an RWCs physical environment may be retraumatizing, such as unlit spaces, lack of gender-neutral bathrooms, uncomfortable exam rooms, uncomfortable waiting areas, lack of security, lack of access for differently

abled people, no accommodations for privacy concerns and unavailability of a gender-appropriate provider. Due to these measures and infrastructural elements that may contribute to a patient's re-traumatization, it is important to consider these elements as RWCs are designed and updated.

In HIV settings, TIC approaches may involve the adjusted delivery of services that work to accommodate challenges faced by patients due to traumatic events such as sexual violence, assault, or abuse. These events could be related to sexual and gender identity, ethnicity, and race. Trauma-informed care creates a comprehensive and holistic approach for patients to be treated. To create effectively improve health outcomes for PLWH at the greatest risk, HIV treatment with TIC programming helps address all a patient's needs.

Ryan White Clinics and the TIC Framework

Utilizing a trauma-informed perspective on the HIV epidemic in Southern US is necessary to maintain PLWH presence in care. As the initial goal of RWC is to aid patients in achieving and maintaining their HIV viral suppression, RWCS must align its resources and activities directly with these goals. To support this goal, it is beneficial to create an understanding of the importance of adopting the TIC (Kalokhe, 2022).

While RWCs continue to provide funding to clinics, training institutions, health departments, and healthcare providers, less is known about the program's implementation of trauma-informed care. Providing safe and trauma-informed care is a recent activity. Furthermore, there is limited research on Ryan White Clinic's "feasibility and capacity to adopt TIC," (Piper et al., n.d.). However, as RWCs commonly utilize integrated care models, the infrastructure suggests a TIC approach can be integrated smoothly (Piper et al., n.d.). Although trauma–informed care in Ryan White Clinics is a newer step taken, in 2017, the National Alliance of State and Territorial AIDS Directors recognized the need for integration

and developed a toolkit, specifically for providers and staff working at Ryan White Clinics, to realize, recognize, respond to, and resist the impacts of trauma on PLWH (Trauma-Informed Approaches, 2018).

Importance of a Safe Environment

People living with HIV experience numerous stresses that affect their maintenance of care, as well as medication adherence. An HIV clinic's environment can have a beneficial and supportive role for PLWH, including a positive influence on health outcomes. Environments can come in different forms including physical and emotional. Not much information is known about the concept of an HIV clinic environment. Environments, though not often featured in clinical discussions, are an important aspect of self-care. Throughout the literature on patient safety and healthcare environments, research has often highlighted the concept of organizational culture and climate. This concept also encapsulates patient safety and culture (Stone et al., 2008). According to Stone, the supportive design of a healthcare facility can reduce a patient's anxiety and stress. For this paper, the research team is using a facility's design as a part of the definition of the physical environment. While stressors can present an obstacle to healing, a supportive physical environment can promote the delivery of high-quality healthcare among healthcare workers, and higher perceived measures of quality care among patients (Carpman, n.d.).

An environment can encourage or discourage a patient's behavior or response. Therefore, safe and supportive environments are important to consider, as previously outlined in the TIC approach. Currently, the design strategies of Ryan White Clinics are unknown, therefore it is important to consider how RWCs are designing their spaces, to establish and maintain a safe and supportive environment. Strategies employed in other settings include creating clinics with humanistic designs. Ryan-White clinics throughout the Southern United States may consider creating humanistic designs. Humanistic design has been achieved by incorporating the perspective of patients and visitors in the process of creating the physical environment. Designs can include a variety of aspects of an environment, including lighting, wayfinding systems, welcoming signage, and open spaces (Carpman, n.d.). Additionally, as mentioned

previously, environments transmit psychological and emotional meaning. A caring and supportive clinic with a physical environment supports the emotional and psychological needs of patients (Carpman, n.d). In tandem, environments can send patients a negative message, making patients feel forgotten or unimportant. For this reason, RWCs need to promote a supportive physical environment for PLWH.

Gaps within Literature

There are many gaps in this research. Although research has been conducted on the importance of a "safe space" in clinical environments, there is a lack of literature within the context of HIV clinics in the Southeastern United States. As the Southeastern US region of the nation has high rates of trauma and high rates of HIV, this study serves to address these gaps. The main research questions of this study include:

Primary question:

How do RWCs in the Southeastern US provide a safe and supportive environment for their patients?

Secondary question:

From the perspective of RWCs in the Southeastern US, how can the safety and support of the environment be enhanced?

CHAPTER 2: MANUSCRIPT

Introduction

The management of HIV care presents a unique set of challenges for those living with the disease. Barriers associated with HIV care can be particularly taxing for people living with HIV (PLWH), thus affecting their retention and maintenance of care and medication adherence (Pence, 2009). While the importance of positive healthcare environments is recognized, little is known about the concept of safe and supportive environments in HIV clinics (Piper et al., n.d) (Kalokhe, 2022). Environments, both physical and emotional, can have a significant impact on a patient's response to treatment, making the creation of supportive and safe environments crucial. The trauma-informed care (TIC) framework is an approach that recognizes trauma patients may experience; it is a commitment to restore safety, and empowerment for patients (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, n.d.). TIC recognizes the affect an individual's trauma can have and how re-traumatization may occur in clinical setting (Trauma-Informed Approaches, 2018). Therefore, the physical and emotional environment also plays a significant role in creating a supportive environment for PLWH (Carpman, n.d.). In this study, the research team investigates barriers, facilitators, and methods to enhance a safe and supportive environment in Ryan White Clinics in the Southern United States. Through the utilization of the TIC framework, Ryan White clinics can strengthen the safety of their clinical environments, strengthening patient's retention in care. By promoting a supportive physical and emotional environment as emphasized by TIC, Ryan White Clinics can better meet the physical, emotional, and psychological needs of PLWH, and thus improve health-related outcomes.

The aims of this sub-study include the following:

Aim 1: To explore the strategies employed by Ryan White clinics in the Southeastern US in creating safe and supportive environments for their patients.

Aim 2: To identify areas for improvement in the safety and support of the environment from the perspective of Ryan White clinics in the Southeastern US.

Methodology

Study Design

This qualitative sub-study is nested within a larger mixed-methods study. The parent study used an explanatory sequential design, that utilized web-based surveys among 400 Ryan White Clinics within the Southeast. Thirty-six (36) key informant interviews were conducted with staff and providers from the targeted RWCs. This sub-study will be utilizing a qualitative methodological approach, analyzing the original 36 KIIs, to answer this study's primary question and secondary questions.

A qualitative research approach was selected to determine participants' views, opinions, knowledge, experiences, or values regarding the safety and support of their clinic's environment. Themes were identified to address the nature of the primary and secondary research questions. Archival data was utilized for this study. The interview guide was developed by the "Trauma-Informed HIV Care in the South" team over 1-4 months, using CFIR and SAMSHA guidance to inform development. Open-ended questions focused on topics of Clinic Environment, Screening/Assessment, Staff/Provider Care, and Priorities for incorporating TIC into practice. For this sub-study, Clinic Environment will be the domain of focus.

Sample and Recruitment

Purposive sampling was utilized to sample participants to ensure adequate representation across different services and staff roles. This sampling strategy was employed to identify staff and providers that were best suited to answer the parent study's research question. Providers were defined: as advanced practice providers and physicians; staff as nurses, case managers, social workers, health educators, patient

navigators, patient access representatives, and administrators as members of the clinic's executive leadership.

Data Collection

The sub-study for this project included the utilization of qualitative data that was previously collected. Within the parent study of this project, in-depth interviews were conducted in person by trained research staff, within private spaces at the clinic. The interviews lasted between 30 to 60 minutes. The parent-study's interview guide was adapted from the "Creating Cultures of Trauma-informed Care" (Fallot and Harris, 2009). Questions explored current center practices, capacity, weaknesses, and strengths in trauma-informed care provision. For this sub-study, questions related to safe and supportive environments were analyzed. Examples include, "What barriers has your clinic encountered, related to creating a safe environment for patients?", "How do you try to create an emotionally safe environment for your patients?" and "How might physical safety look like for a trauma survivor at your clinic?".

Thematic Data Analysis

This sub-study focused on the in-depth analysis of the code "Safe and Supportive Environment," pulled from the parent study's SAMHSA Codebook. According to the previous study, the code of "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 identity, cultural competence, privacy, mutual trust, and confidentiality." Identified sub-codes include:

Emotional Environment: used for “mention of how 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 judgment, ethical boundaries, use of appropriate pronouns\pronouns of choice and name of choice, privacy and confidentiality, cultural competence, sensitivity."

Physical Environment: used 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 areas, security, locked doors, access for differently abled people, accommodations for privacy concerns, and availability of a gender-appropriate provider."

Originally, the parent-study data were transcribed and imported into the qualitative software package, MaxQDA. Interviews were coded using both inductive and deductive approaches. Analysis was centered around the in-depth, and case-based analysis of each participant's experience with safe and supportive environments within their clinic. The coding process utilized a consensual research approach, meaning two members of the research team independently coded each transcript and reviewed and discussed coding discrepancies until consensus was reached. If consensus could not be reached, a third study team member was consulted.

Segments of texts that were coded as "Safe and Supportive Environment," "Emotional Environment," and "Physical Environment," were highlighted and retrieved for this analysis. For this project, the "Safe and Supportive Environment" retrieved segments will be referred to as transcripts. Secondly, each transcript was coded by a data analyst using MaxQDA. New themes were coded inductively from the collected data. Thirdly, the previously coded transcripts were reviewed and coded for a second time. Lastly, analytic case memos were written for each participant, summarizing each transcript with attention to barriers and facilitators of emotional and physical environments in the participant's RWC. Thematic analysis methodology was utilized to explore different patterns that emerge from the previously collected data. The purpose of this approach is to take a closer look at the themes that spring from the "Safe and Supportive Environment" code. These patterns were interpreted by creating codes and constructing themes. The thematic analysis allowed the sub-study to approach the dataset by sorting it into broad themes. After all transcripts were coded and summarized, cases were compared and analyzed

for emergent patterns in the data. We ensured rigor for the qualitative research that by utilizing verbatim transcriptions, a structured codebook and training, double coding, and consensus on themes.

Results

In-depth interviews were conducted with 36 participants from 19 Ryan White clinics (RWCs) of 8 different states in the Southeastern region. Originally, the parent study aimed to complete 48 key-informant interviews, however, the study team determined qualitative data saturation was reached by 36 KIIs. There were additional difficulties recruiting participants, as the parent study occurred during the peak of the coronavirus pandemic. Of the total 36 participants, 10 were clinical providers, 10 clinic administrators, 5 social workers, 5 health educators, 3 nurses, and 3 medical assistants/other staff. A majority of the clinics were hospital-based HIV clinics, which were predominantly located in urban settings. Regarding the stage of TIC implementation, 11 participants were not aware of any TIC discussions at their clinic, 8 participants said they are beginning to have TIC discussions, 11 said they are in the early stages of TIC implementation (e.g., had participated in TIC training), and 5 are in the process of implementing TIC.

Findings

Thematic analysis resulted in four primary themes: 1) Definitions of safety, 2) Barriers to Creating a Safe Environment, 3) Methods Currently Employed to Create a Safe Environment, and 4) Methods for Enhancing a Safe Environment. Within this analysis, themes were developed by consistent descriptions and patterns relating to the safety and security of an RWCs environment. Quotes from participants will be utilized to illustrate the themes.

THEME ONE: DEFINITIONS OF SAFETY

This theme refers to the aspect of a person's state in which conditions leading to physical, emotional, or material harm are addressed to preserve the well-being of individuals and the community

within the clinic setting. This theme was found in descriptions of environments that are safe and supportive for patients and staff.

Overall, participants' perceptions of safety tied to the TIC framework were positive and aligned with their values. A trauma-informed nurse emphasized the importance of a safe space, which consists of a "warm environment coming in, little bit more open space in the back, little more privacy in the back." Often, definitions of safety could be further broken down into two different dimensions: physical and emotional.

Emotional environmental safety refers to the way clinic staff and providers interact with patients which creates an established rapport and intimacy. Participants highlighted that emotionally safe environments are areas where patients feel comfortable and do not experience judgment. Participants mentioned that ethical boundaries, privacy, cultural competency and understanding, and use of appropriate pronouns of choice were elements that contributed towards emotional safety within their clinical settings. Some participants had a difficult time conceptualizing an "emotional" environment, as it is not as tangible or concrete as the physical aspects of a building or surrounding area may be. Upon explanation and further probing, respondents commonly commented on a warm, and welcoming nature, constantly highlighting the importance of "competent providers." One participant highlighted the significance of private time with a non-judgmental clinician.

> *"P: I think allowing one-on-one time with a provider. Making sure that we're explicit about just saying this is a safe space. You know, I think having literature out that shows at least some awareness that trauma is an important aspect of health is important. Just so, you know, as almost an unspoken that if you can – just like if you can walk into a place and see a rainbow flag, you know that's a welcoming and safe place for the LGBTQ community, something similar, I think." --- CLINICAL PROVIDER*

Physical environmental safety refers to clinical infrastructure and measures taken or changes to the physical\built environment that are put in place to help people feel physically safe. Participants highlighted common aspects of physical safety such as the clinic space itself, patient flow, and considerations made to accommodate concerns of individuals that do not feel comfortable in a fixed physical environment that cannot be changed. One participant explains the feeling of comfort a patient may experience due to the well-thought-out and inclusive physical attributes of their clinic:

> *"I mean, even from the moment they get to our parking lot, like I mentioned, just having the feeling of comfort coming in. You know, we have lights in our parking lot. We have a security put into place to make you feel more comfortable. But even like in the waiting rooms we have pamphlets that show diversity. We have a TV that kind of shows like get to know you of the staff so you have an idea of who you're going to be working with. It also talks about like education, so giving you a little bit more comfort of what are different aspects of our roles that we can – or the services we can provide. We try to be inclusive in all areas…inclusive of everybody and make everybody feel comfortable, having gender-neutral bathrooms." –SOCIAL WORKER/CASE MANAGER*

Additionally, a clinical counselor highlighted how important the usage of lighting can be to establish a welcoming space:

> *"I: What do you think… that you have done to allow them to feel like they could be open with you?*
>
> *P: Well, for one my office space. I do try to create good lighting in there. I try to create a very relaxing, safe workspace that isn't- that I don't keep the fluorescent lights on, so I create a nice space for them."- CLINICAL COUNSELOR*

THEME TWO: BARRIERS TO CREATING A SAFE ENVIRONMENT

This theme refers to barriers to the clinic's ability to create a safe environment. Common barriers that participants mentioned include space limitations, limited human resources, and clinic leadership. Many barriers were two-fold, for example, space limitations and funding costs were two major concepts that arose from interviews. There was an insufficient amount of funding to undergo spatial renovations or create more space for private conversations.

Waiting room refers to the lobby or waiting area of a clinic, which represents the physical start of the patient's experience at a clinic. Participants mentioned the daunting nature and challenge that waiting rooms can pose for patients living with trauma, as it is the first entry point into a potentially triggering situation. This signifies the patient's first point of entry. Participants commented that waiting rooms were a challenge for environmental safety, due to a lack of motivational messaging and educational literature on HIV, a lack of TIC training for front desk staff, and shared spaces with other medical departments. One participant addresses the difficulties patients face when encountering a lobby or waiting area that is not a private space:

> *"I think it's definitely an area that could be improved upon. It's a constant battle. We share a waiting room as part of a multidisciplinary internal medicine clinic, and there is just constant pushback about putting materials out in the waiting room that say anything about HIV, about – I mean it's just ridiculous. So I think that could be done a lot better." - MEDICAL DOCTOR*

Additionally, this participant mentions front desk staff that may not have TIC training. As the first individuals a patient meets within the clinic space, front desk staff ought to have TIC so as to not start a patient's experience off negatively.

Limited physical space refers to the level or lack of physical space and area a patient may encounter at a clinic. Many participants highlighted the crowded or busy conditions of their clinics, which may inhibit the sense of privacy of a patient. There was often not enough funding to support an increase in clinic space, as many respondents commented. A nurse stressed that entering a crowded clinic can be "like a tunnel, kinda like a maze," and could negatively impact a patient's experience at a clinic by starting a patient's visit to the clinic uncomfortably. Some participants have additionally highlighted that lack of space contributes to uncomfortable environments. Crowded and busy waiting areas, and clogged-up hallways, for clinics that see many patients, can create an overwhelming environment for patients that may have histories of trauma. One respondent mentions the issues that come along with the insufficient amount of space:

> *"Generally, yeah. As far as changing the counseling rooms, it was a long – we have kind of a space crisis in the building that we're at right now. There's just not a lot of space so it was kind of a long known need that we needed a better space for those services."- RYAN-WHITE CENTER MANAGER*

Staff turnover and understaffing refer to the number of staff and providers that are available and employed at a clinic, specifically referring to the staff turnover rate. Participants mentioned that unstable environments and episodes contributed to the staff turnover rate. Other participants highlighted the challenge of losing long-time staff, which had previously established rapport with patients. When a long-term staff member may have left, patients were distraught and created a sense of discomfort. A respondent explains the challenges with creating a safe environment when a long-time staff member leaves a practice:

> *"There's a lot of turnover with the staff, and I think that can sometimes make people [patients] feel uncomfortable. We had a counselor when I first started that was there for several years. A lot of our staff had seen her several times, they love her, and then she left. And some of those patients were like, "I don't want to go to therapy anymore. I spilled my life out to her and then she moved." Rightfully so, she was having a family and she just got a better opportunity out of state.*
>
> *But I think just turnover and staff, it really makes it hard for people, and I think that a lot of times, we do have a lot of turnover in staff as far as outside of our department in primary and the behavioral health counselors and so forth. I think that makes it a little bit uncomfortable, they may not feel as safe, either. They're telling their whole life or whatever's going on, and all of a sudden, that person's gone and they have to tell somebody else." -CENTER COORDINATOR*

As highlighted in this quote, any sense of trust that has taken years to cultivate is considered lost. Staff turnover puts patients in an uncomfortable position, where they may need to recount traumatic experiences, with can be re-traumatizing.

Trauma uninformed leadership refers to the limited commitment and involvement of clinic leaders and supervisors in TIC implementation and limited support for the creation of a safe and secure environment for a patient. Participants have mentioned that clinical leadership normally remains uninformed and uneducated on TIC as there is a general "disconnect." This challenges the establishment of a safe environment, as it does not provide a TIC-informed example for staff and providers beneath them. In the example below, a participant comments on clinical leadership and discusses the difficulties with creating a safe space that come with leaders that are not engaged in trauma-informed care:

> *"I would say enterprise leadership. I don't think they put as much an emphasis on it [Trauma-informed care] at times as we do…. That would be university healthcare administration. Or university as a whole… If you've got a group of mostly white male leaders at a university, their*

> *perspective on things is not going to be necessarily what's best for a program like ours who's serving a lot of minority patients, a lot of low-income patients. There's just a disconnect. And so until people from more diverse backgrounds are in leadership roles or even if they're not from a different background but are willing to place more priority on those types of things, it's difficult. I mean they say they do, but in practice it doesn't always end up that way." -RYAN-WHITE CENTER MANAGER*

As demonstrated in this quote, the participant comments on the general disconnect between leadership and the patients their very clinic serves. As the leadership group is regularly compromised of white men with higher incomes, their perspective does not often align with most of the patients their clinic serves, as low-income patients from minority populations. This disconnect can be rooted in the lack of shared experience between leadership and patients, most members of leadership are not directly interacting with patients, thus further contributing to the uniformed TIC approach.

THEME THREE: METHODS CURRENTLY EMPLOYED TO CREATE A SAFE ENVIRONMENT

This theme refers to present attributes and actions that are used to facilitate, create, and maintain environments in which patients and staff feel safe. These are current actions and attributes being put in place that help foster the existence of a safe and secure environment, both physically and emotionally. This theme comprised a handful of subthemes, including infrastructure, patient and provider rapport, privacy policies, identity, and security.

Infrastructure signifies any physical modifications or renovations taken in clinical environments, to improve the comfort and safety of the space for both patients and staff. In this theme, participants discussed various methods for enhancing the safety and security of the clinical environment. One approach mentioned was infrastructure improvements, which involved physical modifications or

renovations to the space. Participants noted that such modifications could include the installation of bulletproof glass at the front desk or the use of security cameras to monitor activity in and around the clinic. Moreover, participants also talked about the possibility of moving to larger spaces that offered more room for services. They suggested that having more space would allow for better organization of equipment and supplies, which could help to reduce the risk of accidents or incidents. Participants also felt that having more space would create a more comfortable and less cramped environment for patients and staff, which would contribute to a sense of safety and well-being. Overall, participants emphasized the importance of taking action to enhance the safety and security of the clinical environment and suggested a range of potential attributes and actions that could be used to achieve this goal.

> *"We did some significant renovations to all of our clinics in the last two and a half years. So, when we did the significant renovations, we tried to have some of that mind with how we did things. We make sure that all areas of the building are well-lit. We have tried to choose colors that are research-wise considered to be calming colors for our waiting rooms, our exam rooms, colors that will put people at ease, hopefully relax them. We have tried to put not hokey, but nice motivational, inspirational artwork on the walls so while people wait and they sit. As far as the physical space we make sure that we have privacy, that anyone who might be walking by our clinic that there's no outward indicators that people might be HIV positive who are coming in there. So, we make sure that privacy is there."- CLINICAL COUNSELOR*

Provider and patient rapport signifies the sense of patience, trust, intimacy, and cultural competency, that providers establish with patients that struggle with trauma. This refers to a provider's ability to create a space where patients feel comfortable speaking freely and without judgment. In most cases, a provider will initially foster the rapport, opening the door for trust with the patient. Participants commonly mentioned providers being the backbone of a clinic's environment. A provider's ability to establish a safe

space for patients has a profound impact on the connection and building trust between provider and patient. One participant mentioned how every patient is treated equally and importantly in the clinic:

> *"I: So, you mentioned that two of the other clinics that you've been to, but the ones that you currently work with have created an emotionally safe environment. What have they done to create that environment?*
>
> *P:Honestly, it's the staff.*
>
> *I: Okay.*
>
> *P: It's the staff, it really is. So that is my clinic, and then – so I don't actually receive care in my own clinic. So, I said that there are – so I've had experiences at three, that third clinic is a private clinic, and the staff, the frontend staff to the nursing staff to the doctor, all very supportive, very understanding. Every single individual that goes into that office, just like my office, is important. And is treated as if they are important, and in many cases treated like they're the only one who is being seen there today." – CLINICAL PROVIDER*

In comparison, another participant remarked on the pride the clinic staff has in their relationships with their patients:

> *"A-498: But because they know us and we really try to get to know our patients, we really take pride in knowing our patients and knowing things about them so when they come in, something as simple as what their dog's name is, they feel that they appreciate that. I think we spend a lot of time getting to know them, so I think that's why they feel so comfortable with us, specifically in our department, not necessarily primary, but in our department specifically." - ADMINISTRATOR*

Identity refers to the racial, ethnic, sexual, gender, ability, and religious, elements of a patient's identity that are intersectional and compounding. This signifies a clinic's intentional recognition and respect for how patients choose to identify. Participants mentioned an awareness of identity, specifically including the appropriate use of pronouns and chosen names. Some participants commonly mentioned working with different populations and making a conscious effort to make them feel accepted and seen. In the quote below, one respondent specifically highlights the number of methods and resources their clinic utilizes to be as inclusive as possible for all identities:

> *"Uh, Yes, we have gender-neutral bathrooms and we have on our electronic medical record we've got a place that has gender of birth and gender that patient is transitioning to, and you know, patient name and what they prefer to be called and all of that information in the chart. So, when someone goes to call a trans individual, that they don't slip up and call a trans female by their male name. We want to be as inclusive as possible. So, we've really stressed that everyone follows that, and we always make sure that we've got all the signage up to make sure that you know, we use the correct pronoun, and we ask people you know, which pronoun would you prefer."- HEALTH EDUCATOR*

This participant reports how their healthcare facility has implemented several strategies to promote inclusivity for transgender individuals. These include the use of gender-neutral bathrooms, collecting and displaying accurate patient gender information in the electronic medical record, and ensuring that staff uses the correct pronouns when addressing patients. Following practices such as these promote an inclusive environment.

Privacy policies refer to the procedures and policies put into place to establish and maintain and protect all elements of a patient's identity and personal matters. Participants often mentioned steps or

considerations utilized to ensure patient privacy and confidentiality, and the awareness of not discussing patients' information in front of others. A respondent comments on their utilization of HIPPA:

> *"We always talk about confidentiality; we always talk about HIPAA. We talk about their medical records, and who can get them. So, I think that's a way of how we make them feel safe." – PATIENT SUPPORT SPECIALIST*

Establishing a sense of comfort and privacy is paramount to creating an emotionally safe environment. Privacy was a distinct element touched upon in many interviews. Patient confidentiality is necessary to build trust between patients and healthcare providers. Patients are more likely to disclose health information if they trust their healthcare practitioners.

Security refers to measures taken to ensure physical safety and address the safety concerns of patients and staff. Enhancements or policies put into place, such as security systems, law enforcement, and physical adaptations to a clinic's space. Commonly, participants mentioned police officers and high-security systems as methods to reinforce and build a comfortable environment. One participant highlighted the measures their clinic takes to create a secure physical environment:

> *"I: Right. What do you have besides having alternative entrances in place at your clinics – do you have other things in place to create a physically safe environment?*
>
> *P: Okay. Well, like I said, to even- to even get to the patient area – the patient care area – there are doors that lock automatically. You have to be buzzed back. You have separate entrances, and then all the rooms are secure. There's no examinations or anything going on in an open area where someone could walk by and hear. The doors are always closed. So, for someone, if there were some types of threat or they were trying to hide from someone, they would have to get through at least two levels of physical security to get back there. Now, at our main campus, we do*

have armed, off-duty policemen who are there if you know if something were to go bad."- CENTER COORDINATOR

Additionally, one participant highlights how the presence of a police officer who has developed positive relationships with patients and staff has contributed to an improved sense of safety and comfort at the medical facility. The police officer is easily accessible, and his positive attitude helps make staff and patients feel better:

"I would say that would probably be the two big ones. They did install bulletproof glass in addition at the front desk... So, I think, just having those two things alone I think has really helped in terms of, safety for the patients. And the police officer, it's not like he's constantly patrolling. But everybody knows him. Everybody is comfortable with him. He's not sitting in a car in the parking lot. I mean, he's available and he has a relationship with everybody. And all you all you have to do is overhead page him. And he's there quickly. So I think that's really helped. I think it's made the staff feel a lot better. I think he's developed a relationship with some of the patients, too. People come in so much, he's out there joking around with people. And, he's got a good demeanor, which I think helps a lot." – SUPERVISING PHARMACIST

THEME FOUR: METHODS FOR ENHANCING A SAFE ENVIRONMENT

This theme is focused on identifying methods and actions that can be implemented to enhance safety and security in a clinic's physical environment. This theme is comprised of different attributes and actions clinics can potentially implement to strengthen the safety of their environment, such as a sense of comprehensive understanding, and shared culture and identity among patients and providers.

Comprehensive understanding refers to a provider's ability to step back and contextually assess and understand a patient's experience. Any reference to a judgment-free and holistic approach to a patient's

experience. This also encapsulates comprehensive care. Providers commonly explained their ability to understand a patient beyond their visit.

> *"I: So overall, how do you feel that trauma-informed care fits within the existing care infrastructure at your clinic?*
>
> *P: I think we try to be cognizant of what our patients have been through. I think though as a whole, we all need to be more patient when our patients make difficult or- make frustrating decisions, frustrating moves – to step back and think you know, what is behind this? What are they going through? What have they experienced? You know when someone misses six appointments in a row, what's behind that? You know, maybe instead of sitting back and just griping that oh my gosh, so-and-so missed an appointment again, calling them and you know talking – you know, what's going on? What can we help you with? You know, what's going on in life that's contributing to this?"- SOCIAL WORKER*

This quote highlights the importance of being patient and understanding with patients, taking into consideration their experiences and situations, and offering support and assistance instead of criticizing them for missed appointments or frustrating decisions. This encompasses active forms of patience instead of passive forms of patience. Comprehensive understanding includes active patience and an understanding of the context behind why a patient may behave a certain way.

Shared culture and identity refer to the commonalities in cultural backgrounds, and experiences of providers and patients. In a clinical environment, this theme would enhance trust, understanding, and create effective communication between patients and providers. For example, one participant mentions the need for diverse providers:

> *"Interviewer: Yeah. And how does your clinic create that environment of emotional safety for your patients?*
>
> *P: I think, again, it just kind of comes back to the relationship. Even though, you know, gender-wise – or ethnicity-wise, anyway, we have we have a fair number of female doctors. So, I don't want to say it's all-male. It's not. We have multiple female physicians who serve our HIV patients. But, in terms of race, that definitely needs to be improved on." MEDICAL CASE MANAGER*

Furthermore, another participant explains the lack of minority providers and shared language contributing to a sense of trust:

> *"Interviewer: Okay. And how does your clinic create an environment that makes patients feel emotionally safe?*
>
> *P: I think, there is this culture among most providers of, you know, having like a culturally responsive care. Most of our providers – let me think. Yeah, I think, most of our providers are White. There are only a few minority providers, ah… including myself... I mean, providers, or at least someone who knows how to speak Spanish well. I think that enhances trust from patients."- CLINCIAL PROVIDER*

Discussion

This qualitative sub-study uncovered themes and subthemes that were important to Ryan White provides, staff, and patients regarding their perception of safe and secure environments, with a particular focus on barriers, facilitators, and methods to enhance safety in pre-established clinics. The interviews demonstrated that values underlying safe and secure clinic environments often encompassed trust in providers and clinic staff, comprehensive understanding of providers, general maintenance of privacy,

and physical manifestations of security. These findings provide an opportunity to open and shape conversations with Ryan White clinic staff and HIV patients, surrounding the creation of safe spaces in TIC environments.

Throughout the analysis, it was noted that a safe and secure physical environment is easier to grasp, in comparison to an emotional environment, as the physical characteristics of a clinic are tangible. Participants did not have a difficult time answering the question: "What might physical safety look like for a trauma survivor?" Many participants mentioned open, warm spaces, which were well lit, and had comprehensive and motivating language and literature in the waiting rooms. Waiting rooms and lobbies that created a heightened sense of privacy were commonly the most positive experiences for patients, as they represented the initial stages of a patient's experience in the clinic. In instances where spaces were thought to be crowded or busy, patients were more likely to have a stifling and uncomfortable experience. In contrast, a handful of participants needed to work a little harder to conceptualize the idea of an emotional environment, often asking interviewers for examples.

One of the largest takeaways was the mentioned methods to improve and enhance a clinical environment. Two distinct methods include strengthening the comprehensive understanding of providers and increasing the presence of providers and staff that have diverse cultural, ethnic, and racial backgrounds. Improving infrastructure is an additional action that can be taken within the Ryan White clinic space, to create a safe and comfortable environment. Comprehensive understanding contributes to the emotional and social environment of a clinic, by allowing providers to create a psychologically safer space. Additionally, increasing the number of staff and providers with diverse backgrounds creates a shared sense of cultural and ethnic identity among providers and patients, thus enhancing trust, rapport, and understanding. Although understanding is not a tangible attribute one can hold in the palm of their hand, many participants mentioned the importance of connecting and understanding a patient's background, nonetheless. In tandem, infrastructure, and renovations are large actions that contribute to the

physical environment. The acknowledgment of these two methods alone, both emotional and physical, reinforces the importance of both definitions of a safe and supportive environment.

Across multiple studies, it has been highlighted that the general concept is that the physical environment of a clinic can affect the well-being of patients. In a study conducted by Karin Dijkstra, an investigation takes place to examine the impact that physical environmental stimuli can have on turning environments into healing spaces. In Dijkstra's study, there is no mention of an emotional or psychological environment. Although multiple dimensions of a physical environment are investigated, ambient stimuli, architectural stimuli, and interior design features, there is little to no emphasis on the impact an emotional environment can have on a patient. In contrast, this study examines the effect of both physical and emotional environments, to offer a comprehensive exploration of the influence all environments can have on patients' well-being. Further research such as "Exploring the Impact of the Physical Environment on Patient Outcomes in Ambulatory Care Settings," by Dr. Gulwadi Gowri stressed that design features of a clinic such as, "enhanced waiting experiences, enhanced privacy, enhanced physician/staff-patient communication, reduced patient anxiety," can promote favorable patient outcomes. The following patient outcomes discovered from Gowri's study are exceedingly similar to the subthemes identified in this study. For example, a barrier mentioned in both studies includes the challenges waiting rooms pose for patients. The importance of privacy and patient-provider rapport is also stressed to create beneficial experiences for patients in clinics.

This sub-study had its limitations. As this was a historical data set, the researcher of this study did not have the same level of experiential knowledge of the interviews and transcript data as the original researchers. This limitation may have contributed to less familiarity with the context in which participants responded. The researcher overcame this through multiple reviews of interview data. An additional limitation of this study is that interviews occurred among a convenience sample of clinic providers, staff, and administrators who were willing to participate and thereby may be subject to selection bias. Perspectives from older providers involved in leadership may differ, as they were mentioned to be less

likely involved in trauma-informed care, as providers in leadership roles were not often involved in patient care. These perspectives may have contradicted the findings of providers and staff that were more directly involved with patients.

Strengths of this study include a novel and targeted research question that has served as a foundational basis to fill gaps in TIC among Ryan-White patients. Several other strengths include involving many perceptions from participants involved in the data collection process. Different perceptions that were addressed include different RWC roles, clinics in different states, and participants from different conditions of urbanicity. All interviews were dual coded to ensure consistent findings, and interview guides/data collection instruments were informed by the SAMSHA TIC framework. The findings regarding Ryan White clinics in the Southeast are most likely generalizable, as most Ryan White clinics may share similar characteristics, such as patient population.

CHAPTER 3: PUBLIC HEALTH IMPLICATIONS AND RECOMMENDATIONS

Research

The findings of this study create implications for future public health interventions and programming. More research is needed to recognize the importance of safe and secure physical and emotional environments in varying clinical settings. Additionally, research surrounding the element of a safe and secure environment, both emotional and physical, is needed to compare results across populations and create variation, and comparison groups. The findings from this study create the possibility to spark discussions surrounding safe spaces, and how often they may be overlooked. Due to the lack of current research, limited data suggest that further research is needed to investigate the relationships between a physical and emotional environment and the impact on PLWH who have experienced trauma.

First, the study team recommends further research on the importance of physical and emotionally safe spaces in TIC implementation in HIV clinic settings can help overcome the lack of awareness surrounding environments. Additionally, literature has shown that humanistic-designed spaces help retain patients in care (Carpman, n.d.). Additional recommendations include, involving patients in the structural design of spaces is also a pathway to maintain HIV retention in HIV care, by addressing a patient's perspective throughout the renovation process. Unsurprisingly, patients that are involved in the design process or provide feedback for the creation of clinical environments are more likely to stay in care (Carpman, n.d.).

Future research that will benefit this concept includes taking an in-depth look at safe and supportive environments and implementation of the TIC framework in RWC in other regions of the United States. It would be beneficial to get a different perspective and conceptualize what safe and supportive environments look like in other parts of the United States. Additionally, including a patient's perspective in future research would be beneficial, as they are a participant population this study did not

interview, yet their perspective and the impact environments have on PLWH are important. Additionally, future research should consider examining the impacts of changes in clinic environments, and how these impacts may enhance patient and staff perceptions of safety and patient engagement in HIV care.

Policy

Policy recommendations include requiring Ryan White programs to conduct evaluations of their clinical environments in the Southeastern region of the United States of America. The results from evaluations will help inform areas of improvement and ways to improve the safety and security of an RWCs' environment. As mentioned previously, emotional environments are often overlooked, so evaluations would be deeply impactful.

Practice

Next, clinics should consider strengthening the implementation of the Safe Physical Environment domain of the SAMSHA TIC framework. A clinic's emphasis on this domain will stress the importance and recognition of environmental impacts. By creating this recognition, clinics and staff can assess their own clinic's physical and emotional environment, and take the steps needed to address uncomfortable or unsafe environments.

Additionally, SAMSHA should consider leading training and stress the impedance of this overlooked domain of the TIC framework. As the institution that created this framework, clinics will be more likely to pay attention to recommendations coming from credible agencies. In tandem, more funding should be dedicated to infrastructural change. Furthermore, having a dedicated RWC staff member overseeing the implementation of a safe environment would be a beneficial method to stress the importance of safe spaces. They could function as environmental champions, keeping in mind any changes or actions that may be taken to maintain a safe environment.

Conclusion

These interventions can address the needs of people living with HIV and their communities by stressing the importance of the often-overlooked impact environments can have on patients. This study serves as a foundational basis for strengthening safe and secure environments in HIV settings that implement TIC frameworks. Creating safe spaces for HIV patients fosters a community of comfort, security, trust, and understanding, among patients, providers, and staff. The recognition of both emotional and physical spaces and the impact they can have on a patient's experience is the first step to improving these environments.is imperative, and further research is warranted to build upon this foundational basis. More research is needed to recognize the importance of and results of enhancing the safe and secure physical and emotional environments in varying clinical settings. If this research has proven anything, it highlights how emotional and physical attributes of environments go hand in hand and only complement each other. A safe environment signifies both an emotionally- and physically-safe environment. To have an overall safe and secure environment, physical safety and emotional safety need to be taken into consideration equally.

APPENDICES

Table 1. Participant Characteristics (N=36)

	n (%)
Clinic Role	
Clinical Provider	10 (27.8)
Administrator	10 (27.8)
Social Worker/Case Manager	5 (13.9)
Health Educator/Navigator/Counselor	5 (13.9)
Nurse	3 (8.3)
Med Assistant/Other Staff	3 (8.3)
State	
Georgia	8 (22.2)
North Carolina	8 (22.2)
Alabama	5 (13.9)
Tennessee	4 (11.1)
Florida	4 (11.1)
Kentucky	3 (8.3)
Mississippi	2 (5.6)
South Carolina	2 (5.6)
Location	
Urban	34 (94.4)
Rural	2 (5.6)
Clinic Type	
Hospital-Based HIV/ID Clinic	27 (75.0)
Community/FQHC/Health Department	5 (13.9)
Specialized Stand-Alone HIV Care	4 (11.1)

Table 1 reprinted from:

Piper, K. N., Brown, L. L., Tamler, I., Kalokhe, A. S., & Sales, J. M. (n.d.). Application of the Consolidated Framework for Implementation Research to Facilitate Delivery of Trauma-Informed HIV Care. *Ethnicity & Disease*, *31*(1), 109–118. https://doi.org/10.18865/ed.31.1.109

Table 2. Relevant Themes for Safe and Supportive Environment in TIC Implementation

Theme	Thick Description	Quote
Definitions of Safety	The dimension of safety that allows patients and staff to feel a sense of safety and security inside a clinic's space	
Subthemes		
Emotional Environmental Safety	The condition of peace that is both felt and facilitated by clinic staff, and patients. Emotional safety facilitated by staff and felt by patients. The manner in which clinic staff and providers interact with patients that creates and established rapport and intimacy	*"I think allowing-allowing one-on-one time with a provider. Making sure that we're explicit about just saying this is a safe space. You know, I think having literature out shows at least some awareness that trauma is an important aspect of health is important. Just so, you know, as almost an unspoken that if you can – just like if you can walk into a place and see a rainbow flag, you know that's a welcoming and safe place for the LGBTQ community, something similar, I think."*
Physical Environmental Safety	Infrastructural safety, not feeling threatened by staff. Measures taken or changes made to built-environment that are put in place to help people feel physically safe	*"I mean, even from the moment they get to our parking lot, like I mentioned, just having the feeling of comfort coming in. You know, we have lights in our parking lot. We have a security put into place to make you feel more comfortable. But even in the waiting rooms we have pamphlets that show diversity. We have a TV that kind of shows like getting to know you of the staff so you have an idea of who you're going to be working with. It also talks about like education, so giving you a little bit more comfort of what are different aspects of our roles that we can – or the services we can provide. We try to be inclusive in all areas, so even on our paperwork asking, like, the name you prefer, your gender, whether that be the gender you were assigned at birth or the gender you are – and the pronouns you use. And that is something that's updated each visit you come into, so trying to be, like I said, inclusive of everybody and make everybody feel comfortable, having gender-neutral bathrooms"*
Barriers to Creating a Safe Environment	Historical, current, or future challenges (infrastructural, political, socioeconomic, external) to establishing and maintaining a safe space in a clinic	
Subthemes		

Waiting Room	This refers to the waiting area of a clinic, which represents the physical start of a patient's experience at a clinic. This signifies the patient's first point of entry. Poses a challenge because it is a point of return, and the place where they wait before each appointment. Participants commented that waiting rooms being a challenge for environmental safety, due to lack of motivational messaging and educational literature on HIV, lack of TIC training for front desk staff, and shared spaces with other medical departments.	*"I think it's definitely an area that could be improved upon. It's a constant battle. We share a waiting room as part of a multidisciplinary internal medicine clinic, and there is just constant pushback about putting materials out in the waiting room that say anything about HIV, about – I mean it's just ridiculous. So, I think that could be done a lot better…* And then thankfully the institution is really pushing on getting those trainings too to the front desk staff and kind of the first people that patients come into contact within the waiting room."
Limited Physical Space	This refers to the level or lack of physical space and area a patient may encounter at a clinic. Many participants highlighted the crowded or busy conditions of their clinics, that may inhibit a sense of privacy of a patient. Entering a crowded clinic can be "suffocating, tunnel," and could make a patient's visit to the clinic uncomfortable. Not enough providers for people to be seen fast enough. For services that are offered, there is not enough physical space or square feet to provide space.	*"Generally, yeah. As far as changing the counseling rooms, it was a long – we have kind of a space crisis in the building that we're in right now. There's just not a lot of space so it was kind of a long known need that we needed a better space for those services."*
Staff Turnover, Understaffing	This refers to the number of staff and providers that are available and employed at a clinic, specifically referring to understaff, staff turnover rate. Participants highlighted the challenge of losing long-term staff that had previously established rapports with patients. When a long-term staff member may have left, patients were distraught and created a sense of discomfort. This may contribute to breaking any sense of cultivated trust that was built over time.	*"...But I think just turnover and staff, it really makes it hard for people, and I think that a lot of times, we do have a lot of turnover in staff as far as outside of our department in primary and the behavioral health counselors and so forth. I think that makes it a little bit uncomfortable, they may not feel as safe, either. They're telling their whole life or whatever's going on, and all of a sudden, that person's gone and they have to tell somebody else."*

Clinic Leadership or Trauma Uninformed Leadership	This refers to the commitment and involvement of clinic leaders and supervisors in TIC implementation and supporting the creation of a safe and secure environment for patients. Participants have mentioned that clinical leadership normally remains uninformed and uneducated on TIC as there is a general "disconnect." This challenges the establishment of a safe environment, as it does not provide a TIC informed example for staff and providers beneath them.	*"And I think we have, you know, just to be blunt, I don't think we have an awareness of trauma-informed care. At the org at the upper level of the clinic. So, I think if – I would hope, that if the board and the leadership team had a better understanding, of what kind of trauma that situation could cause? Maybe, you know, maybe we could figure out a way to do something differently."*
Methods Currently Employed to Create a Safe Environment	Present attributes and actions that are used to facilitate, create, and maintain environments in which patients feel safe	
Subthemes		
Provider and Patient Rapport	This signifies the sense of patience, trust, intimacy, cultural competency, that providers establish with patients that struggle with trauma. This refers to a provider's ability to create a space where patients feel comfortable to speak freely and without judgment's provider fosters the rapport initially, opening the door for trust with the patient.	*"But because they know us and we really try to get to know our patients, we really take pride in knowing our patients and knowing things about them so when they come in, something as simple as what their dog's name is, they feel that they appreciate that.* I think we spend a lot of time getting to know them, so I think that's why they feel so comfortable with us, specifically in our department, not necessarily primary, but in our department specifically."
Infrastructure	This signifies any physical modifications or renovations taken in clinic environments, with the intention of improving the comfort and safety of the space for both patients and staff. Along with renovations, participants also mentioned potentially moving to larger spaces that offered more room for services.	*"We did some significant renovations to all of our clinics in the last two and a half years. So, when we did the significant renovations, we tried to have some of that mind with how we did things. We make sure that all areas of the building are well lit. We have tried to choose colors that are research-wise considered to be calming colors for our waiting rooms, our exam rooms, colors that will put people at ease, hopefully relax them. We have tried to put not hokey, but nice motivational, inspirational artwork on the walls so while people wait and they sit. As far as the physical space we make sure that we have privacy, that anyone who might be walking by our clinic that there's no outward indicators that people might be HIV positive who are coming in there. So, we make sure that privacy is there."*

Identity	This refers to the racial, ethnic, sexual, gender, ability religious, elements of a patient's identity that are intersectional and compounding. This signifies a clinic's intentional recognition and respect of how patients choose to identify. Participants mentioned an awareness of identity, specifically including the appropriate use of pronouns and chosen name. Some participants commonly mentioned language barriers among populations of different cultures.	*"Uh, yes, we have gender neutral bathrooms and we have on our electronic medical record we've got a place that has gender of birth and gender that patient is transitioning to, and you know, patient name and what they prefer to be called and all of that information in the chart. So, when someone goes to call a trans individual, that they don't slip up and call a trans female by their male name. We want to be as inclusive as possible. So, we've really stressed that everyone follows that and we always make sure that we've got all the signage up to make sure that you know, we use the correct pronoun, and we ask people you know, which pronoun would you prefer."*
Privacy Policies	This refers to the procedures and policies put into place to establish and maintain and protect all elements of a patient's identity and personal matters. Participants often mentioned steps or considerations utilized to ensure patient privacy and confidentiality, and the awareness to not discuss patients' information in front of others.	*"We always talk about confidentiality; we always talk about HIPAA. We talk about their medical records, and who can get them. So, I think that's a form of how we make them feel safe."*
Security	This refers to measures taken to ensure physical safety and address safety concerns of patients and staff. Enhancements or policies are put into place, such as security systems, law enforcement, and physical adaptations to a clinic's space.	*"Okay. Well, like I said, to even- to even get to the patient area – the patient care area – there are doors that lock automatically. You have to be buzzed back. You have separate entrances, and then all the rooms are secure. There's no examinations or anything going on in an open area where someone could walk by and hear. The doors are always closed. So, for someone, if there were some type of threat or they were trying to hide from someone, they would have to get through at least two levels of physical security to get back there."*
Methods for Enhancing a Safe Environment	Potential attributes and actions that can be used to improve the safety and security of a clinic's space	
Subthemes		
Shared Culture and Identity	This refers to the commonalities in cultural backgrounds, and experiences of providers and patients. In a clinical environment, this theme would enhance trust, understanding, and create effective communication between patients and providers.	*"I think, again, it just kind of comes back to the relationship. Even though, you know, gender-wise – or ethnicity-wise, anyway, we have we have a fair number of female doctors. So, I don't want to say it's all-male. It's not. We have multiple female physicians who serve our HIV patients. But, in terms of race, that definitely needs to be improved on."*

Comprehensive Understanding	This refers to a provider's ability to step back and contextually assess and understand a patient's experience. Any reference to judgment free and a holistic approach to a patient's experience. This also encapsulates comprehensive care. Providers commonly explained their ability to understand a patient beyond their visit.	*"I think we try to be cognizant of what our patients have been through. I think though as a whole, we all need to be more patient when our patients make difficult or- make frustrating decisions, frustrating moves – to step back and think you know, what is behind this. What are they going through? What have they experienced? You know when someone misses six appointments in a row, what's behind that?"*

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