Panel 1: Integrating Primary and Behavioral Health Services for Trafficking Survivors

This panel highlights practical, concrete, and innovative approaches communities are taking to integrate primary and behavioral health care with a trauma-informed approach; why they prioritize such strategies; and how they position them for organizational success.

Following the Power Point presentation is a list of resources suggested by the HHS Health and Human Trafficking Symposium moderators and panelists. The list includes a wide variety of resources, ranging from published research, fact sheets, and tools such as trainings and curriculum.
Integrating Primary and Behavioral Health Services for Trafficking Survivors

Moderator/Panelists

Moderator:
- Dr. Sabrina Matoff-Stepp, Director, Office of Women’s Health, Health Resources and Services Administration

Panelists:
- Dr. Kim Chang, Family Physician, Human Trafficking and Healthcare Policy Fellow, Asian Health Services
- Dr. Annie Lewis O’Connor, Senior Nurse Scientist, Founder and Director of the Women’s CARE Clinic
- Holly Austin Gibbs, Human Trafficking Response Program Director, Dignity Health
- Dr. Renée Ornelas, Tse’hootsooi’ Medical Center

Learning Objectives

- Define integrated care and trauma informed-care, and understand why it is important for this client/patient population.
- Identify models/frameworks that exist for integrating behavioral health and primary care in diverse settings for at-risk, currently trafficked, and previously trafficked individuals.
- Describe organizational conditions necessary for success in establishing and delivering trauma-informed integrated care models.
- Explore culturally specific supportive, wrap-around services that support integrated delivery of care.

Integration: What Does It Take?

“Patients enter the system based on what they need at that point in time within their life context.”

“The integrated systems approach takes a fundamental redesign to justice, legal, medical, health, food, housing, and transportation.”

“Whole re-do, where services are coordinated within an integrated system, include a continuum of care and are available 24/7.”

Dr. Sabrina Matoff-Stepp, Director, Office of Women’s Health, Health Resources and Services Administration

Dr. Kimberly Chang, Family Physician, Human Trafficking and Healthcare Policy Fellow, Asian Health Services
Roadmap for Integration

A Legacy of Separate and Parallel Systems

Medical Care

Mental Health Care

A forced choice between:
• 2 kinds of problems
• 2 kinds of clinicians
• 2 kinds of clinics
• 2 kinds of treatments
• 2 kinds of insurance

Why Should We Integrate Care?

• Mind and body connection
• Patients with mental/behavioral issues present to primary care providers
• Problems: mood, stress, relationship issues, thinking skills, challenges as new immigrant, or creating a healthy lifestyle
• Affect daily functioning/interpersonal relationships, poor coping skills
• Assessment and treatment focus on the present problems

Primary Care Is the “De Facto” Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

Components for Integration

• Partnerships
• Referral systems
• Strong, well-trained competent—compassionate workforce
• Support systems: group visits, nutrition, alternative medicine, exercise
• Case management
• Care coordination
• Co-occurring morbidities, including chronic diseases, behavioral health, substance use and abuse, HIV, HBV, HCV, STIs

Integration: An Evolving Relationship

Consultative/Coordinated Model
- Behavioral health care specialist sees patients in consultation in his/her office—away from primary care

Co-located Model
- Behavioral health care specialist sees patients in primary care

Collaborative/Integrated Model
- Behavioral health care specialist provides coordinated consultation about primary care patients; works closely with primary care providers and other primary care-based behavioral health providers

Adapted from Patient-Centered Primary Care Collaboration, Source: MyJoultaine.org

Adapted from Patient-Centered Primary Care Collaboration, Original Source: C.J. Peek, 1996.

Adapted from Patient-Centered Primary Care Collaboration, Original Source: http://uwaims.org

Integration: Getting started

- Universal assessment/screening for:
  - Human trafficking
  - Childhood trauma
  - Depression, substance use disorders
  - Communicable disease (HIV, hepatitis, and sexually transmitted infections)
  - Patient-centric models that are culturally, linguistically responsible
- Systems approach beginning with prevention, screening, care, treatment, and wellness across systems of care
- Standardized measures
- Remove policy barriers around reimbursement, 42CFR, and HIPAA

FQHCs: National Impact

**Behavioral Health Services**

- Depression screening and referral at least 1x yearly
- 25% to 40% of patients

**Health Center Mental Health Services 2016-2017**

Dr. Annie Lewis O'Connor, Senior Nurse Scientist, Founder and Director of the Women’s CARE Clinic

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What Is Trauma?

- Racism
- Homophobia
- Xenophobia
- Bullying
- Sexual Harassment
- Micro-aggressions
- Abuse of Power and Control
- Community Violence
- Unconscious Bias
- Social and Behavioral Determinants of Health

- Historical and Structural Traumas
- Political/economic trauma across generations
- Adverse Childhood Experiences
- Interpersonal Trauma
- Individual Trauma
- Human Trafficking
- Domestic Violence
- Domestic Terrorism
- Sexual Violence
- Micro-aggressions
- Community Violence
- Unconscious Bias
- Social and Behavioral Determinants of Health
Six Guiding Principles of Trauma-Informed Care

Safety: Physical and psychological

Trustworthiness and transparency

Peer support

Collaboration and mutuality

Empowerment, voice, choice

Cultural, historical, and gender acknowledgment

Basis for Measurement—Return on Investment

- Increase access and engagement with primary care
- Decrease emergency department utilizations
- Decrease no-show rates
- Decrease length of stay
- Improve health outcomes (physical and behavioral)
- Measure the impact of tiered screening, trauma-informed care plans, and warm handovers
- Decrease compassion fatigue for providers, staff

Trauma Assessment and Inquiry

- How?
  - Disclosure is NOT the goal
  - Provide a safe environment for people to share as much or as little as they want
  - Minimize need to retell the story
  - Include education about trauma and its effects
  - Balance trauma with resiliency

Tiered Approach:

1. Broad Inquiry
2. Risk and Safety Assessment
3. Intervention


Strengths of the Approach—Challenges or Barriers?

Strengths
- Access to baseline data
- Institutional support
- Strong steering committee
- Research lab to develop an organizational tool assessment
- Process and outcome measures
- Funding

Challenges
- Shifting the paradigm—change in current practice
- Long-term funding to support tool development
- Utilization of all resources
- Sustainability


Patient's Total Health Care Utilization

- Medical Model of Care

Average Number of Visits

Service Utilized

Emergency Department
Incident Injury
Orthopedics
Primary Care
PT/OT

Lewis-D’Olamode, A. (2017). (N = 10)
Holly Austin Gibbs, Human Trafficking Response Program Director, Dignity Health

A Trauma-Informed Approach—Core Principles

Center for Health Care Strategies recommends changing organizational and clinical practices to reflect the core principles:

- Patient empowerment: using individuals' strengths to empower them
- Choice: informing patients about treatment options
- Collaboration: maximizing collaboration among health care staff, patients, and families in organizational and treatment planning
- Safety: developing health care settings and activities that ensure safety
- Trustworthiness: creating clear expectations with patients about what proposed treatments entail and how care will be provided


Implementing Change

How can YOU change your patient interactions to reflect the core principles of a trauma-informed approach?

- Patient empowerment
- Choice
- Collaboration
- Safety
- Trustworthiness

PEARR Tool

Dignity Health developed the “PEARR Tool” in partnership with HEAL Trafficking and Pacific Survivor Center. The PEARR Tool offers key steps to professionals on how to offer victim assistance to patients in a trauma-informed manner.

PEARR stands for:

- Provide privacy
- Educate
- Ask
- Respect and Respond

PEARR Tool: Download here:
dignityhealth.org/human-trafficking-response

Dr. Renée Ornelas, Tse’hootsooi’ Medical Center

Dignity Health Initiatives

Trauma-Informed Care and Services for Victims/Survivors

- Implementing a “Medical Safe Haven” in Dignity Health residency clinics to provide longitudinal care and services to identified HT survivors
- Implementing a “Domestic Violence Traumatic Brain Injury Program” in the Barrow Neurological Institute to provide care to survivors of DV/HT
- Partnering with Phoenix Dream Center to provide care to HT survivors
Integrating Cultural Competency

The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

—The Office of Minority Health, U.S. Department of Health and Human Services

An Approach to Integrated Care on the Navajo Nation

- Learn about the culture, language, traditions and customs.
- Make your space culturally welcoming and familiar.
- Be humble and honest about your status as a newbie to the area.
- Learn about “local” IHS/638 medical facilities, providers, and programs.
- Identify and partner with tribal and local organizations who provide services.
- Partner with traditional healers.

Tsé hootsooí Medical Center, Fort Defiance, AZ
Navajo Nation

Spiritual Healing
RESOURCES

PANEL 1: INTEGRATING PRIMARY AND BEHAVIORAL HEALTH SERVICES FOR TRAFFICKING SURVIVORS


