Indian Health Service—Billings Area
Trauma-Informed Organizational Change Initiative
Report on Focus Group Findings and Recommendations

Prepared by the National Native Children's Trauma Center
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NATIONAL NATIVE CHILDREN'S TRAUMA CENTER

UNIVERSITY OF MONTANA

Overview

In October and November of 2017, staff from the University of Montana's National Native Children's Trauma Center (NNCTC) conducted focus groups at six service units in the Indian Health Service (IHS) Billings Area: Fort Belknap, Fort Peck, Fort Washakie, Northern Cheyenne, Browning, and Crow. Additionally, focus groups were conducted with staff at the Billings Area Office. The purpose of the focus groups was to gather information from staff and leadership about current policies and practices related to or aligning with culturally appropriate, trauma-informed care. Focus-group assessment was planned as the first step in a larger trauma-informed organizational change initiative overseen by Billings Area leadership.

To prepare for focus groups, NNCTC staff reviewed the literature related to trauma-informed medical care, including relevant assessment tools. We then adapted our existing trauma-informed organizational assessment process (used in a variety of service systems in the past, but not specific to medical systems), which is rooted in the framework for organizational change developed by the U.S. Substance Abuse and Mental Health Service Administration in *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Adaptations addressed the unique nature of the IHS service setting, including the variety of medical and other services provided and the cultural dimensions of care. Focus group questions assessed service units and the Area Office on current practices, policies, and activities across 8 domains of service and operations: 1. Governance, leadership, policies, and procedures; 2. Physical environment; 3. Engagement and involvement; 4. Cross-sector collaboration; 5. Screening, assessment, and treatment services; 6. Training and workforce development; 7. Data collection and performance improvement; and 8. Financing.

The resulting focus group data are subject to some limitations. Group size and composition varied significantly from service unit to service unit, based on internal dynamics at each site. For example, at two service units, groups were very large and included representatives from all relevant departments, including medical and Behavioral Health staff and a mix of both supervisors and staff. At another service unit, representation from staff who are regularly in direct contact with patients was minimal. In some groups, staff responses to questions appeared to be affected by the presence of their supervisors. These factors should be taken into consideration when reviewing our summarized findings. Compensating somewhat for these limitations is the large amount of data collected. By holding multiple focus groups at individual service units and by assessing all Billings Area service units and the Area Office, we were able to corroborate key findings across sites. We thus feel reasonably confident that data are sufficient to provide a generalized picture of conditions across service units and also to suggest key areas of variation among service units.

An internal NNCTC workgroup reviewed focus group data with the objective of locating common themes related to policies, practices, environmental factors, barriers, and activities across service units and the Area Office. Once the internal workgroup reached consensus about findings related to common themes, we developed corresponding recommendations rooted in trauma research and best practices. Our colleagues at the Johns Hopkins Bloomberg School of Public Health, specialists in

trauma-informed medical care who have worked with other Indian Health Service facilities, reviewed our findings and recommendations and offered helpful feedback. We will continue to consult with the Johns Hopkins team as the project moves forward.

Both findings and recommendations are organized below according to common themes that represent key service and operational areas to target in order to bring about meaningful trauma-informed organizational change. The relationship between findings and recommendations is not 1:1. In some cases, a single recommendation responds to multiple findings within one theme. In other cases, the same recommendation appears under multiple theme headings. These repetitions are intentional, indicating that some interventions/activities are expected to have overlapping effects.

Our expectation is that the IHS Billings Area leadership, together with tribal leaders from each service location, will review these recommendations and determine their priority, appropriateness, and feasibility for implementation. We then propose to convene a strategic planning meeting involving IHS leadership, tribal leadership, and the NNCTC to discuss the feedback from leadership and reach consensus. The NNCTC can then assist, as needed, in the development of an Area-wide trauma-informed strategic plan for culturally appropriate, trauma-informed organizational change.

This plan would incorporate all appropriate and feasible recommendations and provide additional detail and implementation strategies. Variations in implementation from service unit to service unit will likely be necessary due to different levels of organizational readiness and other unique factors. We propose that the Area-wide strategic plan be developed first and then adapted as necessary for individual service units in consultation with local leadership. We also suggest that the Area Office consider piloting the initiative at one or two service units prior to full implementation across the Area.

We recognize that one-size-fits-all recommendations may be misplaced, given the unique traditions and circumstances of each tribe served by Billings Area service units. Successful implementation of any of the following recommendations thus depends on active collaboration with tribal leadership, informal leaders such as cultural healers, and community members in each location. We thus strongly recommend, above all specific recommendations, that solutions should be locally and tribally driven to the fullest extent possible.

Findings and Recommendations

Theme 1: Trauma-Informed Knowledge/Principles at the Organizational Level
Findings
• The Indian Health Service Mission Statement ("to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level") aligns closely with the holistic, culturally appropriate approach to services that would characterize a trauma-informed organization. • Billings Area leadership has promoted a patient-centered medical home (PCMH) model across all service units. The PCMH model aligns closely with trauma-informed best practices. There are varying levels of PCMH implementation from service unit to service unit in the Billings Area. • At the Area and service unit level, there are currently no policies/procedures addressing the pervasiveness of trauma in the lives of people using services. • At the Area and service unit level, there are currently no policies/procedures addressing the impact on staff of working with people who have experienced trauma. • At the Area and service unit level, there are currently no policies/procedures promoting the implementation of trauma-informed services and supports.
Recommendations
• Prioritize full implementation of the PCMH model at all service units, and support individual sites in the goal of achieving PCMH certification. • Embed trauma-informed organizational goals and objectives into strategic planning related to PCMH implementation. • Consider obtaining consultation from the Southcentral Foundation's Nuka System of Care, a leading tribally owned health care provider serving Alaska Natives in Anchorage, AK. The Southcentral Foundation has successfully adapted the PCMH model for cultural appropriateness and inclusion of trauma-informed services and supports, and they offer training and consultation to other medical providers. • The Fort Washakie service unit appears to have fully implemented the PCMH model. Leadership and staff appear broadly to have embraced the PCMH paradigm. Fort Washakie leadership and staff may have valuable lessons learned that could be shared with service units that are at earlier stages of implementation. Consider mechanisms for leveraging Fort Washakie's experiences with implementation (e.g., Fort Washakie-led trainings, a PCMH community of practice, using Fort Washakie's experience to develop a formalized framework for change specific to IHS service units in the Billings Area). • Review policies and procedures at the service unit and Billings Area levels to find opportunities for incorporating trauma-informed principles and promoting the use of trauma-informed services and supports for both patients and staff. Develop new policies and procedures as needed.

Theme 2: Community, Family, and Individual Input/Engagement
Findings
• Billings Area leadership routinely meets with and answers to tribal leaders in all service areas. • All service units currently demonstrate support for community voice and participation through regular meetings between CEOs and tribal leadership. • At all service units, there appear to be few mechanisms for proactively incorporating the voice of individual service users and community members into organizational policies and practices. • The input of individual service users (primarily complaints) is obtained through satisfaction surveys in some service units. The survey process, along with reported levels of success in obtaining useful information, varies from service unit to service unit. Various barriers to successful implementation of the surveys were reported at service units. Some service units report not currently utilizing surveys. • The incorporation of community, family, and individual input appears to occur primarily in a reactive manner, in response to problems raised by tribal leadership or particularly dissatisfied individuals. • Input received from community members, family members, and individuals is not necessarily related to, nor is it generally used for, ensuring that services are culturally appropriate. • The Northern Cheyenne service unit is in the early stages of developing a Patient Advisory Council (PAC) intended to create an open channel of communications. between individuals/families and the service unit.
Recommendations
• Involve tribal leadership, 638-compacted tribal agencies, and other relevant tribal agencies at each site in any proposed strategic or implementation plan that may result from these findings and recommendations. • Develop channels for systematically communicating with the community at large for the purpose of promoting trust and transparency and for the purpose of incorporating community input into organizational policies and practices. The Northern Cheyenne PAC, if successfully implemented, could serve as a model that might be adapted for use at other sites. Consider other mechanisms, as well (e.g., regularly scheduled community listening sessions). • Evaluate the format of surveys used to collect patient feedback at individual service units to determine their continued usefulness. Revise or develop new surveys and survey processes with the objective of assessing not only patient satisfaction but also success/progress at promoting trauma-informed principles (e.g., SAMHSA's six key principles of a trauma-informed approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues). • Involve community members in attempts to develop new surveys and other mechanisms for obtaining feedback, as well as in the development of PDSAs to try new approaches. • In all efforts to obtain community input (e.g., meetings with tribal leadership, PACs, listening sessions, surveys), incorporate material related to communities', families',

and individuals' perceptions about the cultural appropriateness of the services they receive so that cultural appropriateness can be assessed in an ongoing manner.
- Formalize processes for promoting staff/provider engagement with the community (e.g., circulate weekly/monthly lists of upcoming community events, host culturally themed enrichment presentations/activities).
- Partner with tribal leadership and tribal agencies to offer community-wide trauma education on an ongoing (e.g., quarterly or biannual) basis.

Theme 3: Physical environment and its effects on the physical and psychological safety of patients, families, and staff.

Findings

- There are significant disparities in physical facilities across the Billings Area. Billings Area staff and leadership, along with staff at the service units occupying older facilities, expressed concern about community perceptions related to older facilities (e.g., "Older buildings give the impression that the community was shortchanged or cheated") and about effects on the morale of staff (e.g., "We hate our building.").
- Staff at older buildings cited connections between their facilities and historical traumas experienced by their communities (e.g., building occupies original military fort, building was known in prior generations as a place where tribal members were mistreated or received substandard care).
- Staff at newer buildings generally expressed pride in their facilities and indicated that service users appreciate and/or feel safe when inside the buildings.
- Staff at all service units expressed concerns about physical security.
  - Across service units there are concerns about security guards' lack of training and ability to promote a safe and secure environment. This security gap appears to have negative effects on staff and patient perceptions of safety.
  - Other security concerns vocalized at multiple service units include a sense of inadequate security standards related to locked doors, patient flow from one building sector to another, consistent enforcement of safety policies, and reliable communication of threats via the public address system.
  - Staff noted that security personnel are hired by the tribes, not by IHS, and that service units have limited influence over hiring/training policies.
- Waiting areas at some facilities fail to protect the confidentiality of Behavioral Health patients, which represents a threat to psychological and physical safety and undermines help seeking.
- Most service units have space available for staff to practice self-care. However, these available spaces are not generally or deliberately being used for this purpose.
- All service units have made meaningful attempts to promote tribal cultural identity through the display of Native art and cultural items. The newer facilities have numerous tribally specific or Native-inspired design elements. The older facilities have fewer such design elements, instead resembling other federal government buildings.

Recommendations

- We recognize that the Billings Area and individual service units have limited ability to make physical changes to their facilities or to replace older buildings with newer

buildings, and we have no knowledge about long-term plans for construction at individual service units. Based on focus group responses, however, the disparities between older and newer buildings appear to have significant consequences related to the emotional and psychological support of staff and service users. We recommend that this issue be considered a high priority in future funding decisions.

- In collaboration with the tribes, prioritize a plan for assessing safety risks in each building.
- In collaboration with the tribes, prioritize a plan for hiring/training security guards so that all service units have guards with law enforcement training.
- Mandate strict enforcement of sign-in/sign-out procedures as well as access restrictions related to patient flow.
- Prioritize the redesign of waiting areas to address confidentiality issues, particularly those related to Behavioral Health.
- Ensure that spaces available for staff to practice self-care are recognized as serving that purpose, and encourage/incentivize their use for that purpose.
- Work with tribal leadership, local cultural leaders, and community members to assess opportunities for promoting cultural identity through artworks, design changes, and other aspects of the physical environment at each service unit on an ongoing basis.
    - Consider making displays of tribal art and cultural items more locally oriented. In many service units, art and cultural items are pan-tribal. Examples of locally oriented items might include copies of treaties, portraits of historical and recent tribal change agents, displays relating tribal historical narratives.
    - Prioritize the inclusion of community members (beyond those in leadership positions) into any culturally oriented redesign/display initiatives to promote a sense of ownership and belonging.

Theme 4: Patient/family education about the impact of trauma on a person's physical and mental health
Findings
• Some amount of education about trauma and its effects appears to occur in Behavioral Health (BH) departments. • Outside of BH departments, there is no evidence that service units are currently educating patients and families about trauma and its effects. • Medical staff have varying levels of trauma knowledge and differing understandings of key concepts. No training in trauma-informed communication or patient/family education has been provided to staff. • Staff are not systematically educated about historical trauma or other social determinants of health. • Staff report a strong preference for in-person over web-based or other distance training. • Medical staff generally indicate that their current practice, when evidence arises that a patient may have trauma-related concerns, is to refer to BH. • There are opportunities for education about trauma in the waiting areas of clinics and hospitals, including Good Health TV programming and printed materials.

- Some nurses see it as their role to provide health-related education to patients and families. This represents another opportunity for education about trauma.
- Time constraints relating to heavy caseloads may be a barrier to promoting trauma education of patients during primary care visits.

Recommendations

- Provide overview training on trauma and its physical and mental health effects for all staff at all service units and the Billings Area Office, with the goal of preparing all staff to support patients and families as necessary.
- Provide overview training on historical trauma and social determinants of health for all staff at all service units and the Billings Area Office, with the goal of preparing all staff to support patients and families as necessary.
- Provide training to medical staff at all service units to educate patients and families on the physical and mental health effects of trauma, to address trauma-related concerns during the patient encounter, and to incorporate trauma awareness into treatment.
- Work with individual site leadership to integrate new training requirements with other training programs and to balance incorporation of this priority with other important priorities.
- Consider ways of developing internal training capacity (e.g., train Area and/or service unit staff as trainers, develop train-the-trainer curricula so that each service unit has a dedicated trainer or team of trainers).
- The NNCTC, working with the Casey Family Foundation, is currently collaborating with Good Health TV to develop trauma-related educational programming. The resulting programming should help fill the need for patient/family education about trauma and its effects. The NNCTC will confirm that this programming will be made available in Billings Area service unit waiting rooms.
- Develop materials to educate patients and families on the physical and mental health effects of trauma.
- Partner with tribal leadership and tribal agencies to offer community-wide trauma education on an ongoing basis. In addition to trainings and presentations, consider engaging tribal radio stations in the development of PSAs and programming.

Theme 5: Patient/family rapport (safety, comfort, voice) in the clinical setting

Findings

- Ample evidence of skillful relationship building between providers and patients/families exists at all service units.
- Evidence also exists that the approach to patient/family rapport varies by individual provider.
- Staff at all service units respect and protect confidentiality to the degree that this is possible in small rural communities.
- Service units that have made significant progress toward becoming patient-centered medical homes report systematic approaches to promoting patient/family safety, comfort, and voice in treatment.
- All service units report that patients/families have some ability to choose and

maintain consistency in primary care providers.

- Staff at multiple service units and at the Billings Area Office express concerns about culturally uninformed or insensitive interactions between non-tribal providers and tribal members.
- Staff at all service units and at the Billings Area Office indicate that current online training in cultural competence is ineffective at preparing non-tribal providers to provide culturally appropriate treatment.
- Some service units and Billings Area staff report that the combination of time constraints and requirements to enter information into computers during the patient encounter results in diminished ability to build rapport.

Recommendations

- Prioritize full implementation of the PCMH model at all service units, and support individual sites in the goal of achieving PCMH certification.
- Consider obtaining consultation from the Southcentral Foundation's Nuka System of Care, a leading health care provider serving Alaska Natives in Anchorage, AK. The Southcentral Foundation has adapted the PCMH model for cultural appropriateness and inclusion of trauma-informed services and supports.
- Provide training to medical staff at all service units to educate patients and families on the physical and mental health effects of trauma, to address trauma-related concerns during the patient encounter, and to incorporate trauma awareness into treatment.
- Provide tribally specific cultural education for non-Native providers.
    - Partner with local tribal experts (e.g., elders, cultural leaders, tribal college faculty) to develop curricula and materials.
- Formalize processes for promoting staff/provider engagement with the community (e.g., circulate weekly/monthly lists of upcoming community events, host culturally themed enrichment presentations/activities).
- Incorporate data collection related to cultural appropriateness into patient surveys and other forms of patient, family, and community feedback.
- Promote the development of systematic methods for obtaining patient and family input at each service unit. The Northern Cheyenne PAC, if successfully implemented, could serve as a model that might be adapted for use at other sites.

Theme 6: Collaborative relationships with other tribal, federal, state/county, and private agencies to support trauma-informed coordination of care

Findings

- IHS procedures for purchased and referred care are well established and provide structure and protocol for out-referrals.
- Collaboration occurs in relation to certain health/safety/wellness initiatives at most locations, and cross-system training sometimes occurs.
- "Siloed" and fragmented services at the community level appear to be the norm at all but one location. Barriers between IHS and tribal programs are common and not necessarily within the control of service units or the Area Office, as are barriers between IHS and private hospitals/agencies.

- Factors affecting service units' ability to create and sustain collaborative relationships include changes in tribal leadership that lead to changes in priorities, a lack of centralized accountability related to collaboration, and time constraints related to staff capacity at both IHS and external agencies.
- Off-reservation facilities to which tribal members are referred do not typically provide culturally appropriate treatment. Some focus group participants suggest that off-reservation treatment is frequently traumatizing to tribal members.
- When individuals are referred off-reservation, following discharge there is typically insufficient coordination of care.

Recommendations

- As part of the out-referral process, educate patients about IHS requirements and procedures (e.g., ensure that they understand what is and is not covered by IHS and that they are aware of the necessary permissions required for appointments/services accessed).
- Actively seek out opportunities to partner with other agencies during outreach, community, and training events.
- Designate relevant providers/staff to attend multidisciplinary team meetings in the community, if not already doing so.
- Actively seek out grant opportunities that allow IHS to partner with tribes and other agencies fund community-wide, trauma-informed systems change.
- Systematically collect follow-up input about patients' experiences obtaining services off-reservation. Use the resulting information to guide future referrals and to address issues with agencies to which out-referrals are made.
- Consult with tribes about formalizing communication and collaboration mechanisms via tribal council resolutions to maintain consistency across changes in tribal leadership.
- Execute Memoranda of Understanding with off-reservation partner agencies (e.g., Billings Clinic) to coordinate care after discharge.

Theme 7: The integration of cultural/spiritual supports into the clinical environment

Findings

- All service units have physical space available for patients and staff to utilize cultural/spiritual supports.
- Currently no service units have formal mechanisms in place for collaborating or referring to cultural/spiritual resources.
- There are numerous potential barriers to incorporating cultural/spiritual supports into the clinical environment.
    - Multiple tribal cultures on some reservations would necessitate engagement with multiple cultural/spiritual leaders.
    - Within each tribe, relationships with cultural/spiritual leaders are often dependent on family/clan/location.
    - Because there are numerous recognized healers on each reservation, partnering with one rather than another has the potential to create tensions in the community.

- There are numerous challenges associated with paying healers for their services.

Recommendations

- Billings Area leadership:
  - Meet with tribal leadership to explore mechanisms and strategies for incorporating cultural/spiritual supports in all service units.
  - Discuss possibilities for compensation, involving IHS national leadership as necessary to troubleshoot barriers.
- Service unit leadership:
  - Meet with tribal leaders and local cultural/spiritual leaders to troubleshoot barriers specific to the community and tribe(s).
  - Obtain initial and ongoing input from families and communities about the types of cultural/spiritual supports desired and the ways they would prefer to access supports.
- Obtain consultation from the Southcentral Foundation's Nuka System of Care or other IHS or tribal providers that have successfully integrated cultural/spiritual supports.
- As a starting point toward fuller integration of cultural/spiritual supports in the clinical environment, we recommend that each service unit compile a list of local healers and other cultural/spiritual supports, including contact information, and that this list be routinely distributed by providers and other staff.
- Consider implementing a Spiritual Assessment to be conducted by primary care and hospital MDs or other medical staff. There are a number of validated tools that could be adapted to account for tribal spirituality in addition to other religious traditions.

Theme 8: Screening for trauma exposure

Findings

- All service units currently screen patients at intake for domestic violence, depression, and substance use, as required under GIPRA.
- Staff members at multiple service units question whether these screenings serve their intended purposes.
  - There are issues with confidentiality in small communities that may encourage patients to avoid being truthful in answering screening questions.
  - Staff implementing screenings receive minimal or no training in how to elicit accurate information in a sensitive manner.
  - Staff members at multiple service units believe that in many cases patients consider screening a formality unrelated to their reasons for seeking services. In these cases patients have little incentive to respond truthfully.
  - A shortage of BH clinicians at most service units limits the ability to provide services based on the results of screening.
- Staff/leadership at all service units and at the Area Office indicated that the incorporation of trauma screening into existing intake procedures is feasible.
- Billings Area Office leadership indicated that the incorporation of screening results into current data systems is feasible.
- Barriers to screening for trauma include the above barriers associated with the current

screening system as well as a high rate of no-shows and limited retention of clients in BH departments.

Recommendations

- Universal screening for trauma supported by integrated medical and behavioral health care and a smoothly functioning referral pipeline to behavioral health providers on and off the reservation would constitute an ideal model for trauma-informed care. However, the realities of BH provider turnover and staffing across the Billings Area make this model unworkable at present. An additional issue to consider is that there are currently no validated instruments for universal trauma screening in medical settings, though numerous medical providers across the U.S. are piloting universal screening protocols. Our recommendation is that this model be considered a long-term goal, contingent on changed patterns of BH staffing and the expected development of validated instruments appropriate for this service setting.
- In the absence of screening, providers at all service units may reasonably operate on the assumption that all patients have been exposed to trauma. High rates of trauma documented in many tribal communities support such an approach. Additionally, trauma-informed communication and care are universally appropriate (i.e., they do not pose risks to patients without trauma histories).
- In the absence of universal screening and subsequent referral, the importance of patient education increases. See the numerous recommendations related to patient education above.
- In the absence of universal screening and subsequent referral, the importance of medical providers' being able to assess and respond to patients' trauma-related needs increases.
    - Prioritize training of medical staff in trauma-informed communication and care. Training should include guidance for doctors on assessing patients for trauma exposure for the purposes of making referrals to BH; providing supports when BH appointments are delayed, unavailable, unwanted, or not indicated (e.g., when symptoms are less severe); and incorporating the possible effects of trauma exposure into clinical judgments and recommendations.
- Prioritize a long-range goal of fully staffing all BH departments in the Billings Area. In all planning initiatives, prioritize the troubleshooting of BH staffing issues as well as issues related to no-shows and limited retention of clients.

Theme 9: Behavioral Health assessment and treatment of trauma exposure/symptoms

Findings

- BH providers at most service units appear knowledgeable about trauma, and some indicate that they have been trained in trauma-informed care practices including assessment.
- There is currently no uniform approach to trauma assessment (i.e., no standard instrumentation or protocol) at individual service units or at the Area level.
- Barriers to comprehensive trauma assessment include time constraints related to the

shortage of BH providers, turnover among BH providers, and the high rate of no-shows.
- BH providers at some service units have obtained continuing education related to trauma, but there has been no systematic training of BH providers in trauma treatment.

Recommendations

- Select a consistent, systematic approach to trauma assessment for all individuals referred to BH and train all BH providers in its use.
- Require training in an evidence-based approach to trauma treatment for all BH providers in the Billings Area.
    - Because of high rates of turnover, we recommend that this requirement apply to BH providers' annual CEU requirements, to be pursued individually, rather than having model developers train all BH providers at one time.
    - We recommend requiring that all BH providers in the Billings Area use the same or a compatible trauma treatment approach that allows tailoring treatment to the family.
    - We recommend requiring that all tele-health BH contractors supporting service units in the Billings Area demonstrate trauma training credentials.

Theme 10: Providers' ability to address the connection between trauma and physical/mental health concerns

Findings

- Providers are thoroughly aware of the pervasiveness of trauma in the communities they serve.
- Staff at some service units have attended presentations on the prevalence and effects of trauma exposure.
- Medical providers have not received training to address the connection between trauma and physical/mental health concerns.
- Medical providers' ability to consult with BH providers to coordinate trauma-informed treatment may be limited by shortages of BH providers.
- Barriers to training include limited time as a result of heavy caseloads and high rates of provider turnover.

Recommendations

- Prioritize training of medical staff in trauma-informed communication and care. Training should include guidance for doctors on assessing patients for trauma exposure for the purposes of making referrals to BH; providing supports when BH appointments are delayed, unavailable, unwanted, or not indicated (e.g., when symptoms are less severe); and incorporating the possible effects of trauma exposure into clinical judgments and recommendations.
- Create a Billings Area medical provider community of practice (e.g., establish a monthly conference call supplemented by a listserv for ongoing online discussion) so that providers across the Billings Area can share experiences and resources related to the implementation of trauma-informed practices.

Theme 11: Supports for staff
Findings
• The secondary traumatic stress (STS) or compassion fatigue (CF) that may affect staff has not been systematically addressed at the organizational level in any of the service units. • Staff at some service units report that in the past, routine debriefing occurred following traumatic events/cases at the service unit or in the community. Debriefing appears to occur only intermittently and unsystematically at present. • The Employee Assistance Program (EAP) is available to help staff who may be experiencing STS/CF. • Staff at multiple service units report that the shortage of BH providers in their communities limits their own ability to seek help, though telehealth resources were cited by some staff as partly filling this gap. • As noted above, all service units have physical space available that could be used for self-care activities that may address STS/CF. • Staff at multiple service units report relying on coworkers for support. This occurs in an informal way rather than as part of organized peer support activities.
Recommendations
• Review policies and procedures at the service unit and Billings Area levels to find opportunities for incorporating items related to trauma-informed services and supports for staff. Develop new policies and procedures as needed. • Provide training on STS/CF and self-care for all staff. • Provide training on crisis response to service unit leadership who can be assigned to coordinate the response to traumatic events that affect staff. • Establish organized self-care programs to be held regularly onsite at each service unit (e.g., group mindfulness meditation, group walks, or other gatherings aimed at promoting healthy habits and reducing stress). • Promote the use of staff common areas for organized as well as impromptu/individual self-care activities. • Promote the use of EAP as a mental health support.

Theme 12: Data collection and performance improvement
Findings
• No data collection related to trauma exposure, symptoms, or treatment currently occurs. • Data related to patient satisfaction (from surveys) appears to be addressed on a case-by-case basis rather than assessed systematically. • Data collection procedures related to trauma-informed patient care could be integrated into the current electronic health records system. The Billings Area Office supports making changes as necessary. • Data collection procedures related to trauma-informed organizational change could be

integrated into the current performance improvement processes. The Billings Area Office supports making changes as necessary.

Recommendations

- As part of any strategic plan or implementation plan that results from these recommendations, develop a data collection and performance improvement plan to evaluate the progress of service units, the Area Office, and the Billings Area as a whole toward becoming trauma informed. Data-related planning should address the following issues:
    - Determine how data related to patient trauma exposure/symptoms (e.g., data from BH assessments) may be tracked and accessed by providers to ensure trauma-sensitive care and to measure progress toward improved outcomes.
    - Determine instruments (e.g., trauma-informed organizational self-assessments) and data collection/analysis procedures to be used in measuring service unit and/or Billings Area progress toward becoming a trauma-informed organization.
    - Determine how data gathered from community, family, and individual sources will be used to ensure progress toward incorporating this input into operations, including input related to trauma-informed principles and cultural appropriateness of IHS services.